EDUCATING ADOLESCENTS ABOUT AIDS: A POLICY ANALYSIS OF AIDS EDUCATION PROGRAMMES IN KWAZULU-NATAL HIGH SCHOOLS

by

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Submitted in partial fulfilment of the requirements for the degree of Master of Arts, in the Department of Political Studies, University of Natal

Pietermaritzburg

February 1996

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ABSTRACT

This thesis is concerned with an evaluation of AIDS education in KwaZulu-Natal schools. Although HIV and AIDS affect all segments of the population and all age groups, prevention efforts aimed at the youth may be the most effective. HIV/AIDS is a disease most prevalent in the fifteen to thirty-five age group, and if we can decrease rates of transmission in people under twenty, we will save much money, pain and suffering in the next ten years. It is often seen as prudent to save young generations, rather than older ones, and this may be especially true in the case of HIV/AIDS, where HIV/AIDS in the younger, reproductive age groups leads to the very youngest group, that it, babies, being born HIV-positive. In addition, the younger generation may be more easy to save: they have not yet formed unsafe sexual practices, and educating them before they develop habits is easier than changing habits of the older generation.

I assessed various education departments' AIDS education programmes, based on the criteria of how well pupils are assisted in changing their unsafe sexual practices, or, if they are not yet sexually active, their attitudes towards sex, and on what type of message and ideal is presented about sexuality and sexual activity.

Judged by my framework, I found the existent programmes to be lacking. But this act of assessment allowed for a more thorough evaluation of AIDS education in the region to emerge, and from this, recommendations for AIDS prevention programmes to be developed: AIDS education must occur in the context of more general skills development, skills in negotiating sexuality and sexual relationships, and skills for the negotiation of life in the late twentieth century.

Innovative developments in the region, regarding AIDS and sexuality education teacher training, and the development of minimum criteria by which to set up and judge programmes, could be used as the basis for a sound AIDS education programme.

ACKNOWLEDGEMENTS

Many thanks are due to many people for assisting me, in one way or another, to complete this thesis. I mention but a few: Gavin Anderson, Francis Antonie, Ashika Buccas, Jean Dyson, Erna Kruger, Prof. Ralph Lawrence who was my supervisor, Crawford McCubbin, Ann Tothill, and Denyse Webbstock.

The financial assistance of the Centre for Science Development of the Human Sciences Research Council towards this research is hereby acknowledged. Opinions expressed and conclusions arrived at are those of the author, and are not necessarily to be attributed to the Centre for Science Development of the Human Sciences Research Council.

DECLARATION

Except where explicitly indicated to the contrary, this study is the original work of the author. This dissertation has not previously been submitted in any form to another university.

ABBREVIATIONS

AIDS: Acquired Immune Deficiency Syndrome.

ATIC: AIDS Training and Information Centre, the name that branches in most cities, including Durban, use.

ATICC: AIDS Training, Information and Counseling Centre, which is in Pietermaritzburg.

CDC: Centre for Diseases Control, USA.

DET: Department of Education and Training.

DNHPD: Department of National Health and Population Development.

HIV: Human Immunodeficiency Virus.

DDEC: House of Delegates' Department of Education and Culture.

IVDUs: Intravenous drug users.

KAP/B: Knowledge, attitudes, practice and behaviour, a shorthand term for what AIDS education should be aiming for, that is, a change in each of these areas.

KDEC: KwaZulu Department of Education and Culture.

NACOSA: National AIDS Co-ordinating Committee of South Africa.

NED: Natal Education Department.

PWA/s: Person/s with AIDS.

PREFACE

A fairy story

There was once a horrible old woman who had three teenage daughters. She was making a cake for Christmas once, and, as she did every year, she told her daughters not to touch it, that only she could make it and eat it. One day, she told them, they would be old enough to make it themselves. The three daughters often spoke about the cake-making business among themselves, and they longed to try it because they thought it sounded like great fun, and lots of other people seemed to think so too.

However, the first daughter decided to heed her mother's warning, and wait until she was older to make the cake. But she started thinking about the cake, and thinking about the cake, until she thought about it all day, every day, and it got so bad that she could hardly eat anything else, and pined away for a taste of it. Many years later, when she was old enough, she tried to make the delicious cake she had been dreaming of for so long, but it did not live up to her expectations, and she was terribly bitter and disappointed, and wept and wept. By that time her mother had died, and she had no-one to turn to for help in making the cake better. There was no-one around to ask, and she did not know how to change the cake and make it better by herself.

The second daughter decided she would go off and make the cake anyway, although she knew her mother would be very angry if she ever found out. She started making the cake, but of course did not know what to do, and she put in too much of that and too little of this, and she hurt her fingers in the mixing, and burnt her arm on the stove, and when the cake came out it was a terrible flop. Her mother found her in the midst of this disaster,

but by then it was too late for the mother to help: the cake was burnt and so was the daughter. The mother was so angry that the daughter had disobeyed her and made such a terrible mess in the kitchen that she made her leave home.

The third daughter also wanted to make the cake, but she knew what had happened to her sister. She was crying in the woods one day, when she heard a voice ask her what was wrong, and why she was so upset. She looked up, and saw that it was a kindly tree that had spoken to her. She told the tree the story about the cake, and her sister, and everything, and she felt greatly relieved just for having told her story. The tree listened, then offered some help. "I will tell you how to make the cake", said the tree, and immediately gave her some useful advice. The young girl rushed home, and while her mother was out, made a cake, very carefully following the tree's instructions. At last the time came when she could taste it, but when she did, it turned out to be not very nice, certainly not the wonderful cake she was expecting. She was about to burst into tears again when she remembered the tree's last words: "if you need any more help, just come and ask." She went back to the tree, and they talked about what she had done, and thought about where she went wrong. She went back home, and tried again, and this time the cake was a little better. She went back to the tree again and again, and asked more advice, and practised making cakes, and each time the result was a little better. At different times she tried a little more sugar, a bit less flour, longer beating, a drop of vanilla essence, until ..... finally she made a cake that was a bit different from her mother's, but she thought it was the best cake she had ever tasted!

And that, my friends, is the story of AIDS education.

CHAPTER ONE

Introduction

Acquired Immune Deficiency Syndrome (AIDS) appears to be a fatal condition, that tends to affect the younger segments of the population, those who are economically active, or have the potential to be so. For each person who dies of AIDS, a number of costs are incurred, and these include direct, indirect and non-monetary costs (Farnham 1995:68ff). Direct costs to the AIDS sufferer include medical care costs fro diagnosis and treatment of the disease, and costs to the state or society include costs for research, blood screening, prevention campaigns, and to maintain support structures, such as the Department of Health AIDS Units, or AIDS Training and Information Centres (ATICs). Indirect costs encompass the lost values of market and non-market output (that is, future earnings, and household activities such as cooking, cleaning and child-care, respectively), due to illness and death. There are also non-monetary costs to be included on the AIDS bill, which are defined as "the value that AIDS patients, their families and friends, and other members of society place on the suffering and death of AIDS patients" (Ibid.:69). Farnham does not mention the costs paid by caregivers, in emotional and physical stress, and opportunity costs of their leisure time which is taken up in looking after the sick patient. Almost all of the costs, of course, are difficult to quantify, but must be paid for in one form or another. For the reason of economics, and for the reasons of pain and suffering, the spread of human immunodeficiency virus (HIV) and AIDS must be curbed, or even stopped, although the latter seems unlikely.

And in South Africa, President Nelson Mandela claims that "according to current estimates

10 000 people in South Africa have fully-blown AIDS, while two million others have tested HIV-positive in the last five years" (Pan African News Agency 4.12.95: World Wide Web). Clearly, the cost to be paid are great, and with HIV spreading, they can only increase. Mandela goes on to say that most of those infected were women, youths and migrant workers. "Factors such as the status of women in society, child abuse, migrant labour, unemployment, lack of housing, illiteracy, sexual prejudice, discrimination in the work place and other settings have contributed, and continue to contribute, to the rapid spread of the virus in South Africa" (Ibid.).

What Mandela's words point to is that AIDS is a disease that flourishes among the poor, although this does not mean that the rich are immune. It is becoming increasingly clear that "the difficulties of surviving structural poverty and underdevelopment" (Preston-Whyte 1994:10) constitute structural constraints on behaviour change, and avoidance of HIV. The migrant labour system and break down of family life, single sex hostels, urbanisation, squatter settlement and the possible alienation that accompany them, all make for impermanent sexual liaisons. "Sex..... is often used..... as a means to 'transcend' the mundane and the daily struggle and to gain, however fleetingly, a sense of pleasure, comfort, intimacy and belonging" (Evian 1993:635ff). This, in combination with high levels of unemployment, poor housing, education and health care, and high levels of violence and crime in the country, contribute to the low priority safer sex[1] is given. Safer sex, as a means of lessening one's chances of dying from AIDS in ten years time, seems a meaningless

[1] Throughout this thesis I refer to 'safer', and not 'safe', sex in referring to AIDS prevention. This is because it has not yet been conclusively proven that condoms do act as a perfect barrier to HIV transmission, and because condoms are not a 100% safe contraceptive, and so cannot be said to be a 100% safe prophylactic to HIV transmission. Condom use, as well as a number of non-penetrative sexual activities, are thought to constitute safer sex.

activity in the face of immediate dangers and uncertainties that plague the lives of many South Africans.

All of these structural constraints require attention in the long term, as part of an ongoing development strategy for South Africa, and AIDS cannot be seen in isolation from these other problems. For this reason, AIDS prevention should 'piggy-back' on all other development initiatives, since they are mutually reinforcing: AIDS education without addressing structural constraints may be meaningless for the reasons outlined above, and development without AIDS education will also be meaningless if people are dying. Development strategies involve planning for the future, long or short term, and AIDS education should seek to do the same. Thus all efforts to improve the lives of South Africans should also include an AIDS education component.

This thesis, then, which is about AIDS education in schools, should be seen in the broader context of development, and I examine just one part of what should be a broad offensive against the disease. AIDS education and prevention should occur in as many ways possible, at as many levels as possible, and linked to as many development initiatives as possible.

However, the school AIDS education initiative, being as it is (or should be), just one part of the broader AIDS campaign, is an important one for a number of reasons. The first is that many school pupils are adolescents, and they are still negotiating their identity as adults, and their sexuality. Many have not yet formed unsafe sexual habits, and thus there is a better chance of instituting safer sexual practices among them than among adults, who are set in their ways.

The second is that, despite the cliché, children are our future, and it is imperative that we ensure their survival if South Africa is to have a future itself. The young girls of today are the mothers of tomorrow, and the higher the number of HIV-positive mothers, the higher the number of HIV-positive babies; protecting the youth from HIV also protects the next generation.

The third reason relates to general development in South Africa, where education is changing in structure, management and content, and there exists the chance that the level of education may improve for a majority of South Africans. AIDS education, then, should piggy-back on this new development. Positively influencing the education departments, to include serious and thorough-going AIDS education, has become a possibility in this time of flux and change. In addition, AIDS education may be further cemented by pupils' perceptions of having an improved chance of escaping poverty and meanness that comes with improved education.

A fourth reason relates to legal obligation of offering AIDS education. Strode and Small (1995) argue that we should take together the Interim Constitution, which states that "every person shall have the right to basic education" (Strode and Small 1995:1), the United Nations Convention on the Rights of the Child (to which South Africa is a signatory), which states that a child must have "access to information..... especially (that) aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health" (Ibid.:2), and the Children's Charter of South Africa, Article Eight of the education clause of which reads "(a)ll children shall have the right to adequate education on issues such as sexuality, AIDS....." (Ibid.:2). These three together lead the authors to conclude that AIDS education

is compulsory in South Africa.

Thus, in terms of writing a thesis, an investigation into what schools are doing in the way of AIDS education and prevention seemed to me an appropriate task to undertake. I have chosen to concentrate on policy, not because it necessarily offers any guarantees of a successful programme, but because a good policy must be in place if any AIDS education programme is to work, on a national or regional level. Without a policy AIDS education may be ignored altogether, or it may be sub-standard. Policy is drawn up by 'experts', with advice from a range of people in different fields, and their combined effort is more likely to be effective in educating adolescents about AIDS/HIV than the individual teacher concerned about the spread of the disease.

I tried to make contact with all education departments in (then) Natal, and to find out about the First AIDS Kit, released by the Department of National Health and Population Development (DNHPD): I met with varying measures of success. Firstly, the First AIDS Kit: it was difficult to locate, and information on who is actually using it impossible to find. Newspaper reports assisted me in identifying which schools were supposed to use it, and how it was developed.

Secondly, the KwaZulu Department of Education and Culture (KDEC) proved equally elusive: telephone calls to Ulundi went unanswered or unreturned, and finally a letter to the Director of Education, in June 1994, went unacknowledged. I found out from personnel in other education departments that nurses at the Edendale Hospital in Pietermaritzburg offered some AIDS education to schools in the area, and I tried to obtain any policy documents from

them. It turned out that there is a section called the Hospital Community Health Services, with an AIDS Unit attached to it. However, when I eventually spoke to a Sister from the AIDS Unit, in February 1994, she said that I had to obtain permission to speak to her about the AIDS education programme from a matron, and cautioned me not to tell the matron that I had already spoken to her, the Sister. On speaking to the matron, I was told that I had to speak to the Sister, to make an appointment with her, and it was never clear whether I would be able to see any documentation, or whether I would simply be able to speak to the Sister about her activities. It also became apparent that I would need a certain doctor's approval to investigate school AIDS prevention programmes, and permission from security guards to enter the gates of the hospital.

All of this came to naught, however, and eventually I gave up trying to track down and speak to all the necessary people: many phone calls that I made to the Edendale Hospital central switchboard were put through to the wrong section of the hospital, and I could not be transferred back to switchboard, and thus had to telephone again; when I did get through to the correct department, the person I wanted to speak to was, more often than not, out on other duties; the matron promised to try to speak to the Sister and the doctor, and intended to get back to me, but she did not do so.

From other sources I found out that KDEC also engages the services of a non-governmental organisation (NGO) called Dramaide, which is a drama-based AIDS education programme. There are ten Dramaide teams throughout KwaZulu-Natal and each team visits schools, and performs a play. The play is participatory one, where audience response and reaction, to some extent, inform the plot. The teams also run workshops about AIDS for pupils and

teachers, and encourage the schools to host an Open Day for the surrounding community, at which pupils perform songs, poetry and drama, all on the theme of AIDS and HIV. In 1995, the KDEC also gave funding to the publishing company Macmillan Boleswa, in order to bolster its AIDS education offerings. Macmillan had already produced booklets about various situations adolescents find themselves in, including relationships, and KDEC wished these to be augmented with teacher training workshops, and manuals, so that the teachers might get maximum benefit out of the booklets. As far as I know, both of these are in the process of being developed. I tried to obtain and peruse these books, but a local bookshop, the Provincial Library Service, and the Pietermaritzburg AIDS Training, Information and Counselling Centre (ATICC) were all unable to furnish me with one.

The contact I had with personnel in the third department, the Department of Education and Training (DET), left me with a sense of confusion. Initially, on telephoning the DET, I was put through to the PR and Communications Officer for the DET, but he was out of his office until the following week. When I eventually spoke to him, I was told that I had been misinformed, and that I should be speaking to someone else. I spoke to the second person, who told me that the DET has no policy around AIDS education, but that I should speak to someone from the regional DET office, and I did manage to get through to them.

In the regional DET office, I spoke to three different people on three occasions, and to two teachers in DET schools, and all five people told me different things. A member of staff in the DET office claimed that the DET uses booklets, produced by Macmillan Boleswa, for AIDS education, while another claimed that that is totally incorrect, the DET guidance syllabus contained a section on AIDS and sexuality education, and this was used in DET

schools. A third maintained that there is a new guidance syllabus, recently released by the Provincial Task Group (PTG), which is new structure, comprising members of all the (ex) education departments, and created to find common ground and reach consensus on syllabi, as a precursor to a single education department for KwaZulu-Natal. Neither of the teachers, though, had any knowledge of this new syllabus. But the major DET initiative in terms of AIDS education is in the form of teacher training, and I did manage to speak to the person who has conducted some of this training, and was lent the trainer's notes from the course. She is an ATICC employee, and the DET are working closely with ATICC on this training.

The Natal Education Department (NED) seemed efficient, and my dealings with them were trouble-free. I spoke to the Lifeskills Co-ordinator, Mrs Joy Frost, who also sent me a copy of the policy documents relating to management of AIDS/HIV in schools, and an example of a school's policy, policy documents relating to sexuality education in schools, and the "AIDS Teachers' Manual: An Education Module for the Secondary School which is Part of the Sexuality Education Programme". The House of Delegates' Department of Education and Culture (DDEC) was also efficient and helpful. I was told over the telephone that the DDEC has a two pronged approach, one for primary schools and one for secondary. For secondary schools the First AIDS Kit is recommended, and for primary, the DDEC has developed a syllabus for "Health and Family Life Education". I was asked to put my request for information in writing, and a few weeks later I received policy documents relating to AIDS and sexuality education in primary and secondary schools, and a syllabus of the "Health and Family Life Education". Thus my foray into AIDS education programmes in high schools also took me to primary schools, and I have included an evaluation of the Health and Family Life programme in this thesis.

Finally, I also attempted to ascertain the state of a single education department in KwaZulu-Natal, and its plans for AIDS education. This, it seems, may be some time in coming, although there have been meetings between syllabi experts from the (ex) departments, and PTGs have formed for various subjects. AIDS/HIV education, it is thought, will be subsumed under health and guidance. However, personnel from the (ex) departments have met, under the auspices of the National AIDS Co-ordinating Committee of South Africa (NACOSA[2]) KwaZulu-Natal, and a NACOSA Lifeskills Education Forum has been set up, which includes representatives from the education departments, as well as business, churches, NGOs and community-based organisations (CBOs). This forum has drawn up Minimum Criteria for AIDS and sexuality programmes, that includes guiding principles (code of ethics), aims and objectives, content, teaching methodology and evaluation. It is hoped that the NACOSA Minimum Criteria will become part of a single education department's AIDS/HIV education programme.

Thus, I had determined that there were a number of AIDS education initiatives in the region, all quite different. The DNHPD and the NED both offer teachers' manuals about AIDS education programmes, and the DDEC has developed a syllabus around Health and Family Life, of which sexuality is a part. There is the Dramaide initiative, and the Macmillan Boleswa books, offered by KDEC, a DET teacher training programme, and the NACOSA Lifeskills Education Forum Minimum Criteria. All of these go to make up AIDS education

[2] NACOSA began in 1991, when the ANC Health Secretariat indicated a willingness to discuss HIV/AIDS prevention with the DNHPD. The two organisations invited others to send representatives to be part of a steering committee - organisations included business, trade unions, churches and civics. After various processes and consultations occurred, a National Conference was held on 23 and 24 October 1992, with 442 delegates from 102 organisations (NACOSA Report 1992:3). One of the questions discussed at the Conference related to national, regional and local structures to co-ordination AIDS prevention. It recommended that regional 'mini-NACOSA meetings' be held (Ibid.:68), and following this, a NACOSA Lifeskills Education Forum was set up in KwaZulu-Natal.

in the region, (perhaps with the exception of NACOSA, since that is not implemented at all) and it was these that I set out to evaluate.

I assumed that the aim of any school AIDS education programme is to ensure that pupils remain HIV-negative, both while they are at school, and after they leave. Thus, the aim of this thesis is to evaluate what chance the various programmes have of keeping the school-going population HIV-free. In other words, schools should be attempting to change pupils' unsafe sexual behaviour, or develop and maintain safer behaviour in those pupils who are not sexually active. As a means of evaluation, I therefore chose to assess the programmes on the basis of two criteria, namely, whether the programme adequately incorporates the notion of changing a behaviour, and what they are attempting to inculcate in pupils as far as sexuality and sexual conduct go.

In terms of behaviour change, it is apparent that most people need more than information to motivate them to change their behaviour, and smoking cigarettes is a case in point: many people who smoke know the health risks it carries, but continue in their actions. Smoking could be said to be slightly different from sexual behaviour, in that nicotine is highly addictive, and the smoker may want to give up, but be unable, or at least find it very difficult; sexual behaviour, in any form, is not addictive. Over-eating, drinking too much alcohol, driving when drunk, taking other drugs, not taking adequate contraceptive precautions: all of these things are generally known to pose risks, yet we do not desist in them. I presumed that education departments were giving pupils information about HIV/AIDS transmission and prevention, but I wanted to know what else they were doing to assist pupils in changing their behaviours.

Similarly with sexuality, I wanted to know what message was being given in that regard. There are any number of attitudes towards sexual behaviour, especially teenage sexual behaviour, ranging from the conservative to the permissive, and probably beyond. I endeavoured to locate the school programmes somewhere on this spectrum, and in some way measure them against the actual sexual behaviour of South African youth, as a means of judging the relevance of the programmes to their audiences.

Part I, then, of this thesis, is a short history of the disease, starting in Chapter Two, with its discovery in the United States of America, investigations into its cause, the wrangling over its name and classification, and some of societal and state responses it elicited. This chapter also reviews some of the literature which suggests that AIDS is not caused by a virus, but by continued wearing down of the immune system, through over-use of prescribed and recreational drugs, as well as insanitary living conditions, malnutrition and under-nourishment. If this multi-factorial argument carries any weight, and I think it does, then other behaviour change, apart from sexual, must also be instituted. The value of this thesis is that it suggests that information alone does not change behaviour, and a more complex education process must be embarked upon to effect that change: that goes for changing sexual behaviour, as well as drug use or abuse, or poor eating habits (when people have the opportunity to change those). Chapter Three briefly outlines international patterns of spread of AIDS, and then offers a history of the South African situation, and some statistics on its present prevalence.

Part II examines the two criteria of assessment, that is, behaviour change and sexuality, on a theoretical level that is not related to school programmes. Chapter Four examines literature

relating to education initiatives that aim to change risk-taking behaviours, and this is found to be a complex phenomenon. Motivation to change a behaviour must first be supplied by the educator, and then people should be encouraged to overcome negative attitudes towards behaviour change, and specifically condom use, negative attitudes of their own, and of others. It is also shown that educators should be sensitive to cultural and gender sensibilities when attempting to modify behaviour, lest the prescribed behaviours are impracticable.

Chapter Five also partly examines theoretical literature, starting with literature on socialisation, written by self-declared feminist writers in the 1970s. Gender roles are shown to be one of the bases of our conception of the world, and upon which the family, child-birth and rearing, and the sexual division of labour are built. Indeed, gender roles have influenced our conceptions of sexuality, since, due to their socialisation, women are taught to be passive, and this passivity extends into the realm of sexuality. Freud, and other sexologists are examined to shed light onto the history of thought about sexuality: a biological determinism, and differences between boys and girls that are based in nature, are pre-eminent. Sexuality was thought to have natural and unnatural forms, called perversities, and it is the natural form that we are still taught to aspire to: heterosexual penetrative intercourse. This is combined with a Christian, or religious notion of the sanctity of marriage, and we are left with what I term a conservative notion of sexuality.

This chapter also outlines the changes that have occurred in the realm of sexuality, since the advent of the contraceptive pill, and more general ideas about the liberation of women, such that the conservative notion is challenged. Increasingly, sex is being seen as something anarchic, and not confined within any definable notion at all. This contradiction, between

what we are taught and what we feel, causes confusion, especially among adolescents. Finally, influences on teenage sexuality are detailed, both here and internationally, but literature and research on the South African adolescent situation is limited.

Part III contains the actual assessment of school education efforts, and an evaluation of the state of AIDS education in the region. Chapter Six presents detail of the First AIDS Kit, and I assess it using its own stated aims, and by my framework developed in Part II. Chapter Seven repeats this process, assessing the NED Teachers' Manual. Chapter Eight combines the other four programmes - DDEC, KDEC, DET and a single education department - although I do assess them each independently. The details of the latter three programmes are not sufficiently clear for me to assess them in the same manner as I did the First AIDS Kit and NED Teachers' Manual: none of them have clearly articulated aims, and none of them have a syllabus, or teachers' manual, or easily identifiable AIDS education processes, which I could assess in terms of my framework. The DDEC, although it has a fully fledged syllabus, is also something of an anomaly, because it is aimed at pupils in primary schools, rather than high schools. Thus Chapter Eight presents details on these programmes, and attempts to measure their worth, but not purely within the strict boundaries of my framework. This framework is used as a guide for these programmes' assessment, but behaviour change is not the aim of all of them, and hence my method seems somewhat inappropriate. These programmes, though, are useful in examining the state of AIDS education in the region on a more general level, and in indicating what should be taught in terms of AIDS education, which I do in Chapter Nine, and in shaping my ideas in the formulation of policy recommendations, which I present in Chapter Ten.

Ultimately, this thesis suggests that in order to remain HIV-negative, adolescents need lifeskills to communicate thoughts and feelings, to make decisions and carry them through, and to negotiate sexual interaction. Thus, AIDS prevention should be located within a much broader programme of lifeskills, that includes these skills and many others. Confining them only to AIDS education is to misunderstand how sexuality is integrated into life as a whole, and the skills we use in dealing with sexuality are the skills we use in daily life: the better we deal with people and relationships generally, the better we will deal with sexuality and issues of HIV/AIDS contraction.

CHAPTER TWO

The AIDS Epidemic in the USA

AIDS, Acquired Immune Deficiency Syndrome, is thought to be a relatively new disease, and as yet scientists know little about its epidemiology, although a short history of the disease will be useful in understanding some of the problems involved in trying to combat it. Randy Shilts, an American journalist, has documented the history of AIDS, from the late 1970s until 1985, in his book And The Band Played On (1987), and focused largely on the United States. Being an American this was an obvious choice, but it is also grounded in common sense. We will probably never know where AIDS really originated, but the USA played a major role in spreading the disease around the world: it was an epicentre, if not the epicentre. Shilts finds that in certain European countries where gay men were the first to contract the disease they had vacationed in the USA (1987:261ff), and some European countries, for example Britain and France, had imported blood products from the USA, which may have contained HIV-contaminated samples. An examination of the various mechanisms of denial and side-stepping, both on the part of society and government, could provide other countries with lessons from which they can learn. To this end I shall closely examine And The Band Played On by Randy Shilts[1], an extremely detailed account of the spread of the epidemic.

Chronology of Events

Shilts starts his tale (although this is not the beginning of the AIDS epidemic) with Dr Grethe Rask, a Danish surgeon, who worked in a remote village in northern Zaire from 1974 until

[1] This is a seminal work, and most other literature that mentions a history of AIDS refers to Shilts.

1976. She then moved to a Red Cross hospital in Kinshasa. She returned to Denmark in 1977, complaining of acute fatigue, her mouth was covered with yeast infections, her body lacked T-cells - those that initiate the body's immune response to disease or foreign bodies - and her breathing was increasingly difficult due to a progressive lung disease. Doctors were unable to save the woman because her body did not respond to treatments, and they were unsure what was slowly killing her. She finally died on December 12 1977 in Denmark, and an autopsy revealed her lungs were filled with millions of organisms known as *Pneumocystis carinii* which had caused a rare pneumonia that had in essence suffocated her (Shilts 1987:5ff). The interest in the mystery of her death died with her.

In 1980 in the United States, around June or July, a few doctors began to notice that some Chicago gay men were having health problems related to poor immunity (Shilts 1987:20), and over the whole year, we can see now with hindsight, there were increasing numbers of gay men diagnosed with *Kaposi's sarcoma*, or KS. This is a fairly benign cancer, usually confined to Italian or Jewish men in their 50s or 60s, that takes the form of flat, painless purple lesions on the skin. However, in gay men in the USA the cancer was deadly, or at least was part of a deadly disease, where the victim slowly wasted away in a painful death.

The first official report on the outbreak of KS was released in the Morbidity and Mortality Weekly Report, MMWR, the Centre for Diseases Control's (CDC's) official publication, on July 4 1981. Four weeks after this report there were already 108 cases nation-wide and 43 of those men were dead (Shilts 1987:87). This was over a year after the first case of the cancer was diagnosed, in a twenty-eight year old Air Canada airline steward named Gaetan Dugas, who had also had swollen lymph nodes for a year (Shilts 1987:22). The CDC set up

a task force to try to diagnose the strange disease, and they set about investigating all the sufferers they could find in New York, San Francisco and Los Angeles in mid 1981. They also uncovered the mysterious disease in some intravenous drug users (IVDUs) in New York; the drug users, however, did not come down with KS, but with *P. Carinii*, the lung disease that had killed Grethe Rask.

In December 1981, in Paris, Dr Jacques Leibowitch realised that there was an African connection, since he knew of two women, a Zairian and a French woman who had lived in Africa, and who had the pneumonia (Shilts 1987:102). "The Parisian case dated back 3 years before the first American patients.... Belgian doctors also had been seeing Pneumocystis cases from countries such as Zaire and Uganda for four years" (Shilts 1987:118).

Also in December 1981 Dr Arye Rubinstein, head of the Division of Allergy and Immunology at the Albert Einstein College of Medicine, Bronx, New York, realised that the immune disorders he had been seeing in children in the area were the same as those plaguing gay men in nearby Manhattan. The first case was in 1979, when a mother brought in her three month old child, suffering from immune deficiency. Of the subsequent children that Dr Rubinstein saw, many had mothers who were IVDUs, or were partners of IVDUs (Shilts 1987:103). By December 1981 there were 152 reported cases of AIDS, in fifteen states in America, although it was still unnamed at this time (Shilts 1987:106).

Despite evidence of the geographical spread of the disease and the fact that it had affected homosexuals, heterosexuals and children, the Americans named it GRID: Gay Related Immune Deficiency, early in 1982. On 19 March 1982 the CDC reported 285 cases of GRID

in seventeen states of America, and five countries in Europe countries had also reported the disease. Yet it seemed that this was still an unknown phenomenon, and the US government was still turning a blind eye. In June 1982 the first haemophiliac case was brought to the attention of the CDC, and a Morbidity and Mortality Weekly Report of July 1982 announced that GRID had been diagnosed in Haitian refugee communities. Finally, on July 27 1982 at a gathering of leaders of the blood industry, haemophiliac groups, the gay community and representatives from the National Institute of Health (NIH), the Food and Drug Administration (FDA) and the CDC, the disease was named AIDS - Acquired Immune Deficiency Syndrome - in recognition that it was not only confined to homosexual men (Shilts 1987:171).

By the end of March 1983 it was clear that the epidemic was taking different faces in different parts of the country. For example, in New Jersey gay/bisexual men were the minority of AIDS sufferers, IVDUs formed 42%, and a total of 68% of New Jersey AIDS cases diagnosed were in black or Hispanic people. "This proliferation of AIDS through the East Coast corridors of poverty heralded the start of the second AIDS epidemic in the United States, distinct from the epidemic in gay men" (Shilts 1987:261). In Europe as well it was becoming clear that there were two epidemics, one linked to Africa and one among gay men who had visited the USA.

In May 1983, an editorial of the Journal of the American Medical Association was reported on in the commercial press, an editorial that was later a source of denial and back tracking. The press reported that, according to the journal, there is evidence that AIDS can be transmitted through "routine household contact" to children and other family members (Shilts

1987:299). This meant that the general population was more at risk than previously believed and that people could get the disease at work, on public transport, in others' homes, at school, playing sport: in fact, anywhere. This one newspaper report caused great panic and gave credibility to ungrounded fears. It also justified, in many peoples' minds, the discrimination of gays, blacks and Hispanics. A few days later, face masks and rubber gloves were given to all in San Francisco police departments and firehouses. On the same day there was a hunger strike at a New York State prison because eating utensils had been used by an inmate who had died of AIDS. Days later, New York morticians discussed whether they should be forced to embalm AIDS victims, and other police departments also started clamouring for protective gear. "The second epidemic had begun - the epidemic of fear" (Shilts 1987:301).

Bathhouses, famous amongst the gay community, were identified by AIDS educators as high risk places because of unfettered sexual contact prevalent there (Shilts 1987:306), but a meeting in May 1983 between educators, gay political leaders and bathhouse owners to change the situation proved fruitless. Educators suggested that patrons be informed of ways to minimise risk of contracting the disease, but bathhouse owners claimed the educators were "sexual fascists" who were trying to stifle hard won sexual liberation, and gay people of the same opinion were apparently suffering from "internalised homophobia" (Shilts 1987:304). In June 1983 the Mayor of San Francisco ordered that the Department of Public Health must require health warnings about AIDS posted in bathhouses, which was duly done, but no health official ever went to check whether the task had been completed (Shilts 1987:317ff).

Blood bankers, too, denied that AIDS presented them with a problem, and claimed that there

was no evidence of transmission of AIDS through blood transfusions. They were technically correct, as were the bathhouse owners, who claimed there was no evidence of AIDS being a sexually transmitted disease, but Shilts argues that this technicality was something of a smokescreen for avoiding action. Action would have meant warning bathhouse patrons about the dangers of AIDS, or even closing down the bathhouses, and for blood bankers, testing all blood, and this, ultimately, would reduce profits. Indeed, at the end of May 1983, the Stanford University blood bank did decide to put each donation through the University's new Fluorescent Activated Cell Sorter machine to detect helper-suppresser cell ratios, evidence of AIDS infection, and this increased the price of each unit of blood: the privatised blood industries would not hear of it (Shilts 1987:301).

It was only later, in July, that blood banks introduced 'donor-deferral guidelines', a series of questions to assess the 'risk category' of the donor, claiming then that this made blood transfusions safe, as 'high-risk donors' were asked not to donate. This entrenched the idea that AIDS is confined to high-risk groups, and thus provided a perceived immunity for people who are not gay, or black, or IVDUs, and further justified stigmatisation and discrimination against those groups.

The first state AIDS education poster was released by the San Francisco Health Department in June 1983. Its message was to "enjoy more time with fewer partners" and " limit your use of recreational drugs", messages that could be criticised as wishy-washy since these are not sure ways of remaining AIDS free, they only (possibly) reduce the risk. Also in San Francisco, in July, the General Hospital opened Ward B5, the first AIDS ward in the country. San Francisco was the only city that had a concerted AIDS education programme.

By contrast, by the end of 1983, New York City's contribution to AIDS services and education equalled only $24 500, given to the Red Cross to provide home attendance to AIDS patients (Shilts 1987:380). By February 1984 the Gay Men's Health Crisis (GMHC), a body set up in New York in response to the AIDS epidemic, was turning away about half of the people seeking clinical services because of lack of resources (Shilts 1987:418). The entire New York education programme was run through the only gay newspaper, the New York Native, which had a circulation of 20 000 in an estimated gay population of 1 million. Thus AIDS education was only aimed at gay men, and only those who read the New York Native. The clear message from the health authorities, in the absence of any AIDS education initiated by them, was that AIDS is a 'gay issue'.

On May 31 1984 the number of AIDS cases diagnosed reached 4 615, one of whom was Rock Hudson, movie star and heart throb of many Americans (Shilts 1987:456). It was only when this fact hit the media later, just before his death in July 1985, that America really sat up and listened to the AIDS education messages, and when the media started to take the disease more seriously. Bayer and Kirp (1992) argue that although he was gay, many people took Rock Hudson's death to signal the possibility of AIDS actually affecting them, and the response was often panicky (Bayer and Kirp 1992:15).

The other phenomenon that Bayer and Kirp document is the issue of public schools. They became a focus of controversy, and resulted in the issue of discrimination against persons with AIDS (PWAs[2]) being raised. Parents acted to keep their children safe from the new

[2] Despite wishing to avoid using too many acronyms, I shall continue to use this one, PWA/s, as it is a recognised acronym in AIDS literature.

disease, and wanted those children who were HIV-positive to be kept out of school. There were actually only a handful of schoolchildren publicly involved, but the ensuing conflicts were widely publicised and rather dramatic. The CDC, in June 1985, convened a meeting of consultants to prepare recommendations on issues raised by the presence of HIV-infected children in a classroom. The CDC concluded that casual contact that would occur among school children appeared to pose no risks. But late in 1985 several school boards had succumbed to parental pressure, and barred HIV-positive, or HIV-suspected children from classrooms. In cases where the boards refused to take such action, parents organised boycotts, and in New York 10 000 children boycotted classes for a week, while parents marched with placards that declared "Our children want grades, not AIDS", and "Stop the lies: We want facts" (Bayer and Kirp 1992:15). It seemed that no-one believed the reassurances from the experts, despite the fact that in 1985 epidemiological evidence and understanding of routes of transmission rendered these actions and fears groundless. Similar concerns were expressed by employers and employees, and efforts were made to bar HIV-positive people from the workplace. This indeed echoes Shilts' "epidemic of fear".

Bayer and Kirp (1992) argue that the CDC was committed to anti-discrimination of HIV and AIDS sufferers. A report by the chief health officer, Surgeon General C. Everett Koop, "epitomised the opposition of public health officials to exclusionary policies" (Bayer and Kirp 1992:17). Koop stressed that casual contact of a non-sexual nature posed no health risk, and that HIV- and AIDS-infected people represented no public danger.

However, the federal government was not so progressive in its attitudes. In October 1985 the Secretary of Defence initiated mandatory testing of the armed forces, to exclude all HIV-

positive recruits. In 1986 the Foreign Service also started to exclude all HIV-positive job applicants, and in 1987 Congress endorsed the screening of immigrants for HIV and those found to be HIV-positive were denied residence in the United States. It was only in 1990, with the Americans with Disabilities Act, that civil rights protections to individuals who face discrimination in the public and private sectors were extended to individuals who are HIV-positive.

But discrimination, profiteering bathhouse owners and blood bankers, lack of state funding for AIDS education, and state discrimination against people who were HIV-positive were not the only controversies in the AIDS drama. The actual discovery of the virus - its isolation and cataloguing into a group of viruses - and the traditional processes and practices of medical science became bound up with personal and national gain, and was the cause of international strain between France and the United States of America. It is to that that I shall now turn.

Discovery of the Virus

Initially, when doctors began to notice that some gay men were showing problems with their immune systems, blood tests revealed that there were no T-helper cells, or that the count of T-helper cells was way below normal. There are two T-lymphocyte cells: T-helper cells, that activate disease fighting cells and give chemical instructions for creating antibodies that destroy microbial invaders; and T-suppresser cells, that tell the immune system when the threat has ended. Here there was a marked absence of the former (Shilts 1987:43).

Shilts (1987:193) notes that as early as October 1982 there was scientific gossip that AIDS

was caused by the Human T-cell Leukaemia Virus (HTLV), a theory that Dr Robert Gallo at the National Cancer Institute believed right up until 1984. The AIDS virus was initially thought to be like HTLV, but had the effect of killing off T-lymphocytes instead of causing them to proliferate, as with leukaemia. Dr Gallo had discovered in the 1970s that the enzyme reverse transcriptase is a marker or chemical footprint of a retrovirus, and he had previously done much work with a specific retrovirus, HTLV. Since AIDS was thought to be similar to HTLV, Gallo saw the AIDS virus as 'his area', in which he was the specialist.

However, in January 1983, Francoise Barre, a researcher at the Pasteur Institute in Paris, thought she had discovered a new human retrovirus in lymphocytes, because she had found evidence of reverse transcriptase, the enzyme that retroviruses secrete to enable their reproduction (Shilts 1987:229). Dr Luc Montagnier, also of the Pasteur Institute, was unhappy with Gallo's theory that AIDS was caused by HTLV, and when, in June 1983 he isolated a virus from the lymph node of a lymphadenopathy patient, and called it LAV - lymphadenopathy associated virus - he believed he had found a new retrovirus. He found similarities between LAV and a family of viruses called lentiviruses, primarily found in animals, that lie dormant in cells for a time and then "burst into frenzied activity" (Shilts 1987:319), in a similar manner to the AIDS virus.

The American scientific community and journal editors, however, were dubious of Montagnier's 'find', preferring to wait and see what Gallo came up with; Gallo, of course, backed his HTLV theory. The French were frustrated by the lack of interest shown in their work, especially when it was ignored at a conference of AIDS researchers, in America, in September 1983. By then, they had a blood test that was more accurate than the HTLV test

Gallo was using, and had done immunological work that defined how the virus attacked T-helper cells (Shilts 1987:371f and 380f). During this period Gallo was extremely uncooperative with the French, who were eager to pool ideas, and view and assist each others' work, and Gallo apparently spread rumours that their LAV results were simply a consequence of lab contaminants.

Recognition finally came to the French at another conference of AIDS researchers in February 1984, in Utah. Their explanation that LAV causes AIDS was taken seriously, and it also dawned upon people that the French had had this information for a year. Towards the end of February 1984 the CDC tested blood for LAV antibodies in blood samples of AIDS patients and the results showed an exact correlation between people showing signs of immuno-suppression, and those showing LAV antibodies. The French had discovered the AIDS virus (Shilts 1987:429). Later it was in fact found that Gallo's HTLV III (as he called it) and LAV are the same virus, although the French isolated it first. They were also more accurate than Gallo in their identification of it, because it was found that HTLV III does not come from the same family as the leukaemia viruses, as Gallo had surmised (Shilts 1987:444).

Yet the story does not end there. In April 1984, the Secretary of the US Department of Health and Human Services, Margaret Heckler, announced at a press conference that Gallo had discovered the cause of AIDS, and it was HTLV III. No recognition was given to the French. Shilts argues that because it was an election year, the Americans needed as much mileage as they could get from the issue (Shilts 1987:450). At the press conference Heckler declared that "today we add another miracle to the long honor roll of American medicine and

science" (Quoted in Caton 1994:44), and this announcement reassured the American public that the Reagan administration was doing its utmost (or at least more than any other nation) to fight the disease.

After the US Patent Office stalled on the Pasteur Institute's application for a patent on the antibody test, but granted the US Department of Health's application almost at once (made on the same day as Heckler's announcement), the French showed their anger. Heads of states, Reagan and Chirac, were eventually called in to form a settlement on the patent and royalties dispute (Caton 1994:47). Poor co-operation between the two countries meant that time was lost in the fight against AIDS. If the French had been believed earlier, then it is probable that the test would have been developed and used earlier, and that would have saved lives, especially in terms of blood transfusions. However it seems that Gallo was looking for fame and glory, and America wanted to be known as the nation which discovered the AIDS virus.

Lessons to be Learnt

The main message that comes through from Shilts' book, And The Band Played On (1987), is that many people in America were tardy, at best, in responding to the AIDS crisis. Researchers and medical personnel did not want anything to do with it, state funders were not convinced of the necessity of pumping money into research or prevention, until, of course, it became clear that there already was a full-blown epidemic. By then it was too late to shut the proverbial stable door.

An important factor in the slow response to the disease, as Shilts sees it, was that it affected

only gay men, at least initially. Shilts argues that competition over limited funding, very low numbers that were initially affected, and it being a gay disease, and therefore of low status, made researchers, federal and government funders, and the media reluctant to get involved in any way (Shilts 1987:172ff). Lack of state funding for investigation into the spread of the disease, for medical research into the virology, and for prevention and education campaigns allowed the virus to spread.

A memo of the 12 April 1983, from the CDC to the Centre for Infectious Diseases notes that "(t)he inadequate funding to date (from the government) has seriously restricted our work and has presumably deepened the invasion of this disease into the American population" (Shilts 1987:273). Another funding fiasco occurred when, in July 1983, the Assistant Secretary for Health, Dr Edward Brandt requested $35 million for AIDS research in the Public Health Service, and requested that this be given priority as "accelerated business". In response, the Secretary, Dr Margaret Heckler, publicly announced that, in keeping with her Administration's commitment to AIDS as its "number one priority", the government would increase AIDS education efforts by adding new staff to its toll-free AIDS hotline; she made no mention of added funds for AIDS research. Further, on the 6 December 1983, an Intergovernmental Relations and Human Resources Subcommittee report found that the Department of Health and Human Services had failed to respond adequately to the AIDS epidemic, and questioned both the federal government's preparedness for national health emergencies and the Reagan Administration's commitment to resolving the AIDS crisis (Shilts 1987:397). However by the end of 1990, "AIDS (was) primarily a disease of the socially marginal: gay and bisexual men, intravenous drug users, their sexual partners and their children", and the proportion of cases linked to heterosexual transmission remained low,

at approximately 6 percent (Bayer and Kirp 1992:11). This gives some clues as to the reasons for the tardy response.

Education around the disease also got off to a slow start, and again, this could be argued as evidence of latent homophobia. In mid 1981 some people at the CDC had pieced together that there was a (retro)virus that could be spread sexually and was causing immune deficiencies in gay men. The New York Native had already published a story on the rumours circulating about this, but the CDC liaison with the local public health department had claimed the rumours to be unfounded (Shilts 1987:67). This meant that education around sexually transmitted disease was avoided, and the state was let off the hook, until more scientific proof could be mustered.

It was only in 1983 that prevention and education about the disease became an issue, as it became clear that "(h)ere we are working on people who are already sick, people for whom it is too late" (Shilts 1987:248). The gay community in San Francisco started their own education campaigns, feeling they could not wait for the state. They were a politicised community, and education campaigns were something they had tackled before, mainly through the use of target mailing and distribution of brochures. "We'll get the message out about safe sex, and repeat it and repeat it until it sinks in" (Shilts 1987:254). However, unlike previous campaigns, information proved insufficient in this one. A survey of 600 gay men in San Francisco done in mid March 1983 showed that gay men knew what put them at risk for AIDS, but 62% still engaged in high risk sex as often or more often than before they had found out about AIDS (Shilts 1987:260). Although many had changed some behaviour, "only a minority had entirely eliminated all behaviour that would put them at risk

for contracting AIDS" (Shilts 1987:415).

Of course, 'the gay community' is not an homogenous group of people, and by October 1983 there was evidence of collective action on the part of some sectors of the gay community in San Francisco (Shilts 1987:376f). A concern over the disease caused a major behavioural shift, and due to the close knit nature of those sectors, the message reached substantial numbers very quickly. Non-sexual alternatives to bathhouses thrived, with alcohol-free evenings of Trivial Pursuit, bingo and canasta, Jerk-Off clubs and parties, videocassette recorders allowed for easy access to gay erotic or pornographic movies, as the 'solo alternative', and telephone sex services also prospered. "This new toned-down gay life-style had started as a vogue in early 1983; by the end of that year, it was a trend; in the year that followed, it would turn into a full scale sociological phenomenon" (Shilts 1987:377). This, of course, gathered momentum as the numbers of AIDS sufferers increased, and more and more gay people knew someone who had died.

So one of the first lessons to learn from predecessors in the AIDS battle is that information alone does not cause people to change their behaviour. There must be some extra motivational factor at play, or people must see benefits from behaviour change. The AIDS epidemic came at a time when gay pride was reaching new heights, and gay liberation, (or at least a reversal of homosexual discrimination) had been a hard won battle. If one's identity, that is, being gay, was so strongly linked to one's sexuality, then an assertion of one's identity and individuality perhaps meant an assertion of one's sexuality.

> Gary Walsh had a far less complicated view of gay sexuality. A passionate devotee of sexual liberation, Gary believed that promiscuity was a means to exorcise the guilt and self-alienation ingrained in all gay men by a heterosexual society clinging to obsolete values of monogamy....Life was for learning... and sex was as legitimate a learning tool as anything else. (Shilts 1987:89.)

In another example of identity being linked to sexuality, Gaetan Dugas, the Canadian airline steward who was thought to have been key in the spread of the disease, "confided rather proudly.... he had 250 sexual contacts a year. He'd been involved in gay life for about ten years and easily had had 2,500 sexual partners" (Shilts 1987:83). Indeed, to stop sex or to change sexual habits meant to stop being gay, or to change the very identity one had won. Thus there were few perceived benefits to changing sexual behaviour.

But on the other hand, the gay community teaches us about the value of community action. Once the safer sex message started to catch on, it spread rapidly, because each sector of the community is so close-knit. And because of this closeness, it later seemed that everyone knew someone who had died from, or was dying from the shocking and undignified AIDS death - being unable to breathe, thrush in the mouth and thus finding eating difficult, dementia, wasting away, being bed-ridden. This may have been the motivational factor that gay people needed to change their behaviour, but a strong impetus also came from the community itself, in the form of a culture of condoms. In some gay circles now, it is completely unacceptable not to use condoms, or practice other forms of safer sex, and these community sanctions are strong. This is an important lesson for South Africa, where community action could also serve as a strong educational tool.

Bayer and Kirp (1992) argue that the American bathhouses marked the meeting of the old and the new. They suggest that public health officials were restrained by liberal values precisely because sexual privacy was a major concern, and particularly to the gay community (homosexual acts were still illegal in twenty-four states, and it was only in 1973 that the American Psychiatric Association had deleted homosexuality from its classification of mental

disorders). Also the cities where AIDS was centred and where the bathhouses took on greatest significance, that is San Francisco and New York, were cities with political cultures of tolerance and where sexual privacy was deemed a pre-eminent concern. There was nothing unusual in the decision to close the baths, when seen in an historical perspective of attempting to control the spread of infectious diseases. However what was remarkable was the circumspection with which it was done, and the respect that was shown to that private realm. "The closing of the baths could thus be seen as reflecting both the traditional orientation of public health and the exceptionalism that characterised AIDS policies in the epidemic's first decade" (Bayer and Kirp 1992:21).

I would argue that this disease challenges the dearly held boundaries of public and private. The fact that sex lies in the realm of the private, the realm of 'acts between consenting adults' and therefore not the business of the state means that making policy becomes that much more difficult. The gay community was reluctant to have 'their' domain, the bathhouses, interfered with by the authorities, and the authorities in turn were reluctant to interfere: both had a clear liberal notion of the private as sacrosanct from state interference. Yet unsafe sexual behaviour becomes a public issue if HIV is transmitted, since the state may become responsible for health care, and this blurring of the boundaries is not acknowledged. Reluctance to act, on the part of the American Health authorities, probably increased the spread of the disease. A similar thing could happen in South Africa: if the government, or school education authorities, are not prepared to debate the private-public distinction in this instance, and tell people, particularly adolescents, that anything other than safer sex is unacceptable, the disease could escalate.

In summary, what I have argued here is that in the United States AIDS was constructed as a gay disease, despite the fact that Hispanics, children and IVDUs were also dying from a malfunction of the immune system. This further entrenched the discrimination directed at gays, and later, blacks and IVDUs, and created a second epidemic, one of fear of contracting the disease through casual contact, and stigmatisation of HIV-positive people. Funding from federal, state and local governments was not forthcoming to the extent it was needed, both for education and medical research, because AIDS was a 'low status' disease. In terms of education, although many people knew about AIDS, and believed it to be a fatal sexually transmitted disease, they did not change their behaviour. Information alone is not enough to convince people to change their behaviour, and further motivation is required. Seeing people die or knowing someone who has died may be one such motivation, and community-wide action around a culture of condoms may be another. Finally, action around preventing AIDS was slow in getting started, and this may have been fuelled by traditionally liberal values of clearly defining the public and private domains in terms of approved governmental action. This liberal notion, however, may have contributed to the spread of the disease.

The story so far is still not complete. It assumes that AIDS is a new disease, whose origins are unclear, and which develops along the lines of the virus-AIDS theory. This theory suggests that HIV is transmitted through bodily fluids and infects the new host. It produces an antibody reaction, which is the basis of the 'AIDS test'. The virus then remains dormant for ten or eleven years (this figure is lower for Third World countries), and thereafter kills off millions of T-cells which usually initiate the body's immune response. Hence the body falls prey to AIDS, that is, opportunistic diseases, some of which are usually quite harmless, and which the body could fight off under normal circumstances. However, this HIV-AIDS

causality is being disputed by a growing international force, centred around the Group for the Scientific Reappraisal of the HIV/AIDS Hypothesis (which has over 300 members), which is questioning the virus-AIDS theory, and postulating instead the drug-AIDS hypothesis. It is to this new AIDS controversy that I shall now turn.

Does HIV cause AIDS?

There are flaws in the virus-AIDS theory: for example, the actual mechanism of how HIV destroys the immune system is unknown. Dr Robert Gallo first suggested that the HI virus replicates rapidly in the body by entering T-cells, and using the cell's DNA to replicate itself and destroy its host cell. But this is no longer thought to be the case because HIV is present in only 1 out of 500 T-cells during AIDS (Duesberg 1991:1575), hence HIV is not destroying large numbers of T-cells.

A second flaw is that there is an imperfect correlation between HIV and AIDS (Thomas *et al* 1994:19). This means that there are people who have the diseases or syndrome associated with AIDS, but are HIV-negative in a test, and those who are HIV-positive, but have lived for eleven years without deterioration to their immune systems (Thomas *et al* 1994:21; Duesberg 1992:5; Caton 1994:115). Indeed, Duesberg found 4 621 cases of AIDS without HIV recorded in the literature (Thomas *et al* 1994:20). "HIV was confirmed up to 1989 in only about 73% of all American AIDS cases, and in only 39% of the AIDS cases from New York and 61% from California" (Duesberg 1991:1577). Thomas *et al* (1994) also make the point that the HIV-AIDS correlation is almost inevitable, because AIDS, by the CDC's definition, can only be diagnosed when a person suffers from one of about 30 AIDS indicator diseases, and has a positive HIV antibody test. (See also Papadopulos-Eleopulos and Turner

1994:3.) Thus a person who has the disease(s), but does not show up positive in a test will not be registered by the CDC as an AIDS case.

A third hole in the virus-AIDS theory is that the predicted massive numbers of infections and deaths due to AIDS have not happened. New infectious diseases generally spread exponentially in susceptible populations up to a certain saturation point, but in the United States "AIDS has since 1987 claimed only about 30 000 or 0.03% per year from a reservoir of over 100 million sexually active Americans", while over that same period STDs have increased in frequency (Duesberg 1992:4). This is evidence to suggest, according to Duesberg, that the HI virus is not new, but has been in the human population for some time and has reached some kind of stability in the USA. Further questions arise when one considers that distributions of STDs are approximately even between the sexes, but 95% of American AIDS is found in males (Duesberg 1992:4).

"If AIDS is caused by HIV, the ratio of infected to diseased carriers should be similar in different countries. However, in the United States about 10% .... of the 1 million HIV-positive have developed AIDS since 1985, but in Uganda only 0.8% .... and in Zaire only 0.15% .... (have developed AIDS)" (Duesberg 1991:1576). Duesberg also notes that "distinct AIDS risk groups have distinct AIDS diseases": homosexuals tend to develop Kaposi's sarcoma, IVDUs get tuberculosis (TB), crack (cocaine) smokers get pneumonia and AZT users often develop leucopenia, anaemia, lymphoma and nausea (Duesberg 1992:5). All of this suggests that there is no common infectious cause of AIDS.

An alternative to the virus-AIDS theory is postulated by Duesberg in the form of a drug-

AIDS theory. This suggests that HIV is a virus that has been around for a long time, and other factors, namely drug intake and immune suppression due to unhealthy or unsterile living conditions, contribute to the break down of the immune system. Duesberg offers the idea that there is a coincidence of chronology between the AIDS and recreational drug epidemics, in that the use of psychoactive and aphrodisiac drugs greatly increased in the 1960s and 1970s, and continued escalating into the 1980s. He cites studies that show that 32% of AIDS patients in America come from groups that use intravenous drugs, and 60% are 20-44 year old male homosexuals who come from groups that use psychoactive and aphrodisiac drugs (1992:6ff). He argues that American AIDS is prevalent in 20 to 44 year old men, (72% of patients fall into that category) because that age group consume 80% of hard psychoactive drugs (Duesberg 1991:1578). Frequent use of psychoactive drugs in the 1960s and 1970s could have caused break downs in immune systems seen in gay men in the early 1980s.

He argues that there is evidence to suggest that HIV-positive people who use these drugs develop AIDS, while those who do not use them remain healthy. Studies have shown between a 69% and 100% correlation between use of nitrates ('poppers', seemingly the preferred and frequently used drug of American gays) and the development of KS. Similarly, "(t)he incidence of AIDS diseases among 297 HIV-positive, asymptomatic intravenous drug users over 16 months was three times higher in those who persisted than in those who stopped injecting drugs" (Duesberg 1992:7). AZT[3] is also classified in the harmful drug category, and Duesberg argues that AZT speeds up the onset of AIDS diseases, and actually kills off

[3] AZT is commonly prescribed for HIV-positive people in the USA and elsewhere, as a means to delay the onset of AIDS.

the immune system. AZT originated as a treatment for cancer, which causes a proliferation of cells, and was aimed at controlling the cancer by killing off cells; it is also supposed to control AIDS by killing off HIV-infected T-cells. However only 1 in 500 T-cells is infected with HIV in AIDS patients, and hence "it kills 500 uninfected cells for every infected cell. Thus AZT is inevitably toxic, killing 500 times more uninfected cells than infected cells" (Duesberg 1992:9). "Ten out of 11 HIV-positive AZT-treated AIDS patients recovered cellular immunity after discontinuing AZT .... suggesting that AZT was a sufficient cause of immuno-deficiency" (Duesberg 1992:8).

On the other side of the coin, AIDS diseases are evident in HIV-negative people who use drugs for a sustained period. Among 86 IVDUs in New York who died of AIDS indicator diseases, HIV was found to be present in only 40 of them. Lymphadenopathy, weight loss, fever, night sweats, diarrhoea and mouth infections were seen in 49 out of 82 HIV-negative and 89 out of 136 HIV-positive long term IVDUs, again from New York (Duesberg 1992:8). "Thus the long-term use of recreational and anti-HIV drugs appears necessary in HIV-positives and sufficient in HIV-negatives to induce AIDS indicator and other diseases" (Duesberg 1992:8).

HIV/AIDS in Africa takes a different form to that of the USA and Europe, in that it afflicts women, in equal or greater numbers than men, and children, to whom it is transmitted *in utero*, during birth, and possibly through breast milk. Diagnosing AIDS is not the same in Africa as it is in the West, where a positive HIV test, and one or more AIDS indicator diseases must be present. This is because it is recognised that many antibody tests may show a false-positive in Africa, because of the presence of 'possible cross-reacting antibodies'

(Papadopulos-Eleopulos and Turner 1994:3). Hence in 1985 the World Health Organisation (WHO) decided to define African AIDS in another way. There is no antibody test, or a list of specific diseases associated with AIDS: it is diagnosed in the presence of symptoms such as weight loss, diarrhoea, fever and persistent cough for over a month. However these are symptoms associated with any number of diseases, and which were common in Africa long before AIDS was discovered. According to this theory, the development of AIDS from HIV, caused by drugs in the First World, is caused by "protein malnutrition, parasitic infections and poor sanitary conditions" in the Third World (Duesberg 1992:10).

False-positive tests seem to have a high possibility in Africa. The HIV-antibody test, that is, the AIDS test, "relies on the presence or absence of reactions between antibodies present in the patients' blood and certain proteins which are believed to be unique to HIV" (Papadopulos-Eleopulos and Turner 1994:6). However other microbacteria (for example, malaria, TB, leprosy and parasitic diseases, such as malaria, trypanosomiasis and filariasis) may cause the production of antibodies, thus giving a false-positive result. "In other words, in Africa, a positive HIV antibody test does not necessarily mean HIV infection but is due to a reaction of 'HIV proteins' with a plethora of non-HIV antibodies present in the blood of Africans" (Papadopulos-Eleopulos and Turner 1994:8).

The WHO definition also states that a patient should be considered an AIDS case only "in the absence of known causes of immunosuppression such as cancer or severe malnutrition or other recognised aetiologies" (Papadopulos-Eleopulos and Turner 1994:5, citing WHO (1986) "Acquired Immunodeficiency Syndrome (AIDS): WHO/CDC Case Definition for AIDS" in Weekly Epidemiological Record. 61. pp69-76.). However, general living

conditions for many Africans may include malnutrition and a lack of medical services leading to diarrhoea, tuberculosis and fevers, all of which can lead to immune deficiency, and these are not considered when making an HIV diagnosis.

The international medical profession has not responded well to the suggestion that AIDS is induced by toxin overload and immune suppression brought about by psychoactive and anti-HIV drugs. One reason given for this lack of reception is that the press conference, called by Dr Gallo and Health Secretary Margaret Heckler to announce that he had isolated HIV and found the cause of AIDS, was held before Gallo had published his findings in any scientific journal. Caton explains that there is a ban on publicly announcing research findings before they have been published in recognised journals, firstly because other scientists cannot comment on research that they have not seen, and secondly because it causes scientists "to see in the articles what the media have acclaimed" (Caton 1994:44). At the same occasion, Margaret Heckler proudly proclaimed a victory for America, (and thus tried to silence those who criticised the Reagan Administration for doing too little to stop the disease), while at the same time she set the agenda governing the allocation of funding. After that, the "research agenda was set in concrete, and sceptics were treated as enemies to be ignored or punished" (Thomas *et al* 1994:23). Critical voices were ignored, despite the fact that the National Cancer Institute (NCI) had another plausible explanation relating to drug use and viral overload of immune systems. A national sigh of relief was breathed: to an American public trusting in the 'miracles' of modern science, the discovery of the virus meant that a cure or vaccination would soon be developed.

In the meantime, the NCI had held a workshop in September 1981 to discuss KS, until then

found in less than twenty men. On examination of the cases they had found what they believed to be a number of reasons for diminished resistance, or immune suppression in these men. They had all had numerous sexual partners, and had "infestations common among fastlane gay men....this was the 'viral overload' hypothesis" (Caton 1994:32ff). All the KS victims had also used nitrates, the heavy use of which "was known to cause severe symptoms and immuno-suppression". They all had "anorectal mucosal trauma", damage of the anus caused by penetrative intercourse, which allows semen to enter the bloodstream: 'foreign' semen is immunosuppressive. Finally they were also all "on heavy antibiotic medication to contain their infectious diseases.....unaware that antibiotics are immunosuppressive" (Ibid.:32ff). The NCI thus suggested a multi-factorial model of AIDS.

The CDC had previously conducted a hepatitis B study on 7 000 gay men, but had found none with KS. The novelty of AIDS lead them to believe that there had to be a new infectious agent causing immune-cell destruction. Further, Don Francis, "architect of the CDC position", had "training as a viral epidemiologist (which) made him impatient of the fuzzy causality of the multi-factorial model. Viral causality by contrast is clean and geometrical: one virus, one disease" (Caton 1994:34). Francis's doctoral thesis was on retroviruses, and he supported a viral cause of cancer. In defining AIDS as a viral disease, the CDC ignored the evidence about nitrates, and the fact that the NCI had proven untrue that the men who had AIDS had 'no known cause for diminished resistance'. "It now seems clear that the CDC engaged in .... 'unprincipled actions'..." (Caton 1994:35).

Caton points to other chicanery, starting with Gallo claiming to have identified the HI virus, when in fact French scientists at the Pasteur Institute did. Gallo also tried to patent the AIDS

test. A report, in June 1994, from the Inspector-General of the US Department of Health and Human Services claimed that "Gallo obtained his patent by unlawfully concealing relevant information from the patent office attorney; that he admitted this unlawful act; that Pasteur scientists were first to discover the AIDS virus, to isolate it successfully from several AIDS patients, to describe it in a scientific article, and to use it to make a diagnostic blood test for antibodies to the AIDS virus" (Caton 1994:47). Caton argues that the whole process of AIDS research is clouded in misrepresentations of 'the truth' and, as a doctor, who was at the Pasteur Institute at the time of the Heckler press conference, said "'The cause of AIDS was discovered by government fiat.....from that point on AIDS research turned into seedy, criminal politics, and it remained that way'" (Caton 1994:45).

Journals have refused to print articles challenging the orthodox version of things; Gallo and his team have refused to respond to Duesberg and his allies; Duesberg is considered part of a loony fringe and spoken of with derision. All of this may be part of the scientific world where funding battles loom large, but the point to make is that "as HIV scientists grow ever more confused about how the virus is supposed to be causing AIDS, their refusal to consider the possibility that it may not be the cause is as rigid as ever" (Thomas *et al* 1994:20). The scientific method of investigating all avenues, trying and testing all possibilities has been waived here, it seems. "Faced with what they said was the gravest health crisis of the century, the AIDS establishment did not do what rational method would seem to suggest: to investigate the alternative hypotheses with all vigour" (Caton 1994:17). The reason? Funding, prestige, and, Caton argues throughout his book The AIDS Mirage, modern medicine's obsession with a 'fix it' paradigm, a 'cure all illnesses' report card, and a movement towards immortality. A cure or a vaccine would herald a major triumph for science, and this

is what is sought, rather than a preventative paradigm, which would involve people desisting from drugs and antibiotics. One could also speculate about the role that drug companies, such as Burroughs Wellcome, producers of AZT, have played in propagating the 'myth', considering Burroughs Wellcome's 1990 annual report showed sales of $284 million (Duesberg 1991:1578).

I would argue that AIDS is likely to be multi-factorial, that is, caused by a number of factors, and not simply by one virus: certainly, poor living conditions are important, in that they assist in the weakening of the immune system. What is important in the alternative hypothesis is that it suggests that policies relating to AIDS education, if based on orthodox medical texts, may be inaccurate. If AIDS is multi-factorial then AIDS education must also seek to address the other factors, be they using recreational drugs, relying heavily on prescribed drugs, or simply living a life of poverty and meanness. If the virus-AIDS theory is true, then the benefits of a broader education campaign are clear - stopping abuse of drugs, and improving people's quality of life are ideals in themselves, irrespective of their link to AIDS. It is in chapter four that I examine the phenomenon of behaviour change, and motivations, seen to be important in the example of the gay community in this chapter, and skills required to convince someone of the necessity of making a change, as was suggested by reactions of the gay community to the disease, as outlined in this chapter. However, before I get there, the next chapter briefly details the development of the South African AIDS epidemic, societal and state responses, and also offers some idea of its prevalence, through official statistics and figures.

CHAPTER THREE

AIDS in South Africa

In the United States of America, AIDS was primarily seen as a disease affecting gay men, although there was evidence to the contrary as early as December 1981 (Shilts 1987:103), and it has been argued that that was one of the reasons that the American state response was so tardy: the gay population did not constitute a high priority constituency (and nor did the other groups AIDS was associated with: IVDUs, Hispanics, Tahitians), except in those cities where there is known to be a large gay population, namely San Francisco and New York. In South Africa, too, the governmental response to the AIDS epidemic was slow, and society's response was virulently anti-homosexual. I shall outline both of these responses in this chapter, as well as the new Government of National Unity's response, but first it is useful to look at AIDS as an international phenomenon, and indicate how South African AIDS is different from that found in the First World.

It is widely recognised that AIDS follows certain patterns of transmission around the world, although it is unclear exactly why this should be so. Some people have argued that there are different strains of HIV, those being HIV-1 and HIV-2, which are transmitted in different ways, but this has not been confirmed by medical science. However, the World Health Organisation (WHO) has developed a global classification of HIV and AIDS epidemics, in terms of dominant patterns of infection, that is, whether spread is mainly homosexual or heterosexual.

Pattern I, then, is found in the developed world, including the USA. Here HIV spread extensively between the late 1970s and early 1980s, and was largely restricted to homosexual or bisexual men, and intravenous drug users (IVDUs), as the American example shows. Control over blood transfusion infection was achieved in about 1985, and thus transfusions do not present a threat of HIV to recipients, except in a small minority of cases[1] (Smallman-Raynor *et al* 1992:30). WHO estimated that in mid-1988 there were approximately 1.5 to 1.8 million infections of this type in the world, or 150 infections per 100 000 population, and that constitutes 25-35% of the global total of AIDS cases (Ibid.:31). Adult males between the ages of 20 and 54 dominate this pattern of infection, forming 81% of all AIDS cases, while females comprise only 10%: the male to female ratio is 6.5:1 (Ibid.:31). Paediatric AIDS is very limited in this type of transmission.

Pattern II, found mainly in sub-Saharan Africa, began spreading in the late 1970s. Transmission is through heterosexual sexual contact, and the male to female ratio is 0.9:1 (Ibid.:32). However, although South Africa does not fit into Pattern II, it is still primarily heterosexually transmitted here, and Abdool Karim (1992) has shown that in 1990, in some rural areas of South Africa, the ratio was much further from parity, and lay at 0.25:1 (Abdool Karim 1992:24). WHO estimates that there are 2.5 million infections of this type, that is, 420 infections per 100 000 population, and making up 40-50% of the global total (Smallman-Raynor *et al* 1992:32). The peak in distribution is in the age group 15-54 years, and females dominate the younger of these age brackets. As a consequence children below the age of 5 comprise 9% of AIDS cases, due to perinatal transmission (Ibid.:32).

[1] Despite screening blood donations, it is thought that HIV can be transmitted to blood recipients if, at the time of the donation, the HIV-positive donor is in the window period, that is, the time before the body produces anti-bodies to the virus. Thus blood will be tested for HIV, but (falsely) show a negative result.

Pattern I/II, meaning a change from Pattern I to II, is found in Central and South America, and the Caribbean Basin. Here Pattern I was initially the dominant mode of transmission (homo/bisexuals and IVDUs), but during the 1980s it changed to Pattern II. By 1987 heterosexual AIDS cases were in the majority of those reported in these areas, and the male to female ratio was 2.8:1 (Ibid.:32). WHO estimates put the figures at 0.8-1.0 million infections worldwide, 200 per 100 000 population, and 13-20% of the global total (Ibid.:32).

Pattern III, covers the area of most of Asia, Oceania (excluding Australia and New Zealand), North Africa and Eastern Europe. There the spread occurred in the early to mid 1980s, but because AIDS is a more recent phenomenon here than in other parts of the world, transmission categories have yet to form well defined patterns. However WHO figures for this geographical area are estimated to be only 100 000 infections, or 4 per 100 000 population, comprising 2% of the global total (Ibid.:32).

Pattern I and II is unique to South Africa in that initially there was a Pattern I spread, in the early 1980s, where AIDS was largely confined to (white) homo/bisexual men, and this continued throughout the 1980s. Pattern II, AIDS in (black) heterosexuals became apparent in 1987, and probably started spreading in the mid 1980s. Prior to 1987 sexually transmitted cases of AIDS were almost always reported in homosexual or bisexual men; however, from 1987 onwards the proportion of sexually transmitted AIDS cases attributed to homo/bisexuals began to decline, while heterosexual transmission increased rapidly. The point must be made that this is not an epidemic transition, but an advancement of the disease separated along racial lines: homo/bisexuals account for 90% of sexually transmitted cases in whites, and from the first black case in 1987, heterosexually transmitted cases were almost exclusively

found in black people (Ibid.:316). "In the South African epidemic, the homosexual/intravenous drug use and heterosexual transmission routes are socially divorced and are progressing together" (Ibid.:315). Sher and Christie, two South African writers, concur with this view of racial bias in the two different patterns, but both state that in the next few years it will change to be predominantly Pattern II transmission (Christie 1991:23, and Sher 1992:56).

Table 1A summary of WHO figures/estimates of worldwide AIDS cases (mid 1988)

Pattern	Geographical area	HIV Infections (millions)	Number per 100 000	Global %	Male: female ratio
I	USA,Europe	1.5-1.8	150	25-35	6.5:1
II	Sub-Saharan Africa	2.5	420	40-50	0.9:1
I/II	Central and S America, Caribbean	0.8-1.0	200	13-20	2.8:1
III	Asia, Oceania, N. Africa, E. Europe	100 000	4	2	Not known
I and II	South Africa	-	-	-	-

1991 figures from the South African Institute for Medical Research (SAIMR) confirm the Smallman-Raynor (*et al*) suggestion of racial bias in patterns of spread, where black homosexual, and white heterosexual cases are limited in number (see Table 2).

Later data, including 1995, also shows that as a percentage of the total AIDS cases, homosexual transmission is declining in importance, while heterosexual transmission is increasing: in 1988 73% of all AIDS cases were ascribed to homosexual transmission, while 15% were heterosexual. But in 1995 77% of transmission was through heterosexual means,

and only 10% was through homosexual (see Table 3).

Table 2 AIDS Transmission Category, By Year and Racial Group (as on 4.3.91)

Year	Black Homo/bi	White Homo/bi	Black Hetero	White Hetero
82-86	0	40	0	1
1987	0	26	6	1
1988	1	57	14	1
1989	1	81	49	5
1990	0	64	141	6
1991	0	3	22	0
Total	2	271	232	14
Total	Homosexual: 273		Heterosexual: 246	

(Figures from SAIMR 1991:4)

Table 3 AIDS Cases by Selected Transmission Categories, Percentage of Total

Type	1988	1989	1990	1991	1992	1993	1994	1995
Homo	73	73	58	44	31	23	15	10
Hetero	15	14	30	37	50	54	67	77
Paed	1	2.5	4	13	15	21	17	13

(Figures adapted from Immunology Newsletter 1995:5)

The fact that in 1995 homosexual transmission accounted for only 10% of total AIDS cases does not necessarily mean that that route is declining; it does mean that it is declining in relative importance. However, Tables 2 and 3 together show that homosexual transmission of the virus is actually declining in real terms, while heterosexual transmission in increasing. Paediatric AIDS, that is, transmission from mother to child, seems to have also declined as

a percentage of AIDS cases, and in real terms. Table 3 supports Sher (1992) and Christie's (1991) contention that AIDS is becoming primarily a heterosexual disease.

Chronology of events in South Africa

AIDS was first seen in South Africa in 1982. The Star (1.4.83) reported that two people had died of AIDS, one in August 1982 and the other at the end of March 1983. Both were white homosexual males, South African Airways (SAA) stewards, who had visited the USA, and are assumed to have contracted the virus there. The first, Ralph Kretzen, had complained of flu and weight loss early in 1982, which worsened in July of that year. The actual cause of his death was *P. carinii* (Ras *et al* 1983:140).

AIDS in South Africa was initially thought to be only a gay disease, and several "Cape Town and Johannesburg" doctors stated that "while the exact cause of AIDS was not known, patterns showed a definite link between the disease and promiscuity" (Rand Daily Mail 6.1.83:1). The Star picked up and reported on an editorial in the South African Medical Journal, in a page 2 story entitled "New AIDS Warning to Homosexuals", which alludes to homosexual promiscuity, and also mentions that "drugs commonly used by homosexuals such as marijuana, cocaine and amyl and butyl nitrate may also be immunosuppressive" (Star 1.8.83:2). Homophobia in society is sharply illustrated in another AIDS article published in the Star, quoting the Rev Attie van der Colf of the Linden NGK congregation. "Quoting Romans 1:24 and 1:25, he (the Reverend) said that God has 'given over' homosexuals. 'That means that the homosexual has chosen to leave behind normal life and therefore he has to accept the consequences'..... homosexuality is contrary to nature. It is an expression of self-

love in place of love of God, he said" (The Star 8.1.83:3).

So a picture of AIDS and the (gay) people who contracted it was painted for the public by the press, often the public's only source of information. Gays are presented as an homogenous group of promiscuous drug addicts, and these "warnings" could be seen to absolve authorities of responsibility for them: to the gay or bisexual man, perhaps unnerved by this disease, this type of press coverage spreads fear and panic, without giving any useful or meaningful information on prevention. To the heterosexual public, AIDS is presented as a gay disease, here and in the USA, where those who have died "have been mainly homosexual and bisexual men with some cases reported among drug-abusers, haemophiliacs and Haitian immigrants" (Star 1.8.83:2). It provides them with the false sense of security that stigma rests on - as long as I do not fall into that category, I cannot get the disease. This misinformation continued, it seems, until in 1985 an Executive member of the Gay Association of South Africa (GASA) called the media to task by claiming that a section of the media had unjustly stigmatised homosexuals by dubbing AIDS a gay plague (Star 27.2.85:6).

In 1985 a 13 year old haemophiliac boy, Marcello Del Frate, died of AIDS. He had been transfused with AIDS-infected Factor VIII plasma, imported from America, and his brother Giovanni was also found to be AIDS antibody positive (Star 5.11.85:14). This was the first haemophiliac case publicly reported, and could perhaps have marked the beginning of a change in perception about AIDS. Unfortunately, this was not the case, and again fingers were pointed at homosexuals: Marcello's father, Apostolic Faith Mission pastor Mr Mike Del Frate said "AIDS is God's curse on homosexuals and they are to blame for this

contamination - they are an abomination" (Star 5.11.85:14).

The Blood Transfusion Service (BTS) released a statement as early as 1983, and, possibly taking their cue from their American counterparts, said that it had not been found necessary to screen blood donors, since the question of whether AIDS can be transmitted through blood was debatable. A spokesperson for the BTS said "(s)o far it has not been a problem in South Africa, where there are more than 1 000 haemophiliacs who have received hundreds of thousands of transfusions. Not one case has been found among them" (Star 21.7.83:11). The Western Province Blood Transfusion Service was, at that time, discouraging gays from donating, by handing out leaflets produced by the American Association of Blood Banks warning against gay donors (Rand Daily Mail 9.7.83:1).

It was only in mid 1985 that the Minister of Health and Welfare, Dr Willie van Niekerk, announced that South Africa was looking into the problem of testing blood, and that the Department of National Health and Population Development was being advised on the matter by a group of experts. He also asked homosexuals and bisexuals not to donate blood (Star 14.8.85:6). Blood donations were eventually tested for HIV-antibodies in 1986, a year after Marcello Del Frate died. Thus the South African blood industry, and Ministry of Health, made a belated attempt to stem the spread of the disease, an attempt similar to that of the American authorities. The reason one can surmise, although not explicitly stated anywhere, was the cost of testing the blood. An obvious point to make here, is that this cost was never compared to the cost of human lives and medical bills of those who may have become HIV-positive as a result.

The National Party Government's Response

The Department of Health and Welfare, after initial evidence of the epidemic's existence in 1983, called a meeting of specialists and doctors to formulate a monitoring strategy for the disease. Recommendations centred around looking out for patients that belonged to any high risk groups, having had a blood transfusion, being in the habit of sniffing amyl or butyl nitrate, being promiscuous or having had sexual relations with American partners, and a history of sexually transmitted diseases (Star 22.1.83:1). Thus the government began to label people as high-risk candidates because they fell into certain categories, instead of condemning and trying to change high-risk behaviours.

Yet, it was only in February 1985 that the Department of Health embarked upon a co-ordinated campaign against AIDS. After talks between the Minister, Dr Nak van der Merwe, the Deputy Minister and senior health officials, a departmental committee was created, in which experts on AIDS were to become involved. This AIDS Advisory Committee, as it was called, was expected to find a way of diagnosing carriers before they showed symptoms of the disease, and also to "investigate the requirements to restrict the spreading of the disease" (Star 26.2.85:1). Another of their tasks, reported in the Star in March 1985, was to monitor the spread of the disease, and for this a "confidential central registry of substantiated cases" was set up (Star 14.3.85:18). It is quite telling that the emphasis was on recording numbers of AIDS/HIV-positive people, rather than on immediate prevention.

Indeed, it was only in December 1987, more than five years after the death of Ralph Kretzen, that the government announced its national anti-AIDS campaign: a campaign, it was

reported, which would flood the country with information on how to avoid the disease. The Department of National Health and Population Development (DNHPD) hired an advertising agency to develop the campaign which was to begin early in 1988, and it was decided that the scare tactics used in Europe and America would not be used in South Africa. This campaign plan was announced when HIV infections were estimated to be at 20 000 people (Star 14.12.87:6). It would cost approximately R1 million, and would make use of posters, radio, television and newspaper adverts (Star 20.1.88:1). The aim of the campaign was to educate, according to Dr Willie van Niekerk, then Minister of Health and Population Development: "(t)he biggest problem we have is that Aids (sic.) can be spread through ignorance. Ignorance about the prevention of Aids is prevalent, and it is this problem which we are now addressing" (Star 4.3.88:3).

So while the government did react to the AIDS crisis by calling meetings of medical personnel, setting up advisory committees, and embarking on an education campaign themselves, there were problems with the response that I shall now examine. The government was first criticised by the Johannesburg gay community after the death of the two SAA air stewards, for withholding information about their deaths and identities. The lack of information caused panic and fear, it was claimed, as people could have contracted the disease from either of the two men. Since it was known that Ralph Kretzen had been ill for at least a year, this was seen as an indication that the disease had been around for some time, and was probably spreading, so that scores of others may have contracted the disease. Nothing had been done to remedy the situation.

In January 1985 the Gay Association of South Africa (GASA) formed an anti-AIDS Action

Group, to inform homosexuals and other members of the public about AIDS (Star 25.1.85:7). This was before the government had started thinking about any structure or organisation to deal with eduction or prevention, as the AIDS Advisory Committee was only formed in February of 1985. In addition, GASA received no money from the government for their counselling service, which included an HIV-positives' support group, and a 'buddy system', where a volunteer 'adopts' a person with AIDS and remains as a support until the sufferer dies. GASA "has at no time received government money and did not apply for a fund-raising number after the Gay Advice Bureau in Johannesburg was twice refused a number, most recently last year (1987)" (Weekly Mail 5.5.88:14). This is a similar pattern found to the one in the USA, where the communities that were affected by AIDS mobilised themselves before the government did.

There were calls in the media in 1985 for the government to supply more information and deal with the crisis more effectively. The Star commentary suggested that the government assurance that there was no epidemic, after the public slumped off in donating blood for fear of contracting the disease, was an inadequate response. "Not for the first time a government department has assumed that if it keeps mum the problem will quietly dissolve. Instead public concern feeds on itself" (Star 27.2.85:10). The Daily News also called for "public education and real reassurance", so that risk of infection through routine household and daily contact with AIDS sufferers is well known - people should be told what is and what is not safe. "These are very real fears and they need to be addressed by the authorities before public worries become public panic" (Daily News 17.8.85:6).

The medical profession also criticised the government for their reaction to the AIDS

epidemic. "Earlier this week top local doctors warned that the Government was dragging its heels over the increasing Aids (sic.) threat and claimed that the authorities were withholding funds urgently needed to combat the syndrome" (Daily News 21.2.87:5). In the same article Mr Peter Moffatt, chairperson of the AIDS Action Group (an organisation set up by business and commerce) attacked the government's lack of educational material. He claimed that all they had done was produce one pamphlet, that "was not freely available; it was published in English and Afrikaans, but in no black languages; dealt only briefly with the Aids syndrome and only cursorily with how to avoid being infected" (Daily News 21.2.87:5).

Further evidence of government incompetence came in May 1987, when Professor Jack Metz, chairperson of the AIDS Advisory Committee, said there was no evidence to support an allegation by the world charity, War on Want, that South Africa faced a AIDS epidemic among its black population. To quote Professor Metz: "(t)here is no evidence that large reservoirs of the virus would build up in the black population of South Africa, a group with probably the lowest incidence of all African countries where Aids is a problem" (Star 14.5.87:15). It was in 1987 that the virus started spreading among black heterosexuals and this comment shows lack of fore-sight at best and complete ineptitude at worst, especially when one considers that it was this committee that advised the government on AIDS policy and prevention.

The government's campaign around AIDS prevention, when it did come, seemed somewhat ineffective. It was severely criticised for its racial bias. The posters and billboards aimed at the white public consisted of a graffiti wall with information about prevention. The ones for blacks showed a picture of some black people around a grave, into which a coffin is being

lowered. The information provided was:

> AIDS. THE NEW KILLER DISEASE IS HERE.
> PREVENT AIDS.
> DO NOT SLEEP AROUND.
> ONE-PARTNER RELATIONSHIPS ARE SAFE.
> IF IN DOUBT, USE A CONDOM. (Star 4.3.88:3)

This is a scare tactic, and offers nothing to the reader: the link between preventing AIDS and using condoms is not made; no reason is given for why one should not sleep around, nor why one-partner relationships are safe; and there is no explanation of "doubt" - doubt about what, exactly, should encourage one to use a condom?

In 1988, five years after the initial detection of the virus, and five months after the start of the campaign, a preliminary survey showed that "54 percent of black people still thought of Aids as a disease from America and most whites thought it came from Africa. Thirty percent of blacks and 89 percent of whites (nine percent more than before the campaign) believed they had no reason to change their behaviour" (Weekly Mail 5.5.88:15). Alan Whiteside of the Economic Research Unit at the University of Natal, commented that the AIDS awareness campaign cost approximately R1 million, which is a quarter of the amount spent on the 'Info Song' and less than what was spent getting rid of the Director-General of the SABC, Mr Riaan Eksteen (Star 14.9.88:7).

The DNHPD AIDS Unit came under severe criticism in 1992, mainly from internal sources. The head of the AIDS Unit, Dr Manda Holmshaw, and her deputy, Dr Wilson Carswell, complained to the Director General of Health that the department had redirected R4,5 million of the AIDS budget (approximately one third of the total) to other uses (Sunday Star

7.6.92:8). They also claimed that the Deputy Director General of Health, Dr Hans Steyn, had been derelict in his duty in the management of the AIDS Unit, had ignored expert advice on critical issues of AIDS prevention, and had shown lack of judgement in handling claims by HIV-positive haemophiliac patients (Citizen 8.6.92:3). Holmshaw and Carswell also claimed that "senior health officials had 'bureaucratised' the department's AIDS unit, which had left it unable to address the disease" (Business Day 30.6.92:7). A week later, and perhaps as a result, Holmshaw was demoted, and Sister Natalie Stockton, a nurse with no little prior experience in AIDS education, became head of the Unit (Sunday Times 5.7.92:14).

Lack of government commitment to containing the spread of AIDS could also be seen in their response to foreign migrant workers with AIDS. One hundred and thirty mine employees, all from Malawi, were found to be HIV-positive in 1986, and the immediate government reaction was to repatriate them, despite Chamber of Commerce recommendations to the contrary. The Chamber did agree, however, that any new foreign workers should be given compulsory AIDS tests (Star 29.8.86:13). The Daily News reported in September 1987 that in the mining industry there were 1 140 known carriers of the virus, 1 000 of whom were foreign workers, and therefore faced repatriation (Daily News 4.9.87:12).

Dr Dennis Sifris, head of the AIDS Unit at the South African Institute for Medical Research, said that since AIDS is a sexually transmitted disease, it posed no health problem for the general population, and emphasised that instead of expending energy on repatriation the government should embark on a national education campaign (Star 22.9.87:1). The Daily News also carried negative comments from the Progressive Federal Party (PFP) Spokesman

(sic.) on Health, and from the National Union of Mineworkers (NUM). The Star reported that 28 555 miners were tested at random in a twelve month study, and that was how the 130 HIV-positive workers were detected (Star 4.9.87:1); to then repatriate these people, and send them home to die, is extremely unfair. Despite the opposition to the move, a law was published in the Government Gazette of 30 October 1987, stating that any non-South African citizen with HIV would fall into the 'prohibited persons' category, and therefore be liable for repatriation (Star 31.10.87:7). This shifts the burden for these people onto the Southern African countries where they came from, but does not significantly alter the extent of the South African problem.

After reports of two Durban escorts suffering from AIDS, and rumours of one in Pretoria, the government announced that there was little it could legally do to clamp down on the infected escorts, because it is "extremely difficult to control any illegal activity such as prostitution by legislation" (Star 12.11.87:1). In the same article Dr George Watermeyer, Deputy Director-General of the Department of Health said that "while prostitution, promiscuity and homosexuality were still accepted in our society, one could not stop the spread of Aids" (Ibid.). It could be argued that he is suggesting that prostitution and homosexuality are responsible for the spread of AIDS, and further argued that his is an attitude of non-acceptance of gays and prostitutes; it is certainly rather defeatist to suggest that nothing can be done about AIDS while prostitutes and homosexuals exist.

I have argued that the National Party Government's attitude to the marginal sectors of society can be useful in examining the general context of AIDS education: gay organisation was limited by lack of funding; foreigners with HIV, who were tested without their consent, were

packed off home; and prostitutes were responsible for the spread of AIDS. All of this suggests that the underlying attitude that proliferated almost all the National Party government actions, in this epidemic, was one of sexual conservatism, and an attempt to uphold traditional, heterosexual, monogamous relations. Anything that deviated from that norm was controlled, or illegalised. AIDS education in South Africa should be seen in that context, especially sexuality and AIDS education in schools, which was part of the system of Christian National Education.

The Government of National Unity's (GNU) Response

The Government of National Unity (GNU) seems to be taking AIDS very seriously: Nelson Mandela claims that "(w)e need to ensure that we provide the supportive environment to afford people the capacity to protect themselves through increasing access to condoms, drugs for sexually transmitted diseases, access to health care, and testing and counselling facilities. We must speak out against the stigma, blame, shame and denial that has thus far been associated with this epidemic" (Pan African News Agency 4.12.95: World Wide Web). A World Wide Web search[2] revealed scores of references to AIDS, but, like Mandela, no-one has much to say on the implementation, the how-and-when of AIDS prevention.

However, the Minister of Health, Dr Nkosazana Zuma, placed AIDS prevention high on her agenda when she took over the position: she was a founder member of the National AIDS Co-ordinating Committee of South Africa (NACOSA). NACOSA developed a National Strategy and Implementation Plan, which Minster Zuma formally adopted as a blueprint for

[2] There seems to be little published literature on the GNU's action around AIDS education, hence the World Wide Web search.

the government's National AIDS Plan (Abdool Karim 1995:11). She also combined the AIDS and STD programmes into a single directorate, the National HIV/AIDS and STD Programme, which comprises a Directorate and nine Provincial Programmes (Ibid.:11). In addition, the President's Office has taken on the responsibility of ensuring the implementation of the NACOSA Plan, and prevention of HIV/AIDS is seen as a priority of the Reconstruction and Development Programme (RDP) (Hambridge 1995:3).

Five key strategies were identified for implementation of the National AIDS Plan in 1995/6, and they are: firstly, lifeskills programmes for youth; second, a mass communication campaign, featuring 200 billboards around the country, whose message will change about every two months, and the aim of which is "to raise awareness around AIDS issues" (SA Family Practice 1995:573); third, appropriate treatment of STDs, including diagnosis, provision of curative drugs, and health education and counselling; fourth, increased access to barrier methods of prevention, that is, condoms, and also female condoms, which are being tested at the moment; and finally, provision of adequate care and support for PWAs and AIDS-orphans (Abdool Karim 1995:11ff).

However, although the GNU may have the commitment and political will to tackle the AIDS pandemic, it does not have the money. The National AIDS Plan estimated a budget of R257 million was needed for AIDS prevention (Ibid.:11, and Hambridge 1995:4), while the Department of Health AIDS budget stood at R41 million for the 1994/5 year (Ibid.:4). Even though this figure represents a doubling of the AIDS prevention expenditure from the previous year (Positive Outlook 1995:3), it is piddling in comparison to what is required. Another factor that could slow down an AIDS prevention plan is the necessary partnership

that AIDS brings: it is not a medical/health problem only, and prevention requires Ministry of Health collaboration with Ministries of Education, both national and regional; Correctional Services (prisons); RDP Offices, to improve general living conditions; trade unions; and even religious groupings. Thus, despite the Ministry of Health making firm strides in the direction of prevention, AIDS prevention is not its sole responsibility, and as such, it may unfortunately be thwarted at one level or another. This collaboration with other departments, however, may result in money being spent by departments other than Health, and thus ease that Ministry's burden.

A Profile of the Disease in South Africa

A person who has AIDS in South Africa is most likely to be African, as Table 4 shows.

Table 4 AIDS Cases by Number and Percentage of the Total (as at 17.10.95)

Race group	Asian	Coloured	African	White	Unknown	Total
No. of cases	16	302	7 703	504	46	8 571
%age of total	0.2	3.5	89.9	5.9	0.5	100

(Adapted from Epidemiological Comments 1995:218)

These figures only become meaningful, however, when compared with population group percentages. In South Africa, Asians comprise 3% of the total population, Coloureds comprise 9%, Africans comprise 76%, and Whites comprise 13% (Figures from Central Statistical Services, Durban, 1995). Since Africans make up 76% of the total population, and almost 90% of AIDS sufferers, we can deduce that AIDS affects Africans more than other race groups in South Africa.

As is seen in Pattern II spread of HIV/AIDS (Smallman-Raynor *et al* 1992:32), South African AIDS affects young people more than old, and females dominate the age group under 30 years, while males dominate the age group over 30 years.

Table 5 Total AIDS Cases by Age Group and Sex (as at 3.8.95)

AGE	MALE	FEMALE	UNKNOWN
0-9	506	435	14
10-14	8	12	-
15-19	57	329	2
20-29	1 200	1 754	22
30-39	1 370	1 024	18
40-49	594	283	3
50+	299	118	12

(AIDS Analysis Africa 1995:11)

As far as geographical distribution goes, KwaZulu-Natal is by far the most AIDS prolific region.

Table 6 AIDS Cases by Regional Breakdown (as at 17.10.95)

Eastern Cape	: 536
Western Cape	: 423
Northern Cape	: 163
KwaZulu-Natal	:4130
Free State	: 910
Gauteng	: 986
Mpumalanga	: 477
North West	: 471
Northern Province	: 475
Total	:8571

(Epidemiological Comments 1995:218)

Of course, KwaZulu-Natal is the second most populous province in South Africa, and its having one of the highest prevalence rates of AIDS cases is not surprising. What is

astonishing, however, is that KwaZulu-Natal has so many more cases than even Gauteng, the most populous province, and the one with second highest number of AIDS cases reported. Thus, we can conclude that KwaZulu-Natal has the highest percentage population of AIDS cases.

Figures for HIV-positivity are harder to find than those of AIDS sufferers, because HIV is more silent than AIDS, and is impossible to detect without a test. There have, though, been five national surveys of women attending antenatal clinics in South Africa. At the end of 1994 7.57% of women were found to be HIV-positive, while at the end of 1993 the figure was 4.25% (Smart 1995:17). "The estimate of HIV prevalence, extrapolated from the survey, is 1,2 million people infected, with approximately 700 new infections occurring each day" (Ibid.:17). Again, KwaZulu-Natal was found to have the highest prevalence rate, as the following figures show.

Table 7 Percentage of HIV Prevalence in Antenatal Clinics (as at end 1994)

South Africa	7.57
Eastern Cape	4.52
Western Cape	1.16
Northern Cape	1.81
KwaZulu-Natal	14.35
Free State	9.19
Gauteng	6.44
Mpumalanga	12.16
North West	6.71
Northern Province	3.04

(Smart 1995:17)

Murray Small, (ex) ATICC Lifeskills Education Officer, estimates that 10% of adults in KwaZulu-Natal are HIV-positive (Small 1995:20).

Of course, with all these figures, it must be borne in mind that all HIV/AIDS data is likely to be underestimated, for a number of reasons. The first is that false-positives must be taken into account, as suggested by Papadopulos-Eleopulos and Turner (1994:3ff). The second is that because reporting of AIDS cases is not compulsory, and because most AIDS-related deaths are not reported as such, but as tuberculosis, malaria, or whatever, figures are almost certainly under-estimates (AIDS Analysis Africa 1995:11).

This brief chapter has shown that HIV/AIDS is primarily a disease of the young heterosexual population[3], and it is also more prevalent in African people that in other race groups. Geographically, it is most common in KwaZulu-Natal, where at least one in twenty, and perhaps one in ten, people is HIV-positive. It is growing daily, and while the GNU Ministers frequently allude to the fact that prevention is a high priority, there are not the funds available for a comprehensive prevention campaign. I would argue though, that school education campaigns constitute cost-effective prevention, because an effective campaign there would abate the spread of the disease, now and in the future. In the next part of this thesis I will examine prevention strategies, as well as notions of sexuality, before I tackle an assessment of present school education efforts.

[3] There is no data on rural-urban distribution of HIV/AIDS, which is unfortunate since that information may assist in the development of appropriate education programmes, and in identifying priorities in the policy considerations of dividing up scarce resources.

PART II

CHAPTER FOUR

Models of Health Promotion and Preventative Interventions

> AIDS is the first epidemic in human history in which we have learned so quickly that the identified noxious agent can be kept from spreading by specific behavioral changes. (Mays *et al* 1989:17)

Traditionally, there have been a number of approaches to public health methodology to prevent widespread disease. The first involves identifying the noxious agent causing the disease and taking steps to neutralise it, kill it or otherwise render it harmless. An example of this type of preventive action would be treating water so that water-borne diseases are no longer virulent. The second strategy involves strengthening resistance to the disease in the host, for example, in the form of inoculation or vaccination. The third strategy available is to prevent transmission of the noxious agent to the host. In the case of malaria, the mosquitoes are killed through widespread spraying of the water where the mosquito larvae live. The first two methods are curative, while the third is preventative.

In the case of AIDS and HIV, preventative measures must be used, since the virus cannot be killed or neutralised, and it is unlikely that a vaccine will be developed in the near future, and even if it is, the logistics and cost of distributing it throughout the world may make it untenable. The same preventative method applies if we are to believe the Duesberg camp, that is, that AIDS has a multi-factorial cause, but the prevention strategy would revolve around reducing the intake of drugs, recreational or medical. The only option left open to

us is to prevent transmission of the virus. "Educating persons with information that leads to changed behaviours (sic.) that reduce or eliminate high-risk, unprotected sexual encounters constitute effective prevention" (Mays *et al* 1989:19).

Why is this so difficult? Why do we all take unnecessary and harmful risks one way or another - we smoke, we drink alcohol and take other drugs, have sex without contraception, lead high-stress, low exercise life styles, we don't floss our teeth or we don't wear seatbelts? There are a vast array of reasons for this, perhaps as many reasons as there are people, but I want to offer only three. The first is that we do not know any better, a consequence of a lack of education. The second reason is that people think 'it won't happen to me', and the third reason I want to posit is that people want present pleasure, and are prepared to believe that they will deal with the consequences when (and if) they happen. It is the purpose of this chapter, then, to examine some ways educators can influence people to change their risk-taking behaviours through education.

But the task is a difficult one, particularly in changing sexual behaviour, since, across all cultures, the sexual is perceived to be a profoundly private realm, in that instructions or suggestions on what to do within this realm are not deemed appropriate. Indeed, I argued in the first chapter that the American Government found the issue of AIDS a challenge, because it blurred the boundaries between public and private. The government, by liberal account anyway, is only supposed to legislate on, and effect, the public domain, but in the case of AIDS, private acts had public consequences that snow-balled into a national, and now international, pandemic. Telling people how they should have sex is not the same as telling them how to brush their teeth, or what to do when they sit in a car, but it is necessary

because unsafe sex has consequences for the sexual partner and society in general.

The other difficulty for AIDS education is that informing the public as to the risks of HIV and AIDS does not necessarily result in behaviour change. There are many factors that influence a person's decision to engage in risky or safer practices, and while these are complex and difficult to unpack, it is the function of this chapter to attempt to do this. However, one thing that we can generalise about is that information alone does not make for safer behaviour, and this is extremely well supported in the literature (Bandura 1989:128 and 131; Flora 1989:381; Aggleton 1989:228; Kelly 1988:60; Mathews *et al* 1990:511; Moore and Rosenthal 1993:134; Perkel 1992:11 and 75), and reasons why this should be so should be clearer by the end of the chapter. In an American study, 99% of young women thought that they would need to make behaviour changes because of AIDS, but of those who were sexually active, half had not made any changes at all (cited in Moore and Rosenthal 1993:134). Again in America, appropriate knowledge in youth surveyed about HIV transmission and contraception only translated into the intention to continue not using condoms (cited in Perkel: 1992:12). Similarly, in South African school-going youth surveyed, of those who had had sex and knew that condoms prevent AIDS, only 15.4% had ever used a condom (Mathews *et al* 1990:511).

So to return to the reasons I posited for risk-taking behaviour: the first I suggested was that people do not know any better, or suffer from a lack of education. It is now clear that information or knowledge alone is not a sufficient cause for behaviour change. "Intervention efforts around the world have demonstrated the need to account for variables other than knowledge in addressing the problem of AIDS. Simply imparting knowledge has proven a

poor motivator of sustained and effective behaviour change, particularly in the area of sexuality" (Perkel 1992:75). Of course some people may change their behaviour when they learn of its harmful long-term consequences, but most people, studied in relation to a range of harmful activities, as cited above, do not change. It is hypothesised that, for these people, a threshold exists, and beyond that threshold "increases in appropriate knowledge no longer have any influence on behaviour" (Perkel 1992:11). "Other variables, such as irrational fears and prejudices (or other mediating variables) may be obstacles to utilising this information" (Ibid.:12)

In an attempt to unpack this discrepancy between knowledge and behaviour, Fishbein and Middlestadt (1989), using the Theory of Reasoned Action, argue that, to change behaviour, educationalists must try to understand the determinants of that behaviour. However, different beliefs underlie different behaviour decisions, and two people making the same decision may have done so out of different sets of beliefs (Fishbein and Middlestadt 1989:94). Fishbein and Middlestadt suggest that a successful preventative intervention must first identify the behaviour that should be changed. This must not be confused with behavioral categories, or a goal, or an outcome, for example, avoiding the AIDS virus (Ibid.:97). They also suggest that the behaviour of interest, that is, that which is to be changed as a result of the intervention, should be under 'volitional control'. By this is meant that people are able to perform the behaviour, and that there are no constraints to it (Ibid.:95).

Indeed, the attainment of goals or outcomes is influenced by external factors, outside the control of the individual, but the performance or non-performance of one behaviour is not. Engaging in safe sex (sic.) is seen by Fishbein and Middlestadt (1989:97ff) as a category of

behaviours, since it is possible for two people to define 'safe' and 'unsafe' in a number of different ways. To one person, limiting his/her number of sexual partners may constitute a safe(r) practice, while to another, it may mean using condoms for every penetrative sexual act. Thus the authors suggest that the focus of intervention programmes should be whether the individual used a condom the last time s/he had anal, oral or vaginal intercourse, as opposed to whether they engaged in safer sex.

The theory states that performance or non-performance of a behaviour is a function of a person's intention to perform. Of course there are many external factors that may influence the performance of a behaviour, but Fishbein and Middlestadt suggest that the educator must distinguish between intentions to perform a behaviour from a class of behaviours (Ibid.:99). Implicit in what they suggest is that the intention to perform one behaviour is fully within an individual's control, while a class of behaviours is susceptible to outside influence. I believe this makes some sense: if there is more than one behaviour at stake then there will be more influences at stake as well, and thus the individual will have less control over the outcome.

Another guiding principle of the Theory of Reasoned Action is that there must be an exact correspondence between behavioral intention and behaviour of interest (that is, that which the educationalist seeks to change), and this correspondence must also be viewed in terms of action, target, context and time. The intention to "use a latex condom every time I have sexual intercourse" is not the same as the intention to "practice safer sex", or "to use a condom" or "to use a condom every time I have sexual intercourse". Also attempting to change intentions to reach a goal (for example, avoiding contracting AIDS) or to perform

classes of behaviours (for example, practising safer sex) are not always reached, since, to reiterate there should be an exact correspondence of intention and behaviour of interest. Since classes of behaviour cannot be changed, due to external influences, the intention to reach a goal that involves changing a class of behaviours will not be realised.

According to the theory, a person's intention to perform a behaviour is a function of two things: attitude towards performance; and/or the subjective norm concerning the behaviour. Attitude towards performance is defined as feelings of favourableness or non-favourableness towards the behaviour, and the subjective norm is that perception that important others think that the individual should or should not perform the behaviour in question (Ibid.:102). In other words, this level of the model suggests that intention to perform a behaviour (for example, intending to use condoms for every penetrative encounter) is a function of one's own attitude, and others' perceived attitude towards the behaviour (in this example, what one thinks of condoms, and what one thinks others think of condoms). Attitudinal and normative components vary from population to population, and may vary between men and women.

The point that Fishbein and Middlestadt do not mention is that the social context enters the equation here, since attitudes and subjective norms are social constructs: the prevailing culture helps construct attitudes and norms, and these are not solely individual choices. For example, I understand that in Japan, where the contraceptive pill is very difficult to get, many people use condoms as a contraceptive, and prevailing culture supports this: condoms are completely acceptable. But here in South Africa condom use as a contraceptive is not common, and many people claim that they do not like condoms. Thus the attitudes and subjective norms of a Japanese person and a South African are likely to be somewhat

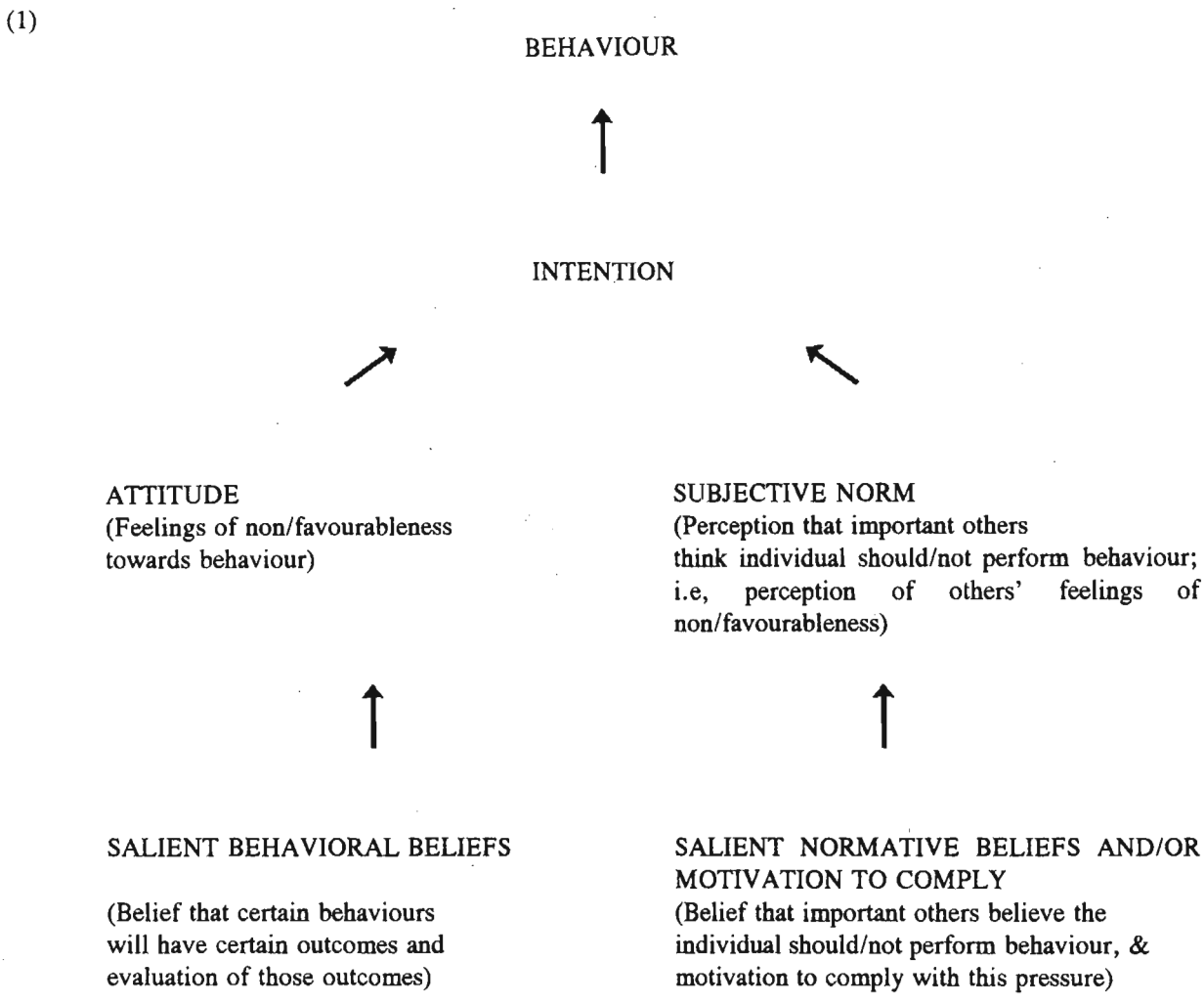
different in the behaviour "using a latex condom every time I have intercourse".

In order to change attitudes towards performing a behaviour, the educator must change the salient behavioral beliefs (what I might do) and/or evaluative aspects (what I should do or not do) underlying the attitude. This is the belief that certain behaviours will have certain outcomes, and the evaluation of those outcomes. And to change the subjective norms towards performing a behaviour, the educator must change the salient normative beliefs and/or motivations to comply. This is the belief that significant others believe that the individual should or should not perform the behaviour, and the motivation possessed in complying with this social pressure (Ibid.:104). Again the cultural or social context is formative in these beliefs. (Please see overleaf for a diagrammatic representation of the Theory of Reasoned Action.)

In attempting to change these salient beliefs, and develop a successful intervention strategy, there are four elements that should be taken cognisance of. Firstly, identification of salient outcomes and referents of particular behaviours for the population under consideration, and as suggested above, these vary from population to population. In other words, the behavioral and normative beliefs that underlie the attitude or subjective norm must be identified. Secondly, once salient outcomes and referents have been identified,

DIAGRAMMATIC REPRESENTATION OF THE THEORY OF REASONED ACTION (Fishbein & Middlestadt, 1989) (1), AND A PRACTICAL EXAMPLE OF THE SAME (2).

(1)



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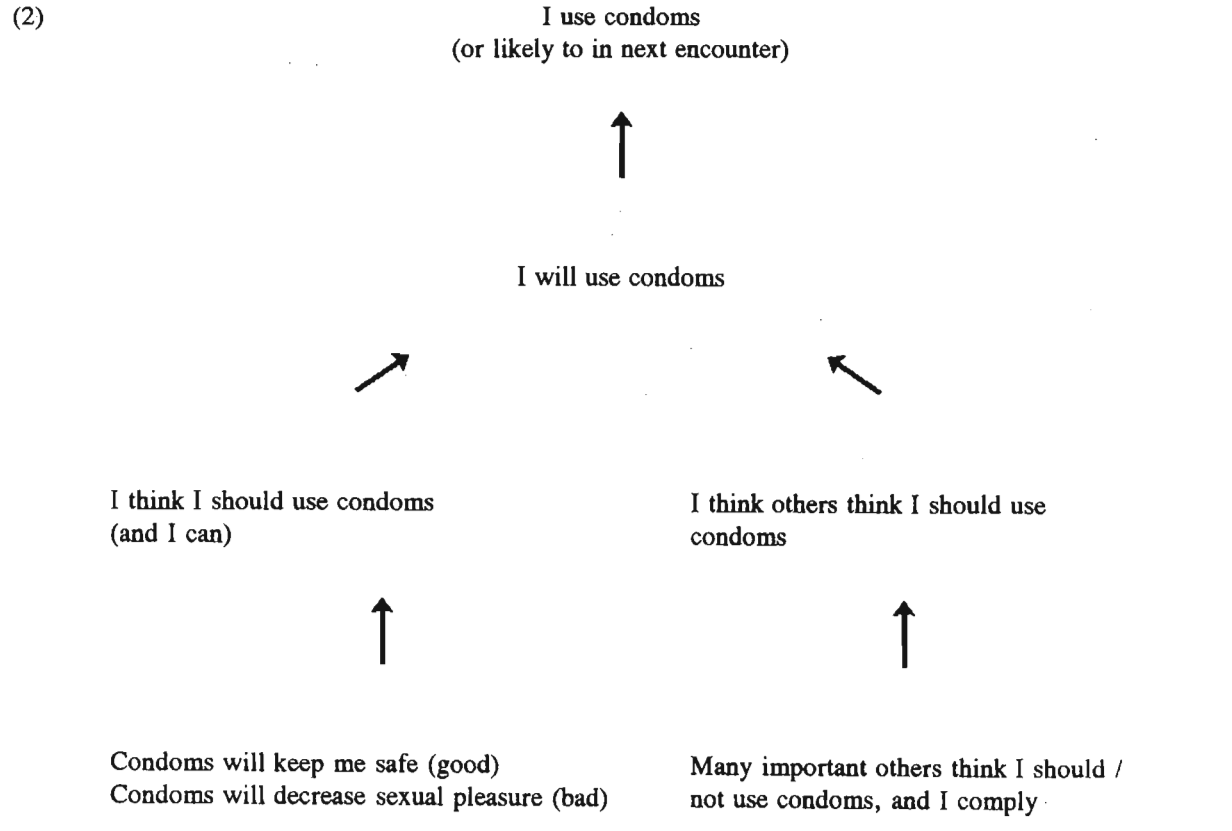
(2)



only the appropriate behavioral and normative beliefs must be targeted for intervention, and not information or beliefs that the population has already acquired. For example, if the majority of the population believe that using latex condoms every time an individual has penetrative sex reduces their chances of contracting AIDS, then launching a campaign to convince the population of this would be futile. This points to the need for research before the intervention is begun, to ascertain these facts, and to develop the intervention around them. Thirdly, attitudes and subjective norms are based on sets of beliefs, so that a change in one behavioral or normative belief may not be enough to produce a change in attitude or subjective norm. Success requires changing the evaluative or normative implications of the underlying cognitive structure. And fourthly, as discussed above, required correspondence between beliefs, attitudes and/or subjective norms, intention and behaviour. Intervention programmes require studies both before and after the intervention: before, to elicit information on the target group of a certain population, and their beliefs; and after, to evaluate the effectiveness of the intervention. "What we have tried to show ..... is that there are certain types of information that are necessary for developing effective educational communications or other types of intervention" (Ibid.:109).

With respect to the decision to use condoms or not, the theory of reasoned action fails to take into account that a whole process has occurred before the salient behavioral and normative beliefs can be constructed. For the behavioral and normative belief that "I want to reduce the risk of getting AIDS", and that "condoms may decrease my sexual pleasure", the individual must already have gone through a process, and this is taken for granted. Before arriving at these beliefs there must firstly be the recognition, for example, that AIDS exists, is a fatal disease, that it is passed (primarily) through sexual contact, that one is at risk for contracting

it, and that there are ways of minimising one's risk etc. I believe that this stage, before beliefs about prevention, and specifically condom use, are formed, must be more clearly examined in order to better develop AIDS education interventions, and other models of health promotion may offer some insight in this.

The Health Belief Model is one such theory that may be of some illuminating value on beliefs. Action towards avoiding a negative health condition, that is, changing behaviour, rests on the evaluation of four components. These are: perceived personal susceptibility to a negative health condition; perceived severity of the condition; value of a (different) behaviour or line of action (also called efficacy or effectiveness); and barriers to action (Kirscht and Joseph 1989:111ff). In other words, in order to stay healthy one assesses one's own chances of getting a particular disease or illness, how bad that disease or illness really is, how effective a behaviour change will be in stopping the disease or lessening its effects, and what is stopping one from making that change. Kirscht and Joseph suggest that "the health belief model may have significant value as a heuristic device in the development of interventions. Such application can consider the nature of existing beliefs and what aspects need most attention" (Ibid.:116).

They do stress, however, that behaviour is extremely complex, and simple models may not be able to account for it. However, the health belief model would be useful in examining health threats and reasons for action or inaction, particularly if used in conjunction with other models (Ibid.:124). Studies on health belief and personal prevention mechanisms were done for various diseases, and while no conclusive results can be formulated across all diseases, it seems that perceived susceptibility is an important factor in determining a preventative

response (Ibid.:113). This is evidenced in the gay communities in the USA in the 1980s. Life-style of the promiscuous in that community was seen to be a major factor in determining whether an individual contracted the HI virus, and this led to life-style changes, as documented elsewhere in this thesis: individuals felt themselves to be in danger of contracting AIDS, and were thus motivated to change their behaviour.

However, with regard to susceptibility, Weinstein suggests that there is a difference between objective and subjective risk (Weinstein 1989:148ff). For those who drive cars there is the objective risk of having an accident. But many people reason along the lines of whether the national figures of car fatalities really relate to them, considering the distance they travel, their reaction time, precautions they take, the chance of an accident today vs sometime in the future etc, and thus can conclude that their risk (that is, the subjective risk) is not so severe. People also show "optimistic bias", in that they see their own vulnerability as being less than their peers, and use "downward comparisons", in that they compare themselves to people who are more vulnerable than them, or in a worse situation than themselves.

Perceived susceptibility is also influenced by 'high-risk' categories, and people feel that if they do not fall into one of those categories, they are not at risk (Weinstein 1989:153). This is a very grave danger, and points to the fact that labelling people as high-risk because they belong to a particular group, for example homosexual, prostitute, black heterosexual, does not address the problem. It is specific high-risk behaviours that are at issue, not categories of people.

Perkel (1992) uses other terms for what amounts to the same thing. He suggests (1992:20ff)

that we have defence mechanisms of repression (where stimuli that create too much anxiety are pushed into the unconscious), and denial (which contradicts ego threatening realities). Defences 'block' messages that cause us too much anxiety associated with perceived risk (and thus threaten our egos). In order to protect ourselves and our psyches we use our defence to reduce stress, inoculate ourselves against the AIDS doom, and become desensitised to the fear; in short, defence lower perceived self-risk[1]. Defensiveness can also take the form of stereotyping (Perkel 1992:21). I can defend myself against the threat of HIV/AIDS if I believe that gays, or prostitutes, or blacks, or men, or the youth or..... get it, and I am not a member of any of those groups. Comparisons with others, in the context of stereotyping, allow me to believe that I am less at risk that anyone else.

This goes some way to responding to the second reason for risky behaviour that I posited in the beginning of this chapter: the "it won't happen to me" response. People do think it will not happen to them because they compare themselves positively with others to whom it has happened, and their defence, in the face of a life-threatening disease, lead them to believe their risk is lower than others', especially others in 'high-risk' categories. Objectively we all have a chance of paying the price, but subjectively I think I have a much smaller chance than you.

One way of trying to limit this subjective risk factor is to use people with AIDS to give public talks and spread the 'safer sex message'. Tversky and Kahneman (1982) suggest that people assess probabilities of events happening in a number of complex ways, that are not

[1] Thus Perkel suggests that fear-based education campaigns do not work, since we are likely to block them out.

completely rational (1982:11ff). One way of assessing is through the ease with which instances and occurrences can be brought to mind, that is, the availability of the event. This includes familiarity - knowing that famous people have erred in their judgement - and salience - seeing rather than reading. As applied to AIDS education, people will make judgements to reduce their high-risk behaviours if they can easily recall seeing someone who is suffering the consequences of not practising safer sex. If people actually see someone who has AIDS, the impact of the message that AIDS exists, kills and can and should be avoided will be given extra impetus.

Perceived benefits of a behaviour or line of action have also proved to be significant determinants to behaviour change (Kirscht and Joseph 1989:113). However, with AIDS and HIV, benefits are not so easy to discern, since the 'costs' of AIDS would only be known and felt up to ten years later. In the South African context, there are many other priorities, of health and other issues, and benefits that are in the long term are often not perceived as benefits. Telling someone that if they practise safer sex they will reduce their chances of contracting AIDS and dying in ten years time, when more immediate problems of poverty and violence threaten their daily existence, will not be taken seriously and may even be treated with derision. Thus I would argue that one barrier to action, the fourth factor that the health belief model suggests educators must take account of, is a poorly developed sense of the future. Low quality life-styles now give rise to the perception that the future will not be any different, and so planning for it is a wasted effort. Under these circumstances AIDS education becomes extremely difficult, and must be linked to the possibility of a general improvement in life-style.

This is also related to the three reasons I offered at the beginning of the chapter for why people persist in risky activities - the third reason was that people want present pleasure, and are not prepared to forsake the present for a better future. To take to example of alcohol, an extra drink at the end of a long evening will only increase the hang-over the next day, but at the time of the drink only the present is considered, and the consequences will be dealt with later. It would thus be useful to offer people immediate benefits of behaviour change, such as improved feelings of self-worth and liking, or prevention of pregnancy, or improved assertion of the self.

"To achieve self-directed change, people need to be given not only reasons to alter risk habits but also the means and resources to do so" (Bandura 1989:128). This requires skills in self-motivation and self-guidance, but also self-belief in one's capabilities to exercise personal control and thus put the skills into practice, that is, perceived self-efficacy. This perceived self-efficacy is concerned with people's beliefs that they can put a decision into action. I suggest that in terms of the theory of reasoned action, this impacts on the level of belief systems that contribute to behavioral and normative beliefs (for example, "using condoms may reduce my susceptibility to AIDS"), and in translating intentions into behaviours ("I can put my intention to use condoms into practice, so I will use condoms for every sexual encounter"). Self-efficacy is also associated with "contraceptive skill acquisition and use" (Perkel 1992:29). If individuals lack a sense of self-efficacy, situations are not managed effectively, even though people know what they want to do and possess the skills required.

The weaker the perceived self-efficacy, the more likely it is that an individual will give in to social pressures, for example, coercive power, allurement, desire for social acceptance,

situational constraints, fear of rejection, wanting to fit in (Bandura 1989:129). In relating this to the theory of reasoned action it means that subjective norms will play a greater role in forming intentions than if perceived self-efficacy was greater. In other words, if significant others, or a specific target population, believe that the use of condoms is a low priority, those with low perceived self-efficacy are more likely to comply with the group sentiment, and thus behave in a risky way.

Perkel suggests that external factors, such as peer pressure and reference groups, and internal ones, such as self-efficacy, need to be examined together (Perkel 1992:23). He cites a study by Nelkin (1987) which shows that people only use information from the media when "it corresponds to prior inclinations or when it is reinforced by their social situation and the beliefs and attitudes of their reference groups" (Ibid.:22). Thus the norms and values that others, particularly significant others, seem to have are important in determining one's own values, and this may be due to people's need to be liked. Often this requires not appearing to be dissimilar from the group or individual, in case of sanctions for non-conformity. Of course an individual with a very strong perceived self-efficacy may disregard peer opinion, but it is likely that we are all subject to it at one level or another, and this may be especially true for teenagers: forming an autonomous identity separate from the family tends, ironically, to result in strong peer group conformity. Thus Perkel suggests that in terms of intervention, messages should not be given that undermine or contradict the peer group values and attitudes, but rather there should be an attempt to reframe those values in health-affirmative terms (Ibid.:24).

Thus I believe that there are problems with the theory of reasoned action, and because of

them this model must be used in conjunction with others. The first objection to the theory is that it states the behaviour must be under volitional control, which assumes a rationality to the individual. This assumption is problematic when it comes to AIDS education, because sex is not always a rational act, but rather one of desire, passion and immediate satisfaction. In these circumstances rationality may go out the window. In addition, this model has been used to explain behaviour change in various risky habits, such as smoking, drinking, lack of exercise, but importantly, these are all personal choices and habits, and they do not involve another person - the risk one takes is a personal risk (with the exception of passive smoking). But changing sexual behaviour to using condoms for every penetrative sexual encounter requires that two (or more) people must agree, and thus volitional control is compromised. This must be borne in mind when using the theory of reasoned action as a model for AIDS education.

The model also assumes that behaviour is intentional, but the individualistic rationality that this model works on crumbles with the introduction of one, or more, other people. A woman may have every intention of using a latex condom every time she has penetrative sexual intercourse, but this intention may be thwarted by a conflicting intention of her partner, that is, he does not want to use condoms. If the wishes and intentions of men tend to hold sway over those of women, as is sometimes the case, then the woman's intention may not be translated into behaviour. Any behaviour that relates to safer penetrative sex involves at least two people, and therefore there exists the possibility for conflicting beliefs, which may lead to conflicting intentions and thus to behaviour that is compromised. In addition, if a woman is having sex for material gain then her power in the relationship or interaction may be lessened, and insisting on, or even suggesting, condom use may be out of the question. Any

woman may intend to use condoms, but it is men who have to wear them, and thus their consent is vital. In short, I take issue with the theory of reasoned action's assumption that behaviour is under volitional control, and that intentions are easily translated into behaviours

In terms of attitudes and subjective norms, the importance of the social context again mitigates against the volitional control over the behaviour of interest. This level requires a cost-benefit analysis for the individual: if there is peer pressure, or traditional values against use of condoms, then the costs of use will be great. We know that this is the case in South Africa, where contraception is often unwanted, and condoms constitute a threat to manhood (Preston-Whyte and Zondi 1990:59; Flisher *et al* 1992:105). Further, if condoms are perceived to lessen sexual pleasure (Abdool Karim *et al* 1992:108), then this is weighed against the benefits of use. This constitutes a cultural barrier to safer sexual practices, which inform attitudes and subjective norms. If "my friends think condoms are awful, and they might find out that I use them" is weighed against "if I use a condom I might not get sick and die in ten years time" the likely result will be that "I will not use condoms". I shall return to cultural practices and constructions of sexuality in Chapter Five. However, if self-concept and self-worth are strong and positive, then this peer pressure may not be so effective.

Perkel employs this useful term, self-concept (1992:25ff). This "refers to the beliefs and evaluations an individual has about himself or herself, these determining not only who the individual is as a person, but also how the self and future potential are perceived (Ibid.). Later he also refers to "a liking and respect for self (that is, an evaluation of self-worth)" (Ibid.:28). This is related to resisting peer pressure, since both concepts are related to the

idea of being liked by friends, and what one does to maintain that. If one has a strong liking for oneself, and thinks one is great, then affirmation for one's actions from a peer group are less likely to be required, and thus one is more likely to do what one wants and thinks is correct, instead of what the group wants. Improved self-concept and self-worth may also be related to a well developed sense of the future, cited earlier as a barrier to action or behaviour change. If an individual thinks about their potential self in positive terms, and about them being a worthwhile individual, then the future becomes important. It is then more likely that they will disregard the cost of action now, in favour of benefits in the future.

At the level of behavioral and normative beliefs, the concepts of self-efficacy and locus of control enter, concepts which Perkel suggests should be used together (1989:29). For these beliefs to be translated into attitudes and norms the individual has to believe, firstly, that s/he is personally able to effect and influence the outcome of an event or decision if s/he puts her/his mind to it, that is, that s/he has an internal locus of control (Ibid.:16ff), and secondly, that s/he has the capabilities to carry through that decision, that is, s/he has a strong self-efficacy. This is not always the case, especially for teenagers, if there is peer pressure against the decision, since adolescence is a time of great uncertainty and experimentation, a time of forming an adult identity, when peer pressure is strong. Being able to stand out in defiance of codes of behaviour requires fortitude, and hence many teenagers have a low perceived self-efficacy. An external locus of control may result in increased peer pressure, since that is associated with feelings of inability to perform tasks, a lack of belief in the self, and a reliance on others for assistance. Girls and women may also have low perceived self-efficacy, due to their socialisation and lower status in society.

Finally, in the theory of reasoned action, the fact that before behavioural and normative beliefs are formed a whole process has to have occurred brings in the problem of knowledge and perceived susceptibility. This, as Weinstein (1989:149ff) and Perkel (1992:73ff) document, is always lower for ourselves than for others. (Please see overleaf for diagrammatic representation of Problems with the Theory of Reasoned Action, and KAP.)

Another model of intervention has been developed by Chris Albertyn, (ex) Counsellor and Trainer at ATICC Pietermaritzburg, and this model was used by him in training educators. This models works in terms of stages of behaviour change, of which there are four. They include: a preparation to change; being ready to change; trial period; and maintenance (Albertyn 16.2.93: pers.comm.). I suggest that these four stages correlate somewhat with the theory of reasoned action, and as I have argued, the other influencing factors and models, such as health belief.

At the first, preparation, stage, the individual has to have information or knowledge - knowing that AIDS exists, how it is transmitted and what can prevent transmission. But it also requires that the individual perceives him/herself to be at risk, and wants to do something about that risk. Here assessment of perceived susceptibility, severity and effectiveness play important roles in deciding whether change is necessary. Also at this level the individual's behavioral and normative beliefs inform the decision to change, that is "what will be the consequences of behaviour change?", and "what will others think of that change?". Finally the individual must believe that the benefits of the change outweigh the costs, for example embarrassment, loss of pleasure, fear of failure. A successful intervention should lead the individual to conclude that s/he thinks that s/he should make the change.

Theory of Reasoned Action
(Fishbein & Middlestadt, 1989)

BEHAVIOUR

INTENTION

ATTITUDE SUBJECTIVE NORM

SALIENT BELIEFS
NORMATIVE BELIEFS AND/OR MOTIVATION TO COMPLY

Knowledge/information; susceptibility (objective & subjective risk); severity; effectiveness of change; barriers to action (structural constraints & poor sense of the future)

Practical Example of the Theory of Reasoned Action

I use condoms
(or likely to in next encounter)

I will use condoms

I think I should use condoms (and I can)

I think others think I should use condoms

Condoms will keep me safe (good)
Condoms will decrease sexual pleasure (bad)

Many important others think I should/not use condoms, and I comply

Problems with the Theory of Reasoned Action

Assumes volitional control, but sex is not a personal choice behaviour since it involves two (or more) people

Power relations between men and women could lead to intentions being compromised

Cultural, pleasure or peer barriers to safer sex require a cost benefit analysis, and self-concept is not considered in this process

Individual must believe s/he can effect outcome, and has the capabilities to carry through the decision, and this internal locus of control and self-efficacy are not considered

Theory of reasoned action ignores knowledge/information; susceptability; severity; effectiveness of change; barriers to action

PRACTICES

ATTITUDES

KNOWLEDGE

The second stage, of being ready to change, can also be seen to be that of having the intention to change. Informed by the previous thoughts and decisions, the individual now intends to make the behaviour change, whatever that might be for the individual concerned. Here external and internal constraints will still influence the ability to enforce the intention.

The third stage, of a trial of the behaviour change, obviously correlates to the category of 'behaviour' of the theory of reasoned action, and again there will be mitigating influences. One such influence is that of perceived self-efficacy, and other influences relate to whether the individual has the resources on hand to actually behave in a particular way. At this level certain skills are needed, and as such may have to be taught and practised previous to this level being reached. They include: how to say "no" to sex; how to use a condom properly; how to talk about sex with a partner; seeking HIV-related services, such as testing and counselling.

The final stage of maintenance of the desired behaviour will also be influenced by the availability of resources, and also societal influences, or peer pressure.

Interventions should assess at what stage the target populations are at, or indeed, whether they have yet reached stage one, that is, whether they have the knowledge about AIDS that is required to consider a behaviour change. The other most important consideration is making the intervention specific to the target group, so that race, class and gender differences in values and interpretation are reflected. What this comes down to is basically a required change in knowledge, attitudes, and practices (or behaviour), or KAP. I suggest that all intervention strategies in essence say this, directly or indirectly, taking into account that

many factors influence all three. How changes in these three are actually effected is what I shall turn to now.

Ideas on Prevention Programmes

Bandura (1989:130ff) suggests four components to an effective programme of widespread behaviour change. They are: an informational component; one which deals with developing social and self-regulatory skills; skill enhancement and building self-efficacy; and enlisting social supports for desired personal change.

The informational component is an extremely necessary one, but is not enough in and of itself. It requires that information be presented in an understandable and persuasive way, that is not fear based. (This anti-fear tactic is corroborated by Mays 1993:208, Kelly and St. Lawrence 1988:71, and Perkel 1992:21.) It also requires that the information be disseminated. This may seem an obvious point, but the terrain of sexuality has not in the past been spoken about very freely, and there is no reason to believe it will become easier to talk about in the future. There are also moral questions of dealing with sex and sexuality that may, for example, confront AIDS educators in schools. Any social, religious, recreational, occupational or educational organisation can and should disseminate information, and thus could also take into account socio-economic, religious, racial and ethnic differences in value orientations that Fishbein and Middlestadt (1989) (and others) mention time and again.

But information does not convince people that they need to change their behaviour: they need to first implicitly believe that they are susceptible to transmission, and that it is worth trying to avoid it, and this is something Bandura omits. This requires that people believe they are

vulnerable, and not that "it won't happen to me", and also that the perceived severity of HIV/AIDS is not overshadowed by other dangers of South African life. Structural constraints to safer sex include violence, poverty, poor access to health facilities, and poor education and chances for the future, since any or all of the first three could seriously compromise health, or lead to death, and the last constraint, poor education, makes the future rather bleak, even if one does survive. Suffice to say that if the perceived dangers of AIDS have to fit into a hierarchy of other dangers and difficulties in the 'average' South African's life, they will be low on the scale. In the light of this hierarchy, present pleasure and any sex, safe or unsafe, is preferable to none.

Simply convincing people that they must change their risky habits is not enough, because most people also need guidance on how to translate their concerns into action. Bandura's second component to an educational intervention, then, (developing social and self-regulatory skills) must encourage self-belief in capabilities to act upon information (self-efficacy), belief in abilities to effect a positive outcome of a decision (internal locus of control), and more generally, reinforce and fortify ideas of self-worth, self-image and a liking for the self (self-concept). Lack of these qualities, I have argued, will negatively effect an individual's decision to initiate a change in his/her behaviour, but improvement of these qualities will have other positive spin-offs in life more generally: they are not confined to the sexual realm, but are useful skills for life.

The third component, skill enhancement and building self-efficacy may be successfully achieved through the use of role-playing (Bandura 1989:130). This allows people to act out a situation in a safe environment with their peers, in a way that allows them to decide on the

outcome of an interaction, and effect that decision. The safety of the environment is key, and people must feel able to say and do what they want, without derision or comeback. They are given practice in dealing with difficult situations, albeit in the classroom, and this gives them confidence to try out their assertiveness in real situations. So adolescents may role-play the situation of a girl suggesting condom use, and encountering resistance from her young man. Dealing with this tricky situation gives her a 'script' to deal with a similar situation: she has rehearsed her words and actions, but in a different, and more rational place. Others watching can give ideas on better strategies, or simply learn form watching the role-play. The girl may also find that her perceived self-efficacy and internal locus of control are boosted because she has successfully negotiated a situation, and thus be more willing to initiate similar conversations in 'real life'. Indeed, Bandura argues that an effective education programme must include a component for building self-efficacy, with opportunities for guided practice and corrective feedback (Ibid.:130).

What should be emphasised is that difficulties in 'real' situations bring self doubts, and the important thing is that the individual recover from this quickly, and be able to continue dealing with the situation. "It is the resilience in perceived self-efficacy that counts in maintenance of changes in health habits" (Ibid.:135). Studies have also shown that perceived self-efficacy in management of sexuality is associated with more effective use of contraceptives (Moore and Rosenthal 1993:18, and Perkel 1992:29). Since many of the same issues are involved, one could perhaps argue that perceived self-efficacy in the management of sexuality would be associated with greater safer sexual practices.

The final component suggested by Bandura is that of social support for personal change. This

again relates to salient subjective norms of the theory of reasoned action, and the role the group or society plays in formulating individuals' beliefs, and sustaining them. One method of doing this, advocated by Bandura (1989:35ff), and also by Kelly and St. Lawrence (1988:71), is through the use of role-models. They should be people who can be related to, and who offer an ideal of behaviour change. As such, Mays and Cochran (1993:210) argue, models should be of similar age, sex and status, and should be known to have dealt with the same problem. However other role-models can also be useful in creating the idea that changed behaviour is a good thing, for example the State President, Miss South Africa, Teenage Dladla, Dr Khumalo.

A second way of supporting personal change is through general community action, and/or developing a culture of condoms. If the society at large, or the particular sub-culture or group, positively reinforces the individual's decision to practise safer sex and behaviour, then it is much more likely to be maintained. "A major benefit of community-mediated programs is that they can mobilise the power of formal and informal networks of influence for transmitting knowledge and cultivating beneficial patterns of behaviour" (Bandura 1989:138).

Erben (1991) also suggests that strengthening community action is an important component of any intervention. Instead of asking "how can we as educators, design a programme that is acceptable to the community?", we should rather be asking "how can we involve all sectors of the community so that an effective programme can be developed?" (Erben 1991:32). These social or environmental supports not only help to initiate the process of safer sexual practises, but also sustain new patterns of risk-reduction activities (Kelly and St. Lawrence 1988:74).

Many writers point to the fact that education and intervention programmes must be culture specific, and take into account differences in population (Kelly and St Lawrence 1988; Fishbein and Middlestadt 1989; Weinstein 1989). The implications of this is that interventions must be different for different target groups: for example, black and white people may impute different values and cultural meanings to the same message, and perhaps more to the point, may impute different meanings to sexual behaviour; men and women may also carry different interpretations of actions. "Risk is not just an individual judgement, but also a social and cultural construct reflecting values, symbols, history and ideology" (Weinstein 1989:146).

> Overall, in the poorer Black community there may be a greater likelihood of sexual activities for survival or in exchange or barter for needed resources. These behavioral differences in Black women result from sociocultural and economic differences between the Black community and White America (Cochran 1989:314).

Of course this applies to America, but I believe the same to be true for South Africa as well. Andre Croucamp, an employee of the Medical Research Council AIDS Unit, suggested that a high percentage of women in South Africa have sex for reasons other than pleasure: for clothes, food, presents, children's school fees being paid, and money (Croucamp 3.2.92:pers. comm.). Cochran argues that for under- or unemployed women coping with the inequalities of society and seeking a sense of belonging, creativity or achievement, they may find sexuality to be a way of demonstrating womanhood and independence through having children and being sexually experienced.

Here in South Africa there is also the added imperative to prove fertility to prospective husbands, and thus the use of contraception is not seen as a high priority, and this is an issue I will return to in more detail in Chapter 5. The use of condoms as a prophylactic against

possible AIDS contraction then, would be seen as a contraceptive and not as a method of safer sex, and thus dismissed by some women. In the case of those who barter sex for money, food or gifts, the power to be able to insist on safer sexual practices is likely to be diminished, and the responsibility for these practises will probably fall onto the partner(s). "For some individuals, prevention behaviour can be a luxury to be afforded only if they do not conflict with other primary needs" (Cochran 1989:317).

The problem with women (so to speak) is that, as stated previously, they have to control the behaviour of men when it comes to safer sexual practices. Women can act somewhat independently of men for contraceptive purposes, but condoms are worn by men, and women must make men comply with their wishes if they are to use them. This is not to say that no man willingly practises safer sex, but if there is a conflict of wills, the woman is at a disadvantage from the beginning because it is not her body that bears the burden of the prophylactic. Bandura suggests that men will resist condoms if they reduce pleasure, threaten manliness and authority, cast aspersions on their fidelity, or imply the man may be carrying the disease. Women often will not press the issue because of emotional of economic dependence, coercive threat or socially expected compliance with men. He recommends that women be taught to negotiate safer sex in a non-confrontational way (Bandura 1989:137).

To restate the case: "(t)he key to their (women's) response to AIDS is their perception of its real danger relative to the hierarchy of other risks present in their lives and the existence of resources available to act differently" (Mays and Cochran 1993:208). They suggest that appealing to culturally-based values of co-operation and unity, such as "be responsible as a daughter/parent/wife/friend" may have more impact than appeals to the individual action such

as "protect yourself". Thus the gender issue is not just about men having to wear the condoms, but a more general situation of lack of female empowerment - in sex, in sexuality and in life. This must be addressed in any AIDS education intervention if it is to be successful.

Lessons from America, or anywhere else, cannot necessarily be applied to South Africa, but I believe that in this instance, lack of assertion in the sexual realm, and having sex for material gain, is applicable to South Africa. It again points to the fact of studying a population before an intervention is started, to assess the real issues and causes of concern in the target group. It is suggested that, in America, interventions are more successful if they help young women (and young men, although Cochran does not mention this) to develop achievable life plans first, then fit issues of sexuality and risk-reduction into that picture (Cochran 1989:315). By way of illustration, contracting AIDS or getting pregnant as a single person unable to afford a child, do not fit in with life goals of a steady, well paid job, perhaps further study, etc.

Aggleton (1989) writes that on a broader scale there are a number of models of health education (Aggleton 1989:223). The first is the information-giving model, where the 'facts' are disseminated among the general population of a country, and the expectation is that people will change their behaviour once they know the risks. This brings me back to the reasons for lack of action I posited at the beginning of the chapter. It is now clearer why information does not necessarily result in a change of behaviour: knowledge or information is filtered through a number of beliefs, attitudes, personal skills of decision-making and carrying out the decision, and perceptions of one's own chance of having to pay for the risk

taken.

The second model is that of self-empowerment, where the aim is to enhance the individual's ability to act rationally, and not on the basis of emotions and feelings. In other words, to avoid succumbing to peer pressure, and to make individual choices. This would be done through participatory learning and group work, to identify the choices people can make. However, it has been established elsewhere in this chapter that the emphasis on the individual is the not the optimal intervention aim, and because of behavioral beliefs and subjective norms, that is, social pressure, an intervention requires a broader focus than individuals.

The third model, known as the community orientated model, attempts to enhance health in the community through collective action - identification of the needs of the community and planning for meeting them (or pressurising authorities to meet them).

The socially transformatory model is the final one, that advocates changing health through far reaching social change. The method of this model is one of developing a critical awareness of social factors affecting health and well-being, and then acting to change those conditions that limit health. Aggleton suggests that the third model may well lead to the conclusion that society needs to be transformed, for example, to make it more equitable, to challenge the poverty and violence that are seen to be impacting negatively on health decisions.

In South African terms, Mary Crewe (1992) asserts that the primary method of health education is the information-giving model. She argues that health education forms the terrain

for the juncture "of two traditionally conservative disciplines (ie health and education) both of which are convinced that there is something fundamentally good in their practice and that we live in a rational world where, as autonomous agents, people can take decisions and make choices about their lives" (Crewe 1992:16). She further advises that to give people information that they cannot act upon, due to structural, social or economic constraints, is disempowering and discriminatory. Aggleton's models of health education are also criticised by Crewe, for the reason that they cannot take enough cognisance of the structural constraints operating in people's lives. Education must be a liberating force, not a constraining one.

All of the above models and ideas for intervention programmes can be criticised in one way or another, especially when translated into the South African context. In this chapter, though, I have tried to develop a set of broad guidelines that should be adhered to when developing any AIDS education programme.

The first comes from the theory of reasoned action, and involves assessing the target population before the intervention is actually tackled, to appraise baseline knowledge, beliefs and actual practises, (KAP), as well as general sexual and behavioral concerns of the target population. The content and type of intervention will be informed by this initial survey.

The second imperative is that the intervention does not fall into an information-giving trap, that is, telling people about the risks of HIV/AIDS without giving them the motivations and skills to change their behaviour. Thirdly, and one of the most important motivations to change, people should be convinced of their own susceptibility to the disease, as without this they will do nothing to avoid contraction. Introducing the target population to PWAs may go

some way towards this. Another important motivation to behaviour change is that structural constraints are addressed, and this would involve encouraging people to make realisable life goals, as well as teaching women the skills to mitigate their social powerlessness.

In order to effect behaviour change and overcome barriers to action, behavioral and normative beliefs, and attitudes and subjective norms must be challenged, and I have argued that strengthened notions of self-efficacy, internal locus of control and self-concept will assist in making the decision to change behaviour. If an individual believes that s/he has the abilities and capabilities to see through a decision, and sees him/herself as a worthy individual, then s/he is more likely to initiate a change. But the behaviour must also be maintained, and practising these skills, and getting corrective feedback in their manipulation adds to the resilience of the individual's decision to change, and indeed, changed behaviour. However Bandura (1989) asserts that there should also be social support for personal change, and this could come, firstly, in the form of role-models, important or well-known people, who claim to have also made a behaviour change, and secondly, through community-wide action in creating a culture of condoms. This culture of condoms will also positively affect individuals' subjective norms, and make peer pressure more likely to support condom use.

But the acceptability of a culture of condoms, beliefs, attitudes and norms will all vary according to culture of the target population, and although I shall deal with this at greater length later in the thesis, evidence of cultural difference exists. In a Cape study, for example, Xhosa-speaking youth seemed to prefer a different method of contraception from all other language groups (Flisher *et al* 1993:496). Thus any intervention around HIV/AIDS and sexuality must be culturally specific, and these specificities should be assessed in the pre-

intervention KAP survey. Gender also creates different perceptions, attitudes and practices in relation to sexuality, and these must also be accommodated in the intervention through plans that specifically mitigate women's less powerful position in society. This could be achieved by focusing on women when teaching self-efficacy and self-belief, and by encouraging women to be more assertive (in sex and in life more generally), and giving them the opportunity to practice negotiating safer sex, and other self-assertion techniques, in a non-threatening way, as Bandura (1989) suggests. The other side of this coin is to educate men about socialised gender divisions, and encourage them to be more sensitive to women's rights.

Finally, a successful programme must incorporate an evaluative aspect. The educators themselves could evaluate the process of the intervention, for example, whether the programme was implemented as planned, which parts worked well, and which did not, whether the resources were adequate, whether the programme was culturally and gender specific enough, whether (in their opinion) recipients gained anything from it, what they did and did not gain that the programme intended them to. The recipients of the programme should be asked a set of questions evaluating the outcome of the intervention, and these will be greatly informed by the pre-intervention questions. However, changes in ideas of susceptibility could be assessed, as well as changes in KAP; they could also be asked whether they found the programme useful, and what they think they learnt from it.

Yet, I believe that an AIDS education programme could follow these guidelines to the letter, and still fail. Unless the education programme takes into account real concerns about sexuality, sexual practices, and relationships, it may fall on deaf ears. The pre-intervention

survey should ensure that this does not happen, but the possibility exists that the designers of the programme feel that teenagers should not be having sex, or that they should not be told about sex, in case it encourages them to go out and try it, and thus avoid the issue, or skirt around it. In the next chapter, I shall examine the gender relations that our society is based upon, and from there, attempt to construct a model of sexuality that I believe to be hegemonic, and conservative. Unless this conservative notion of sexuality is challenged, any AIDS education programme that employs it is bound to fail.

CHAPTER FIVE

Sexuality

In the last chapter I looked at how AIDS educators can effect behaviour change, from a risky or unhealthy action, to one that is safer or healthier. Examples used come from a range of risk-taking behaviours, such as smoking, not wearing seatbelts, living a high-stress low-exercise lifestyle, not using contraception, and not using condoms to prevent AIDS and other STDs. The rationale behind this foray into the realms of psychology is that directing behaviour change involves much more than letting people know of the dangers of their choices, and hoping they will use this information to change. It involves understanding how decisions to act are made, what influences people to act in certain ways, and how we incorporate this into a behaviour change programme.

In this chapter I will examine a specific type of behaviour, that is, sexual behaviour, since changing this is the aim of any AIDS education programme (or changing another type of behaviour, like drug-taking, if AIDS is multi-factorially caused). In order to do this, one must try to understand what sexual behaviour is about, try to uncover motivations and beliefs about it, and analyse to what extent gender differences play a role in these behaviours: in short, one must investigate sexuality. In this task I shall start by looking at the notions of sex and gender, and how they differ, and thereafter examine the work of various sexologists, starting with Freud, and the work of other people concerned with sexual relations.

Everyone knows that men and women differ anatomically, and in terms of their chromosomal

make-up, and we also know that men and women are different in terms of their behaviour, personalities and psychologies. Feminist writers, such as Greer, Millett, Oakley and Friedan (and others)[1] have attempted to distinguish between biology and personality or behaviour with the use of the terms 'sex' and 'gender': "'Sex' is a word that refers to the biological differences between male and female: the visible difference in genitalia, the related difference in procreative function. 'Gender' however is a matter of culture: it refers to the social classification into 'masculine' and 'feminine'" (Oakley 1972:16).

These writers sought to uncover how different we really are, and how much these differences are exacerbated for the control and oppression of women. If biology creates women weak, emotional, unintelligent and unambitious then that is one thing, but feminists suspected that society creates these notions, or at least over-emphasises biology's role in their making. Hence the research into the actual physiological similarities and differences between men and women, and the reflection and observation of how society treats men and women differently, and has different expectations and rules for the two sexes. This became known as the nature-nurture debate: what percentage or part of us is made in nature or biology, and what through nurturing or culture.

'Masculine' has connotations of "aggression, intelligence, force, and efficacy", while 'feminine' incorporates "passivity, ignorance, docility, 'virtue', and ineffectuality" (Millett 1969:26) and the masculine traits are much more highly prized in our culture: this bias was

[1] I have used the work of some of these early writers to explain socialisation as it was first conceived in the early 1970s. Writers in the 1990s are not so concerned with the mechanics of socialisation, but rather more with the manifestations in in social, economic and political terms, as some of the quotes from Lorber (1994) show.

at the root of the feminist suspicion that society oppresses women. "Feminists from the late sixties had stressed the distinction between biological 'sex; and socially constructed 'gender', in order to challenge and reject the ubiquitous mythologisizing of women's 'nature' and place in the world" (Segal 1994:222). As Segal's words suggest, masculinity and femininity give both the genders definite roles and "places in the world" that they are obliged to conform to; restrictive to both genders, even though the male role is more valued. In addition men have more freedom to engage with the world, because the woman's role, traditionally speaking, is to look after house and home, and to produce and look after children. Even in this (post-) modern era domestic equality in terms of shopping, cooking, cleaning and child-care is confined to a minority (Lorber 1994:172).

Society generally perceived women as subordinate to men, and herein lies the rub. It is not the gender-roles themselves that they necessarily objected to, but the fact that "(t)he point of the (gender) differences is to justify the exploitation of an identifiable group - women" (Lorber 1994:5). It is the exploitation, borne out of gender roles that are thought to be constructed rather than inevitable, that feminists have objected to. Millett argues that "sex is a status category with political implications ..... (t)he word 'politics' is enlisted here when speaking of the sexes primarily because such a word is eminently useful in outlining the real nature of their relative status, historically and at present" (1969:24). As we understand racial interaction and oppression to be a political phenomena, due to power relations in society that maintain the system of racial discrimination, so, she argues, should we see interaction between the sexes as a political experience: "birthright priority whereby

males rule females" (1969:25). This state of affairs she calls patriarchy[2].

So how is it that society is able to create, define and maintain gender stereotypes? It is socialisation that gives people their genders and the roles that go along with them, and this process starts, usually, with birth, and different clothes, expressions used for girls and boys: indeed, the most common question on seeing a new baby is an enquiry into its gender. Many children are given sex-appropriate toys - dolls for girls, and tanks and cars and planes for boys. The significance of sex-appropriate toys is that they train children for different roles when they grow up: for example, girls nurture their dolls and their families, play house and run a household, and are trained in cooking and cleaning; boys, on the other hand, make and construct things, and their cars, tanks and planes focus their vision to a world beyond the home, to travel and interaction with others.

However, it has been suggested to me by two friends that even when parents consciously try to give their children sex-neutral, or sex-inappropriate toys, children tend to gravitate towards appropriate toys and behaviour, and this may be seen to be an argument for biological determinism: boys are naturally more aggressive, and girls more passive. I would argue that the nature of socialisation is that it is not limited to one person or environment, and other socialising factors include the peer group and the education system (Haralambous 1980:4), as well as books, television and movies. But "probably the most important aspect of the socialisation process takes place during infancy, usually within the family" (Ibid.).

[2] Various types of feminsts have associated 'patriarchy' with different explanatory frameworks: liberal feminists (who avoid the term 'patriarchy') see in equality as being on the level of political and legal institutions; radical feminists argue that patriarchy seeks to control women's sexuality and reproductive capacities, through permeating all social institutions; while marxist feminists see the oppression of women as something akin to the oppression of the proletariat: the family exploits women, as capitalism exploits workers.

Oakley suggests that children learn from imitating and identifying with their parents, and are given rewards for doing so (1972:179), and this is corroborated by Haralambous (Ibid.:4): strong gender roles at home reinforce gender roles in children.

Luria suggests a time framework for children developing and internalising this gender stereotyping. The critical period in gender identification comes at about 18 months, at the same time as language develops. By 24 months children begin to sex-sort the outside world of people and objects, and by 30 months can sex-sort themselves, that is, they can identify themselves as girls or boys. By 36 months they use gender labels to guide their choices, so that when offered a range of toys to play with the girls go for the 'female' toys and the boys for the 'male' ones (Luria 1979:173ff). Eleanor Maccoby disputes Luria's documentation of the age boundary of the critical period in formulating gender identity, but she does not dispute the fact that this identification happens (Maccoby 1979:193).

The finer timing of language and gender identity development are not important here. What is important is that gender identity is linked to language acquisition and thus to cultural influences. Gagnon supports the notion the children acquire their gender identities "early in life", and these are developed and strengthened until they cumulate into gender specific roles and performances. By the time they are teenagers, people have a well-developed sense of 'boyness' and 'girlness', 'manness' and 'womanness' (Gagnon 1979:229).

At puberty, too, boys and girls are treated differently. There are differences in the physiological changes that take place in young girls and boys, but these differences can either be minimised or exaggerated. Usually biological differences are exacerbated, since there is

no reason why young girls should not also be encouraged to go out and explore: nothing in the young girl's physiology stops her from doing so. It is our cultural belief and gender stereotyping that suggests a young girl should not be too active and interactive lest 'something' happen to her, and this could be construed to mean that girls, and later women, need protection.

Girls' whereabouts are monitored more closely than boys' during this time, in an effort to keep them safe from their own libidos, or perhaps someone else's. There is also a sense that young girls cannot wander alone at night, for fear of rape, while boys can.

> Implicit in all the gender identity development which takes place through childhood is the sum total of the parents', the peers', and the culture's notions of what is appropriate to each gender by way of temperament, character, interests, status, worth, gesture, and expression. Every moment of the child's life is a clue to how he or she must think and behave to attain or satisfy the demands which gender places upon one. In adolescence, the merciless task of conformity grows to crisis proportions. (Millett 1969:31)

Gender, and the corresponding values, become internalised, so that they become second nature, or indeed, nature itself.

> Children are transformed into adults who are not only conscious of their gender roles but have, through long years of learning, internalised them and made them part of their own personalities. The process of socialisation by which this is done extends through childhood into adult life. (Oakley 1972:186)

It may be suggested that times have changed, that crude stereotypes about gender and oppression of women, at least in industrial democracies, are no longer valid. These are the nineties, decade of the SNAG (sensitive new age guy), where 'masculine' is not equated with aggression and ambition, and where women are seen to be equal partners in all facets of society, and not passive, ineffectual homemakers and child-minders. Women's claims to

sexual equality and pleasure are recognised as equally important to men's, perhaps more so. Awareness of the phenomenon of socialisation may have provoked some changes in child rearing practises, such that we avoid the blue-pink dichotomy for babies, the dolls and guns distinction for older children, and double standards that we set for our teenagers. It is true, times have changed since the 1960s and 1970s, and our notions of gender are better informed, less inflexible, and less restrictive. Yet, we are still located within a paradigm of gender, and that gender is still a social construct that gives women a lower status. "Gender has changed in the past and will change in the future, but without deliberate restructuring it will not necessarily change in the direction of greater equality between women and men" (Lorber 1994:6).

Lorber makes a more sophisticated argument than Oakley, analysing "gender as a process of social construction, a system of social stratification, and an institution that structures every aspect of our lives because of its embeddedness in the family, the workplace, and the state, as well as in sexuality, language, and culture" (Lorber 1994:5), but her analysis is based on the ground-breaking work of Oakley and other feminists. Their initial, and perhaps extreme or simplified, examination of the organisation of society which results in women's lower status and power, has meant that Lorber, and anyone else writing about society, social relations or sexuality, can no longer ignore the issue of gender. These women asked the first sets of questions, and provided some of the answers, and while some of their notions may be outdated, their concepts have proved solid.

Lorber builds on earlier feminist theory, in that she contends that gender organises both everyday life, and major social structures, what she terms "gendered microstructures" and

"gendered macrostructures" respectively. These two forces reproduce and reinforce each other, since "(t)he social reproduction of gender in individuals reproduces the gendered societal structure; as individuals act out gendered norms and expectations in face-to-face interaction, they are constructing gendered systems of dominance and power (Ibid.:6). Thus we can never get away from gender, and the inequalities it brings.

But what has this to do with sexuality, and what exactly is it? Sexuality is very difficult to define exactly, although it may be that we have an intuitive understanding of it. "As formally defined, *sexuality* is the quality of being sexual, the possessing of sexual capacity and the capability of sexual feelings. But in common usage the term is endowed with additional meanings..... the term seems always to represent something more than *sex*" (Katchadourian 1979:12). Katchadourian offers another definition, again pointing to the fact that sexuality is a rather amorphous term: "(b)eyond reproduction, beyond orgasmic pleasure, sexuality permeates our thoughts and feelings in countless ways, sometimes without our knowing it" (Ibid.:2).

If gender is constructed, what are we to make of sexuality, and any linkage between the two? According to Lynne Segal (1994), the relationship is clear:

> Gender and sexuality provide two of the most basic narratives through which our identities are forged and developed. If there are no certainties here, there are no certainties anywhere. In the West, at least, we live in a subjective world where the dynamics of gender, tied in with heterosexual imperatives (or our resistance to them), provide the foundations for our sense of self. (Segal 1994:269)

John Gagnon (1979) argues, in his article "The Interaction of Gender Roles and Sexual Conduct" that these gender roles and other issues pertaining to sex and sexuality often have

an ideological component; approval from society in sexuality and sexual behaviour is usually based on and mimicked in approval in gender roles (Gagnon 1979:226). Thus good gender roles give rise to good sexuality roles. Katchadourian (1979) also argues that sexuality is influenced by gender, and that psychological and cultural meanings of gender influence sexual behaviour (1979:3).

If gender is culturally constructed, and gender and sexuality inextricably linked, then we can conclude that sexuality is also, at least partially, a construct of culture. "In this (the social-construction) view, ideas about sexuality have a history, structure, and politics that affect any individual's developing sexual desires and behaviour" (Lorber 1994:56). Sexual practices are organised into what society approves, permits and taboos, and these are internalised by individuals. Not surprisingly the meanings of sexual behaviour vary greatly over time and place, depending on cultural changes. But culture not only tells us what we can and cannot do in terms of sexual practices, but also creates our sexual identities, which are encoded in a web of social practices - legal, pedagogic, medical, moral and personal (Weeks 1987:48). (The cultural construction of identity and sexuality is supported by a range of writers: Katchadourian 1979; Gagnon 1979; Lees 1986; Jackson 1987; Caplan 1987; Moore and Rosenthal 1993; Foucault 1990.)

Again, if our gender is constructed, and if it is linked inextricably with our sexuality, then we must ask how our sexuality is constructed, and to what end. I turn now to Sigmund Freud, the man who is said to be responsible for the basis of our present notions of child and adult sexuality, and thus, his writings are a good place to start to try to understand the origins of our sexuality.

Freud was born in 1856 in Morovia, but he grew up in Vienna. He studied psychology in Paris, and later developed a method of hypnosis and 'free association' to treat patients who were neurotic or hysterical. He wrote a paper on the subject, together with his great friend Dr Josef Breuer, in 1895 (Jones 1963:159). The aim of hypnosis is catharsis, and free association is meant to be the same, with the analyst asking questions, and urging and pressing for associated words or ideas, and this exposure giving rise to a purging of painful emotions. However, Freud found that, in the conscious state, there was 'resistance' and 'repression' of these painful memories, and since they are hidden, Freud believed they are all the more important. This was the beginning of psychoanalysis, a method of enquiry in to the human psyche or unconscious.

The unconscious was found to hold desires and wishes that get their energy from the primary physical instincts. These are mainly of a sexual or destructive nature and their only aim is to obtain immediate satisfaction. They can be, and often are, at odds with the conscious parts of the mind, which is constricted by societal pressures and perceptions of danger. Freud also used such techniques as examining dreams, slips of the tongue or pen, and humour, to allow him access to the unconscious. He later attempted to do away with the word 'unconscious' because of its vagueness, and instead posited a theory of three levels to the unconscious: the id, which comprises the instinctual trends; the ego, which is the 'organised realistic part'; and the super-ego which acts as the moral and critical watchdog. But what was of primary importance and something he did not initially pursue, was that many significant memories, associations and dreams, that is, the contents of the unconscious, concerned sexual experiences, which Freud interpreted to be 'phantasies' (Jones 1963:172).

It has been suggested that to read Freud one must understand two core concepts, namely the unconscious, and infantile sexuality (Mitchell 1974:7ff, and Wright 1992:129). Mitchell claims that critics of Freud, such as de Beauvoir, miss the point, because they impute conscious decisions and perceptions onto Freud's notion of the unconscious (Mitchell 1974:8). Thus, Freud is unfairly criticised for his ideas of penis envy, by women claiming that they have never felt such a thing: of course, they could not have, because that envy, and other desires, all happen in the subconscious. For Freud the definition of sexuality was very broad, and included all the components of life-energies or libido, and all their manifestations, both conscious and unconscious (Ibid.:19ff).

Another important aspect to note in Freud's work involves the concepts of masculine and feminine. The two do not correlate to male and female, nor to men and women. Instead when Freud uses masculine he refers to something active, while femininity connotes passivity. As an example, masturbation is a masculine trait, that appears in boys and girls, because it implies an active seeking of pleasure. He goes on to stress the importance of the concept of bisexuality, without which, he claims, "it would scarcely be possible to arrive at an understanding of the sexual manifestations that are actually to be observed in men and women" (Freud 1905:142). By bisexuality, Freud means the combination of both masculine and feminine traits in one person - something that we all have to a greater or lesser degree (Ibid.:79).

The final point to make is that because of his changing ideas, and the vast amounts he wrote, it is easy to find discrepancies in his work, eliciting arguments against him and counter-arguments to these. Sigmund Freud was a prolific writer, his works spanning from 1893 to

1938, who changed his ideas and theories in accordance with his continuing clinical observations. What he has to say about sexuality can be found in many different places, (indeed, since the unconscious and sexuality were his life's main project, something on both is to be found in almost all of his work) and ranging in time from 1905 ('Three Essays on the Theory of Sexuality') to 1931 ('Female Sexuality') and beyond. For the purposes of this chapter I have decided to outline the development of sexuality in children's lives, according to Freud, in accordance with their maturation, and not always following Freud's chronology.

The first time Freud tried to grapple directly with 'sexuality' was in 1905 when he wrote 'Three Essays on the Theory of Sexuality', the first of which was entitled 'The Sexual Aberrations'. In this Freud suggested that there are two components to the sex act that must be recognised, these being the sexual object and the sexual aim. By using 'deviations' from the 'normal' object to illustrate, he defined the sexual object as the person (or thing) to whom the sexual attraction proceeds (Ibid.:45ff). In the case of homosexuals, the object is a person of the same sex, as opposed to the object 'norm' of an adult of the opposite sex. Other inversions, as he named this 'aberration', include the object being a child or an animal. Deviations in relation to the sexual aim were labelled perversions, the aim being the act towards which the instinct tends. For example oral sex was seen as a perversion in that the 'aim' is not sexual satisfaction through genital intercourse, but through oral stimulation.

In other words, the object is the thing through which the instinct can achieve its aim, and becomes an object only through its ability to give satisfaction: there is no natural object to the desires of the unconscious, and 'normal' sexuality develops from many component drives (Mitchell 1974:28). In 'normal' sexuality these components have been sublimated

(redirected), unified at puberty to allow primacy of the genitals in attaining sexual satisfaction, to constitute an appropriate object (adult of the opposite sex) and appropriate aim (reproductive intercourse). We are all polymorphously perverse, but through cultural feelings of guilt and shame we reign in our desires and take on the idea that 'normal' sexuality is heterosexual, genital and reproductive.

In the second of the essays, on 'Infantile Sexuality', Freud outlines the development of sexual objects that children progress through: firstly an oral stage, where pleasure is found through suckling on the mother's breast; secondly, an anal stage, where pleasure comes from defecating (and probably being cleaned and held afterwards); and finally a genital stage, which involves masturbation. The child, at this time, is said to be autoerotic, in that satisfaction comes from all sources, and is not yet combined to form a conception of sexuality, or an object (Freud 1905:157). This auto-erotic, pleasure-seeking being is polymorphously perverse, and its desires are completely unchecked, since the as yet untalking child has no conception of society.

The final essay of the 'Three Essays' is entitled 'The Transformations of Puberty'. The main change in puberty is that the sexual instinct finds an object. It also marks the combination of all the erotogenic zones, subsumed under the primacy of the genital zone which becomes the focus of the new aim. "The sexual instinct is now subordinated to the reproductive function" (Ibid.:128). In this sense our sexuality is constructed: it is changed from its natural state, moulded and shaped by society's notion of what it should be like, to meet some end. That end is reproduction, and for Freud this sublimation was key to developing societies: the redirected sexual energy is used in the construction of 'civilisation'.

The instinct can also be repressed by the mental process of social acceptability, and is not admissible to the consciousness. However it must find expression somehow, and the libidinal impulses that cannot be expressed are transformed into symptoms of an illness (neurosis) and thus escape (Ibid.:162). Or, as the other side of the neurotic coin, the instincts may grow into perversions that act as the actual vehicle of sexual activity, for example, homosexuality. Perversions occur when there is no, or little, unity of component drives at puberty, and some of the components of sexuality continue to be active. Any sexual activity that was not aimed at heterosexual intercourse was labelled unnatural, incorrect and perverse.

In a paper of 1925, entitled 'Some Psychical Consequences of the Anatomical Distinction Between the Sexes', Freud suggests that the genital zone is discovered in girls and boys at the same time, but that girls "notice the penis of a brother or playmate ..... and at once recognise it as the superior counterpart of their own small and inconspicuous organ, and from that time forward fall victim to envy for a penis" (Freud 1925:335). When boys see girls' genitals they are uninterested, but later this serves as a confirmation of the reality of castration, which previously was perceived only to have been threatened. This, claims Freud, leads the young lad to a state of "horror of the mutilated creature or triumphant contempt for her" (Ibid.:336).

Boys have formed an Oedipal relationship with their mothers - wanting love, attention and satisfaction from birth. Once the genital stage has been discovered castigation for masturbation, usually by the mother, and the abovementioned 'horror' for girls, leads the boy to believe he will in fact be castrated, by his jealous father. Since this is a shocking state of affairs, he gives up his incestuous longing for his mother, and thus his Oedipus complex is

shattered. For girls the consequences of penis-envy are that they feel inferior because of their castration or 'lack' (this is not Freud's term, but Jacques Lacan's), and start to show contempt for their mothers, for creating them inadequate, and so moving away from their first love-object. The father becomes the true love-object, and it is with them that girls form an Oedipal bond: castration creates the Oedipus complex in girls, while castration shatters the Oedipus complex in boys.

Most girls also all but stop masturbating because it reminds them of their unfortunate condition, and this is an important pivot of the argument, because Freud claims that masturbation of the clitoris is a masculine activity, and giving up this masculine activity is a "necessary precondition" for the development of the girl's femininity (Ibid.:340). Girls go on to develop an antipathy for their mothers, for creating them 'lacking', and from a strong attachment to their fathers. Finally the little girl no longer wants a penis, but wishes for a child instead: she takes the father as the love object and becomes jealous of her mother. Here Freud is clearly working in a patriarchal paradigm because the point of reference is boys and men. Essentially what he is arguing is that it is necessary for women to become passive, or feminine.

For a boy it is the narcissistic interest in the preservation of his genitals that ends the possibility of achieving satisfaction of his desire. The first threat involves castration by his jealous father, and the second involves being castrated (as all women are), as a precondition to sex with the father (Ibid.:317ff). The narcissism usually wins out and the ego repudiates the Oedipus complex. This is not a repression, but a destruction. "The authority of the father or the parents is introjected into the ego, and there it forms the nucleus of the super-

ego, which takes over the severity of the father" (Ibid.:319). Boys leave behind their infantile sexuality, and thus go on to 'normal' adult life.

For a girl, since castration is not a threat, but a *fait accompli*, there is no reason for her to resolve the Oedipus complex and it persists far into normal mental life, such that "for women the level of what is ethically normal is different from what it is in men. Their super-ego is never so inexorable, so impersonal, so independent of its emotional origins as we require it to be in men" (Ibid.:342).

After the infantile stage, characterised by the three erotogenic zones, the child goes through a period of latency, at approximately age four. This is the time when the learning and sublimation occur, and what Freud pointed to was disgust, shame, claims of aesthetic and moral ideas, and the influence of education in the development of these (Freud 1905:93). "To Freud society demands of the psychological bisexuality of both sexes that one attain a preponderance of femininity, the other of masculinity: man and woman are *made* in culture" (Mitchell 1974:131, her emphasis).

Indeed, in "Totem and Taboo" (1913), Freud argued that carnal desires had to be reigned in for the survival of civilisation: the natural perversions - as evidenced in the promiscuity and matriarchy of the 'primitives'- had in the course of history been subsumed to the forces of civilisation - natural monogamy and patriarchy (Weeks 1985:101). However Dollimore (1991) draws some implications from this, although he essentially attributes them to Freud, or rather, his reading of Freud. Freud argues that modern civilisation requires heavy repression of people's perversions, and the resultant energy is displaced into increased or

high cultural activity. However, perversions may occur if they are not adequately sublimated, and this goes against the grain of civilised sexual morality, because they are counter to marriage and hetero-reproductive relations (both of which are crucial to the maintenance of the patriarchal society). As civilisation becomes more sophisticated, so do our wants and needs. This sophistication also corresponds to an increase in cases of neuroses. Quoting Freud, "the physical value of sexual satisfaction increases with its frustration", thus suppression may have the opposite effect to what was intended. What culture should repress, for its own reproduction, it actually produces, through the very act of repression. This Dollimore calls the 'paradoxical perverse' or the 'perverse dynamic' (Dollimore 1991:186ff).

Sayers (1986) corroborates Mitchell's findings that Freud did indeed understand something of the cultural or societal shaping of women's, and men's sexuality. She notes that a girl not having a penis is a biological fact, that also carries with it a sociological connotation, and this is acknowledged in 'Three Essays'. In other words there is a cultural elaboration of the sex differences which expresses men's dominance and women's subordination: active is equated with masculinity, and passive with femininity (Sayers 1986:111ff).

Freud's definitions of the object and aim, and the assumptions upon which they are premised, could be seen to place Freud into a paradigm of heterosexist patriarchy, where the only normal sex is that of penetrative intercourse, and anything else is relegated to the abnormal. However, he also claimed that we all have perversions, which become pathological when they take place in all circumstances; that is, when they are exclusive and fixated, not merely appearing along side the 'normal' sexual object and aim. He concluded firstly that sexual instincts struggle against mental forces, for example, shame, disgust and morality: thus,

society and culture act as a resistance or check on the instinct, thereby making it 'normal'; and secondly that the sexual instinct has a composite nature (Freud 1905:76). It has been suggested that he was trying to describe his culture not judge it. He can still be admonished, though, for not trying sufficiently hard to step back from his own culture and assumptions, especially his (hetero-)sexism.

Responses to Freud have abounded, not least in his own time, as suggested by Paul Robinson (1993:115). Freud came up with an extremely contentious idea, "an idea that was (even more) offensive to the prejudices of this culture, the theory of infantile sexuality." But the first in a long series of feminist criticisms came from Simone de Beauvior, in The Second Sex, first published in 1949. Wright suggests that in the 1960s there was a wave of feminist and leftist critique of psychoanalysis, with Greer, Millet, de Beauvior, Freidan and Weisstein constituting the core of the feminist attack (Wright 1992:132): it is de Beauvior who comprises the backbone of this grouping.

de Beauvoir's criticisms stem, as Mitchell has correctly pointed out, from the stance of existentialism (Mitchell 1974:306), a philosophy that understands humans as taking on meaning of their existence in the actions and projects performed. Each person takes responsibility for and seeks freedom or autonomy from these acts, determining their own lives and futures. Anyone tampering with that autonomy is interfering in one's life, oppressing one and is, therefore, an oppressor. Thus, according to de Beauvoir, Freud was an oppressor, since he sees women not as autonomous individuals, but defined in relation to men, and as 'the other'. The female libido is a deviation from the male one, and does not have its own inalienable nature (de Beauvior 1949:71). Here Freud is being criticised for

exacerbating differences in sex, and inculcating gender differences.

Mitchell postulates that the castration complex is key for Freud because it marks the psychological distinction between the sexes, and it must be taken together with the ideas of bisexuality and the Oedipus complex (Mitchell 1974:74). For Freud then, biological differences create gender differences, because the anatomy of girls and boys causes the development of very different sexualities and personalities, through the super-ego. Culture, though, plays a large role in dictating appropriate sexuality, so much so that at puberty sexuality is reconstructed, from being polymorphously perverse, to being 'normal' in its aim and object: the reproductive couple is given pride of place, in fact the only place.

A reading of Freud is not complete without an examination of his times, and others types of research that were going on. I refer here particularly to the sexologists, as they were called, although some would argue that Freud was one of these. The word sexology means "the study of sexual life or relationships" (The Oxford Dictionary of Current English:1986), but more than that, I think it is the making of sex into a scientific field of study. The studies are based on scientific principles of investigation, and this implies 'laws' and 'universals' that cannot be changed.

Richard von Krafft-Ebing was the first explorer in this field, writing the first edition of his now famous Psychopathia Sexualis in 1886. The aim was to discover, describe and analyse the laws of nature, to find out the secrets of this natural phenomenon[3]. He focused on the

[3] This, of course, happened at the same time as others were trying to understand the laws of society - Marx and Engels, Maw Weber, Emile Durkheim and others (Weeks 1985:64).

'sexual perversions' - sexuality gone wrong - in order to better understand the workings of the 'true' sexuality inherent to human nature. He catalogued an amazing array of these 'perversions', and his work, and that of Havelock Ellis was cognisant of gender differences. Writing Man and Woman in 1894 Havelock Ellis sought to understand the differences between men and women, arguing that the basis of the differences lay in the fact that men's natural object was women, and women were the passive recipients of that desire. This is significant, as it marks a definite time when we see the passivity of women, and the sexual aggressiveness of men, as being noted and labelled natural. It also sets parameters by which to judge sexuality, in that it defines the norm, and what is integral to our very beings. "Sexology came to mean ... both the study of the sexual impulse and of relations between the sexes, for ultimately they were seen as the same: sex, gender, sexuality were locked together as the biological imperative" (Weeks 1985:69).

These sexologists believed that although there is a wide range of individual differences and experiences in relation to sex, a complex natural process underlay all sexual activity, and this had to be understood (Weeks 1987:34). We can see how Freud fits into this paradigm - he also looked to the perversions to understand the normal, and also worked within the assumption of a 'normal' or 'natural' sexuality. To Freud it was civilisation, to other sexologists it was biology and mother nature that wanted and expected heterosexual coupling. Either way, that was created as the norm. Anyone not pursuing this natural and innate goal was therefore 'sick' in some way, denying their 'true' essence and thus perverse. But the investigation of sexuality had to be scientifically pursued, and all of these writers saw themselves chiefly as 'scientists'. This presumes of course that there is a sexuality waiting to be investigated, and there was no thought given to social construction of sexuality, as

noted above.

Later sexologists, such as Alfred Cans, writing in the late 1940s, and Masters and Johnson, from 1966 onwards, and various others who wrote manuals about sex, all fell into the same paradigm. Manuals advise men on how to woo women, how to arouse them, but Jackson argues that this is always in the form of what is perceived as 'natural' sexual practice, and man as the sexual aggressor. She suggests that the sexologists' messages had five essential characteristics (Jackson 1987:72ff):

1. Sexual desire is a natural instinct that needs outlets.
2. If the (male) drive is denied legitimate outlets it will find illegitimate ones, for example rape, OR
3. Repression may lead to physical or mental illness, for example neurosis in women.
4. The need for sex is as basic as the need for food and sexual starvation has dire consequences.
5. The sex we need is penetrative intercourse, that is copulation or coitus.

These 'laws' legitimise the myth that male urges must be satisfied, and they define the nature of sex in male terms and thus "male sexuality has been universalised and now serves as the model of *human* sexuality" (Ibid.:73, her emphasis).

> The pioneers of sexology played their role in re-affirming male domination as biological inevitability, portraying 'the sex act', understood as heterosexual genital engagement, as its exemplary moment. A woman's sexuality, although given a (more) autonomous existence, still required a man to initiate and release it (Segal 1994:79)

It was with the work of anthropologists that the cultural setting of sexual activity came to be seen as informing practice - most importantly with Bronislaw Malinowski's The Sexual Life of Savages, published in the 1930s. He started his investigations of other people's sexual habits (specifically the people of North-Western Melanesia) with the assumption that their habits could be interpreted along evolutionary lines, that is, he saw their practices as a mirror

of our forebears'.

But Malinowski went further than this simple relativist model, and suggested that the differences of sexual behaviour provide evidence for the variety of sexual and social developments possible. The human instincts have the potential to adapt to different environmental conditions, and over time these become habits. Margaret Mead, investigating adolescents in Samoa also showed that different cultures displayed different attitudes to sex and gender, and this could not be seen in a purely linear and evolutionary way. However what could be seen in all of these societies was that gender differences still manifest themselves in a sexual division of labour (SDL), due to biological differences, and in the formation of the family. There is no dispute about biological differences between women and men, but what Mead and Malinowski show is that the consequences of these differences are not inevitable, and they are certainly not set in nature.

Weeks asserts that none of these pioneers could actually explain the social origins of sexuality - instead they assumed an individual human nature, that was adaptable, but that existed as a universal. Thus biology is the chief determinant of sexuality. This explanation, though, cannot shed any light on motives, passion, object choice or identity that we in the modern world take to be part of our sexuality (Weeks 1985:122). These things come from social relations and psychic conflict, where norms abound, but where 'the natural', or 'the truth' about sexuality cannot be uncovered, at least not for society as a whole. The body, then, must be seen as an "ensemble of potentialities which are given meaning only in society" (Ibid.:123). In other words, sexuality is, at least partly, culturally constructed.

Jonathan Dollimore (1991) also examines the issue of perversity, in an attempt to better understand society's attitudes to it and, more generally, to sexuality. Using Freud as his starting point he teases out the relationship between the normal and the perverse, and bases his findings on three important premises, all taken from Freud: firstly he believes that some perverse trait is seldom absent from the sexual life of 'normal' adults; secondly, there is then a continuum between normal and perverted; and thirdly he asserts we can only understand normal sexuality by understanding its pathological forms.

However, Dollimore argues that the distinction between normality and perversity is steeped in morality, and again this morality is a cultural notion: he adapts Freud to argue that "sexual morality (is) imposed by and within modern civilisation to secure its survival" (1991:186). Perversions and deviations, then, undermine marriage, which is central to that morality, as marriage leads to reproduction and the maintenance of society. Hence biology, reproduction and marriage are all created as imperatives in our society[4], the 'natural' way to be, and perversions are thus immoral and unnatural. I turn now to Foucault for a more thorough examination of how and why these imperatives were created.

Michel Foucault has been most influential in this century, as his ways of thinking and writing marked a radical change from mainstream academia. He turned theories on their heads, and challenged notions that we took, and still take, to be commonplace. One such notion was that of sexuality, about which he wrote in 1976. In The History of Sexuality (1990), Volume One, he argues against the 'repressive hypothesis' - that is, the hang-ups from the Victorian

[4] The same is true for other, non-western. societies, in that marriage can be found as a cultura phenomenon the world over.

era, when sex was not discussed, and when it only happened in the home, for the purpose of procreation, between married couples.

> The legitimate and procreative couple laid down the law. The couple imposed itself as model, enforced the norm, safeguarded the truth, and reserved the right to speak while retaining the principle of secrecy ..... And sterile behaviour carried the taint of abnormality; if it insisted on making itself too visible, it would be designated accordingly and would have to pay the penalty. (Foucault 1990:3ff)

This, he argues, is not the whole picture, since while indeed the procreative couple became dominant, and 'abnormality' ignored or silenced, our sexuality has not been repressed, but was created or invented. In Europe, prior to the seventeenth century the Sovereign had power over the death of his (invariably) subjects, and various crimes carried with them the penalty of death. Treason was the notable forerunner in this regard, and the Sovereign was deemed justified in any measures he wished to take in order to maintain his sovereignty and security. However after the seventeenth century, as the bourgeoisie instead of the aristocracy became the leaders of society, and the state became an entity in itself, the power over death became the power over life, and this power became more diffuse, not centred in the Sovereign, but in the state, in all its manifest forms. The formation of capitalism was precipitated on the idea of a healthy and continuing workforce, and, as feminists would argue, on ensuring the laws of hereditary. (This link between the repression of sexuality and the rise of capitalism is also supported by Caplan 1987:6.) Thus marriage and reproduction were essential to the capitalist society of the nineteenth century.

Laws and norms of behaviour were inculcated in society, and some of them pertained to sex and the family (Foucault 1990:26). As the power of the Sovereign became institutionalised in the state, that power proliferated, and became more subtle and insidious. One focus of this

power was sex and sexuality. Thus power over death becomes the power over life, the body, reproduction and sexuality. This is achieved through the power to "qualify, measure, appraise, hierarchize, rather than display itself in its murderous splendour; it does not have to draw the line that separates the enemies of the sovereign from his obedient subjects; it effects distribution around the norm" (Ibid.:144). Further "power remains in this argument a kind of agency, one which is ubiquitous and pervasive yet also insidious and unlocatable; everywhere vaguely, nowhere primarily" (Dollimore 1991:224).

Foucault sees this power as being exercised through a discursive explosion, "a regulated and polymorphous incitement to discourse" (Foucault 1990:19ff), one of which was centred in the Catholic Church. To transgress 'pure' action and thought meant that in Confessional these things had to be aired, and penance paid. But what this did, in effect, was allow for a massive discourse on sex and sexuality, so that it was thought about and spoken about, *ad nauseam*, although perhaps not being directly named. The Church became the 'police' of desire, but they also sought that people police themselves - thoughts, actions, words and even dreams - and see in these unclean thoughts the sins that so anger God. Through Confession and penance came the ability to transform desire, so that individuals were not held hostage by it. Here was a notion of morality attached to sexuality, and its 'proper' use.

Discourse on sexuality flared up during the eighteenth and nineteenth centuries from the medical profession, and in the fields of psychiatry and criminal justice. The discourse was based on examining nervous disorders, frauds against procreation, and crimes against nature respectively (Ibid.:30). It is interesting to note, however, that Giddens suggests that the texts and medical fraternity that Foucault deems responsible for the explosion of discourses were

not available to the most of the population, primarily because of illiteracy (Giddens 1992:25).

Despite this objection, which I think is well founded, Foucault's argument is that present notions of sexuality are an invention of modern societies. By so scrutinising sexuality, cataloguing it and trying to find the truth about it, modern science has actually facilitated the spread of sexuality, and numerous sex acts. "(T)he more attention that was focused on sex, and the more information about unusual sexual acts was gathered and circulated, the easier it became to imagine committing such acts" (Miller 1994:292). Thus seeking the truth about sexuality is to miss its historical development. But by propagating information about sexuality, society also controls it, as the parameters are quite clearly demarcated: marriage and reproduction exist as one option; their antithesis exists as another. What is excluded is a questioning of the very fact that there are parameters, and thus all sexuality exists in a controlled environment. Imagining committing "unusual sexual acts" focuses sexual energy, and gives vent to frustrations and a wish to explore sexual pleasures, all the while keeping that experimentation within a defined framework.

Biology, reproductive sex and morality became inextricably interwoven as a means of exerting power. Capitalism and civilisation required reproduction, and some docility in the population, thus controlling reproduction (as well as production) became key. The state with its now diffuse power structure, which included Christian religion and the medical profession, invented, or created, present sexuality as a means to maintain itself. Morality gave 'natural acts' the will of God, while perverse acts, which threatened the state's power, angered God. The Christian tradition of the Middle Ages had also ensured the control of women, who were labelled witches, temptresses, filthy and vile. The Christian ethic and the

work of the sexologists dovetailed here: in the Christian tradition sex is seen as something that society, or morality, or the medical profession has to control, and sexologists sought to give this a scientific explanation (Weeks 1985:36). The sexologists' implicit assumption is that sexuality is a 'drive', or an 'instinct' that requires an outlet, something 'natural' that is however, very disruptive and needs to be checked through cultural regulation and taboos (Ibid.:103).

Jeffrey Weeks (1985) argues that the Christian West has offered three strategies for the regulation and control of sexuality (1985:53ff). The first is an absolutist approach, involving "a conviction that there is a clear morality (usually a strongly familial and monogamous one) which must guide personal and social life." The second is a liberal or liberal-pluralist approach, based on the work of J.S. Mill, and embodying his liberal ideals. The concern here is over how to define the public and private spheres, and how far should the public intervene into private behaviour. The law is for the maintenance of order and ensuring public decency, and not to moralise, and patrol personal life. The problem here is clear - how does one define public and private in the light of, for example, rape and/or battery within marriage? The final strategy is labelled libertarian, and developed from the counter-culture of the 1960s and the radical sex movement of the 1970s. Sexuality is seen to have been denied, to the detriment of individual freedom and social health.

What is important in Weeks' absolutist approach is the idea of there being a normal (and moral) sexuality, and that sexuality has as its aim the formation of the heterosexual couple. I would argue that this ideology is a hegemonic one: the libertarian model is confined to small pockets of individuals, hang-overs from the 1960s and '70s, while liberals have fallen

into the gender trap: the law is the law, and that holds, in true liberal fashion, to everyone, and thus the problems raised about difficulty in defining the private and public spheres cannot be overcome without compromising liberal values. The liberal model fails to take into account the construction of gender roles, and the discrimination women face. The liberal-pluralist model does hold out some scope for these gender differences to be accommodated in the law, but that does not get around the fact that the absolutist model and the liberal (pluralist) one are not mutually exclusive. One could hold a moral perspective on sexuality, and believe that that constitutes individual choice, where the law has no place. Besides the law is only one influence on sexuality, and the law by itself cannot hope to influence or transform all the other cultural imperatives - religion, the schools, and some governments.

In summary then, what I have argued is that discourse on sex and sexuality has been firmly lodged within a paradigm of the heterosexual couple, and is confined to the family. This discourse was implicit in the work of Freud, who assumed a 'normal' sexuality to be that of penetrative intercourse, and appropriate sublimation of the natural (read: wild, unstoppable, male) drives was vital for the building and continuation of civilisation. This sublimation was part of a process to integrate individuals into a particular culture, and as the anthropologists discovered, this sublimation had different results in different parts of the world. One thing was undisputed though, and that was that the male sexual urges are always stronger than those of women, and this was a natural phenomenon and thus unchangeable.

Thus I have argued that sexuality has been constructed around a conservative morality, that dictates the 'natural' and appropriate aim and object: genital intercourse with one person of the opposite sex. The reason for this conservative notion of sexuality: it ensures the

continued control over people in society, and maintains that society. This conservative morality had its foundations, although not solely, in the development of capitalism. But we now live in the twentieth century, and are nearly into the twenty-first, and the philosophy and morality of sexuality cannot remain so conservative and unchanging, while the practice changes. The fact that they do only serves to confuse, and seen within this project of AIDS education initiatives, confusion will not help in changing behaviour and making safer choices about sex.

However, since the making of those sexual mores, times have changed, and it is said that we have been through a sexual revolution. Lynne Segal (1994) documents some of the changes that women of the 1960s felt at the time of this revolution. She argues that there was a close link between sexual revolution and political change, forged through the music of the time, and the young generation, in rejecting the sexual conservatism of their parents, were also rejecting their political conservatism:

> But whether screaming, swooning and fainting at Beetles concerts, or lining up to compete with other groupies and score a fuck with the Rolling Stones, ... it was sexual excitement ..... that so many young women were after ..... Having sex with men and flaunting rather than hiding it was the single main way in which young women in the sixties rebelled against parental and middle-class norms. (Segal 1994:7ff)

As Sheila Rowbotham explains: "the first part of the sixties were spent outwitting a veritable conspiracy of fathers, teachers, ex-safe breakers, Methodist ministers, and university dons, who persisted in trying to prevent me from losing my virginity" (Ibid.:9).

The contraceptive pill played a large role in giving women their sexual freedom, and it came on the market in 1961 and "many millions of women worldwide used this form of contraception by the close of the decade" (Ibid.:8). It allowed women to have sex without

consequences (well at least the consequence of pregnancy: STDs were still a danger, and the pill is not without its side-effects). Quoting a respondent: "I was allowed to have what I liked and didn't have to be frightened of sex because it could trap me into things, I didn't have to be punished" (Ibid.:9). Giddens uses the term "plastic sexuality" (Giddens 1992:2) to encapsulate this concept. It is "decentred sexuality, freed from the needs of reproduction" (Ibid.), and since "(f)or most women, in most cultures ..... sexual pleasure ..... was intrinsically bound up with fear" (Ibid.:27), the breaking of those connections with reproduction had profound implications.

Whether this revolution ever penetrated the mainstream, and became the 'rule', or whether it remained in the realms of middle-class youth it not important for my purposes: what is is that many young people (and old) came not to associate sex with reproduction, nor with it happening in the confines of marriage:

> Most people, men and women, now come to marriage bringing with them a substantial fund of sexual experience and knowledge ..... Newly wed marriage partners today are for the most part sexually experienced, and there is no period of sexual apprenticeship in the early stages of marriage. (Giddens 1992:11ff)

Giddens also reports on research conducted in 1989 by Lillian Rubin, which suggests that although men welcome women's equality and sexual liberation, "they show obvious and deep-seated unease when faced with the implications of such preferences". They complain that women have "lost the capacity for kindness", "don't know how to compromise any more", and "women today don't want to be wives, they want wives" (Ibid.:11).

Weeks (1985) argues that times have not only changed, but these changes have precipitated a crisis in contemporary sexuality (1985:21ff). There has been over the last thirty to forty

years an increase in the commodification of sex, through 'girlie' magazines, phone sex, sex aids, manuals on sex etc, and the use of female sexuality to sell other products. This has happened at the same time as eroticism has been separated from procreation, through the contraceptive pill and the pursuit of pleasure as an end in itself. He argues that there has been a major incitement to female sexual fulfilment (Ibid.:26), and this has been linked to family life. As kinship ties have fallen in significance, family ties, especially the nuclear family, have taken their place. Sex validates that couple, and "sex has become the cement that binds people together" (Ibid.:28). In addition there have been legal changes in the regulation of sexuality, through an increase in divorce, and the legalisation of homosexuality and abortion, and these have marked a move away from a legal moralism. Finally, social antagonisms and political movements have brought questions of sexual identity, pleasure, consent, and choice into the realm of the political. These four changes have meant that sexuality is no longer something confined to married couples, beds, homes, or penetration.

Indeed, as Foucault argues, "there is an infinitive range of what we call sexual behaviour" (Miller 1994:254). He roots sex and sexuality in the possibilities of the body, through pleasure and pain, and removes them from biology, culture, the genitalia (Ibid.:273ff). This came mainly from his life experiences, and he attempted a 'Limit Experience' in California when he first visited there in 1975. He explored the thriving bath-house culture there, and later was introduced to the sadomasochism scene, with which he was absolutely enthraled. The body then became the focus for pleasure, not just sexual pleasure, and the line between pleasure and pain blurred to the point that pain became pleasure. In the bath-houses "(y)ou meet men there who are to you as you are to them: nothing but a body with which combinations and productions of pleasure are possible. You cease to be imprisoned in you

own fate, in your own past, in your own identity" (Ibid.:264, quoting Foucault.). In this type of experimental game, numerous possibilities were opened, and the potential for great creativity is opened. Thus the more subtle argument is one for the primacy of the body as a whole, and this is the antithesis of repression, and of penetrative heterosexual sex.

So we have a tradition of patriarchal, authoritarian sexual relations, infused with a Christian morality, (or one located in another religion), yet we feel that sex is anarchic. Weeks' hegemonic absolutist model largely dictates our sexuality, or at least it forms the backdrop to the world in which each individual must negotiate and formulate his/her own sexual identity. However there exists today, for the first time in history, the possibility of equality between men and women, and this has enormous implications for individuals and society as a whole (Giddens 1992:1ff). It is within this contradiction, between the morality associated with sex and its actual practice, that we are caught. This is especially sharp for adolescents, who are trying to forge their sexual, and other, identities in this tricky climate of steadfast morality, imperatives to conform to peers and others, yet also, greater permissiveness and sexual freedom. The result, I would argue, is confusion. It is to this confusion and contradiction that I now turn, particularly in relation to teenagers, and the mixed messages that are conveyed to them.

Adolescent Sexuality and Sexual Behaviour

I have not separated South African and other adolescents' behaviour, nor black and white, because I want to show that influences on South African teenagers show definite similarities to experiences of other teenagers. Although African society is traditionally quite different from white, there are similarities: African culture has been greatly influenced by the

(Western) Church, which inculcates a conservative morality, the sanctity of marriage and virginity; gender relations are male dominated; the youth are influenced by a Western sub-culture, made up of movies, music and other things; a culture of democracy and emphasis on children's rights are also common. I found no literature on specifically white adolescent sexuality, but for my purposes this does not matter too much. The point is to show that adolescent sexuality has many influences on it, and these must be taken account of in any AIDS education programme; the specifics can be ascertained from a pre-intervention survey, as suggested in Chapter Four.

Lees (1986) documents the double standard that adolescent girls face. Boys' sexual activity is condoned and even encouraged by peers, and the more experiences the young lad has, the more he is looked up to. However girls having the same number of sexual partners are labelled slags or sluts. These are girls worth screwing, but not worth developing any kind of meaningful relationship with, and they are certainly not marriage material. This attitude comes from biological essentialism: the male libido is massive, unstoppable, and must be treated very delicately, lest the hapless boy becomes excited. Once this happens, of course, there is no stopping him, and sexual release is the only solution to the unfortunate problem of an erection. Female sexuality on the other hand is seen as passive and mute, receptive to men, and associated with motherhood and reproduction (Lees 1986:19). Lees (1986), and Moore and Rosenthal (1993), have adequately documented the fact that both boys and girls think it is okay for a male to sleep around, but not so for a female (Giddens 1992:10; Moore and Rosenthal 1993:4ff). In the African community in KwaZulu-Natal, boys who have many girlfriends and who are known to have fathered children are admired by friends, and often this admiration is shared by the boys' fathers (Preston-Whyte and Zondi 1990:57; Mokhobo

1989:20).

As our primary socialisers, parents also give out mixed messages about sexuality. Many children get negative messages about sex, be it from the chastisement for masturbating, to the child's perception that sex is something not to be discussed openly, to messages about chastity because of the dangers of sex out of marriage. Any confusion that the parent shows about sex and sexuality is communicated to the child, and with increasing rates of divorce, single parenthood and remarriage, one assumes that many parents do feel the uncertainties and confusions characteristic of adolescents. Some single parents have lovers that sleep over or that live with them, but tell their children not to have sex outside of marriage, which provide contradictory messages for children. But Moore and Rosenthal (1993) also note that it is not only attitudes and behaviour that influence children, but also the general way in which parents cope with life and difficulties, and how warm and loving and concerned they are (Moore and Rosenthal 1993:63ff).

Another factor to take into account is that there are many single parent role models for girls to follow, especially in the black community. The 1986 census figures for the Mpumalanga area show that 40% of households included the child of an unmarried child of the head (Preston-Whyte and Zondi 1990:55). There are many widowed, divorced or abandoned older women, and an increasing number of women choosing children but not marriage (Ibid.:56). This lack of interest in marriage comes from the fact that an unmarried woman retains her independence, has no mother-in-law to please, and has her own accommodation, and also perhaps a cynicism borne out of seeing failed marriages and desertion (Preston-Whyte 1981:166). The payment of bride-wealth may also act as an impediment to young men and

women getting married, but for many not being married does not mean that they do not have sex.

Preston-Whyte and Zondi (1990) found that among the black community in Durban (and one assumes this can be extrapolated to elsewhere in KwaZulu-Natal, if not the whole of South Africa,) that with "the overwhelming value placed on sexual performance in men and fertility in women and girls it is hardly surprising that teenagers find it difficult to take seriously the commands of their elders to remain a virgin before marriage" (Preston-Whyte and Zondi 1990:62).

Further mixed messages revolve around the issue of pregnancy. For black teenage girls pregnancy out of marriage may incur the wrath of parents, but often this is short-lived, and they almost always get support from their families. It also means that the girl has proven her fertility, and thus will be considered marriageable: bearing children is seen by many as being an essential part of being a woman and achieving success as a woman (Preston-Whyte and Zondi 1990:59; Preston-Whyte 1988:19). In fact ridicule can follow the girl who is known to be having sex, but does not fall pregnant (Preston-Whyte and Zondi 1990:65). "(I)t cannot be sufficiently emphasised that the birth of a child is the occasion for rejoicing whatever the circumstances" (Preston-Whyte 1988:18). Flisher *et al* (1993:168) found that 20.0% of the youth they interviewed in Cape Town wished a pregnancy to result from their previous sexual encounter. Dr Olive Shisana, Director-General of Health, claims that South Africa has the highest teenage pregnancy rate in the world, and that in 1990 four out of every ten births in South Africa were to teenagers (The Star 19.1.96:World Wide Web).

Children are also important 'assets' for the future and old age. In a situation where black people are not guaranteed financial security in their old age because of meagre pensions, limited or no land, no old-age homes etc, children are seen as playing that role. The more children one has, the greater the chance that one of them will earn a good living (Preston-Whyte 1988:20; 1981:168). Here we see an economic rationale intersecting with the more conservative ideas about sexuality, and challenging those ideas.

Thus in the black population in South Africa there is a high value placed on fertility, and this is one issue that pertains specifically to South African black adolescents, in that I have not come across a reference to this in literature from any other country. This is an essential influence on black teenagers, that must be taken cognisance of in any AIDS intervention. While teenage pregnancy is not encouraged, it is condoned, because it means proof of fertility. For the girls themselves it means an improved status, and indicates the achievement of womanhood, and there are many other single mothers around, and women who do not want to be married because of the constraints that brings. For all these reasons a culture of virginity before marriage does not exist, and neither do imperatives for use of contraception.

I cannot say much about white adolescents as such, although some studies I refer to have included white respondents. However my feeling is that teenage pregnancy is very much more frowned upon in the white community, and is much more disruptive for the white girl because the culture does not so easily assimilate her offspring. It is only later in life that one finds single mothers (and fathers), and not at school going age. This is not to say that young white girls don't get pregnant, but my feeling is that contraception is more readily available to them, as are abortions if they want them.

Further influences are religion and race. Religion often makes children themselves believe they should not have sex, because in most religions virginity in marriage is law. The influence of religion on South African teenagers is unknown to me, however, I suspect that a large number of them would claim to have some religious faith and devotion. This again should be ascertained before any AIDS prevention intervention begins. As for race, in the USA blacks become sexually active earlier than their white counterparts, and Moore and Rosenthal (1993) suggest that living in poverty, "poor life satisfaction and even poorer prospects" are reasons for this (1993:13). On the other hand higher levels of educational achievement and clear educational goals are related to lower rates of pre-marital sex (Ibid:15). Again, no studies in South Africa have compared teenagers of different races and their attitudes to sexuality, and age of first intercourse. This issue would also have implication for AIDS education, especially in a cross-cultural classroom.

At adolescence there is a shift in emphasis in influence from parents and religion to peers. Almost everyone, both black and white find it difficult to talk about sex (Zazayokwe undated:3), and parents particularly are uncomfortable talking about sex with their children. One reason for this, apart from the obvious embarrassment, could be that parents believe that if children know about sex they will go out and try it. The fact that in the Department of Education and Training (DET) and KwaZulu Department of Education and Culture (DEC) schools much parental opposition was encountered to AIDS and sex education would support this suggestion, as would the fact that Mathews *et al* found that only 3.2% of high school students in Cape Town surveyed felt completely comfortable discussing sexuality with parents (1990:512). Parents also argue against free access to contraception at clinics or schools for the same reason: it will encourage sexual experimentation (Preston-Whyte and Zondi

1990:58).

However Moore and Rosenthal (1993) document studies that show that discussing sex does not encourage sexual activity, and caution that "Brooks-Gunn and Furstenberg (1990) argue that framing adolescent sexuality as a moral issue can be counterproductive to encouraging safe and responsible sexual practice because of the underlying message that if intercourse is wrong, then it is wrong to plan for it" (1993:78). Mary Crewe also quite correctly remarked that sex education is happening whether parents like it not, and that education comes from peers. Surely it is better to give teenagers correct information, rather than rely on the often dubious peer-type education (Crewe 1993: UNP College Lecture).

In the absence of parents, peers are the main source of sex education for each other, but this type of education is not always accurate or complete, and often adolescents carry a confusing and partially true picture of reality. Peers' attitudes and behaviours are strongly influential as it is important to do what others are doing. This can act as a check on sexual activity, but may also be a spur. In this regard it is important to note that teenagers tend to overestimate the sexual activities of their peers, and three independent surveys confirmed this (Moore and Rosenthal 1993:6). Most teenagers report fair permissiveness in regard to what they think is allowed in sexual behaviour (particularly for boys, who are allowed to do more, without compromising their 'reputations'), more permissiveness in what they do, and very permissive in what they think others are doing. This then sets up something of a vicious cycle - some in the group think others are having sex, and to be part of the group think they should as well, and this in turn encourages others to have sex, while no-one was having sex in the first place. This peer influence mainly consists of same-sex groups, and Gagnon notes that gender

segregation becomes more sharp in adolescence (Gagnon 1979:229).

This peer influence forms a part of a broader influence, loosely called 'the adolescent sub-culture', and defined as a more or less standardised way of thinking, feeling, acting and dressing that is characteristic of a large number of youth (Moore and Rosenthal 1993:69). Music plays a part here, and song lyrics can inform sexuality, and movies and the media are also key. As movies have changed over the years, from "Gone with the Wind" to "Pulp Fiction" teenagers increasingly know what sex is, and how it is done, at earlier ages; these movies almost never show people planning for sex, safer sex or the consequences of sex. Moore and Rosenthal (1993) argue that many teenagers learn a lot about sexuality from movies, and they are important for giving adolescents a 'script' for interacting with people of the opposite sex[5]. The fact that negotiating sex, planning around contraception and protecting oneself against potential contraction of STDs and HIV is seldom mentioned means that adolescents are left without a script for those important moments (1993:73). Movies also often depict stereotyped images of how men and women relate.

I would also argue that teenagers do many things that they know will be frowned upon by parents or other adults, and that is simply a part of being a teenager, and forming one's own identity, quite separate from that of the parents (Segal 1994:7ff; Oakley 1972:106ff; Moore and Rosenthal 1993:65). It has been suggested to me that this forms a part of a kind of modern 'initiation rite', and after that has been negotiated the person emerges as an adult. Control by parents and dependence on them changes to a situation of self-identity and

[5] It is interesting to note that as movies have become more sexually explicit, they have also become more gratuitously violent, and one wonders whay effect this has on the youth.

responsibility, and this shift starts in adolescence. Although teenagers are still financially dependent, most begin to form their own identity, and experimentation in many things is an important part of this. Smoking, drinking, having sex and doing drugs may form part of this 'rebellion'.

Moore and Rosenthal (1993) suggest four discourses about sexuality, all of which influence adolescents, and which may give conflicting messages (1993:77ff). The first is a discourse of morality, which usually focuses on the moral reprehensibility of, for example, sex before marriage. The second discourse is that of desire, in contrast to parents' attitudes. Parents often do not want to know what is going on, and some teenagers are hard-pushed to find a sympathetic listener. That coupled with the media presentation of desire can also lead to confusion - compare Kurt Cobain and Madonna with Mom and Dad. The third is the discourse of danger, of harassment or rape, and thus sexuality is at the same time seen as pleasurable and dangerous. This is particularly emphasised to girls. The fourth also applies more to girls and this is the discourse of victimisation. Women are depicted and seen as victims, needing protection, and this assumes a lack of power in sexual negotiation, and implies a lack of responsibility. The conflict between these four discourses that the teenager actually experiences in his/her life, in trying to balance them, means that the adolescent becomes confused. This would perhaps be more pronounced in girls because more discourses are speaking to them directly.

In all, I have argued that gender is constructed, through the process of socialisation. Some people would argue that the aim of this construction is the control and oppression of women, that is, that socialisation has a deliberate focus. Others would say that discrimination against

women is a result of socialisation, but that the aim of it is not so purposeful and explicit. Gender is linked to sexuality, in that our roles as men or women are closely tied to the way we are as sexual beings, and masculinity and femininity are concepts that rule our daily lives, be it at work, at home, or at play. Indeed, the way we dress, act, speak, and perhaps even how we think, are all rooted in our gendering, and these things relate to our sexual selves, as well as our other selves. This sexuality has also been constructed then, and I have shown how we can interpret this construction to have been bound by two factors: conservatism and morality. The work of Freud, other sexologists of his time and ours, and the work of anthropologists researching cultures quite different from our own, all make certain assumptions: firstly that nature gives us innate drives and instincts, that must be checked in some way; secondly, men have a much higher sexual drive than women, as they have higher other drives too; thirdly, genital, heterosexual, reproductive intercourse should be the aim of all liaisons, as, following a Darwinian notion, our natures and our DNA want us to reproduce. The morality of the whole is set up by religious authorities, which has never condoned sex outside of marriage, nor indeed, 'impure thoughts' of a sexual nature. The flesh is weak, wanting pleasure, and we must be vigilant about pursuing higher spiritual ends and purge the body of 'unclean' impulses. However this conservative morality has been interpreted by some, for example, Foucault (1990) and Weeks (1987), as a means of controlling sexuality, necessary for the exertion of power, and necessary for the development of capitalism.

But this conservative morality is no longer tenable, as a number of changes in gender relations have challenged ideas about sex and pleasure, whereby, increasingly, pleasure is more important than reproduction, and sex is an important part of any intimate relationship,

an end in itself. Contraception and the sexual revolution freed some women from the dangers of sex, pregnancy and childbirth, and that, combined with more general notions of women's liberation, has meant that many women do not buy into the biological essentialism that presupposes their inequality. Marriage is not the sacred cow it once was, and a woman's virginity in marriage is now the exception rather than the rule (Giddens 1992:11ff). In addition alternative sexualities and the right to forge one's own identity in whatever way possible have become much more public, and political issues, evidenced by gay activism and rights. Sex as anarchy has come into its own, and this is incompatible with morality. However we are caught between these two discourses: sex as immoral and/or procreational, and sex as fun and recreational. The changes in gender and sexual relations have occurred only in the last thirty years, and only for some people - it is not a hegemonic phenomenon.

There are a number of implications of the conservative morality, and a number that arise from the fact that we are caught in a contradiction between conservatism and changing times. The first is that women continue to be oppressed in the name of nature and what is natural. Gender roles can at times be extremely curtailing, and men's physical power and power in society means that women continue to be battered, and forced to have sex. If sexual urges are natural, and for men at least, unstoppable, then rape continues to be justified through men needing release. It also perpetuates the myth that rape is a sexual offence, and downplays the violent side of it. If women are supposed to stay at home and make babies then there is no need for child-care facilities, equal pay for women (because they only need pin-money, the real wage comes from the husband), nor a sharing of domestic tasks between partners. However, in this day and age, many women do work, and in fact want careers of their own. Yet many still face the double shift: working all day, and going home to cook,

clean, wash and iron at night. There is still a double standard facing women when it comes to sexual activity: their sexual freedom and experimentation is allowed, but the woman who has had many lovers is still thought of as 'loose'. Men are still allowed greater freedom and experimentation.

In terms of AIDS education, continuing to lecture against sex outside of marriage and promoting a conservative morality can be discriminatory. Some of the target audience might be gay, some might come from single-parent families, and some may already be involved in sexual relationships. A conservative moral message about sexuality that is presented as the only alternative, may induce feelings of guilt and shame resulting from non-conformity, and this may be particularly destructive if aimed at parents of those receiving the AIDS intervention. Our notion of sexuality has not moved with changes in technology, and this leads to confusion. As we have seen, sexuality and sexual practices vary from culture to culture, and giving a Western Christian basis for judging all acts is imperialistic. There are no universals when it comes to sexuality, yet the conservative position has as its very basis the fact that there is a universal, based in biology.

Finally, giving messages about sexuality that are too far removed from the reality leaves people, especially adolescents, daunted and unable to make good decisions. Adolescents are trying to map out their identities in a rapidly changing world, and I would assert that AIDS education programmes should aim to assist them in this difficult process, not confuse them further. Conservative notions, by their nature, do not help people through times of change, and attempting to keep children within the bounds of marriage, means they are given no skills with which to negotiate their way through the world, where they will probably have

sex outside of marriage. It also relegates sex to the secret, the unapproved of, and perhaps the dirty, and in terms of gender equality and fulfilling relationships, it is only destructive. However I shall deal with these issues in more detail in Part III; the point to make here is that the conservative notions of sexuality, on which our present mores are based, have not changed significantly since their inception some two hundred years ago, but the culture and society within which they play themselves out has changed most remarkably, and will probably continue to change in the years to come.

PART III

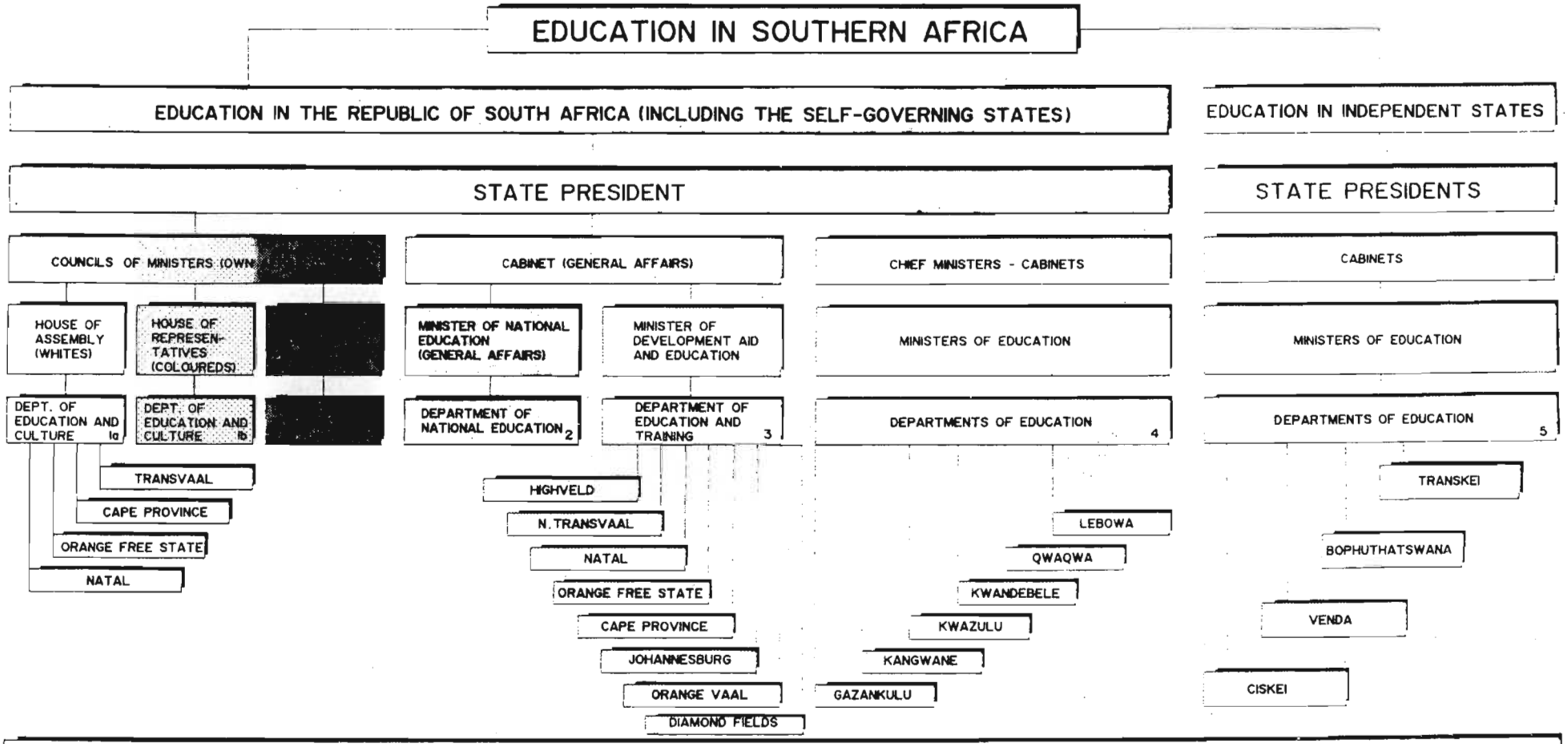
Part Three of this thesis examines the actual AIDS education programmes that exist in schools in KwaZulu-Natal. Before I explain them, I shall give an overview of the education departments, and how they fit into the whole education system in South Africa.

Before the Interim Constitution came into existence, the Education Act 76 of 1984 governed the structure of education (REIP 1994:2). After the Tricameral Parliament was set up in 1984, education was declared an 'own affair', and each of the three groups represented in that Parliament had their own Ministry of Education, and Department of Education and Culture, accountable to the respective House. It is the House of Delegates' Department of Education and Culture (DDEC), the education department that educated Asian pupils, that I refer to in this thesis. The House of Assembly, in addition to a national Department of Education and Culture, had four regional education departments, of which the Natal Education Department (NED) was one. Also created by the Tricameral Parliament were the position of Minister of National Education, and the Department of Education and Training (DET), charged with the task of educating Africans who lived outside of the homelands. The National DET controlled eight regional education departments as well, one of which was in Natal. Each of the homelands had its own Minster of Education, and Department of Education, and the KwaZulu Department of Education and Culture (KDEC) falls under the auspices of this Department. The diagram overleaf outlines this education structure.

In the 1994 "Draft White Paper on Education and Training", which appears in the Government Gazette 351(15974), a new structure for education in South Africa is proposed.

This legislation has not yet been passed, and thus the structures suggested do not yet exist. The "Draft White Paper" recommends a Department of National Education, and a Minster of National Education, which is a Cabinet position. The Minister will be responsible for overarching policy decisions relating to school education, and will directly control higher education. In each of the nine provinces there will be a Member of the Executive Council (MEC) for education, and a department of education. Each provincial Department of Education will be structured differently, according to local needs. However, it is envisaged that each province will be divided into a number of regions, and each of those further divided into districts. Each provincial office will have a Director of Education, responsible the implementation of policy, each regional office will have a Deputy-Director of Education, and each district will have an Inspectorate. As this structure is not yet in place, de facto the ex-education departments are operating fairly autonomously (Wedekind 1995:47).

THE DECENTRALISED EDUCATION STRUCTURE IN SOUTHERN AFRICA



1. (a,b,c) The administration of education for Whites, Coloureds and Asians is considered to be an own affair and is managed by separate departments of education for each of these population groups.
2. The Minister of National Education is responsible for policy [Act 76 of 1984: Article 2(1)] regarding formal, nonformal and informal education in the Republic of South Africa in respect of:
   — Norms and standards for the financing of running and capital costs of education for all population groups;
   — Salaries and conditions of employment of staff;
   — The professional registration of teachers;
   — Norms and standards for syllabuses and examination, and for certification of qualifications.
   The Minister may therefore determine general policy only in respect of certain predefined matters and he must first consult with each Minister of a department or state responsible for education, as well as the South African Council for Education or with the Universities and Technikons Advisory Council and, in some cases, also with the Minister of Finance. In terms of Section 2(4) of the Act, each Minister of a department of state responsible for education must execute the policy determined in accordance with Subsection 2(1), in so far as it applies to the population group for which he is responsible.
3. The Department of Education and Training administers the education of Blacks outside the Self-governing and Independent States.
4. Six separate departments of education administer education for Blacks of the different ethnic groups in the Self-governing States.
5. Four departments of education administer education for Blacks in the Independent States.

CHAPTER SIX

An Assessment of the Department of National Health and Population Development's First AIDS Kit

The Department of National Health and Population Development (DNHPD) AIDS Unit engineered the first national AIDS education campaign aimed at the youth. This 'AIDS and Lifestyle Education' programme was launched by Dr Rina Venter, then Minister of National Health, on 30 March 1992, and at a cost of R6 million (Daily News 31.3.92:12). It was aimed at the youth because "South African children between the ages of three and 13 are universally free of AIDS" (Natal Witness 31.3.92:1), and if they can be kept free of AIDS through their teenage years and into adulthood "we will successfully meet and beat the African Aids (sic.) pandemic" (Ibid.:1). The First AIDS Kit, intended for use with school pupils, was available for any education department or school to use, and was available in seven languages (Daily News 31.3.92:12). It comes in a small suitcase, which contains a teachers' manual, various posters for use in the lessons, and a video about AIDS, and it was envisaged that every school would receive one Kit. The school initiative was part of the broader education campaign, and the whole programme was unified through its logo: a yellow hand with "AIDS: don't let it happen" underneath it. However, production of the Kit was stopped later in 1992, although the reasons for this are unclear (Business Day 30.6.92:7). The number of schools that actually got the Kit, and which schools they were, is also unclear. Despite this, an assessment of the Kit may be useful as a means of illustrating problems in AIDS education.

The introduction of the manual of the Kit states that "(e)very effort should be made to educate them (teenagers) to adopt healthy and safe life-styles which eliminate the risk of becoming infected with AIDS" (First AIDS Kit 1992:1), and this could be seen as the aim of the education effort. It also states that AIDS education programmes in other countries have not worked previously because education has followed the wrong approach: an information-giving one, and this strategy does not convince people to act differently (Ibid.:2). Telling people not to have sex is not enough - they must also be taught how to cope with the peer pressure that encourages them to have sex, hence the Kit provides a "Lifestyle and AIDS programme" (Ibid.:3). It does not help to say that teenagers should not have sex in the first place, because many of them do: a "sizable minority of children between the ages of 13 and 16 is already sexually active" (Ibid.:8). Thus the Department claims to be morally obliged to offer information about safe (sic.) sexual behaviour (Ibid.:8).

Thus the aims of the Programme are as follows:

> * To provide factual information about AIDS and other sexually transmitted diseases, including ways of transmission and prevention;
> * To teach adolescents effective communication and relationship skills, including responsible decision making and self-assertiveness;
> * To reduce fear of becoming casually infected
> * To develop positive and non-blaming attitudes towards persons with AIDS. (Ibid.:7).

It is thought that large group teaching should be used to convey factual information, but interactive teaching is emphasised for the teaching of skills, especially through the use of small group discussions and role plays. Indeed teachers are encouraged to pursue "unusual methods of teaching ... with as much interaction as possible" (Ibid.:8). There is no indication of what constitutes these methods, or suggestions on how to use them. Nevertheless, these

methods are thought to be useful in a number of respects, in that they encourage a number of skills and abilities: including expression; communication, relationship and problem solving skills; responsibility of decisions; confidence and self-assertiveness (Ibid.:9). From the outset this Kit consciously creates itself as more than an information-giving model of education, since it combines information and the skills to effect decisions based on that information.

Selection of educators also deserves attention: they should be comfortable working with teenagers, and "(t)hey should also be persons whom teenagers feel they can trust and confide in" (Ibid.:9). It is also mentioned that these teachers (or possibly parents, if they want to) must be appropriately trained, and education authorities and personnel at ATIC centers will help with this training. However there is no indication what the training involves, and how long it will last.

Other preconditions of success stated in the Kit include parents being involved at all stages, so as to reinforce the educational process, and the programme having the support of opinion makers (including church leaders, community leaders and politicians), in order to positively influence the community. This last recommendation is supported by Kelly and St Lawrence (1988:71), who suggest that a community wide anti-AIDS message gives impetus to safer sex decisions, but Cochran and Mays (1993:210) argue that a more positive message will be created if the 'leaders' and 'opinion makers' are similar in age, gender, and interests to the target population.

Use of the Kit is based mainly on a teachers' manual that is divided into various modules, not all of which need to be covered, and "(b)y choosing appropriate modules for their

teenagers, communities can elect to leave out those aspects of the educational package which they regard as unsuitable for their pupils" (First AIDS Kit 1993:8). However this is problematic because it allows the community, that is, principals, teachers and/or parent committees, to decide what is 'unsuitable', and it is possible that the module on Safe Sex would be excluded, and thus sexuality remain in silence. A similar fear of avoiding the issue was expressed at the NACOSA Lifeskills Education Forum (5.9.94:4). The Kit also contains posters, which are used to prompt discussion and thought. They depict Keith Haring type figures[1], although less adult. An explanation of each module follows.

Module 1: Adolescence - A Time of Change

Adolescence is a time when the body and the emotions undergo changes, and when the individual starts to appreciate him/herself as a boy or a girl, and is fascinated with members of the opposite sex. However the manual goes on to say that this fascination is not sexual to start off with, but has to do with the adolescent needing to understand him or herself. Adults tend to interpret this fascination as physical/sexual, making the "adolescent feel that his/her interest can only be satisfied by physical experimentation with gender differences" (Ibid.:13). What the adolescent really needs is to learn about "how to relate with members of the opposite sex, rather than learning about the physical sex act" (Ibid.:13). Thus the adolescent must be taught the meaning of the changes in the body and in the emotions, so that s/he does not "interpret them as pressures to start performing physical/sexual acts" (Ibid.:14).

This module then is about the changes during adolescence, and the important relationships

[1] Keith Haring was an American artist, who drew simple iconoclastic figures, and, interestingly, who died of AIDS in the late 1980s.

that adolescents have. It is hoped the skills will be taught so that the adolescents "can find themselves as individuals and decide about their place in society in the future" (Ibid.:14). This will allow all relationships to be put in perspective, and will imply that "sexual interaction will change from being a peer group-driven, impulse driven activity, to being only one aspect of much broader relationships with members of the opposite sex" (Ibid.:14).

The suggested lessons revolve around changes in the adolescent body with the onset of puberty, 'normal' feelings of inferiority and rejection, and how to combat them; how to avoid destructive arguments with parents or teachers; confidence building and earning the trust of parents by proving responsibility; recognising anger and dealing with it appropriately, not through doing something - drinking, smoking, having sex, or being aggressive. The emphasis in this module is on peer pressure, how people, especially teenagers, want to be liked, and on self-image. This module gives pupils a sense that rapid mood changes, and feelings of anger and frustration are all characteristic of adolescence, and are not indicative of abnormality or a particularly troublesome teenagers. It gives them something through which to make sense of the (at times) overwhelming feelings that teenagers experience. They are also given some means by which to channel their frustrations, and methods for dealing with their feelings.

This is all very positive, as it gives sexual activity a place in the life of an adolescent, but suggests that sex is not the only thing adolescents should be concerned about. It attempts to put sex into some perspective, and is very straight-forward in its terms and language: it discusses, among other things, vaginas, penises, erections, sexual fluids, and even wet dreams and fantasies. Sex is not presented as something dirty or closet. But it plays down

the importance of love and romance in the adolescent's life, and the contents of the module suggest that family relations and friendships should be just as important as those with a boyfriend or girlfriend. I suspect that for many teenagers this may be incorrect, and is evidence of an adult morality presenting itself: the Department and teachers may wish that teenagers spent more time thinking about family and friends, but this may not be the case.

Gender inequality is mentioned, and this is defined as the traditionally submissive roles that women have played and "the perceived lack of intellectual and social equality between men and women" (Ibid.:14). A rather large jump is made here, and the manual claims that because of this inequality "many societies reduce male-female relationships to the single act of penetration or sex" (Ibid.:14). Stopping these assumptions and teaching for a more equal society should be done while pupils are adolescents, but there are no ideas or lessons plans supplied on how to do this.

So the Kit falls into the trap it explicitly aims to avoid, that is, of giving information (to both pupils and teachers), but not the skills to put it into practice. None of the power differences between the sexes, that mitigate against intentions being translated into practices, are remarked upon in the Kit, nor indeed is any cultural disempowerment or discrimination mentioned. There is one activity suggested that could be seen to be an attempt to take on gender inequality, and that is girls play boys, and boys play girls in role play. This may devolve into an opportunity to take a dig at the opposite sex, however.

Module 2: AIDS and STDs

This is a mainly factual module on how one is infected with AIDS and STDs, how one can

avoid infection, and people's attitudes to people with AIDS. A video is shown at the beginning, which shows a group of teenagers rafting on a river. But then there is a fork, and they have to decide which way to go - one will lead to the rapids, the other is a safe route (rather an obvious metaphor perhaps!). It goes on to give the facts about AIDS, and how it is transmitted, mainly through sexual intercourse. It suggests the pupils should "obey certain rules" and they won't get AIDS: do not have sex before marriage, or use condoms; avoid peer pressure, boredom, and the use of alcohol and drugs, sine they lead people to do what they otherwise would not have. "Be smart. Stay healthy."

However this module does not offer any skills, or scripts, or means of initiating discussion about not having sex before marriage, using condoms, or avoiding peer pressure. Similarly, it suggests that to avoid other adolescent risk-taking behaviours, such as drinking and doing drugs, the adolescent should find something to do, that alleviates his/her boredom: nothing, though, is suggested as an alternative. 'Be smart. Stay healthy' in this context begins to become simple information, full of morals, but without the skills to back it up.

This module attempts to get students to examine their own prejudices in relation to PWAs, and this is useful in building an ethos of individuals having to come to terms with his/her own ethics and lifestyle. However the message that AIDS is not casually transmitted could be more forcefully presented by using a PWA to give some input. This would have the additional benefit of making AIDS a 'real' disease, less abstract and more concrete, and one teacher reported this to be the case (Findlay 15.12.95: pers. comm.). She suggested that it would be even more effective if the PWA was a teenager, or at least closer in age to the students. Seeing PWAs and speaking to them might contribute to individuals' perceived

susceptibility and the severity of the disease, which the Health Belief Model, as described by Kirscht and Joseph, holds as key in prompting a behaviour change (Kirscht and Joseph 1989:110ff).

Module 3: Our Relationships

"Just as it is inappropriate to give a person without driving skills a car, it is similarly inappropriate to give a person information about AIDS without providing relationship skills" (First AIDS Kit 1993:47). This is module three - although the description of it may be a little quirky. Information, knowledge and skills about relationships will allow teenagers to make correct decisions, and convey them to others without problems. It aims to explore the various relationships we have - with friends, parents, relatives and with the opposite sex - and come to understand the positive and negative qualities in good and bad relationships. This, it is assumed, leads to developing effective communication, assertion and decision-making skills, and dealing with conflict in relationships. It is acknowledged that relationships with the opposite sex take up much time and thought in the teenage years, and that this is quite natural. However, the introduction of the manual states that "(i)t should be generally agreed that sexual intercourse before marriage is not advisable" (Ibid.:7), and while this is a thread running through the manual, it is strongly emphasised here.

Types of love are discussed with students (Ibid.:65ff), and thereafter various activities are outlined, where students act as an agony aunt, or simply write letters to friends, giving advice about love. What is stressed is that many young people confuse love and sex, and although many teenagers think they are in love, this, in fact, is only a passing fancy, and is not love. This is may be rather undermining of adolescents, since it declares their very strong

feelings are not the 'real thing', but only puppy-love, or infatuation. The Manual states that it is hoped that if teenagers realize that what they feel is not love, they will not be so willing to have intercourse with their partners.

There is an emphasis on the family, correspondent with the emphasis on abstaining from sex before marriage, and while family values cannot be denigrated, they should not be exonerated either. As documented elsewhere in this thesis, the nuclear family is not the hegemonic family structure in South Africa, and indeed of the late twentieth century, and single parents are increasingly more common. Although it is never explicitly stated, the ethos of this module, and the whole Kit, is one of presenting the family as a happy, balanced unit, comprising two (heterosexual) parents, with two or three children, and with no problems. This takes no account of single parent households, and may be construed as implicitly racist (although I do not know the race of the authors), in that there is an assumption that African culture, which accommodates single mothers, is wrong and immoral. Clearly this is not a constructive message to give children, white or black. The problem with this conservatism is that it offers nothing to adolescents trying to come to terms with their own identities and personalities, and all the choices these imply. The only choice presented as correct is that of having sex within a happy marriage, and eventually having children within that union. The lifeskills, and ability to deal with complexity, that children increasingly require are not accommodated in such a message.

Module 4: Life Skills

When confronted with situations we all deal with them in different ways, according to the skills that we have. But we can improve these skills and deal with situations in a more

satisfactory way - situations that we ordinarily come across and those that are more unusual. When we are able to handle situations in an advantageous way, and one that we are happy with (this implies a value system in each of us), this gives the feeling of self-efficacy (Ibid.:70). "We believe that, if we can provide our children with the right information AS WELL AS the skills to induce a feeling of control or self-efficacy, they will be able not only to stay free from AIDS, but they will also be given the best possible chance to have a happy life" (Ibid.:70).

According to the Manual, important skills are: decision making skills, including thinking about the harmful effects of a choice on the self and others, now and in the future, and whether there is any pressure to conform to a group decision; negotiating or bargaining skills, especially to say "no" to sex or to negotiate condom use; social skills, dealing with one's own and others' aggression, and the ability to be friendly and talk to people you do not know well; self-acceptance, future projection, and hope for the future. This avoids the one-day-at-a-time life-style that would be conducive to the spread of AIDS (Ibid.:73ff).

These are all important skills in relation to behaviour change, as these are what inform attitudes and behavioral beliefs. They seem to be centered around notions of self-acceptance, self-efficacy and internal locus of control, and if pupils are strong in these areas then sustained behaviour change becomes much easier to effect, as Bandura outlines (1989:128ff). Indeed, as Cochran has indicated, planning for the future and making realizable life plans are important factors in people making decisions and taking actions that will reduce risks, as taking risks now and living for a bright future are mutually exclusive (Cochran 1989:315).

However the main skill that pupils are taught is saying "no": to sex, smoking, drinking alcohol, and this saying "no" is practised again and again. There is no sense of suggesting alternatives and compromising, or giving vent to some frustration through responsible experimentation: it is always "no". Saying "no" may give pupils adequate practice at just that, but gives them nothing in the realm of compromise and innovation in difficult situations. Self-efficacy is not only about saying "no", but also includes weighing up the consequences of actions, and feeling able to make a decision and carry it through, despite peer pressure to do the opposite. In the Kit, self-efficacy is couched only in terms of "no", and this is incomplete.

There is also a problem in the life skills being taught in a module all on their own, and not being integrated into the content of the programme. Life skills are not presented as being integral to dealing with 'Our Relationships' (Module Three), or with 'Safe Sex' (Module Five), because the module on life skills is separate from these. The only life skill that is practiced is saying "no", and others dealing with relationships and safer sex are not practised, and held up for peer review feedback and reinforcement, as Bandura suggests they should, in order to enhance social proficiency and resilience in self-efficacy (Bandura 1989:130).

In addition, since the life skills are supposed to be applied in the contexts of relationships and safer sex, but are not taught in that context, problems of transfer may be encountered here (Grayson 1994:7ff). Skills taught in calculus are not always applied in differentiation problems by students, because it seems that many people learn in boxes. The 'calculus box' is not always accessed when doing differentiation, and this is known as lack of transfer. Similarly transfer problems may arise from the fact that life skills are taught in one 'box',

while relationships and safer sex in two other 'boxes'.

Module 5: What is Safe Sex?

This module deals with the ways that HIV/AIDS is transmitted sexually - what is and what is not "safe". This is also a primarily factual module. The very fact that the Kit always refers to "safe" and not "safer" sex suggests a naive and poorly conceived message: it is widely acknowledged that the only sex that is "safe" is no sex at all, since condoms are not 100% safe, either as a contraceptive, or as an HIV barrier.

The emphasis on marriage and the family lends itself to avoiding discussions on safer sex, since it is seen as unnecessary within the monogamous heterosexual situation. Safe sex, according to the Kit, consists in using condoms, and no other safer sexual methods are mentioned, for example, non-penetrative sex. But a greater oversight than that is that there is no mention to the students of where condoms are available, nor how to use them, although teachers are provided with a pamphlet on the correct use of a condom, which students read individually and then hand back to the teacher. As such, the programme smacks of grave conservatism: it tell students that to avoid HIV they should use condoms, but does not recommend that students be told where to get them, or how to use them. The fact that students read about condom use, and that it is not discussed, suggests that this information is being shied away from, and no frank and open discussion about sex and sexuality is encouraged. There is no other sex or sexuality education recommended.

This fails even as an information-giving model, since insufficient information is given, and taints the Kit's commitment to keeping the school-going population HIV negative. Full

information on keeping HIV-free, and the skills to put that information into use, are not demonstrated in this First AIDS Kit. This is particularly disturbing in light of research done by Mathews *et al* (1990:515), and Flisher *et al* (1993:496), which suggests that condom use is low among school-going youth, and access and knowledge of their use are consistently cited as reasons for this low usage. Some youth in Cape Town, for example, reported that they did not know how to use condoms, and therefore would not use them (Mathews *et al* 1990:515).

Another omission from the Kit, and an implication of the emphasis on "no", is that contraception is not mentioned. Since all pupils are taught to say "no" one assumes it is thought that they have no need for contraception, and again this is a major oversight. Flisher *et al* (1992), researching youth in the Cape Peninsula, found that 63.6% of adolescents interviewed would like information on contraception, but only 23.6% did receive it (Flisher *et al* 1992:105).

It may be argued that the youth should not be having sex, and the Kit suggests that they "are not prepared socially, psychologically and interpersonally for the implications of sexual behaviour" (First AIDS Kit 1992:3). In response, and this is something the Kit acknowledges (Ibid.:8), school-going youth do have sex, although figures on the proportion that are sexually active differ. Research in KwaZulu-Natal schools, where respondents had a mean age of 16.6 years, showed that 34% of students reported sexual activity (Abdool Karim *et al* 1992:107ff). In the Cape, the figure appears to be higher, with 73.3% of youth, aged between 15 and 24, reporting sexual experience in one survey (Flisher *et al* 1992:104), and 75.4% in another survey among Cape Town township school pupils (Mathews *et al*

1990:512). However a much lower figure of 17.4% was also found among Cape Peninsular high school students ranging from Standard 6 to Standard 10 pupils (Flisher *et al* 1993:495). What this research points to is that as much as three-quarters of school populations may be sexually active, and they must be catered for. The range of figures also points to the necessity for pre-intervention testing for baseline knowledge, attitudes and behaviours, so that the intervention devised is appropriate for the target population.

The other response that can be made to the argument that students should not be having sex is that, even if they are not having sex now, while at school, they will have it one day (apart, perhaps, from a very small minority). Talking about sex, negotiating its terms and planning for contraception must happen to everyone, in marriage, or out. Thus the Kit caters for no student who will ever have sex, and that is most of them. By avoiding the issues of safer sex, condom use and contraception the First AIDS Kit does nothing to ensure an HIV-negative population, either in schools or out of them. One wonders why the Kit does not take its own advice to heart: "(i)t is important to reassure parents and educators alike that education about sexual behaviour does not lead to promiscuity. Usually the opposite is achieved" (First AIDS Kit 1992:8). If this is recognised then there can be no reason for not giving pupils information and corresponding skill for condoms and other contraceptive use, since this is a real life skill, and something almost all of us have to deal with at some time in our lives.

Module 6: Practical Ideas

This module deals with ways to keep the ideas and lessons on AIDS prevention alive. Pupils should be encouraged to make AIDS posters and rap songs, a school newsletter could cover the topic, a play could be performed, or an open day held. These are all important ways of

getting the information to more pupils, and to help the whole school community, or even the whole community, become part of the anti-AIDS message. This is also important in keeping the message alive and in encouraging people to continue with their behaviour changes.

However I suggest that the whole programme does not make enough of an effort to ensure sustained behaviour change. There is no indication which standard or age group it is aimed at, and it is unclear whether AIDS education is supposed to be taught only once in the five years of high school, or whether a different part of the Kit is supposed to be taught every year for a number of years. All the teachers that I have spoken to say that AIDS and sexuality education are dealt with in a few lessons, and a number of other guidance or lifeskills topics are covered in a year, and thus the aim of the Kit is unclear to me: should one whole year be devoted to AIDS and sexuality education, or should the Kit be used over a number of years. It seems that the Kit was not designed with practical problems of implementation in mind.

In conclusion I will evaluate the First AIDS Kit in terms of its own aims (First AIDS Kit 1992:7), and in terms of my own framework. The aims of the Kit are firstly, "(t)o provide factual information about AIDS and other sexually transmitted diseases, including ways of transmission and prevention". Facts about HIV/AIDS, and transmission routes should be clear by the end of the programme.

The second aim is "(t)o teach adolescents effective communication and relationship skills, including responsible decision making and self-assertiveness". One assumes that these first two aims are separated (into information, and skills to put it into practice) for ease of

explanation, and the formulation of clear aims, but this artificial divide extends into the actual curriculum, and the life skills are taught as separate items from the real life contexts within which they will be used. Hence the learning and practicing of the skills will not be as meaningful as if the content and skills were integrated.

In addition, the "responsible decision making and self-assertiveness" are really about saying "no". Responsible decision making, to an adult, may mean saying "no" to sex and drugs and rock and roll, but to adolescents this may not pertain. Pupils are not encouraged to weigh up consequences of actions, and decide whether they are willing to face those consequences, but are only encouraged to avoid sex, alcohol, tobacco and other drugs. "Responsible" in this context has been confused with moral, but they are not the same thing. Pupils are not taught to develop their own ethics and codes for life (real life skills), but to just say no to anything that comes their way. Similarly, "self-assertiveness" is really about saying "no", and not about, for example, asserting one's rights as a woman. Indeed the fact that self-assertion of women is not explicitly taught may mean that many women will never gain the self-efficacy to demand condom use, or to negotiate safer sex.

Thirdly, "(t)o reduce fear of becoming casually infected": it is unclear whether this means infected through casual contact with HIV-positive people and PWAs, or through casual sexual interactions. If it means the former, then this may be quite successfully catered for, since students should be clear that HIV is not spread through shaking hands, hugging, sharing utensils etc, although the message could be made sharper through the use of PWAs giving talks, and actually coming into the classroom. If it means the latter, then the aim fails dismally, since chance of HIV infection is lowered through correct condom usage, and this

is touched upon very briefly, and even then, where to get condoms, and how to use them are not dealt with at all.

Finally "(t)o develop positive and non-blaming attitudes towards persons with AIDS": this is attempted in one lesson, and from previous chapters of this thesis, one can see that changing attitudes and behaviours is not easy, and perhaps well-nigh impossible in one lesson. The fostering of non-blaming attitudes is very difficult, because blame is linked to people's own moralities and conceptions of sexual activity, and perhaps to connecting HIV/AIDS with homosexuality as well, and thus attitudes towards those with AIDS may be based on deep seated convictions, which are extremely difficult to challenge.

In terms of my own model of AIDS education evaluation, I suggested in Chapter 4 that there are a number of guidelines in developing an intervention. First, there should be a pre-intervention assessment of the target population's knowledge, beliefs and actual practices, and this should inform the rest of the programme. This allows the intervention to be tailored for cultural specificity, and other differences, such as different levels of sexual activity, as was found among South African youth. If the majority of the target population is sexually active, giving advise on how to say 'no' and remain celibate will be of little use to them. This the First AIDS Kit does not suggest, since much research was done before the Kit was released. However this national research to develop a programme assumes some homogeneity, and cannot accommodate regional, cultural and religious differences.

Information-giving is my next issue of concern, and here the Kit falls down, especially with regard to condoms. Although it explicitly sets itself up as more than an information-giving

model, in terms of information about condoms and their use, there is a lack, and there is a total dearth of skills, 'scripts' and negotiations associated with their use. Modules 1, 2, 5, and 6 are all information based modules, that have a body of content to communicate with students, and activities revolve around this. As suggested above, the separation of the module on life skills from the rest of the programme could also lead to those skills being under-used and -valued, and this could compound an information-giving ethos. Thirdly, structural constraints to safer sex are not fully addressed, but some thoughts on the future are encouraged, and this may go some way to alleviating the structural problem.

Forthly, I suggest that in order to change behaviour people must perceive themselves to be susceptible to the disease, and the Kit assumes that pupils have already made the decision to change, and they only need correct information and skills to effect that decision. No effort is made to convince pupils of their own jeopardy, and it is suggested that introducing people to PWAs may assist this.

Fifth, behavioural and normative beliefs must also be challenged, and perceived self-efficacy and internal locus of control inform these beliefs, that is, the ability to make a decision and the believe in one's capabilities to carry it out. The Kit attempts to improve self-efficacy in students, although this mainly revolves around being able to say "no" and resisting peer pressure, rather than making one's own decisions, which sometimes involve "yes". I have argued previously that self-concept can inform attitudes and subjective norms that influence a decision to try to remain HIV-negative. Again, this quality is not developed in pupils, although understanding changes in the adolescent body, and resulting mood swings, may give them less cause for concern about themselves. Although the future is briefly touched upon

in the Kit, this is not linked to self-concept, or a future needing to be HIV-free. As far as resilience of these skills, and of the decision made, there is little opportunity for pupils to practise skills, and received critical feedback on them, both in the classroom and out.

Community-wide action is catered for through the suggested Open Day, AIDS forum and school newsletter, while the use of positive role models is totally neglected, although this is something that schools do not really have much control over. However, there is no sense from the Kit that a culture of condoms is being, or should be, created, since pupils are not given sufficient information or encouragement in their use.

Next, I suggest that interventions should be culture specific, and this is not taken into account in the Kit, except by accident, when the teacher is of the same culture as all the students. There is one message for all students, regardless of age, race, gender and culture. The next suggestion relates to gender-consciousness of interventions, and attempts to mitigate against women's less powerful position in society. Again, this area is briefly touched upon, but comes nowhere near encouraging women to be more assertive.

The programme is not evaluated, either by the educators or the students, and since there is never any sense of what works and what does not, there is also no room for change and improvement. There is no indication of whether students gained anything from the programme, and what they found helpful and what not, thus the programme runs year after year without change. This is problematic because if the programme has problems, which I suggest it does, and which, incidentally, is likely in any programme, then they are not addressed, and continued effort in the same vein amounts to a waste of resources. A simple

evaluation could make the programme more relevant and useful.

Finally the First AIDS Kit seems to be located within a conservative notion of sexuality, in that the ultimate message is that adolescents should not have sex outside of marriage, and they are given practise in saying "no" to sex and peer pressure. The Kit attempts to downplay at best, and ignore at worst, sexuality in adolescents. Although it is recognised that teenagers want to explore their sexuality, they are told that doing so is giving in to peer pressure, and carries only risks with it: sexual expression of any kind is thought not to be healthy. Relationships with family and friends are emphasised, in what one can only imagine is an attempt to pull the wool over adolescents' eyes. Failing to address real, and legitimate, concerns and frustrations means that this must fail as a sex education programme, and that failure has implications for AIDS education.

Contraception, as a means of preventing pregnancy rather than HIV, is not mentioned, and thus the Kit offers little to those students who are already having sex, and does not cater for their needs. Gender relations get a cursory mention, but power inequalities, and difficulties in transcending socialised roles are not mentioned or examined and challenged. A particular family structure is presented as the aim of all people, but again power relations that exist there are not explicated or held up for discussion. All of this suggests a conservative paradigm within which sexuality located. Although the introduction mentions some of the difficulties that teenagers face in coming to terms with their selves and identities, this complexity is not dealt with in the actual programme. The programme actually aims to inculcate a single morality for all adolescents, facing any situation - be it sex, alcohol, other drugs, driving drunk etc. The problem with this is that the milieu of the late twentieth

century does not lend itself to simple solutions, and teenagers should be taught to deal with difficulties with innovation and imagination, not a "no" answer. Indeed giving one solution for everyone lacks a vision of the teenager as an evolving person, whose identity will be somewhat the same and somewhat different from those around him/her. Homogeneity in the school population does not exist, yet a simple morality that is given, rather than worked out by individuals for themselves, is deemed sufficient for this massive population, incorporating massive differences.

CHAPTER SEVEN

Assessment of the Natal Education Department's "Teachers' Manual"

The Natal Education Department (NED) policy in relation to AIDS is a 'Policy and Procedures' document, regarding the Management of HIV/AIDS in schools and colleges (Circular No. 88/1992). The purpose of the circular is to provide guidelines for admission, education, employment and management of persons with HIV/AIDS, to deal with legal implications thereof, to offer names of people in the NED whom principals may refer to for assistance, in dealing with person with HIV/AIDS, and to survey the incidence of HIV/AIDS. In short, this Policy is written to the authorities, for the authorities, and refers to the management and risks of HIV/AIDS students or staff: there is nothing here on education.

A sexuality education programme for schools was approved in 1990 (Circular No. 72/1990). This document refers to "Policy: Sexuality Education in Schools", and was sent with sexuality education guidelines. The policy focuses on schools' duties with regard to collaboration with parents on the issue of sexuality education, and on training of teachers who are responsible for this type of education. Important points in the document are 2. and 3.1. - relating to parental approval and involvement - and 3.3. - the right of parents to exclude their children from the programme - and 4. - principals are advised to use teachers who have been through on a training course in sexuality education.

Sexuality education was augmented in 1993 by an "AIDS Teachers' Manual: An Education

Module for the Secondary School which is part of the Sexuality Education Programme" (1993). This in turn is an integral part of a value-based lifeskills programme known as 'Family Life Education'. This was described to me as a means for teachers to help pupils help themselves in the realm of forming relationships of all kinds (Frost 7.1.95:pers. comm.). Mrs Frost used the analogy of a table, whereby the table-top is the help given by the teacher, but that requires two supports, the first of which is values, such as respect for the self and others, and for the general environment. To live by values one needs skills, and this is the second support of the table-top. These skills include communication, responsibility, choice, and coping with one's sexuality. A narrative model of skills development is used, based on values, where an individual or group is encouraged and assisted to tell the story of their life at the moment. From that, problems are identified, possibilities for change are identified, options open to the individual/group are identified, and a choice is made between these options. Planning and implementation of that choice is then undertaken. From this process, claimed Mrs Frost, the teachers and the NED are able to discern certain generic skills, which are applicable to many situations, including dealing with HIV/AIDS (Ibid.). The AIDS education intervention, then, should not be seen as something that stands on its own, but as something that is part of, and piggy-backs on, a more general skills-based programme.

In terms of developing the "AIDS Teachers' Manual", the Pietermaritzburg ATICC manager, Rose Smart, ran an initial fifteen hour teacher training course, and the attendants of that course selected, designed and tested materials with their classes, and gave feed-back which was incorporated into the manual. These teachers taught in black and white schools, English and Afrikaans schools, secondary and primary schools (although it is aimed primarily at secondary schools), and thus, although the NED was primarily responsible for white

school pupils, the manual need not be confined to use with that race group only.

The objectives of the programme/manual are to:

- inform pupils about AIDS;
- build upon the lifeskills of assertiveness, value clarification and self-concept as developed in the Family Life Education Programme;
- give them freedom to discuss sexual issues with informed adults;
- help them make informed, responsible decisions concerning relationships;
- look at issues of racism, prejudice and other issues related to people with AIDS;
- teach them how to protect themselves and others against the spread of HIV;
- enable them to seek immediate help, counseling and testing as required.

(Teachers' Manual 1993:Introduction)

All teachers are encouraged to attend an ATICC training workshop before they teach the material, although this is not compulsory. Again, I shall provide detail of each of the modules in the Manual.

Module 1: Sexual Responsibility

This module is about thinking through consequences of a number of actions, for example having sex before marriage, smoking cigarettes, drinking alcohol, doing wrong things to remain part of a gang or group (for example stealing, using parents' car without their permission). There is an emphasis on saying "no" to all these things, particularly sex before marriage, because of their consequences: pregnancy, which may destroy future plans for study or career; STDs and AIDS; cancer of the cervix; emotional problems, such as guilt, insecurity, anxiety; disappointment in oneself.

This is a very pupil-centered module, where the students are asked to make a list of interpersonal problems, and these are role-played by the class. They also debate smoking,

drinking and sex, or they discuss statements in groups - for example "casual sexual intercourse will improve a person's standing within his/her group of friends" - and present a response (AIDS Teachers' Manual 1993:15). There is also a section on discussing the options of saying 'maybe' or 'yes' to sex (Ibid.:18). However, in the Manual, there is a lesson on building a repertoire of 'no' responses (Ibid.:4), and five explicated reasons for saying 'no' to sex before marriage. Teachers are then instructed to "discuss and list the possible consequences of 'Maybe' and 'Yes'" (Ibid.:20), but no suggestions are provided for these options. Thus there is an implicit bias towards saying 'no', and skills for this scripted and practised; the skills for yes, or for negotiation are not mentioned.

There are also various activities where students have to think about consequences of various actions both now and later (Ibid.:12 and 14), and students are also encouraged to think of their life plans in terms of when they will get married, how many children they would like and when they will become sexually mature (Ibid.:18). Thoughts about the future are extremely important for the success of AIDS education, in that they give students some benefits of reducing their risky behaviours. If one has no hope for the future, then there is little point in trying to remain HIV-negative; hope and plans for the future, on the other hand, give impetus to decisions to remain HIV-negative. Marriage and children are presented as the only options: students are asked "When do you plan to marry?", and not "Do you plan to marry" If so, when?". These questions, of course, discriminate against homosexual students because they presume heterosexuality, or those who have decided that they would not like to get married.

This module takes students and the immediate problems they face as its starting point, and

to a large extent encourages them to decide on their own individual morality and positions in relation to difficult decisions, and thus is very much student-centered. There is a guiding principle, though, that teachers are expected to present: one of saying "no" to sex, alcohol and other drugs. Negotiation of "yes' or "maybe" is not formally assisted, and teachers themselves are given no guidance in this area.

Module 2: STDs: An Introduction to AIDS

This is an information-giving module, about a range of STDs, their symptoms and their cures (except for AIDS of course). The information/knowledge is reinforced through exercises on fitting sentences together, and filling in tables. The main message here is that "(o)ne can avoid AIDS by behaving in a sensible, moral and responsible manner. The decision is yours" (Ibid.:28). There is a cursory mention of condoms as a means to preventing STDs (Ibid.:24).

Module 3: AIDS/HIV: Background and Information

The background given is the various patterns of transmission found around the world, and information is given on a range of issues, from testing to treatment. The difference between HIV and AIDS is stressed, and the stages of decay, from HIV infection to full-blown AIDS is explained, including the types of diseases that AIDS victims can suffer and/or die from. Finally, ways that AIDS cannot be spread are mentioned, to encourage non-discrimination towards people with AIDS. One of the aims of this module is to give students information regarding the "geographical location and distribution of AIDS and HIV" (Ibid.:33), and this interdisciplinarity, that is, a reference to geography, could make the lessons more varied and exciting, as well as bolster students' knowledge of maps and the world.

The activities for students are fairly minimal, but extremely important: groups of 2 or 3 pupils suggest one vital thing people need to know to protect themselves from HIV/AIDS, and these are made into slogans for a badge. Pupils are also asked to write down 3 places where they can get information on HIV/AIDS. But here again students are encouraged to think of their life plans by drawing a lifeline for themselves (birth - school - relationships - study - job etc), and indicating "the issues to do with HIV that could arise at each point on the lifeline" (Ibid.:37).

Module 4: Prevention

Prevention is the only option, because there is no cure for AIDS: "(t)he aim of education is to change high-risk behaviours" (Ibid. :51). There are three options for prevention (of sexual transmission):

> 1. ABSTINENCE
> 2. FAITHFULNESS
> **Only if these two options are not acceptable, then limit the number of sexual partners, and practise safer sex.**
> 3. SAFER SEX. This means not exchanging body fluids during sex.
> Use a condom, don't have unprotected sex.
> **N.B.** Insist on using a condom: it is your RIGHT to do so.
> Be in CONTROL of your life. (Ibid.:51, emphasis in the original.)

Talking about rights and control could be made very meaningful to pupils, especially if taught in conjunction with the ideas of a new dispensation, Bill of Rights, and the new South Africa. The only problem is that "faithfulness" is not a guarantee, if one of the partners was HIV positive before the relationship started.

There is also advice on such things as not mixing alcohol and other drugs with sex, since that can impair judgment and lead to risky sex, and on people who inject drugs having to use new

needles and syringes, or cleaning used ones by soaking them in bleach and rinsing thoroughly before use (Ibid.:51ff). This is useful because it encourages non-judgmental acceptance of things that people do.

Small groups brainstorm sexual practices that they know of and categorise them into high, slight to moderate, and low risk behaviours. This gives students a sense of the range of sexual activities that exist, but more importantly, gives students ten 'low risk' options that may not have occurred to them before. Mention here is made of non-penetrative sex, sex toys, masturbation and thigh sex. This, again, is presented in a non-judgmental way, and by way of illustration, one low risk practice that is mentioned is sex between two or more persons who are all HIV-negative and remain faithful. Thus, what some would deem as 'kinky' sexual activity is presented here as legitimate, because this option constitutes safer sex. The aim is to minimise HIV, and not to moralise, since judgment of a practice is not based on whether we like it or agree with it, but whether it reduces the risk of HIV infection.

There is also a comprehensive section on various methods of contraception, and a "graphic illustration and demonstration" of condoms (Ibid.:53). Teachers are given 'points to stress' about condoms: checking expiry date; ensuring the packet is sealed; use of lubricants (not petroleum-based); using the condom ONCE; and safe disposal of it. A problem here is that although the section is on contraception, condoms are not stressed as a method of contraception, and an anti-AIDS device:

> * Used correctly, the condom will protect you against possible infection by the AIDS virus, and other sexually transmitted diseases, like syphilis, herpes or gonorrhoea.
> * Condoms **used to be** a device to prevent birth. Now they are used to prevent death.
> * All SEXUALLY ACTIVE PEOPLE WHO HAVE MORE THAN ONE SEXUAL PARTNER SHOULD USE CONDOMS. (Ibid.:54, my emphasis, capitals in the original.)

Here the twofold use of condoms could be emphasised, that is, as an anti-AIDS devise and as a contraceptive, since two reasons for doing something are more persuasive than one. This presentation makes an artificial divide between an HIV prophylactic, and a conception prophylactic, and there seems to be no good reason for not suggesting that all sexually active people who do not use another contraceptive should use condoms. Further, the way this is written implicitly condones serialised monogamy as 'safer': if you have only one partner, then condoms are unnecessary. However five or ten relationships, each one involving only one faithful partner, is the same as having five or ten partners as once, in terms of HIV risk, and this, obviously, is unsafe. Thus the message should be more along the lines of all sexually active people should use condoms all the time, unless you can be sure of mutual HIV-negativity through a blood test.

This module also contains important information about where to buy condoms or acquire them for free. There is also information about the femidom and C-film, two new methods of contraception that women can use. These are presented as options for women who want to control conception, but do not want to use a male-based method, which the condom is.

Module 5: Exploring Prejudice

The module starts by explaining what 'self-esteem' is:

> *appreciating my own worth and importance;
> *accepting accountability for my own actions;
> *acting responsibly towards others. (Ibid.:68)

This module is about encouraging students overcome their own prejudices through exploring their self-esteem, and once they are confident in themselves they are more able to accept the

rights of others to be different from them. The concept of self-esteem is not developed, however, no lesson plans evolve around this, and methods for improving self-esteem are not mentioned. The subtle approach of hoping that self-esteem will be built through students giving their opinions on issues is not a good enough base to start from.

The activities here revolve around assessing levels of awareness of how HIV is transmitted, asking students to agree or disagree, or indicate uncertainty to statements, for example, "You can become infected with HIV by sleeping around" and "Married people don't become infected with HIV" (Ibid.:71). These are quite challenging questions (although there are easier ones) because they need to be thought through. People who 'sleep around', but use condoms or practise safer sex, are perhaps less at risk than people who have unprotected sex once. As for the second question, many people would assume the answer is 'true' or 'agree' because it is assumed that married people are monogamous. However this is not always the case, and marriage in itself is no guarantee of immunity.

In another exercise students become peer counselors, who are presented with various problems relating to fear of being HIV positive, AIDS, sex, drug use, homosexuality, rights of HIV positive people at work and in leasing homes, single parenthood, sexual abuse, disability etc, and they must give advice to other students on these issues. This helps them to think through their own ideas, prejudices and views on various subjects. Prejudice towards PWAs is explored, seeking individuals' reaction to scenarios - for example, your cousin has AIDS, and he wants you to bring your toddler the next time you visit - and various examples aim to make students aware of the plight of disabled people, single mothers etc.

This exercise is used to assess knowledge levels, and to put that knowledge to use. Assessing knowledge levels is useful for the teacher to see how effective his/her teaching has been, and whether further input is required, and for the students, applying newly acquired knowledge makes it easier to remember. This is also an example of letting the students come to their own individual conceptions of morality, instead of it being presented to them. They are forced to think about their own ideas about sex before marriage, whether women enjoy sex as much as men, homosexuality, and having more than one boyfriend at a time, and to articulate their opinions to others. This could be a useful exercise in building self-esteem and self-confidence, through articulating opinions, and at the same time building a culture of tolerance. This, however, is not the same as self-efficacy or self-concept, both of which involve actions and effecting decisions made, not only opinions given.

Issues of race, class, gender and religious differences are not dealt with directly, and no problems aimed specifically at exposing gender inequality, or racial prejudice are given. Some of these questions, though, are examined in a more subtle way by juxtaposing two situations, which differ only in the race or gender of the hypothetical person involved, and comparing responses and feelings to the situations and hypothetical people. However gender inequality is not dealt with as thoroughly as it could be, and there are no activities aimed at specifically empowering women, encouraging assertiveness, or exposing the double standards that women and girls face.

Module 6: Infection Control: Procedures

This is a straight-forward section on how to deal with accidents, bearing in mind that people may be HIV-positive, and rules for infection control for the HIV-positive person.

In summary then, this programme seeks to explain STDs, of which AIDS is one, and methods of prevention and cure. Although sex out of marriage is presented as a negative, because of its consequences, use of condoms is strongly emphasised and demonstrated, through an explicit series of pictures, for those who do have sex. Assertiveness and saying "no" to sex, as well as other drugs and alcohol, is inculcated, and this is important for those who want to abstain. Thus pupils are given information and (some of) the skills for enforcing their abstemious decisions. But, as stated above, there is little in terms of "yes" or "maybe" decisions. This programme acknowledges that sex is happening, but does not give the necessary skills to make it safer, such as communication and negotiation skills. Innovative teaching methods are employed, and pupils are given many opportunities to air their views, debate with others, and some of the sections build on the information pupils already have. Finally, their level of knowledge and awareness, and prejudice are assessed, allowing the teacher to repeat areas of common difficulty.

However a major drawback with this programme is that individual schools can choose whether to participate in an AIDS programme, or not, and what parts of the manual they would teach. This should be considered in conjunction with the fact that at a National AIDS Co-ordinating Committee of South Africa (NACOSA) Lifeskills Education Forum meeting a representative from (ex)NED reported that resistance to lifeskills education came firstly from principals, teachers and others involved in its implementation. "(M)ore conservative sections of the teaching fraternity were identified as being opposed to lifeskills education. Many paid 'lip service' to the concept without actually implementing a package. As a result, it was difficult to distinguish between those schools implementing programmes and those who were claiming to" (NACOSA Minutes 5.9.94:2). There are no circuit inspectors for

guidance, and hence schools can choose whether to do AIDS education or not. While principals seem to have power in this respect, and can stop this type of education, usually guidance counsellors go ahead and do it without seeking permission first (Findlay 15.12.95: pers. comm.). Thus the NED does not usually act as a hindrance, but neither does it ensure that AIDS education does happen.

If an Education Department takes on the responsibility of educating children about AIDS to ensure they remain HIV-negative, then the responsibility lies with them, as well as the principal or teacher in a school. Keeping kids HIV-negative is an important role of an Education Department because if children die then their whole education has been in vain. Thus, along with study skills, career information, getting good matric results, encouraging sports and sociability must come the information and skills to ensure the pupils stay alive to achieve the goals they are groomed for at school. The fact that lip-service can be paid to these programmes also points to the fact that there is no overall authority to ensure AIDS education occurs, and, more importantly, neither is there any evaluator of the programme. This seems short-sighted to me since without evaluation it is unlikely that the programme will improve.

Resistance to the programme did come from parents, but this was less than anticipated. Parents who were opposed to the programme were permitted to withhold their children from the lessons. What these things mean is that the information is not reaching all students. Resistance from the school or the parents may have the effect of the programme being watered down (perhaps excluding the section on condoms and safer sex), or not being implemented at all, and this is problematic. There may be something of a tension here,

between the rights of the parents over what they think appropriate for their children to learn, and the rights of an education department and/or school over the business of education. However, the NACOSA Lifeskills Education Forum, comprising representatives from all the education departments, as well as NGOs, CBOs, business and the churches, comes down clearly in favour of making this type of education compulsory, despite parental pressure (NACOSA Minutes 5.9.94:4).

The NED fairly adequately fulfills its own aims. It aims to "inform pupils about AIDS", which I think it does. Secondly it seeks to "build upon the lifeskills of assertiveness, value clarification and self-concept as developed in the Family Life Education Programme": assertiveness is developed mainly in terms of pupils being able to articulate opinions on contentious issues, while value clarification is well developed, I think. Self-concept is not defined, but students are encouraged to think of themselves as important individuals, with positive attributes, and this would go some way to ensuring that they like themselves, which is what self-concept is based upon. And these cannot be seen in isolation from the Family Life Education, so the presentation of the skills here cannot be judged fairly, and since these skills are reinforced, I think this aim is fulfilled. Thirdly, the programme tries give students freedom to discuss sexual issues with informed adults, and while this is not explicitly mentioned in the Manual, the general ethos is one of talking openly about sex and sexuality. The extent to which this is imbibed by teachers is unclear, but a teacher claimed to base much of her teaching on what students ask questions about, and what she perceives their needs to be (Findlay 15.12.95:pers. comm.).

The fourth aim is to "help them make informed, responsible decisions concerning

relationships", and here there could be more work done. Many of the activities revolve around issues other than one's own relationship and how to deal with it, but in terms of ideals, and values around relationships, students are adequately "helped".

Fifthly, to "look at issues of racism, prejudice and other issues related to people with AIDS": racism is not addressed at all in the Manual, however prejudice against PWAs is dealt with well. Sixthly the Manual seeks to "teach them how to protect themselves and others against the spread of HIV", and this is done quite well: high, medium and low level risks in relation to sexual activity are outlined, and availability and use of condoms is stressed.

Finally, to "enable them to seek immediate help, counseling and testing as required": the Manual makes clear the circumstances in which an AIDS test is required, or advisable, but where to go for such a test is not mentioned at all.

In terms of my own framework, there is no pre-intervention survey recommended in the NED Teachers' Manual, although there was research and piloting done before the Manual was released to schools. Perceived susceptibility is also not communicated, and the use of PWAs is not mentioned. In terms of challenging behavioral and normative beliefs, self-concept, or rather self-esteem, is seen to be a key concept in the teaching of AIDS and sexuality. The NED does raise the issue of planning for the future, and encourages pupils to think in terms of their own life plans. Attitudes and subjective norms are not analysed as such, although pupils are assisted in forming their own morality and value system, and this is related to forming their own internal locus of control. Self-efficacy is attempted, but, as

with the First AIDS Kit, there is not enough practising of negotiating skills, and initiating conversations about safer sex.

The Manual does not alert teachers to cultural differences, and nor are pupils initiated into thinking about other cultures. Gender consciousness is not inculcated, and there are no lessons that are aimed at improving the girls' assertiveness, nor the boys' understanding and tolerance. However this Manual definitely does more than give information, especially since it goes in conjunction with a broader, lifeskills programme. Finally the Manual does not mention any form of evaluation, although some of the lessons are designed for the teacher to assess how much information has been correctly learnt by the pupils.

The notion of sexuality communicated through the Manual seems to be much less conservative than that of the First AIDS Kit, and more in touch with teenagers generally. The first module suggests a lesson plan where the pupils themselves list the dilemmas they are facing, and this is important because it allows the intervention to be pitched at the correct level for the class concerned. Unfortunately, this is not sustained, and all other lessons are presented to the teacher without any mention of the pupil consultation. Sexually active pupils are partially catered for, through discussion of contraception and STDs, and while there is a little practice in negotiating sex, there is a strong emphasis on saying "no". Consequently, the Manual lacks the courage of its convictions, as it were, and inadequately prepares pupils for a range of situations that they might face. However, a range of sexual behaviour is detailed, in the form of low, medium and high risk activities, and none of these are presented as unhealthy or unacceptable, except if they constitute unsafe practices. Thus, the heterosexual penetrative imperative of the conservative morality is somewhat moderated.

But the whole Manual is constructed within the heterosexual marriage paradigm, and, similar to the Kit, marriage and a nuclear family are unthinkingly presented as the only options. Choices of, say, single parenthood, having a homosexual relationship, or living in a long-term heterosexual relationship without getting married, are not presented. Gender, too, is not examined, nor the gender relations on which marriage is historically based.

Finally, pupils are encouraged to form their own morality, through debates and peer counseling, and this is extremely important in helping them shape their own identity. But, as stated above, this morality is steered in a particular way, and within a familiar, and familial, paradigm. In addition, if more situations to be discussed were elicited from pupils, rather than presented to them by the teacher, the values and morality attached might be more meaningful. However, this morality may be an important lifeskill in assisting students to navigate their way through adolescence, and later life.

CHAPTER EIGHT

Assessment of the Programmes Offered by the House of Delegates' Department of Education and Culture (DDEC), KwaZulu Department of Education and Culture (KDEC), Department of Education and Training (DET), and a Single KwaZulu-Natal Education Department

In this chapter I shall examine four initiatives that are somewhat different from the previous two, in that none of them seem to have the explicit aim of changing behaviour, and therefore cannot easily be assessed in terms of my framework. This, however, does not necessarily mean they should be written off: the House of Delegates' Department of Education and Culture (DDEC) syllabus is aimed only at Primary School pupils, and it is thought inappropriate to teach people of that age about safer sex and behaviour change; and there is, as yet, no programme offered from a single KwaZulu-Natal Education Department, only some NACOSA initiatives, that, it is hoped, will inform the future programme of this department. The NACOSA documentation is not in the form of a fully fledged programme, but both of these initiatives have considerable value as part of as AIDS education programme. But it is also worth examining the KwaZulu Department of Education (KDEC), and Department of Education and Training (DET) initiatives, because they too have something to offer, especially if used in conduction with other initiatives. Most important in this regard is the DET teacher training that is going on in the area of AIDS and sexuality education.

House of Delegate's Department of Education and Culture(DDEC)

In correspondence to principals of all primary and secondary schools (E.C. Circular No. 32 of 1991), AIDS Education Policy, and Guidelines and Arrangements for AIDS Education are set out.

> A. Policy
> 2. It is the policy of the Department to ensure that every pupil has access to AIDS education, as a short-term measure. However, it is envisaged that in the long-term pupils will develop wholesome attitudes towards human sexuality through a course of instruction in a new Health and Family Life Education Programme ..... which will include components relating to sexuality education, drug education and nutrition education.
> 3.3 ..... The decision by a parent not to allow his/her child to be exposed to AIDS education in the classroom must be respected. (HOD E.C. Circular No. 32: 1991)
>
> B. Guidelines
> 2. Ideally, Aids (sic.) education should occur in Guidance periods .....
> 3. Only those teachers who have attended workshops on AIDS education should be utilised to handle AIDS Education at the school. In the main, it would be the school counselors at secondary schools, a large number of whom have already undergone training conducted by ATIC in Durban ..... In the primary school, one of the members of the Management Staff will be responsible for AIDS Education. Arrangements are being made for those selected to attend workshops conducted by ATIC.
> 4. AIDS Education materials are available from various organisations involved in AIDS prevention including City Health Departments, Department of Health and Population Development and AIDS Training and Information Centres (ATIC), ... the Department of Health and Welfare in the House of Delegates, (and) the Department will be making material available. (HOD E.C. Circular No.32:1991)

In October 1992 Primary School Principals were alerted to the fact that in 1993 all schools in (the then) Natal would implement a new package called Health and Family Life Education, from pre-primary to Std 5 (E.C. Circular No. 36 of 1992), and copies of the syllabus were sent out. It was noted in that circular that a pilot project was being run in ten primary schools in (then) Natal, in order to get feedback on the programme. In September 1993 the above circular and syllabus were withdrawn, and a new revised syllabus sent, "taking into

account inputs made by teachers, pupils, religious organisations and the parent community" (E.C. Circular No. 26 of 1993).

A number of key factors are mentioned in the 1992 circular, as needing to be taken into account when implementing the package. The first is selection of teachers, and they, it is mentioned, need to be thoroughly familiar with the curriculum package. An orientation course, run by the Department, for those chosen to teach this programme was planned, and teachers should not tackle the sections on sexuality, drug/substance abuse and nutrition until after having undergone the course; in the meantime they could concentrate on physiology and first-aid. The Health and Family Life Education syllabus is detailed from pre-primary to Std 5; in Standards 2, 3 and 4 two half-hour periods are allocated a week, while in Standard 5 the Guidance period was increased from one to two periods per week. Parental consent has to be given for each pupil before s/he participates in the programme, and the consent form is provided in the package sent to principals. There is some Departmental support offered, whereby a Departmental official will call on principals to discuss the implementation of the programme (E.C. Circular No. 36 of 1992).

The introduction of the preamble of the syllabus for the Health and Family Life Education (1993) states that

> Health and Family Life Education is intended to provide learning experiences and guidance relevant to the needs, concerns, interests and aspirations that arise out of the physical, mental, social, psychological and moral development of pupils. It is also intended to help young people to develop attitudes, values, goals and behaviours - based on sound knowledge - that will enable them to cope with an ever-changing environment. A course of instruction on the subject will offer pupils learning experiences that will have lifelong value. (Health and Family Life Education Syllabus 1993:Preamble)

There are three main components to the programme:

* Sexuality Education (including child abuse);
* Drug/Substance/Alcohol Abuse;
* Nutrition Education.

N.B. (i) Simple Psychology and First Aid are also included in the programme

(ii) The development of self-esteem, the acquiring of decision making skills and the ability to cope with peer pressure are key issues which must permeate in (sic.) all programmes being implemented (Heath and Family Life Education 1993:Preamble 1).

This is encouraging - these are all important life skills, and starting at the pre-primary phase is a good idea - the earlier the better. It is also encouraging to see that the programme is conceived with skills being integrated into the rest of the programme, and that the skills should have lifelong value. This hopefully will offer young pupils a sound basis for negotiating the difficult adolescent years, when the individual's own identity is forged, separate from that of the parents.

Each of the three components is then expanded upon. Sexuality education is important, and it is necessary to start at an early age because attitudes towards sexuality develop during the child's early life and remain with "him" (sic.) throughout "his" life. There is a need to make children aware of the significance of their sexuality and "to foster desirable social and moral attitudes, practices and personal behaviour" (Ibid.:1). The programme should enable children to :

- be aware of differences and similarities between boys and girls;
- learn correct names for parts of the reproductive system;
- understand the natural life cycle, from conception to the onset of puberty;
- be aware of ways of expressing friendship and love, in the family and beyond;
- be aware of peer pressure;

- "realise sex will be given its rightful place within the context of a committed marriage relationship and healthy family life";
- be aware of sexual abuse and exploitation, and how to handle them (Ibid.:1ff).

As far as drug, substance and alcohol abuse are concerned the programme states that "it needs to be made clear from a very early age that non-medical use of chemical substances is ..... potentially damaging to physical and intellectual development." Children need to be aware that it is acceptable to say "no" to drugs, and abstinence should be approved and encouraged. One of the objectives of this section is for students to make "informed personal choices" and "have a thorough knowledge of "acceptable values" (Ibid.:2). Similarly with nutrition, the aim is to get children to see the value of healthy eating, what that actually means, and to understand food hygiene, all from an early age.

Again, I believe this is a useful programme, and all of these intentions seem important and constructive, and the emphasis on lifeskills, and inculcating good values from an early age is most sensible. However the question of values enters the picture here, as in all other programmes, and while values are not bad by any means, and are in fact necessary for every individual, I question what it means "to have a thorough knowledge of *acceptable* values" (Ibid.:2, my emphasis). Whose values are acceptable, and whose are not? It may be that the acceptable values are those of a conservative morality, ones that are handed down from teacher to pupil, and thus giving the pupil no room or autonomy to create his/her own values. A similar difficulty comes in with the apparent contradiction between accepting and encouraging abstinence, while asking children to make informed personal choices.

The role of individuals in families is included in this programme, as well as healthy eating, personal hygiene, wise spending of pocket money, environmental pollution, birth in various animals, care of the young, some first aid, cell structure, heredity, social relations, and AIDS. Not all are taught at each level, and some are taught more than once, with each standard incorporating more detail.

Sexuality is dealt with in terms of the physiology of the body, including the structure of cells, tissues, organs and systems, changes in puberty, reproduction including heredity and environmental factors in one's personality. Older classes discuss body image and why it is so important to adolescents; mood swings and how to deal with these feelings and emotions; developing an (individual) set of values and beliefs which will guide behaviour (Ibid.:54 and 67); saying "no" to peer pressure and other influences, and how this is linked to responsibility; double standards are mentioned: "what is good for the boy is not good for the girl" (Ibid.:54); the consequences of irresponsible sexual behaviour is also discussed, for example, pregnancy (Ibid.:68). Mention is made of abuse and sexual exploitation, explored through the concepts of good and bad touching (Ibid.:32), and the potential danger posed by strangers (Ibid.:27 and :55).

AIDS is dealt with in the older classes as well, and information about STDs is included in the book, but teachers are instructed not to mention them, unless they come up in discussion. Similarly, there are instructions to teachers not to mention contraception, like condoms (Ibid.:56 and 69). Prevention of AIDS is subsumed under abstaining from pre-marital sex. This is necessarily a simple model of how the world works, as it is aimed at young people, but not mentioning contraception or condoms is not justified, in my mind. Pupils of twelve

or thirteen years, who have been taught all about reproduction can surely also be given information on contraception. Other issues that cannot be mentioned are homosexuality, transvestitism, rape, pornography, prostitution, abortion, and masturbation (Ibid.:68).

This compromises the programme's commitment to open and frank discussion, and perhaps betrays a latent conservatism, especially in suppressing information about rape and masturbation, since these are issues that may directly affect young people. Masturbation may still be seen to be dirty, and not quite acceptable. References to the Creator, and him having made out bodies, and thus us having to be thankful and respectful of them (Ibid.:10, 17, 32 and 66), may be meaningless to pupils who do not believe in a Creator, and may also create an external locus of control. A more positive message for them may be that we should be thankful for and respectful of our bodies because they are uniquely ours, and the only ones we are going to get, etc: in short, because they are ours, and not because someone else made them. This is fostering an attitude of internal locus of control, and this is a useful lifeskill.

Of course, it is vital that religious sensibilities be taken into account, but here religion is assumed and presented, rather than accommodated. If calling upon religious reasons for not abusing one's body works, then it should be continued, but it should be stressed to pupils that there are differing points of view, not least between different religions, and all should be tolerated.

Drugs are presented as coming in different forms, for example, over-the-counter drugs, which are socially acceptable, prescription drugs, and illegal drugs (Ibid.:28). Further most people use drugs of some sort, such as tea, coffee, cigarettes and alcohol, and the harmful

effects of all drugs are stressed. The distinction between using and abusing drugs is made (Ibid.:33), and the issue of addiction is brought up (Ibid.:44). However addiction is presented in a non-judgmental way, in that people get addicted to drugs as a means of escaping reality, because of troubles at home, peer pressure, physical abuse, sexual abuse and other problems (Ibid.:44). Thus pupils are later taught about being able to cope with the pressures of daily life, how to start a support group to prevent the spread of drug use, and how children of drug-dependants can cope with the problem. A number of resources are named for help, such as AA, SANCA (Ibid.:70). Finally, pupils are taught about nutrition, food groups, requirements from a diet, budgeting, meal planning and dieting to lose weight, as well as over-eating, malnutrition, undernutrition, food additives etc.

The real problem with the Health and Family Life Education (1993) is that it is light on skills. Pupils do discuss and debate things, and act out role-plays, but most of the activities outlined relate to a reading from a book or magazine, which pupils read, or the teacher making a chart, or showing photographs or pictures cut out of magazines: very little involves much student activity, and this is unfortunate. It is very much an information-giving model of education, and while most of the information is good, non-judgmental, and helpful in terms of living one's life, imparting skills is lacking.

For example under "Sexual Responsibilities: Objective" it is stated that "(p)upils should understand the importance of making their own choices and accepting responsibility for these" (Ibid.:54). They are taught about "Decision-making, Lifestyles and Consequences and Peer Pressure", mainly by the teacher talking and with the instructions "Pupils: write (on various related themes); debate (on various related themes)" (Ibid.:54), both of which are

unspecified. These are important for encouraging pupils to think about things for themselves, and start to develop their own values and sense of morality, but does nothing to enhance self-concept, or self-efficacy, that is, make these decisions stick in the face of adversity. It also does not assist pupils in dealing with real life situations of interactions with others.

Similarly with "Sexual Responsibility (How to say no)" the advice to students is to:

> * Tell him/her about your beliefs and values.
> * Examine the consequences of irresponsible behaviour.
> * State your answer firmly and clearly in a voice that does not show your uncertainty.
> * Refraining from pre-marital sex is a sign of love and respect of the other person. (Ibid.:68)

There are no other skills suggested, and the activity here is for the teacher to illustrate a case study of a teenager who has fallen pregnant through irresponsible behaviour. The implications are then examined, for example, leaving school, parental disapproval, etc. This offers the children nothing in terms of making their skills work, and having the ability to keep to their decisions and avoid peer pressure.

By way of assessment, the aims of Health and Family Life Education are divided in to the sections that the syllabus follows, that is, sexuality, drug abuse and nutrition. The aims mainly relate to information-based tasks, so that, by way of example, children, after sexuality education:

> * can become aware of similarities and differences between boys and girls
> * learn correct anatomical names.....
> * develop a basic understanding of the normal life cycle.....
> * be aware of the different ways of expressing friendship and love.....
> * be aware of the many difficulties and challenges related to peer pressure.....
> * realise that sex will be given its rightful place.....
> * be aware of the contemporary realities of sexual abuse.... and how to handle these (Health and Family Life Education 1993:1ff).

Similarly, the sections on drug abuse should enable pupils to "acquire knowledge of....", "make informed personal choices", "have a thorough knowledge of....", "understand the harmful effects of drugs", and "abstain from drugs", and on nutrition, children are expected to "realise the importance of....", realise the value of....", "make a judicious selection of...", and "understand the role which..." (Ibid.:2ff). Thus, this programme is mainly one of information-giving, and creating, or assisting in creating, values for pupils, and at this level I think that most of these will be achieved.

In terms of my model of assessment, which, as stated previously, is not a fair one to use, since there is no aim of behaviour change, there is no pre-intervention assessment, no communicating a sense of susceptibility, and unsurprisingly, no social support for change offered. Yet this programme does more than merely give information. I think it attempts to instil in pupils a sense of self-concept and internal locus of control, through developing a value system, and giving them information to make sense of their world. This is am important basis upon which skills can later be built, but, as mentioned above, this programme could offer more in the way of practising skills, and assertion of self-efficacy. it is problematic that gender relations are not brought to the attention of pupils, and neither are cultural differences, although one teacher mentioned a programme of Cultural Studies that exists at her school, aimed at letting pupils understand accept and respect other cultures (Maharaj 13.12.95:pers. comm.). And finally, there is no evaluation of the programme.

Its conception of sexuality is one alert to the dangers that exist for young people, and calling body parts by their correct names, and showing that sex, or mating, is a natural phenomenon, that is not shameful. Beyond that, though, sex is clearly to be contained within a marriage,

and 'deviant' sexual practices are kept from the knowledge of children: homosexuality, transvestitism, and even masturbation. Condoms and other forms of contraception are not to be mentioned by teachers.

However, I think this is a programme that could be adapted, and used as the basis for school AIDS education programmes. The information is useful, and intending to "provide learning experiences and guidance relevant to the..... pupils", and to help them develop "attitudes, values, goals and behaviours..... that will enable them to cope with an ever-changing environment", and offering "learning experiences that will have lifelong value" are all useful educational endeavours. This programme would be acceptable if the skills were given greater emphasis, expression, practise and feedback in high schools, such that the programmes there built on what was learnt in primary school. Unfortunately this is not the case, because at HOD secondary schools the DNHPD's First AIDS Kit is used, and this, as detailed in Chapter Six, is sorely lacking. School counsellors are required to "evaluate the (First AIDS) Kit and implement those programmes they consider suitable for pupils of different standards", and consultation with the Parent Teacher Association and informing parents are prerequisites (E.C. Circular Minute DK of 1992). Thus, sections on safer sex, the point of AIDS education, may be left out.

KwaZulu Department of Eudcation and Culture (KDEC)

The KDEC relies on a number of strategies for AIDS education. One is through nurses at

KwaZulu hospitals, and at Edendale Hospital in Pietermaritzburg there is a Community Health Services AIDS Unit, which sends nurses to schools in the area. However, as detailed in Chapter One, I was unable to ascertain further detail of these activities. Almost certainly, though, they would be of an information-giving kind, due to the small numbers of nurses, and large number of schools: nurses could do little more than visit a school once or twice a term, and in this time little behaviour change can be effected.

The main AIDS education intervention is through an non-governmental organisation (NGO) called Dramaide, started by the Drama Department at the University of Zululand and now with ten teams actually taking Dramaide to schools. Dramaide was originally funded by the ex-KwaZulu Government, but this has now been taken over by the Ministry of Health in the KwaZulu-Natal region. Each team uses the same basic approach, but a slightly different methodology based on their own experiences. The teams go into the schools for a period of time, and in Pietermaritzburg that is two full days (Tromp 15.12.94:pers. comm.). On the first day they perform a play for all pupils and staff, then run workshops for all the teachers, and one for each class or standard. The play is a participatory one, where the audience response to events is elicited, and the audience is encouraged to go up on stage and participate. After the play there is a question and answer session, where the audience may ask questions about what they do not know, or discuss an issue that was raised by the play. The aims of the Pietermaritzburg Dramaide play are to develop a questioning mind, give information about AIDS/HIV and STDs, encourage non-discrimination against people who are HIV positive or have AIDS, and challenge the myths that abound about the disease (Ibid.).

The school then has a period of time to organise an Open Day for the community, where the pupils put on plays, songs, dances, make posters, do an information display etc, all with the theme of AIDS/HIV. The Dramaide team goes back to the school for the Open Day, and helps judge the pieces offered. Teachers are expected to continue the process, but lack of time and incentives means that often they do not, and thus the AIDS education only takes place on the two days that the team is at the school (Ibid.).

Dramaide has incorporated changes and lessons that have been learnt in the field, and because of this experience, the play has changed and been adapted to give more positive messages. For example, in 1993 the play showed a person who is diagnosed HIV positive, is rejected by the community and dies, almost on the spot. But in the 1994 play the person is diagnosed, is rejected, but after some time is welcomed back into the community, thereby instilling a message of non-discrimination towards PWAs. The link between AIDS and STDs is also included. In 1995 it was planned that more peer-education and fully trained teachers would be used, in order to allow support for positive behaviour change, and to encourage the use of condoms, and there was also to be a movement to incorporate life-skills into the content. In this regard Dramaide was working with the NACOSA Lifeskills Education Forum (Ibid.).

The aim of the Project is not to attempt to instil behaviour changes, but, as Deborah Tromp put it, bring the pupils to zero, while now they are on a negative scale. Many come from broken families, many live in a culture of violence and are quite aggressive. They are searching for an identity around sexuality and they only have their peers to help them. Thus the Project aims to dispel the many myths that exist around the transmission and prevention

of AIDS, make the pupils think 'I am important', and make them want to use condoms. In other words, this is an information giving exercise, and one that incorporates some form of intention or desire to change behaviour (Ibid.). There is also a nurse at each KwaZulu hospital, known as the Dramaide Nurse, who supports the schools after the Dramaide team has left. However each nurse has a large number of schools under their care, and one problem they face is lack of transport to get to the schools, hence their visits there are irregular (Tromp 15.12.95:pers. comm.).

One problem that does exist, however, is that it is a slow process. In KwaZulu-Natal as a whole it is estimated that there are 5,007 schools and 2,449,829 pupils (Small 8.12.94:pers. comm.), and a large number of these will be (ex)DEC schools. Further, not all the Dramaide teams are thoroughly trained in AIDS information: only the Pietermaritzburg team is formally trained by ATICC, in correct information about transmission and prevention of AIDS, and sexuality. Other teams have no formal training, and hence the information that they convey may not always be absolutely accurate (Tromp 15.12.94:pers. comm.).

In 1995 KwaZulu DEC decided to augment the Dramaide initiative by using booklets about AIDS education, published by Macmillan Boleswa. It has pledged funding, said to amount to R6 million (Tromp 15.12.95:pers. comm.), for further development of materials and teacher training facilities (NACOSA Minutes 24.11.94:6). Macmillan has already produced eighteen readers, with true to life stories about young people and the dilemmas they face, aimed at students from Std 4 to Std 10. They are accompanied by teachers' guides and three day workshops to train teachers in their use (Ibid.:6), and further funding for this aspect of the Macmillan Boleswa project may greatly improve it. However, there has been some

criticism levelled at the readers: they are said to be judgmental, contain misinformation, and be culturally incorrect, in that they were produced in Gauteng, and are not appropriate for KwaZulu-Natal youth; there is also no mention made of consultation with parents and communities (Tromp 15.12.95:pers. comm.).

In terms of assessment of the KDEC programme, there is, again, no pre-intervention survey. The Dramaide plays attempt to instil ideas of susceptibility, and self-concept, but these are not aimed at effecting behaviour change. The aim, instead, is to encourage pupils to think about change, or prepare for it. Peer pressure, or normative beliefs, are challenged by Dramaide, but the intervention is not long enough to sustain these ideas. Similarly, the Macmillan Boleswa booklets may encourage pupils to examine their own attitudes towards condoms and safer sex, and more importantly, give pupils some scripts for discussing sex with their partners. Gender relations are also dealt with by Dramaide, and this may get adolescents thinking about gender roles and their response to them.

Community and school involvement is the aim of the Open Day, and while this may keep the anti-AIDS message alive for a short period, the danger exists that it will soon be forgotten, since there is little follow up after the Open Day. The play is a participatory one, and this concepts of sexuality come directly from the audience involved, hence it will be more appropriate for the specific group than anything coming from a textbook or manual. Again though, only the surface of these issues can be scraped in the time allocated to the intervention, and this is unfortunate. I would characterise this programme - Dramaide and the booklets - as more than an information-giving model, but not much more. However the two programmes in conjunction do complement and strengthen each other.

A further problem with the KDEC programme is that it is unco-ordinated, and a number of piecemeal efforts require some overall structure if they are to be effective, and avoid duplication. In addition, an unacknowledged letter to the Director of Education, which I wrote on 27 June 1994, smacks of a lack of organisation, and one could arguably extrapolate this to apply to the whole department.

Department of Education and Training (DET)

One of the DET's strategies also apparently involves the use of the Macmillan Boleswa AIDS Awareness booklets. The age group aimed at is 16 to 18 years, and the stories deal with "real developmental issues confronting teenagers" (Ngcobo 5.1.95:pers. comm.). However, another DET official said that these booklets were not used by DET because they were mainly for primary school ages (Muller 11.12.95:pers. comm.). This points to the fact that there is no one source of information and co-ordination on AIDS education, and this is problematic.

AIDS education is part of a broader sexuality programme, AIDS Awareness and Sexuality Education, and that is part of Guidance in DET schools. Guidance takes up two lessons per week, from Class 1 to Standard 10, but the content of what is taught in those two lessons is left up to the school to decide (Muller 11.12.95:pers. comm.). The content of the Guidance lessons depends on a number of things: whether there are teachers available; what the burning issues of the day are; and whether parents in the community agree with the proposed

content. There are not enough Guidance teachers for all DET schools, and those who are trained are often used by schools for other teaching (van der Merwe 4.8.95, and Muller 11.12.95:pers. comm.), so only an estimated 35-40% of schools and 65% of young people know about AIDS and what to do about it due to education at schools (figures from Ngcobo 5.1.95:pers. comm.). Mr Muller, the Guidance Circuit Inspector, stressed that he was not prescriptive in what Guidance should cover, and the teachers should be flexible, and deal with issues at hand: for example voter education was dealt with prior to April 1994, and will be dealt with again in 1996 prior to local government elections in KwaZulu-Natal.

Parents, and in some cases principals, acted as a handbrake on AIDS and sexuality education, since parents believe it is their right to education their own children in these issues, so that their standards of what is right and wrong are not compromised. In some of the rural areas, principals may not have heard of AIDS, or believe it only happens in the city (van der Merwe 4.8.95:pers. comm.). Parents do not like the idea of their children receiving information on sex, as they believe it will encourage the youth to be promiscuous (van der Merwe 4.8.95 and Muller 11.12.95:pers. comm.). However lifeskills are seen to be a major part of Guidance, and these can be taught in isolation from sexuality.

There is no formal evaluation of programmes: "what would we do with it?" (Muller 11.12.91:pers. comm.), but it does come out in informal discussions. There is also no way of monitoring the Guidance programme to ensure that AIDS and sexuality education occur, since Mr Muller explained that he did not believe in being prescriptive, and forcing people to teach certain things, and Mr van der Merwe suggested that the fault lay with the Circuit Inspectors, or rather that there were not enough of them in the Psychological Services of the

DET. Whole levels of authorities, from Directors to teachers, Inspectors to principals, do not take the issue seriously enough (van der Merwe 4.8.95:pers. comm.).

In relation to sexuality, it seems that there is no clear message being given to school pupils: teachers do not always use correct terms for body parts, for example, penis, vagina, because they may be fired for doing so (van der Merwe 4.8.95:pers. comm.), although one is not sure how this is possible. This issue was discussed in one of the ATICC training workshops, and since there is no policy or directive on this, it depends on the perspective of the teacher: some promote abstinence at all costs; others suggest that since students are already sexually active, their duty is to hand out condoms (Muller 11.12.95: pers. comm.).

The DET does seem to take community involvement in AIDS and sexuality programmes very seriously, and parental approval must be granted for all programmes. This, however, can result in a very conservative programme being offered, where sex and sexuality is not mentioned at all. The problem of parental and school authority conservatism was confirmed by the NACOSA Minutes, and it seems that it is very difficult to overcome (NACOSA Minutes 1994:4). One teacher suggested that parents are happier about sexuality programmes if they see a syllabus (Marais 12.12.95:pers. comm.), and this may be one way of overcoming the difficulty. However another teacher reported that parents presented no resistance to AIDS and sexuality programmes, because they are worried about their children being sexually active, and the resulting pregnancy; education was a means of preventing this (Ngcana 15.12.95:pers. comm.).

In 1994 the DET decided to focus time and money on teacher training for AIDS and

sexuality education, and this began in 1995, in conjunction with ATICC Pietermaritzburg. By August 1995 125 teachers had been trained by ATICC, and it was estimated that this would reach between 25 000 and 30 000 pupils (van der Merwe 4.8.95:pers. comm.); another five workshops were run in September and October 1995, for approximately another 125 teachers (NACOSA Life Skills Education Activities Draft Report Undated:7).

The original course was evaluated and changed somewhat for the second round of training, the main change being that the first course insufficiently trained teachers to teach and communicate about lifeskills (Ibid.:6). The course runs for four days, although it may be lengthened in the future, and is broken in the middle: the first two days of the course are followed by a two week break, so that it is not too intense an experience for participants. The aim of the course is "to equip teachers to run basic HIV/AIDS and sexuality programmes in schools through an exploration of information, attitude, behaviour, skills and teaching approaches" (Tromp Undated:3). Objectives include participants having an understanding of: first, AIDS information, including transmission and prevention; second, how attitudes, values and beliefs influence behaviour; third, the role of skills development in HIV/AIDS and sexuality education; and finally, the range of teaching techniques that are available for this type of content (Tromp Undated:3ff).

The content of the course comprises three core modules: HIV/AIDS information, including the difference between HIV and AIDS, its history, prevalence, how the immune system works, transmission, prevention, living with HIV/AIDS, and testing; sexuality, including the difference between 'sex' and 'sexuality', where we learn about sex and the relative importance of these sources, puberty, and sexual activity; and classroom practice,

including dealing with objections from teachers and parents, choosing content of AIDS education, choosing methods of teaching, dealing with sexuality and pupils in the classroom, and how to make the best use of resources and information centres in the area surrounding the school. All three of these core modules are designed to explore information, attitudes, behaviour and skills for behaviour (Tromp Undated:3ff).

The method used of examining attitudes, and reasons for holding them, and reasons for changing them, is the most innovative I have read about, and the only practical example of how to change attitudes and behaviours, concomitant with the theory of reasoned action, and other models outlined in Chapter Four. Participants on the training course are first asked how prevalent a certain attitude is, for example, "AIDS only affects homosexuals and prostitutes and not me or my community", and what that attitude means in terms of behaviour. Usually an attitude disguises an excuse not to confront one's own vulnerability, and not change one's behaviour, and this could be true for this example: saying AIDS is a gay disease means that if you are not gay, then you are safe from it. Once the attitude is uncovered, and the attitude better understood, facts or examples of why the attitude is untrue are more easily accepted and integrated into thought patterns. So here, HIV figures of women reporting at antenatal clinics could be provided, suggesting that not all of them are prostitutes, or Magic Johnson[1], a self-confessed heterosexual, could be presented as evidence of the disease affecting anyone. From there, new behaviour correspondent with new attitudes is explored, such that people are safer in

[1] Magic Johnson was a famous American basketball player, who announced to the world that he was HIV-positive in the early 1990s. He claimed that he had not used needles to inject drugs, nor was he gay: he became HIV-positive through heterosexual contact.

their practices.

In short, prevalent attitudes and behaviours are examined, why these are incorrect in the face of the epidemic, and reasons for adopting different ones are explored. Finally skills required to effect new behaviours are discussed. The deconstructing of attitudes, giving reasons for why they are upheld, offers people a way in to their own psyches, and change based on understanding is easier to accept. All 'unsafe' attitudes could be examined in this way, but none are, by any of the education departments, except possibly by the DET. It is stressed on the training course that teachers could use the same methods of teaching pupils as they themselves have experienced; so as well as understanding their own attitudes, teachers are also learning about innovative teaching methods.

The DET seems to be taking this training very seriously, and teachers are given time off from school to attend training and follow-up seminars, and the DET have paid ATICC for the training, and pay for a venue and hotel accommodation for the four days of the course (Tromp 15.12.95:pers. comm.). On the course teachers develop aims for their own education programme, and together identify core ideas for a curriculum, such as, what should be the main message for particular age groups (Ibid.). Teachers on the courses have included those who teach in primary schools.

The DET also runs follow-up workshops for teachers who have attended the ATICC training workshops, where there is an open agenda, and individuals can bring up issues that are pertinent: for example, at one such workshop, sexual abuse, harassment and rape were brought up, and teachers present workshopped how such an issue could be dealt with in the

classroom (Muller 11.12.95:pers. comm.).

Although this training seems extremely thorough and well researched, the general sense of the DET AIDS education programme is one of confusion. Officials in the department seem to contradict each other, and the actual guidance syllabus itself is in question. It seems that there is a core syllabus from the Provincial Task Group (a structure that came out of discussions aimed at creating one education department) on guidance, which the DET received before July 1995, and which details guidance topics from Std 5 to Std 10, and, according to Mr Muller, this is being implemented in DET schools (Muller 11.12.95:pers. comm.). However teachers that I spoke to had no knowledge of this syllabus. Again, this points to the need for efficient co-ordination and an overarching structure. The other major concern in relation to guidance, and indeed other subjects, is that there is a severe lack of teachers in DET schools, and as a result classrooms are overcrowded, and teachers over-stretched.

The DET, like all the other education department AIDS education programmes, has no pre-intervention survey of baseline knowledge, attitudes and practices. However, in the teacher training workshop, as stated previously, teachers are encouraged to form their own syllabi, while the workshop is still fresh in their minds. If they decide to follow the same format as the workshop, they may well examine baseline attitudes, since this is exactly what the workshop seeks to do. Thus ideas about personal susceptibility may be covered, and feelings of non-susceptibility may be challenged. Skills for behaviour change are heavily emphasised, although they are not identified as self-efficacy, internal locus of control and self-concept. Ways of teaching skills and resilience of them is not sufficiently emphasised, although

community involvement in AIDS education does seem high on the DET's priority list. If attitudes are being exposed and challenged, then this programme has the potential to create a culture of condoms, where those pupils who are sexually active may meet less and less resistance to condoms, resistance of their own making, and from a peer group.

There is a section of the course that deals specifically with the myths that feed into the continued subordination of women, and how this increases the risks of HIV, and the uncovering of attitudes may means that culture is taken into account as well. Cultural differences in attitudes towards condoms, relationships, sex and gender will surface as these attitudes are examined, and change in attitudes will also incorporate cultural and gender specificities. The DET teacher workshop also has an evaluative component, and teachers may wish to replicate that in their classrooms. Thus the DET teacher training has great potential as an effective AIDS education programme, and would be extremely effective if combined with a syllabus that more thoroughly covers lifeskills and resilience of them.

A Single KwaZulu-Natal Education Department

As far as one education department goes, this is still a long way off, although there is a lot of informal networking, and discussion about a potential department (van der Merwe 4.8.95 and Muller 11.12.95:pers. comm.). The control structures have not changed for the ex-education departments, but Provincial Task Groups (PTGs) have been set up in various curriculum areas to develop core curricula for all the schools in the province, and it is

envisaged that these will be able to offer new syllabi to the education department when it is set up, by amalgamating existing syllabi from (ex) education departments.

As far as AIDS, sexuality and lifeskills education go, NACOSA (KwaZulu-Natal), as a sub-section of NACOSA National, is very active in trying to develop lifeskills education around AIDS/HIV in the province. In 1992 and 1993 there were consultative workshops on AIDS education, and in 1994 commissions from those workshops developed a regional Implementation Plan, which includes the provision of AIDS education and prevention, counselling, care of PWAs, STD management, provision and distribution of condoms, human rights and law reform, special programmes for women, as well as research (NACOSA Minutes 24.11.94:2). This Plan was accepted by the Premier of KwaZulu-Natal in October 1994.

This NACOSA Implementation Plan is not formally linked to education departments, and discussions surrounding their amalgamation. However the educationalists involved in the NACOSA Life Skills Education Forum are people from the existing departments, and it is hoped that through this personal contact, when one department is formed, the NACOSA recommendations will become educational policy (Tromp 15.12.95:pers. comm.). At a national level, NACOSA and the National AIDS Plan personnel are lobbying the Minister of Education to support AIDS and sexuality education as a core component of the Guidance syllabus for schools. If a national directive goes out, it is hoped that this type of education will become compulsory in every school in the country.

However primary and secondary education fall under the auspices of the regional

government, and thus regional resistance may be encountered to this. In addition, some people in positions of authority in KwaZulu-Natal education departments are resigning, because of fear of KwaZulu DEC dominance in a single education department, and expectations that KwaZulu personnel will be favoured for employment. People also fear the education department being moved to Ulundi, since they would have to move there as well (Ibid.). But the major fear in terms of life skills education in KwaZulu-Natal is that the KDEC's programme will be adopted for the region, that comprising Macmillan Boleswa booklets, which the department is heavily funding, and Dramaide. Thus the NACOSA plans and minimum criteria are tenuously linked to the future of AIDS/HIV and sexuality education in the province, and this is unfortunate.

In September 1994 the KwaZulu-Natal NACOSA Life Skills Education Forum was established, comprising members of education departments and ATICC, with the aim of implementing life skills education in educational institutions in KwaZulu-Natal. It was recognised that some co-ordination was needed if life skills education was to be effective in the region, since all the education departments were doing different things in this regard, and the first meeting of the Forum was to gather information on activities. Later in September 1994 another Forum was held that included NGOs, CBOs, business and church representatives. At the end of 1995 NACOSA comprised a total of 109 individuals, representing 51 organisations from the province (NACOSA Life Skills Education Activities Undated:3).

Various activities have been outlined as tasks for the regional NACOSA:

1. a situational analysis of what is going on in the province, what education departments

offer, and which NGOs and CBOs offer any AIDS/HIV or sexuality education, and of what kind. This has been achieved;

2. the establishment of minimum criteria for life skills programmes, and a draft of this has been drawn up and is circulating among stakeholders;

3. curriculum development for courses in teaching teachers and other trainers, and again this has been initiated, and a curriculum is being tested on DET teachers;

4. drafting a policy document, and here the process has only just begun;

5. train-the-trainer workshops, with the aim of training as many people (mainly teachers) as possible in life skills education. This is planned for early in 1996, with the assistance of Senior Lecturers from Indumiso College of Education;

6. teacher training workshops, which are being conducted, at this stage only with DET teachers;

7. a publicity campaign is planned, but few concrete steps have been taken in relation to this;

8. out-of-school-youth were identified as requiring life skills education, and the Midlands Out of School Youth Forum was established in June 1995;

9. the development of pre-teen media is underway (Ibid.:1ff).

A budget for these activities was secured from the Department of Health in the region.

In June 1995 NACOSA held a consultative workshop on "AIDS and Sexuality Education in Schools", with the aim of creating a vision of life skills education in the region. From this workshop came working groups to develop minimum criteria for life skills programmes, and to develop policy recommendations. The criteria are to be used to offer guidelines to NACOSA and the Department of Health about which life skills programmes are adequate and which need additional assistance, how to measure the programmes offered by outside

agencies, how to develop sexuality and HIV/AIDS/STD education programmes, and to set standards for evaluation of programmes. These minimum criteria are explicated in terms of

1. Definition

2 Orientation, that is, what lifeskills are, and who needs them

3. Guiding Principles (code of ethics), "for lifeskills orientated sexuality and HIV/AIDS/STD programmes for school going young people. Such programmes or components of the programme shall: .... be participatory...., be evaluated...., be non-judgmental and encourage consideration of all options...., respect different cultures...., recognise..... knowledge, attitude, behaviour...., strive to impart skills and not only information...., be gender sensitive and challenging of negative attitudes...., consult with parents and community...., be developmental...." (NACOSA Life Skills Education Forum: Draft Minimum Criteria for Sexuality and HIV/AIDS/STD Education Within Schools Undated:2ff).

4. Aims and Objectives, which relate to imparting knowledge, exploring attitudes regarding sexuality and HIV/AIDS/STDs, and exploring and impacting on behaviour that increases risk for HIV/AIDS/STDs, developing skills "required to choose and practice healthy behaviours" (Ibid.:4), and build capacity at all levels.

5. Content, which "shall be related to the identified needs of each community (class, school, culture)" (Ibid.:4).

6. Teaching Methodology,

7. Life skills education being an integral and compulsory component of school education,

8. Evaluation of education interventions, appraising "factual information...., skills in applying theory to practice,.... attitudes.... in narrative or simulated real life situations" (Ibid.:6).

9. The provision of follow-up procedures for sustaining behaviour change.

The content is detailed in terms of core topics that must be reach all pupils before they complete Matric/Std 10. The core topics are themselves further detailed, and include:

information, about human reproduction, relationships, family planning, transmission and prevention of HIV and STDs, understanding gender as a cultural practice;

values, of self and others, including peer pressure, media, envisaging options and outcomes of scenarios, being non-judgmental and respectful of individual differences;

core skills of independence, including realistic self-esteem, self-awareness and self-knowledge, planning and problem solving, decision-making, communication, assertiveness, coping with change;

core skills of inter-dependence, that is, developing conflict resolution, listening, assertiveness, creative co-operation in a group, leadership skills, needing to belong, initiating and sustaining relationships, understanding cultural differences, dealing with authority. negotiating;

core skills for the renewal of the four dimensions of human nature: physical, which includes exercise, nutrition and stress management; spiritual, which includes value clarification, and any means of spiritual renewal - prayer, meditation, music, art, nature; mental, through reading, visualising, planning; social/emotional, through empathy, creative co-operation and security (Ibid.:4ff).

This document is extremely thorough in what it attempts to provide in terms of life skills, sexuality and AIDS education, how they are expected to be taught, and the evaluation that is expected of them. The only omission it makes is mention of selection of teachers: innovative teaching methods are compulsory, and mention is made of the training of teachers, and ensuring they have the requisite skills and information to teach the subject innovatively.

But needing to have enthusiastic, relaxed teachers who are open about sex and sexuality is not mentioned. In addition, peer teaching and counselling could be better emphasised, where students themselves become teachers.

A pre-evaluation survey is hinted at, at least that the programme should "be related to identified needs of each community" (Ibid.:4), and attitudes and behaviours that are risky should be challenged. Although perceived-susceptibility is subsumed under attitudes, it is not explicitly mentioned, and thus it may be overlooked, which is a problem. However, as far as the rest of my assessment goes, everything else is covered by this Minimum Criteria - it is indeed a most comprehensive document. The conception of sexuality, however, is not totally clear, and there is not sense of the conservative-modern contradiction that I identified, and no mention of portrayal of family structure. However, sexual orientation is to be included in core content topics, as are challenging gender roles, and contraception, and this may go some way in challenging conservative notions.

Overall Assessment of Various AIDS Education Programmes in KwaZulu-Natal, By Behaviour Change and Notions of Sexuality

Means of assessment[1]	Pre-int survey	Info-giving	Suscept	Struct/ Future	SE	ILC	SC	Resilience	Community support	Cult. Specific	Gender	Eval.	Contraception	Notion of sexuality
First AIDS Kit	No, but research done before	*Little on condoms *Separate lifeskills module	No	F[2]-some	Only in terms of "no"		Tries, through puberty info.	No practice, especially in "yes" and "maybe"	Open Day, newsletter, AIDS forum	No	Touched upon	No	No	*Conservative * "No" *Homogenous
NED	As above	No, part of broader lifeskills prog.	No	F-yes	Self-esteem	Yes, own morality and values encouraged		No practice, especially in "yes" and "maybe"	No	No	Touched upon	Very limited	Yes	Tolerant
DDEC	As above	No, but aims are mainly info based	No	F-yes	Yes, dealing with problems eg drugs, alcohol, abuse			Light on use of ideas and values	Parental approval required	No	No	No	Condoms not to be mentioned	*Conservative and mainly silent about it *Alert to dangers eg abuse
KDEC	No	Yes, but D[3] aimed at prep. to change	D tries to instill this	F-M[4] yes	D tries, but intervention not long enough			M gives scripts	D - school hosts an Open Day	Tried	D tries to highlight this	No	Condoms mentioned and demonstrated	D - comes from audience of play
DET (teacher training)	Teachers are tested	No, attitudes examined	Yes	No	Skills greatly emphasised			No practice	No, but parental resistance anticipated	Tried	Section on myths & subordina -tion	Yes	Teachers given condoms and demonstrated	Unclear
Single KZN educ. dept.	Yes "related to identified needs"	No	SBNES[5]	F-yes	Yes	SBNES[6]	Yes	Stated that resilience is required	Parental consultation required	Yes "related to identified needs"	Yes	Yes	Subsumed but not explicitly stated	Unclear

[1] From left to right: pre-intervention survey done; information-giving model; susceptibility broached; structural constraints and thoughts about the future; self-efficacy, internal locus of control, self-concept; corrective feedback and resilience of skills taught; community support for the porogramme; culture taken into account; gender issues examined; evaluation; contraception included in the programme; notion of sexuality communicated to pupils.

[2] F = encouraging thoughts about the future

[3] D = Dramaide

[4] M = Macmillan Boleswa

[5] SBNES = subsumed but not explicitly stated

[6] SBNES = subsumed but not explicitly stated

Chapter Nine

General Evaluation of AIDS Education Programmes in Schools in KwaZulu-Natal

In this chapter I will offer an overall assessment of AIDS education programmes in KwaZulu-Natal: I will assess the region's initiatives as a whole, in terms of their general communication and message about behaviour change, or modification, and in terms of their conception of sexuality. I will also suggest some ways of overcoming the problems encountered by some of the individual programmes, as a means of showing how an AIDS education programme should work. I will use this in Chapter Ten, where I make some recommendations for AIDS education in schools.

Firstly, to assess the policies in terms of two criteria, behaviour change, and a concept of sexuality: behaviour change means a change from X to Y, where X is any sexual behaviour that puts one at risk for contracting HIV, and Y is any safer sexual activity, but specifically, using a latex condom every time one has penetrative sexual intercourse. A behaviour, as I have argued in this thesis, is informed by behavioural and normative beliefs, attitudes and subjective norms, and intentions, and changing behaviour requires changing these beliefs, attitudes and norms. I defined sexuality as something changing, and challenging of the largely hegemonic ideology governing it: one that implies that sex should be geared towards procreative marriage, and this implies that it is heterosexual, penetrative, and located within a religious morality. In the last, perhaps, thirty years, since the advent of the contraceptive pill, and the so-called sexual revolution, this dominant hegemony has been challenged, and now our sexuality can more easily be moulded by personal choices. Sexual anarchy is being

given vent, and we have many more options open to us. More generally, too, the milieu of the late twentieth century is one of changes and challenges: new forms of employment and job descriptions, new options and skills, new technology, new (cyber)space, new types of information, and indeed, new diseases.

How well, then, do the education departments in KwaZulu-Natal, and the National Department of Health and Population Development fare in equipping school pupils with the knowledge/information, attitudes and skills to enable them to deal with safer sex? If a behaviour change is required, then, as stated above, that implies a movement from X to Y. None of the AIDS education programmes, however, attempts to find out what are the current levels of information, attitudes and behaviours of the students they are trying to change. It is assumed that the teacher will know these things, since it is the teacher who uses the curricula to create the lessons, or it is assumed that the curricula itself is appropriate. This, of course, is no guarantee that the intervention will be pitched at the correct level for the particular audience.

Studies have indicated a great variation in sexual activity and behaviour, with rates of sexual activity for adolescents being reported as between 73% (Flisher *et al* (1992)), and 17% (Flisher *et al* (1993)), as well as quite different strategies that various groups use to avoid pregnancy and HIV. In the Mathews' *et al* (1990) study of Cape Town school pupils, 57.1% reported changing their sexual behaviour to protect themselves against AIDS (1990:514). Boys tended to report condom use, while the girls indicated fewer sexual partners as their strategy. However, of all those who had had sex, and believed that condoms protect against AIDS, only 15.4% had ever used a condom (Ibid.). In Cape Peninsula schools Flisher *et al*

(1993) found that the percentages of students who had had intercourse was much higher for Xhosa speaking youth than for those who spoke English and/or Afrikaans (68% for Xhosa males, and 61% for females, versus below 20% for males and females speaking other languages). In terms of doing something to prevent pregnancy, there was marked gender differentiation for Afrikaans and Xhosa speakers, while the gender difference for English, and English and Afrikaans speakers was slight, with, predictably, females more commonly reporting doing something to prevent pregnancy during their last coitus. The third variation in Cape Peninsular youth was that condoms were found to be used by 16% of Xhosa speaking youth, while the figure for the other language groups varied above 69%. The most common method of contraception for Xhosas was the injectable steroid, at 75.5% (Flisher *et al* 1993:496).

What this points to is that there must be a pre-intervention assessment of baseline KAPB, that can take into account cultural (and gender) differences such as these, and, even more local variation, say, between neighbouring schools. One hears of the 'reputations' of certain schools, and this may impact on the behaviour of the students: if a school is said to be 'loose', then the pupils there may (falsely) believe that all or most of their friends are having sex, and, as documented elsewhere in this thesis, this encourages those abstemious pupils to have sex themselves, and a vicious cycle is created. Thus neighbouring schools may have different reputations, (and other things, such as different principals, may affect this) and show quite different behaviour amongst their pupils.

In terms of the regional picture of AIDS education interventions, the NED, DDEC, and the First AIDS Kit (importantly a national strategy) all claim to have done research and piloting

before the current versions of their programmes were released to schools, and while it is important to elicit young people's views on a programmes aimed at them, it is insufficient to address the variations outlined above, since it assumes an homogeneity in the school population. The NACOSA Minimum Criteria document alludes to something that may be a pre-intervention survey, by stating that programmes should "be related to identified needs of each community" (NACOSA Lifeskills Education Forum Undated:4). The specifics of how it is to be done are not mentioned.

The implications of a lack of pre-intervention baseline KAP assessment are that cultural differences are not sufficiently taken cognisance of in AIDS education programmes. As outlined above, different racial and cultural groups have vastly different perceptions about condom use, and that translates into different practices. A pre-intervention assessment could assist teachers in understanding normative beliefs, attitudes and norms that inform condom use, or any other behaviour, and thus the intervention could attempt to replace those with health-conscious beliefs, attitudes, and thus practices. So, in the Flisher *et al* (1993) study, giving the same intervention to Xhosa and English and Afrikaans speaking youth would have resulted in some of the people not 'hearing' the message, since it would not fit with their intentions, attitudes, norms and beliefs. There must be, if my model of behaviour change is correct, underlying behavioural and normative beliefs that create attitudes and intentions towards condoms that are different in Xhosa youth from those youth from other language groups. Only by unpacking and challenging specific beliefs and attitudes can behaviour be changed or modified, since, as Fishbein and Middlestadt (1989) argue, there must be an exact correspondence between behavioural intentions, and the behaviour of interest, that is, that which the intervention is aiming to change (Fishbein and Middlestadt 1989:100). Thus

differences in beliefs and attitudes must be taken into account in attempting to change different behaviours, such as use or avoidance of condoms. Without specific interventions aimed at modifying specific behaviours, through challenging specific attitudes and beliefs, some of the message may fall on deaf ears.

Of course, differences may exist within one class, and these must be accommodated by the teacher within the class context. However broader cultural differences, as well as individual attitudinal differences, can be taken into account if they are more fully understood before the intervention begins. None of the education programmes attempts to cater for specific cultural differences.

No AIDS education effort in KwaZulu-Natal tries to account for gender differences in KAP either. If some school girls are sexually harassed and have sex in return for improved school marks, or if they have sex for material gain, then their beliefs, attitudes, subjective norms and intentions may be quite different to those girls and boys who have sex for other reasons. Further, as Moore and Rosenthal (1993), Oakley (1970) and Zazayokwe (undated) suggest, girls are reluctant to carry condoms, or suggest their use, as this is to set themselves up as being loose, or willing to 'go all the way', that is, to have full intercourse. A teacher said that she had the impression that the girls she teaches feel that condoms are the boys' department, and that they (the girls) should go on the pill if they need a contraceptive (Findlay 1512.95:pers. comm.). Gender differences such as these would need to be addressed.

Gender, as a societal position that militates against safer sexual practices, is not built into any

of the AIDS education programmes either, although the First AIDS Kit cites gender as a reason for lack of condom use. The DET teacher training course, too, does to a certain extent contain a section on myths that feed into the subordination of women, and increase women's risk of contracting HIV (Tromp Undated:53), but there is no guarantee that the contents of the course will be communicated to pupils in an education programme. Perceived self-efficacy may not be as strong for girls as it is for boys, since girls may not believe they can carry out a decision, due to socialisation and lack of assertiveness. Although self-efficacy may be inculcated generally by the programmes, the most notable attempt being by the NED through the notion of self-esteem, there is nothing specifically aimed at improving young girls' assertion and confidence, and neither is there any attempt to educate the boys about women's rights, sexual harassment, and that "no" means "no".

In the light of the less powerful social and sexual position of women in society, an AIDS education programme that fails to mention gender differences would only be doing half the job: if women cannot broach the subject of safer sex, then HIV prevention is left up to men only. "Many women, and this is especially true of teenagers, fear ridicule and even violence if they try to initiate intimate discussions, let alone insist in 'safe sex' (sic.)" (Preston-Whyte 1994:11). Without attempting to empower women, and teaching sexual negotiation and communication to both young men and women, messages about condoms are unlikely to be heeded.

In essence then, what I am arguing is that none of the AIDS education initiatives, (except the DET teacher training) recommend anything but a blanket programme, assuming an homogenous target audience. However, the school-going population is patently heterogenous,

since differences in race, gender and class and culture make it so. Thus a pre-intervention survey is necessary to ascertain the extent of these differences, and the syllabus may then be altered to accommodate specific needs.

These programmes, by working with a conception of an homogenous school population, and by not considering gender differences in attitudes and behaviour, locate themselves within the ethos of the conservative sexuality. This notion of sexuality, in its most extreme form, finds any deviation from monogamous heterosexual intercourse unacceptable, and thus prescribes one form of sexual activity for all (men), and at the same time it encourages the passivity and submission of women. This, of course, is all within the paradigm of marriage, Christian or religious morality, and one partner for life. None of the programmes examines in any seriousness alternative sexual practices to penetration (which, incidentally, are usually safer), with the exception of the NED. But even the NED offers the alternatives as something to be tolerated and accepted, not judged, in other people, but they are just that - in other people - and practice of these behaviours by the target audience is not considered. As outlined above, none of the programmes examines gender socialisation and gender roles, nor offers ways of overcoming discrimination based on them. And finally, all of the programmes unquestioningly present marriage and children as the legitimate and necessary aim of every adult: the only type of family structure presented is the nuclear one. Hence homogeneity, or sameness, is prized, and the changing world, with its implications for sexuality and family structure is avoided. The latter, that is, avoiding a changing world, is profoundly conservative.

The unintended consequences of the AIDS education programmes may be that adolescents

feel confused in a changing world, have not the skills to deal with it, and indeed may have false expectations about the 'bliss' of marriage and family life. In terms of HIV, students may find little in the way of motivations to change their behaviour.

What is required to keep the school-going youth HIV-negative is a change in knowledge or information, attitude and behaviour, and it is to these three that I shall now turn. All of the programmes offer extensive information on AIDS and HIV, how it is transmitted and how it is not, although the Delegates Department of Education and Culture (DDEC) fails to mention condoms as a means of prevention, suggesting instead that fidelity to one's marriage partner will ensure protection. The other programmes state that use of condoms constitutes safer practice, but none except the NED gives information on their purchase or otherwise availability, and correct usage. The DET teacher training course does have a section on condoms, where all the teachers are given a condoms and shown how to use them (Tromp Undated:45).

In terms of beliefs and attitudes required to remain HIV-negative, I have argued that people must first believe that they may get the disease, that is, that they are susceptible, and this means changing the "it will never happen to me" attitude. Attitudes towards condoms should be changed, both those of an individual and those of important others. Thus secondly, the target audience must change their salient behavioral beliefs, such as "condoms will decrease my sexual pleasure and that is bad", or, in other words, "it's like eating a sweet with the wrapper on"; and thirdly, salient normative beliefs must be challenged, that is, that important others don't think condoms are acceptable - 'cool', 'hip', or 'manly'; this leads to the fourth area, which is about complying with social pressure, or pressure from an individual,

that is about perceived self-efficacy and self-concept. I have also argued in this thesis that structural constraints may also impact on wishing to do something about remaining HIV-negative: both high levels of violence - political and criminal - and unemployment make for an uncertain future, and this causes HIV-negativity to be given low priority in the face of a number of more immediate day-to-day problems. Finally attitudes towards unplanned pregnancy and early conception, a problem that seems particularly to confront South Africa, could be examined, and challenged.

I shall examine each of these attitudes in turn, in the KwaZulu-Natal school context, but first I would like to refer readers back to the previous chapter, where training of DET teachers was outlined. This is the only method I have come across in the literature of examining and challenging beliefs, attitudes and norms, and I believe it to be a useful tool in AIDS education. The method is a participatory one, where teachers on the training course are show how to unpack attitudes towards AIDS, its prevalence, transmission modes, as well as condom use and sexuality. As was previously discussed, attitudes often disguise an unwillingness to accept personal vulnerability, or making changes in one's life, and this method of examining the attitude, and revealing the underlying reasons may assist people in being ready to make a behaviour change more easily. This deconstruction is then combined with reasons to change the attitude, and skills for effecting the new behaviour, that the new attitudes underpin. This method could be used for all of the following changes required in belief, attitude and norm.

In terms of beliefs and attitudes that need to be challenged, then, none of the education programmes seems to have an explicit aim of increasing students' perceptions of their own

susceptibility to HIV/AIDS, although every teacher that I spoke to thought that his/her students believed it would never happen to them, and one went so far as to say that her students thought AIDS was a bit of a joke (Ngcana 15.12.95:pers. comm.). It is assumed that pupils want to change behaviour, but lack the skills to do so, and this is only half the picture: they also need the motivation. By way of example of how people rationalise their actions, in Perkel's study of third year university students 94% saw AIDS as a threat to their campus community, but 63% saw the threat to themselves as not likely at all. 32% said the threat was somewhat likely, and only 3% saw the threat of AIDS to themselves as very likely (Perkel 1992:50ff).

Perceived susceptibility could be increased by introducing students to PWAs of students' own age, race, gender, and even better, from their own community, although this may result in stigmatisation of the PWA. Figures of HIV prevalence for the region and area, as well as unplanned pregnancy rates and STD rates, may offer adolescents reasons for changing their attitudes and thus behaviours, as well as focusing on the future, and developing realistic life plans and goals. These are not examined in schools, although the NED manual focuses quite some time on what the different STDs are, their symptoms and cures.

There is also no effort made to change adolescents' attitudes towards condoms, either their own, or those of important others. South African youth have given a number of reasons for not using condoms, some of which refer to lack of information about condoms, and others of which relate to negative attitudes towards their use. Again, only the NED gives information on how to use condoms and where to get them. However there is no effort to dispel myths about condoms, for example, that they will get lost inside a woman (Abdool

Karim *et al* 1992:108, and Zazayokwe Undated:7). And there is no effort to examine the "eating a sweet with the wrapper on" attitude (Abdool Karim *et al* 1992:108, and Zazayokwe Undated:6), and attempting to reframe it in health-conscious terms. In Perkel's study of university students 47.7% of respondents believed that condoms make sex less enjoyable (Perkel 1992:51ff). Although the NED gives information on condom use, it does not help pupils understand why they may have such an aversion to condoms. Going to this level of uncovering attitudes, which is deeper than a pure information level, is vital if education departments are serious about condom use.

Behavioral beliefs, such as "condoms decrease my pleasure" could be countered with "some pleasure is better than none", or "slight lessening of sexual pleasure now is better than the life long commitment that a baby requires". In essence students need to reframe their negative attitudes towards condoms in terms of a trade-off between present pleasure and more long-term safety. Of course plans for the future would figure significantly here, as any future requires long-term safety.

Important normative beliefs against condoms, that is, social pressures against them, seem to stem from the fact that wanting to use a condom indicates lack of love and fidelity (Abdool Karim *et al* 1992:108 and Mathews *et al* 1990:515). It seems that condom use is associated with casual sexual partners only, with 76% of Perkel's respondents reporting this to be so (Perkel 1992:51ff, and Abdool Karim *et al* 1992:109). Zazayokwe asserts that condoms are traditionally associated with the prevention of STDs among the black population, and use of a condom labels a partner as having an STD (Zazayokwe undated:6). 25% of Perkel's study reported that condoms are offensive to sexual partners, 27% said use may make partner think

they are dirty or not trustworthy, and 24% said condom use is embarrassing or uncomfortable in front of a partner (Perkel 1992:51ff).

Again school education programmes do not offer a deconstruction of these attitudes in order to change them, nor any sense that love is not a prophylactic, since some students suggest that a love relationship requires no condoms (Abdool Karim *et al* 1992:108ff, and Moore and Rosenthal 1993:135ff). Condoms could be presented as actually proving love or trust, since they imply a shared commitment to safety and a respect for a partner's wishes. This in turn is related to students understanding about gender roles and women's lack of power, and to them being encouraged to form their own morality and make choices for themselves. The use of positive role models would be important here, as well as slogans, adverts and a general culture of condoms. Schools should try to create this culture, as part of their AIDS education efforts, since a prevalent culture would be an important part of positively influencing the youth's salient normative beliefs.

Finally, young people also reported that actually getting condoms was too embarrassing (Ibid.:135ff), and "the reportedly antagonistic attitudes of some of the clinic staff and supermarket cashiers, particularly to teenagers, discouraged the students" (Abdool Karim *et al* 1992:108) (See also Zazayokwe Undated:5, and Moore and Rosenthal 1993:137.) Abdool Karim *et al* (1992:108) also noted that some male students felt that condoms was damaging to the male ego, and to boys' manliness, particularly if suggested by the girl.

School programmes do try to make students see that they do not have to follow the crowd, that they should resist peer pressure and make their own decisions, but this only really relates

to abstaining from sex. In other words school do try to influence subjective norms, that is, motivation to comply with social pressure, but this is framed only in terms of "no". Students are not encouraged to form their own morality, and stand by their own decisions in the light of social pressure, except if that decision involves saying "no" to sex, alcohol or other drugs. The NED and DDEC are less at fault here than the other departments.

Motivation to comply with social pressure decreases as self-efficacy increases, and again, self-efficacy and self-concept are not well dealt with in schools; they are heavily emphasised by NACOSA and in the DET teacher training course, but these are not necessarily implemented. The NED tries to develop the idea of self-esteem, through encouraging students to take moral stands, and make decisions on issues, and this is useful. However self-efficacy involves making a decision, and believing one can carry that decision out, and there is little covered in any of the syllabi that relates to real-life decisions and negotiating skills and 'scripts' (other than saying "no"). All of this relates to an internal locus of control, and the programmes, with the possible exception of the NED, lack this. The schools, or education departments, try to impose a made and ready morality on to students, a morality that incorporates sexuality, as well as broader issues. This imposition is authoritarian, and also does nothing to encourage students to think for themselves, and take control of their own lives and decisions. As pointed out before, this internal locus of control, and own responsibility is becoming increasingly necessary in the late twentieth century.

Resilience in skills is also not specifically encouraged, although this could be achieved through frequent role-playing, which gives pupils a chance to practice skills in the real world, and return to the classroom for further encouragement in the light of possible failure.

Compliance to perceived norms and social pressure may be mitigated by encouraging students to develop an internal locus of control, self-worth and self-importance, knowing their own strengths and weaknesses, leadership abilities, and also future plans. Planning for the future, and making realisable life goals may give some impetus to concepts of self-esteem and self-worth. Only the NED incorporates thoughts about the future in its programme.

Planning for the future may also go some way towards mitigating against structural constraints to safer sex. If the future is deemed important by students, then it may be given a high priority in students' lives, and the attitude of living life one day at a time, and thus disregarding future implications of disease, may be lessened. None of the education departments make any mention of these structural constraints, nor offer any ideas on alleviating them. Other things that create a worthwhile future include giving students career information, bursary information for further study, study skills, self-employment ideas and skills, community upliftment, and action around environmental degradation.

Finally, I have argued that attitudes towards condom use are related to ideas about conception and pregnancy, and these have a particular meaning in South Africa, due to imperatives of proving fertility and virility amongst some sections of the population. If young people do not see pregnancy as a gravely negative consequence of sexual activity, then they are less likely to plan against it through contraceptive use. Or, to put it another way, if pregnancy continues to be seen as something which confers manhood or womanhood, and as an achievement, then condoms, as a means of preventing this, are not likely to become acceptable. This issue is not addressed by any of the education departments, but it is a tricky issue, because it relates mainly to black students. If teenage pregnancy is accepted by African cultures, then

discouraging pregnancy in the name of AIDS prevention is tantamount to tampering with a traditional culture, and this is an extremely contentious issue. Attitudes towards early pregnancy could be assessed in the initial pre-intervention survey, and attempts to discourage it ensue from there. It is important to note that pregnancy itself is not the problem here, but rather that unprotected sex, from which pregnancy results, can also result in the transmission of HIV. To deal with this, students should be encouraged to think about these unintended consequences, such as AIDS/HIV and other STDs. Proof of man- or womanhood could come from educational or sporting achievements, or being recognised as a moral or fair person. Thus future plans for education or careers again become important.

In summary then, in terms of attitudes towards condom use, that ultimately inform intentions and behaviour, little is being done by AIDS education programmes in KwaZulu-Natal towards modification. Individual perceived susceptibility is not being examined or encouraged (except in the DET teacher training course), such that pupils are motivated to change their risky behaviours. Attitudes towards condoms are also not explored, either the behavioral beliefs that individuals themselves have, nor normative beliefs of the perception of what others think about condoms. Motivation to comply with social pressure, or pressure from a partner is dealt with by most programmes through teaching students to say "no", and there is little in the form of negotiation and compromise. Improved self-efficacy and self-concept are the most useful tools in overcoming peer pressure, and only the NED tackles this idea with any vigour. Structural constraints are not addressed, although they are mentioned for teachers' benefit in the introduction of the First AIDS Kit. Finally attitudes towards teenage pregnancy, which are linked to condom use, are not mentioned at all in any programme, including NACOSA proposals and DET teacher training.

I have examined how education departments attempt to change students' knowledge or information and attitudes towards condoms and safer sex, and I shall now delve into the issue of actual behaviour. The aim of an AIDS education programme should be to assist people in remaining celibate, or, if they are sexually active, in using condoms or practising other forms of safer sex. Celibacy is well catered for, and all the programmes emphasise saying "no" to pre-marital sex. Indeed this is the central message in all except the NED programme and NACOSA proposals, and indicates a conservative notion of sexuality. There is no reason given for abstaining from sex, except out of fear - fear of pregnancy and STDs, of guilt, of parental wrath, and of emotional problems that are thought to be inevitably linked to teenage sexual activity.

As for condoms, none of the programmes except the NED even give information about condom use, and where to obtain them, although DET teacher training and Dramaide do have demonstrations on their use. There is nothing, either, on tackling attitudes towards young women carrying condoms, and that this does not always imply she is willing to have full intercourse. There is plenty of opportunity to practise saying "no" to sex, but no scripts are practised that relate to negotiating safer sex or condom use, or simply talking about sex or relationships. Broaching these delicate subjects is, in some senses, a matter of self-concept and self-efficacy, and when these issues are developed, they are not explicitly linked to negotiation around sexuality.

Other forms of safer sex, that is, non-penetrative sex, or not 'going all the way', are not included, except as a cursory mention in the DET teacher training course. Again, I would argue this indicates a conservative sexuality, where heterosexual intercourse is the only

accepted form of sex. The NED programme does list a range of sexual activities that include low, medium and high risk activities, and this may give students some ideas on alternative forms of sexual activity. However, there is no stress on the fact that these forms could be engaged in and experimented with. Masturbation, as a means of finding out about one's own body, and thought to be particularly important for women to understand and achieve orgasm, is not mentioned by any of the programmes. This smacks of Victorian conservatism, when it was thought that masturbation caused all kinds of illnesses, including blindness. The programmes still give a sense that sex is forbidden fruit, that should not really be tasted. Thus all information is geared towards this, and sex may remain furtive, haphazard, and unsafe. Encouraging (safer) experimentation in an open environment is not accepted.

All of these behaviours require certain skills to implement: the First AIDS Kit's only skills involve saying "no" to sex and drugs; the DDEC is a mainly information-based programme, with limited skills; the DET may greatly improve its skills teaching with new training of teachers, but until now, skills have been lacking in their programme; KwaZulu, through Dramaide and Macmillan Boleswa booklets, may offer some scripts to pupils, but behaviour change is not the primary aim; the NED fares reasonably well in the area of skills, especially since the AIDS Teachers' Manual is part of a broader values-based life skills Family Life Education programme.

Finally, none of the programmes explicitly attempts to evaluate the learning and behaviour change achieved from the education intervention, with the possible exception of the NED, which recommends an exercise that will indicate to teachers how much of the information they have taught has been absorbed by the students, and the NACOSA proposals. Thus

programmes run year after year in the same vein, without any modification.

From this picture of what is lacking in the region as far as AIDS education goes, I shall go on, in the next chapter, to recommend how such a programme should operate. I attempt to answer a number of questions: who should be taught, what should they be taught, who is going to teach them, how, and when?

CHAPTER TEN

Recommendations and Conclusions

It seems to me that the main problem with AIDS education programmes in the region is that they are all different, and they range in quality. All, however, need improvement, and one well designed programme for the region would be better than a number of misguided piecemeal efforts. Thus the region needs a curriculum, based on the principles espoused in this thesis: syllabi need to be appropriate for the target audience; recognition of susceptibility encouraged; attitudes towards condom use examined and reframed in positive terms; skills of self-efficacy, internal locus of control and self-concept, all important in changing behaviour, taught and practised; cultural and religious specificities examined; gender constructs that render women less powerful to negotiate safer sex uncovered and challenged; and the whole evaluated.

The appropriateness of the syllabus can only be achieved with any accuracy if the target audience is first surveyed to ascertain their levels of knowledge, their attitudes towards AIDS, condoms, PWAs, and sexual activity, and their actual sexual behaviour. The survey should also include questions on drug use and nutrition, issues that must be addressed if it is believed that AIDS has a multi-factorial cause. Of course all of these will not be appropriate for all Standards. Thus I suggest that there a number of questionnaires could be devised: one for pupils in Std 2 to 4, a second for Stds 5 to 7, and finally one for Stds 8 to 10, although it may be deemed appropriate for questionnaires to be given only to the latter two groups. The anonymous questionnaires should also leave space for students to write

down questions that they would like to see answered in the course of the year. Pupils in Class One cannot read or write, and thus a questionnaire is useless for this age group. However, the Class One to Std One age group needs could be accommodated through question and answer sessions, or possibly, allowing the pupils to express themselves through drawing.

Curricula could be drawn up with these various age groups in mind, so that teachers have a basis from which to work. The NACOSA Lifeskills Education Forum: Draft Minimum Criteria for HIV/AIDS/STD Education Within Schools (1995:4ff) with regard to content could be used as an excellent base: core topics (each of which is more detailed) include information relating to sexuality and HIV/AIDS/STDs, values relating to sexuality and HIV/AIDS/STDs, skills relating to HIV/AIDS/STDs - including core skills of independence and of inter-dependence, and core skills for the renewal of the four dimensions of human nature (physical, spiritual, mental, social/emotional). Although the NACOSA content includes 'understanding gender construction as a cultural practice" (Ibid.:4), I think this should be especially emphasised, due to the problems some girls and women face in translating their intentions into behaviours.

Content should aim at convincing pupils of their vulnerability to HIV/AIDS, and improve their skills required to remain HIV-negative. These are, as I have argued, self-efficacy, internal locus of control, and self-concept. However, cultural and religious sensibilities must also be accommodated, and thus 'difference' and tolerance should be included. A pre-intervention survey would give teachers a conception of the differences existent in his/her classroom, but pupils themselves must be made aware of these. Thus activities included in

the curriculum should encourage discussion about different pupils' different attitudes and behaviours, and reasons for them, and, most importantly, tolerance of them. Tolerance itself is a vital lifeskill, and should be inculcated with respect to sexual activity, as well as more general living. Student projects on different cultures could assist this.

An important part of the process of AIDS and sexuality education is consultation with parents. Although they may be reluctant to agree to sex education for their children, this hurdle must be overcome. If parents are told what the syllabus contains, and are given the opportunity to ask questions, they may be more accepting (Marais 12.12.95:pers. comm). If sex education came from a regional directive this may also persuade parents that it is a necessity, and something taken very seriously by education authorities. Parents themselves may find information of benefit, and if they are coaxed into seeing that information about sex does not result in children going out and having it, then they are more likely to agree. The point that must be stressed is that without this education some of their children will die.

The syllabus would form only the basis for AIDS and sexuality education, since specific needs of specific classes must be taken into account when actually teaching. All teachers I have spoken to seem to do this anyway, and none sticks to the letter of the law of the syllabus. All teachers saw this arrangement, rather loose in comparison to other subjects, as being quite advantageous, because it allows them to deal with issues and questions as they arise. However developing useful and appropriate lessons will be that much easier if the teacher is armed with the pre-intervention survey that indicates to him/her what students already know and what they wish to know, as well as the education department syllabus that gives ideas on topics that might be requested, or which are thought to be appropriate for

particular age groups, and ways of doing this. Teacher training for this arrangement becomes very important.

However there already are syllabi available for teachers, although, as it should be clear, they are inadequate. Thus one of the other problems arising from school AIDS education is that there is no formal structure that ensures, firstly, that all schools are giving this type of education, and secondly, that schools and individual teachers have somewhere to turn to if there are problems, in other words, to assist them. In other subjects there are inspectors who check on teachers and schools, and there should be a similar position for lifeskills: a Regional Lifeskills Co-ordinator. This precludes that the programme is compulsory, and this, I think, is essential, notwithstanding problems of understaffing in schools. I have indicated previously that there is resistance from school and educational personnel in the region to AIDS, and more specifically sexuality, education. However, unless schools actively tackle the AIDS and sexuality issues, more young people are going to die, and this is unacceptable. The NACOSA Lifeskills Education Forum, comprising officials from all the education departments, recommends that this type of education be compulsory, so that it deprives the "more resistant factions (of) the opportunity to avoid any lifeskills programmes at all" (NACOSA Lifeskills Education Forum Minutes 5.9.94:9).

Just as there are personnel in every department who are concerned with the history or geography or zulu syllabi, so should there be a lifeskills syllabus, with its concomitant personnel and structures of enforcement, that is, a Lifeskills Co-ordinator. This structure, though, would not have to be a watchdog all the time, wielding a stick, but could also offer valuable assistance to those teachers who feel under-equipped, or who are simply battling

with one particular topic or area.

So far I have assumed that there are any number of fully qualified, keen and trained teachers to implement the syllabus once it is developed. Unfortunately this is not the case, and hence teachers need to be trained. This goes for all teachers who are to teach AIDS and sexuality programmes, so that they are sure to have correct and up-to-date information about the disease, and also to ensure that teachers are apprised of various teaching methods that could be used, and to train the teachers to be as objective as possible, without their own prejudices and problems being transmitted to the students. The DET teacher training, for example, never resorts to a lecture-type method of training, and this would encourage those teachers to try out the same alternative methods in class. This training also encourages teachers to examine their own misconceptions, prejudices and attitudes, and this is a useful exercise for them to go through so that they have some idea of how to do it with their own students. In addition, any training of teachers must also include some sort of support structure from the education department, of the type I refer to above. Once teachers are trained, the role of a regional Lifeskills Co-ordinator may become more one of assisting teachers who are having difficulties, and of offering ideas, and general support, instead of a watchdog role.

But perhaps the most important thing about the teachers of this programme is that they must be well-liked teachers. They are those whose relationships with the pupils encourage open and honest discussion and action, frank questioning, and answering, in what is perceived to be a safe environment, and teachers whom students feel they can trust. This points to careful selection of teachers to be trained, and who will teach the AIDS and sexuality programme. Joy Frost of the NED identifies the ability to demonstrate empathy, respect and integrity, that

is, congruency of intention and behaviour (Frost undated:1), as qualities vital for teachers. It is not impossible, however, to train teachers in these qualities.

Lack of qualified teachers, understaffing of some schools, and the mammoth task of training all lifeskills teachers for AIDS and sexuality programmes suggests that another route for AIDS education should be sought. One such route is through using a roving team of lifeskills teachers or facilitators, who move from school to school teaching about AIDS and sexuality. This 'outsider' would not be associated with the school or its authority structures, and thus students would know that free and open speech would in no way jeopardise their marks or school standing. These people could be intensely trained in AIDS education, problems of sexuality, counselling etc, and thus avoid all the prejudices and poorer training of all the teachers, as exists at present. This strategy is one of giving better and more intense training to a few teachers/facilitators, instead of spreading that training more thinly among a lot more teachers, perhaps one or two from every school. This arrangement would also make the job of regional co-ordination and inspection easier, and the education department could be more sure of a standardised programme that was going out to all, or most, school pupils.

However, it is also a wasteful arrangement, because guidance, or lifeskills teachers also play other roles in the school. They may teach another subject, either academic, vocational or sporting, or they may have some administrative or fund-raising activities. Thus the outside teacher would have to be added-on, as it were, and at the moment, employment of an additional teacher for every five or even ten schools in KwaZulu-Natal would amount to about 500 or 250 teachers respectively, and this is highly unlikely. Pupils may take a long time to learn to trust an outsider, to be really sure that s/he has no effect on school records,

and the possibility also exists that pupils will not take the subject very seriously.

The other route that might be advanced in order to avoid teachers, as it were, is to train peer-educators. These are school pupils who are trained in issues of AIDS prevention and sex education, and in counselling and assisting others, and who tell other pupils about AIDS and sex. The advantage of this is that pupils are more in touch with what their peers are feeling and thinking and doing, and where the problems lie, than teachers. I know of one peer education initiative in a Pietermaritzburg school, called Youth Help Youth, and one of the trained educators or helpers said he felt that pupils could be more open with him, another pupil, and ask him more honest questions, and reveal more of their actions (Singh 16.12.95:pers. comm.).

Problems associated with this type of education are that co-ordination is very difficult, because pupils are not beholden to the education department, and once trained have no obligation to provide peers with any education. Selection of peer educators is also very difficult, since it is hard for the adult school authorities to understand how pupils are perceived by other pupils. There may be a tendency to choose those pupils that the teachers and principal deem responsible, mature, likeable or trustworthy, but such students may be deemed goody-goody, naive, teacher's pets, and completely untrustworthy by the other pupils. This model of education may fall into the information-giving trap, since developing skills, and notions of self-efficacy and self-concept may be missed out. I envisage that peer educators could only spent short amounts of time with large number of students, and the time needed to develop these skills and their resilience would be lacking. This type of education is associated with AIDS education, rather then sexuality and lifeskills. Finally, trained

educators would continually be leaving the schools, and thus training would have to be continually updated.

There are problems with a system of peer-education, and with roving lifeskills teachers as outlined above, but I think it is surprising that there is no thought being given to either of these issues in any of the documentation in the region, except for a cursory mention by NACOSA. It seems to me that if all three types of education were used, then the advantages of each could accrue to the system, while the combination would militate against their disadvantages. Further investigation into this is required.

Indeed I would also recommend that any and all means available for AIDS education be utilised, in order to develop a culture of AIDS tolerance, and condom acceptance in South Africa. If this existed, normative beliefs and subjective norms would work in favour of condoms, instead of against them, that is, it would be "many important others think I should use condoms", instead of the present "many important others think I should not use condoms, and I comply". Also a number of varied messages and initiatives may offer more insight for more people: if there was only one programme, and pupils found it boring or unhelpful, that would be unfortunate. There is a greater chance of all pupils finding something of interest and help in a varied range of programmes, than in just one. Thus Dramaide should be seen to be a useful programme, among a number of others, such as the Macmillan Boleswa booklets and those suggested by the First AIDS Kit: AIDS posters and rap songs, a school newsletter, a letterbox for questions, a drama and a story. (There is a danger here that pupils get an AIDS overload, and on hearing too much about AIDS block out all further messages.) This reinforcement of school education programmes may also have

the added benefits of continuing pupils' perceived susceptibility, so that it does not lapse, and of contributing more generally to a sustained behaviour change.

Another issue that has been raised is whether the subject of lifeskills, that includes AIDS and sexuality education, should be examinable. The Draft Report of the NACOSA Workshop "AIDS and Sexuality Education in Schools" (7.6.95:4) reports that in plenary discussion it was suggested that if it is examined it "would show the pupil that it is a serious subject", and "(t)he only way to get teachers' time is to make it examinable". However, I would argue that it should not be examinable, since that would pile all of the schools' authority on to a subject that requires trust and discussion of personal matters, and this may destroy it. In addition, the examinations may only test for information retained by pupils, as many school exams do, and thus the subject would devolve into one of cramming facts, instead of being about developing skills, ideas, and a value system. This again might destroy the programme.

However, this does not preclude some form of evaluation of the programme, and testing what its learning outcomes are, in order to improve the programme. Indeed, this evaluation is a crucial part of the programme, to ensure that pupils find it interesting, informative, developmental, and in some measure assists them in remaining HIV-negative. Implicit in this is that the programme should be evaluated from the pupils' perspective, and from their experience, and expectations of it, and not from the teachers' perspective or morality. The pupils could be asked whether the programme has changed them in knowledge, attitude and behaviour: knowledge about HIV/AIDS transmission, condom use and availability; attitudes towards their vulnerability to AIDS, themselves as capable beings, relationships and the role of sex within a relationship, gender roles and rights, their futures, a conviction to remain

HIV-negative, and their values; behaviour, or intention, that exhibits respect for one's own life and the life of others, especially one's partner, communication with one's partner about relationships and sex, negotiation and resistance around negative peer pressure, practising safer sex (condom use or non-penetrative forms), or delaying sexual activity, and non-discrimination towards people with AIDS. In short, the evaluation seeks to find out whether the intervention has changed the individual as a person, and if so, how.

Finally, the language of instruction of the programme should be considered. If the teacher and the class all speak the same first language, and if pupils generally interact with friends and partners in that same language, then having this lesson conducted in the home language seems appropriate. I am referring here specifically, but not exclusively, to African pupils, whose school language of instruction is English, but whose home language is not English. I think there is some value in giving role-plays, negotiation skills, and scripts for sexuality in the language in which they will be spoken and used, rather than in the more difficult non-mother tongue. This would allow pupils to grasp the skills and ideas first, and deal with the language issue, when it inevitably arises in dealing with the world, as a separate issue.

I have alluded to the fact that people can get an AIDS overload, and if presented with too much information, and hear "AIDS" too often, may think they know it all, and desist from listening. Thus all the information and skills that are presented to children should be located within a broader framework of lifeskills, that relate to AIDS/HIV, but also to general living. "Lifeskills" implies the skills we require to live life, and those are vast in range. Throughout their school years pupils should have guidance or lifeskills lessons that include AIDS and sexuality education, but these would form a small part of the broader programme. Any

number of other issues could be covered, and I suggest that some of these should be geared towards overcoming structural constraints to safer sex. Things to be covered could include awareness of the environment and how to live a 'green' life, community upliftment, democracy and citizenship rights and duties, vegetable gardening, household budgeting, how to open a bank account, how a cheque-book works, how an Edgars account works, making presents instead of buying them, cultural studies, how to change a plug, how to use a library, critical thinking.

But also included in this must be lifeskills for change. The times in which the youth are growing up are different from other times, in that the rate of change of the world, information production and distribution, employment opportunities and patterns, and technology is much faster now than ever before. If pupils are taught to accept change, and how to adapt to it, this is the most important life skill we can offer them. All other difficulties will be subsumed under this, and, for example, those people who are ready and willing to deal with change will have no problems in engaging in safer sex, since they will understand that safer sex has become something that simply has to be done, and there are no good reasons for not doing it. Change is often painful to contemplate, but once initiated, we may find that it is not as bad as anticipated.

The other advantage of being able to deal with change is that it may equip young people to live in the new South Africa. In this country there are a range of languages, cultures, traditions, and people who could be said to be pre-modern, modern, and even post-modern. Coping with this plethora, or melting pot, may be very difficult if coming from a conservative outlook, where change and difference are avoided. Instead, embracing

difference, trying to understand it, tolerating it, and being comfortable with it, might assist the youth to live peacefully and harmoniously alongside people different to themselves.

As a final summary, this thesis set out to examine policy with regard to AIDS education initiatives in KwaZulu-Natal schools. However, I found that policy does not exist in all of the (ex) education departments, the notable exceptions being the Department of Education and Training, and the KwaZulu Department of Education and Culture. Yet, AIDS education does happen in schools, being taught either by guidance teachers, or by NGOs. Thus I had something to evaluate from every eduction department, and even something from the Department of National Health.

I chose to evaluate the offerings on the basis of two criteria: the first was behaviour change, since it became clear to me that the obvious educational strategy, informing people of their risks, does not work, and people need further motivation and skills to remain HIV-negative. The second criterion was notions of sexuality, the reason being that AIDS is primarily transmitted in South Africa through heterosexual sexual intercourse, and a clear conception of sexuality must inform any programme that seeks to change sexual behaviour. I found that behavioural and normative beliefs, attitudes, subjective norms and intentions all inform behaviour, and to change behaviour all of the preceding thoughts and processes must also be modified. Perceived susceptibility to the disease is an important first step in change, and skills required to continue the process include self-efficacy, internal locus of control and self-concept. Maintenance of behaviour change requires continual reinforcement of vulnerability, as well as resilience in skills. None of the AIDS education programmes in KwaZulu-Natal schools offer any suggestion of vulnerability, none combines the three qualities that I mention

either, and only the Natal Education Department gives pupils a chance of developing resilience.

In examining sexuality, I found that we are somehow caught between antiquated notions of gender roles, virginity, heterosexual marriage, and reproduction on the one hand, and more contemporary ideas of individuality, sexual freedom and pleasure, even anarchy, on the other. This contradiction between ideal and reality can only confuse young people attempting to come to terms with a new reality, that of their own adult lives, and thus I suggested that any AIDS education programme that compounds this confusion is not assisting adolescents in forming safer attitudes to sexual interaction. Instead, pupils need to be taught skills of growth and change, to equip them for both sex and life in the twenty-first century. The school initiatives vary from being sexually dogmatic and conservative (First AIDS Kit), to being potentially useful to teenagers negotiating their sexuality. The latter comes from Dramaide, and possibly also the DET trained teachers' programme, because both of those use the pupils' own conceptions of their worlds as a basis for the intervention. None of the programmes, however, seek to inculcate values relating to change, tolerance or negotiation.

I also obtained NACOSA documentation on HIV/AIDS/STD and sexuality education that may be incorporated into the syllabus for the new KwaZulu-Natal Education Department, and this is extremely comprehensive and well formulated. Instead of a syllabus, NACOSA opts for a system of minimum criteria for AIDS education initiatives, so that schools already implementing programmes can assess them, see where they are lacking, and improve. If a curriculum can be developed, based on the NACOSA Minimum Criteria, then chances are that it will be excellent. One of the main problems, to my mind, with AIDS education in the

region is that there are too many piecemeal efforts, without structures of co-ordination, or support for schools or teachers in need of assistance. Any programme, based on the NACOSA Criteria or not, would need a structure of enforcement and evaluation, and support.

AIDS education will be all the more effective if the skills necessary there are seen to be useful in other areas of life, and if they are taught in conjunction with broader life skills and goals. Thus I have suggested that AIDS must form a small part of a more general lifeskills course, that equips pupils for life: during school as well as after. The sentiment of change and tolerance are key in this. Thus, my concluding recommendations for AIDS education in schools relate to:

Who should be taught: all school-going youth, from Class One to Std Ten.

Who should teach it: trained lifeskills teachers, who have some formal link in terms of syllabus and structure with a regional lifeskills office, located in the education department.

What should be taught: information, attitudes and behaviours and skills required to remain HIV-negative, as well as broader lifeskills.

How should it be taught: the teacher teaching type of approach is of limited use. So any alternative to that should be included: role-plays, drama, songs, peer teaching, group work, project work.

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