Barriers to HIV/AIDS Protective Behavior Among African Adolescent Males in Township Secondary Schools in Durban, South Africa

by

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Declaration

This dissertation represents original work by the author and has not been submitted in any form to another university. Where use has been made of the work of others it has been duly acknowledged and referenced in the text.

The research for this dissertation was performed in the School of Development Studies at the University of Natal. Field research was conducted in Inanda, Umlazi, and Clermont townships outside Durban, South Africa. Pranitha Maharaj was supervisor for this study from the period November 2000 to April 2001.

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Contents

"They are telling us a thin piece of rubber stands between us and the future of our Continent"

President Yoweri Museveni of Uganda, 1991

Abstract

This exploratory qualitative study investigates possible barriers to HIV preventive behavior amongst Zulu-speaking, black adolescent males, aged 15-23, in township secondary schools in Durban, South Africa. Perceptions, attitudes, beliefs, and practices concerning HIV prevention and transmission are elicited using semi-structured focus groups and mixed open-ended and closed-ended questionnaires. Thematic analysis of the data is used to identify possible barriers to protection. Issues specifically investigated are condom use and multiple sexual partners. Belief in the ability to choose uninfected girlfriends, a distrust of and misperceptions about condoms, the importance of trust to a sexual relationship, false optimism engendered by fast-spreading myths about cures, and skewed risk perception engendered by conspiracy theory narratives and overestimation of the severity of the epidemic were found to be possible barriers to protection amongst males and controlling the spread of HIV. A discussion of these barriers ensues the results.

1. Introduction

President Yoweri Museveni's above equation of lack of condom use with an African apocalypse is unfortunately entirely relevant to South Africa today, where incidence and prevalence levels of HIV are among the highest in the world. This exploratory qualitative study investigates possible barriers to HIV preventive behavior amongst Zulu-speaking, African adolescent males, aged 15-23, in township secondary schools in Durban, South Africa. Perceptions, attitudes, beliefs, and practices concerning HIV/AIDS prevention and transmission are elicited using semi-structured and mixed open-ended and closed-ended questionnaires. Issues specifically investigated are condom use and multiple sexual partners. The investigation of barriers to HIV/AIDS has been limited on adolescents and males in sub-Saharan Africa, and especially on adolescent males. The popularity of blaming epidemics in sub-Saharan Africa on males has not led to widespread qualitative inquiry into how they approach sex and risk-taking in an environment of HIV/AIDS. Certainly in South Africa there has been an unfortunate dearth of research on adolescent

males. Identifying possible barriers to changing sexual risk-taking behavior in the face of HIV/AIDS in adolescent males is urgent, given the catastrophic scale and impact of HIV/AIDS in South Africa, the susceptibility of adolescents to infection, and the need to protect the next generation from the scourge of the epidemic. It is also important because the effect behavior change can have on reducing HIV incidence and prevalence, and importantly, the copious amounts of research showing that males control most decisions concerning sex that could prevent HIV transmission. There are various theories on what contributes to risk-taking behavior. Past research on sexual risk-taking has often been quantitative, not fully penetrating subjects' perceptions of and narratives about HIV/AIDS. It has also often been contradictory. Focus groups and open-ended questionnaires are used in this study to generate a deeper psychosocial insight into widespread quantitative evidence pointing to a lack of behavior change in South Africa. The findings emphasize the highly dynamic narratives and attitudes about HIV amongst South African township youth. The need to penetrate and keep up with the perceptions of youth in order to construct appropriate and effective interventions is therefore highlighted.

Keywords: HIV/AIDS; South Africa; Adolescent males; Barriers to protection

2. HIV/AIDS in South Africa: Impact and Status

There are currently 34.3 million people living with HIV/AIDS in the world. 24.5 million of these are in sub-Saharan Africa, and South Africa accounts for 4.2 million of these (Adler 58, 2000). The South African epidemic is the most severe in the world, with the most and fastest-growing number of infections (Whiteside & Sunter, 2000). The epidemic was the most severe in KwaZulu-Natal in 1999, with a seroprevalence rate of 32.5% amongst women attending antenatal clinics (Whiteside & Sunter, 2000). Due to South Africa's system of migrant labor and good transport infrastructure, South Africa's epidemic is growing equally as fast in rural and urban areas (Whiteside & Sunter, 2000).

The HIV/AIDS epidemic is much more than a health challenge. Because of the nature of the disease in South Africa and its prognosis, it is the most ominous developmental challenge facing the new South Africa (UNAIDS, 1998). HIV infection is increasing much faster and is ten times more common among

black South Africans than other race groups, due to the multifarious consequences of apartheid-engendered inequality and the migrant labor system (S.S.A. Karim, 2000). Optimistic outlooks for an AIDS vaccine place it ten years away and the prohibitive costs of ante-retroviral "cocktail" therapies place them out of the reach of a black South African population where the majority live below the poverty line. For most black South Africans, therefore, infection with HIV means imminent onset of AIDS and death. Worldwide, the time frame from seropositivity to death can be from 6 weeks to 30 years, though the average time in developing countries is 5 years (Whiteside, 1997: p. 55).

Since HIV/AIDS strikes those in their productive years of 25-40 the most and 30% of HIV-infected pregnant mothers can be expected to pass on HIV to their children, the demographic impact of AIDS will change the population "tree" into a population "chimney". The deaths of this middle generation will increase the already growing numbers of AIDS orphans, of which there will be 1 million by 2005 (Kinghorn & Steinberg, 1998). The full and most devastating impact of HIV/AIDS will not be entirely reflected in its macro impact or effect on GDP. It is expected to reduce GDP by only 1% per annum (Kinghorn & Steinberg, 1998). The full scourge of the epidemic will be felt on human development indicators. The United Nations human development index for South Africa, which combines life expectancy, infant mortality, and literacy, will be 85% in 2006 of what it had risen to in 1996. This means an actual drop of 15% drop in the human development index after a decade, and will largely be due to the impact of AIDS on these indicators (UNAIDS, 1998a). The impact of HIV/AIDS will be devastating at the micro level, and especially among poor households (Desmond, Michael & Gow, 2000). Adult sickness leads households to expend more on health care and less on productivity. Adult deaths entail income shocks, and in agricultural households, a large loss of productivity.

The full macro impact of HIV/AIDS will not be felt in sub-Saharan African countries for 51-75 years (Whiteside and Stover, 1997). In South Africa, as in other African countries, however, AIDS is already affecting and will increasingly adversely affect all sectors, from industry to education. Companies are losing workers and money due to health insurance plans, while schools are losing teachers and students. Health, a sector in South Africa already plagued by lack of resources, will be severely strained by the epidemic, through resources devoted, staff lost, and hospital beds taken by HIV/ AIDS patients. In Durban,

for example, 50% of admissions hospitals in 1999 were related to HIV-related illnesses (Baleta, 1999). The impact of HIV/AIDS on South Africa is and will increasingly become more catastrophic indeed.

3. The Epidemiological and Behavioral Context of HIV/AIDS

3.1 Theories of Behavioral Change and Determinants of HIV/AIDS Epidemiology

Today, most HIV/AIDS primary prevention efforts rely on ideas and theories concerning human behavior. Multifarious factors affect the spread of HIV, but sexual behavior and risk-taking is one of the most important to understand today for the design of prevention efforts. Sexual behavior, especially among adolescents, is among the least researched and understood areas of behavior (Donovan & Ross, 2000). The neglect of this aspect of human behavior has proven a handicap for the design of studies and interventions for HIV/AIDS prevention.

AIDS interventions are often built around theories or ideas of human behavior, and most AIDS interventions thus far have originated in the West (Fishbein, 2000). These have often placed their confidence in the decision-making ability of the individual, relying on the assumption that correct information on transmission and prevention will lead to behavioral change (Muli, 2000; UNAIDS, 1999). Most of these models were not originated to specifically address AIDS-related risk behavior, and generally ignore the effect that environmental, social, and cultural factors play in the transmission of the virus (Auerbach, Wypijewska, & Brodil, 1994). They range from those that place full confidence in the rational decision-making ability of the individual, such as the theory of reasoned action (Ajzen & Fishbein, 1980), to those that include social influences to some extent (Abraham, Sheeran, & Orbell, 1998).

Concurrent high awareness and lack of behavior change, however, has prompted more attention to the contextual environment in which transmission of the disease takes place. For example, women's risk-taking is now seen in the broader context of socioeconomic dependency and gender inequality (see below). Many are arguing that HIV transmission needs to take account of the broader psychosocial, community and societal contexts in which considerations of sexual health and sexual behavior take place (Campbell, Mzaidume, & Williams, 1998). Social models now include the influence of social factors on individual decision-making. Peer pressure (Howard & McCabe, 1990), communication (Rogers, 1983), and perceived

community norms are seen as important factors that can influence an individual's decision-making. The social network theory highlights the importance of both partners' sexual risks threatening the other through "bridging" into high-risk populations (Morris, 1997). For example, if a husband has unprotected intercourse with a HIV-infected sex worker and then with his wife, he in effect possibly transmits the disease from the sex worker to his wife, thus "bridging" the two.

Determinants of sexual behavior not only have to be individual and/or social, but also can be structural and environmental (Sweat & Denison, 1995). For example, South Africa's system of migrant labor is a structural problem in the transmission of HIV/AIDS, in that many men stay for long periods away from their families and thus look for other sexual partners. These models include influences from the community, mass media, institutions and public policy as well as socioeconomic factors (UNAIDS, 1999).

Though biological, social, structural, and environmental factors are said to effect transmission epidemiology and hence individual behavior, the social context in which HIV behavior is spreading is still created and interpreted by individuals (Webb, 1997). Barring force and coercion, the individual is the final decision-maker regarding sex. Perceptions, attitudes, beliefs, and dyadic negotiations of an individual in their HIV/AIDS environment are still of paramount importance (Mogenson, 1998; Webb, 1997). It is important to point out here that individuals always will act in the same manner regarding risk-taking. Decisions concerning sex can be entirely situation-specific. Penetrating individuals' or groups' perceptions and beliefs about HIV can reveal possible barriers to protection.

3.2 Thailand and Uganda: Behavior Change and Reduced HIV Incidence

There are two fundamental ways an individual can protect themselves from HIV and other STD infections: limiting the number of partners and using a condom (Ulin, 1992). Though research has shown treatment of STDs can reduce HIV prevalence (see Grosskurth, 1999), the use of condoms and limiting partners can prevent transmission of both. The need to identify barriers to these protective behaviors is given greater urgency by evidence connecting behavior change with lower incidence and prevalence levels. Given the lack of alternatives for treatment or prevention in resource-poor settings, primary prevention through behavior change is one of the few viable and potentially effective options to halt the spread of HIV

transmission in developing countries, including South Africa (Davis & Weller, 1999; Donovan & Ross 2000; Pequegnat & Stover, 2000).

The Ugandan and Thai HIV/AIDS epidemics are two of the most thoroughly observed and researched epidemics in the world. Myriad longitudinal studies comparing incidence and behavior change have been conducted in these countries, leading many to conclude that changes in risk-taking behavior can reduce incidence and eventually prevalence levels. At the end of the 1980s and early 1990s, Uganda saw the highest HIV prevalence in the world. Realizing the threat, President Museveni broke traditional taboos on open discussion of sex in his country. Public awareness campaigns and social condom marketing went into effect. Sentinel surveillance sites were established to track HIV incidence and prevalence and risk-taking behavior among population cohorts. Over a seven-year period in which condom use increased and female fertility went down, HIV prevalence at a surveillance site in rural Uganda decreased from 8.2% to 6.9% overall, and 11.7 to 3.6% in men aged 20-24 (Kamali, Carpenter, Whitworth, Pool, Ruberantawi, & Ojwiya, 2000). Among antenatal clinic attendees in Nsambya and Jinja, prevalence among 15-19 year olds and HIV infection incidence dropped dramatically from 1990-96 (UNAIDS, 1999). Reductions in risk behavior provide the most consistent explanation in studies for declining HIV incidence and prevalence all over Uganda.

In Thailand the Ministry of Public Health reacted quickly to the threat of an HIV epidemic in 1987, establishing 14 sentinel surveillance sites, and by 1996, spending US$80 million a year on prevention, education, care, and impact alleviation (UNAIDS, 1999). Cohort studies among young male military conscripts have found lower HIV infection rates correlate with increased condom use and less sex worker visits (Carr, Sirisopana, Torugsa, Jugsudee, Supapongse, Chuenchitra, et. al, 1994; Nopkesorn, Mastro, Sangkhaomya, Sweat, Gayle, Weniger, et, al 1993). Numerous studies in Thailand have shown that less self-reported risk-behaviors, including visits to sex workers and failure to use condoms are closely related to less HIV infection at an individual level (UNAIDS, 1998b).

These studies and others from around the world show that behavioral data is consistent temporally and spatially with changes in HIV infection (UNAIDS, 1998b). Recent studies showing that behavioral intervention can also reduce risk-taking behavior amongst adolescents (Kann, Lowry, Brener & Kolbe 2000; Danella, Galbraith, Bain, & Brathwaithe, 2000) places greater urgency on studying adolescents'

various nuances in sexual behavior, risk-taking and decision-making. Understanding what attitudes, beliefs, and misperceptions may affect adolescents' behavior, and thus ability to protect themselves, is of great importance (Varga, 1997).

3.3 Research on Sexual Risk-taking

Many studies from around the world have found that high awareness does not always translate into more condom use or less partners, as one study comparing Nigerian and American adolescents demonstrated. Though the Americans had more knowledge, held more favorable attitudes towards prevention and towards condoms, they reported more partners and cases of unprotected vaginal intercourse (St. Lawrence, 1995). A KAPB (knowledge, attitudes, practices and beliefs) study of secondary school students in Kenya revealed that despite very high levels of awareness, 60% of students had never used condoms (Pattullo, Malonzo, Kimani, Muthee, Otieno, Odhiambo, et. al, 1994).

What research has been done on adolescents in South Africa and the developing world has commonly used the ubiquitous KAPB method (see Venier & Ross, 2000). These are effective for describing and recognizing behavior, but not appropriate for examining behavior in the context it occurs or explaining the critical question of why risk behavior persists (Campbell & Williams, 1996; Jackson and Harrison, 1999). These KAPB studies often use indicators such as sex with non-regular partners in last 12 months or condom use during last sexual intercourse to understand trends over time or help interpret epidemiological data. The utilization of these studies for any practical intervention design has been slow to come, however, as many of them produce contradictory results, even in the same region (Preston-Whyte, 1999). A true understanding of risk-behavior that penetrates what contextual idiosyncrasies affect beliefs, attitudes and practices must use qualitative approaches (Monitoring the AIDS Pandemic [MAP], 2000). Exploring the nuances of multiple risk factors that influence risk behavior is less likely to produce answers with a short quantitative questionnaire (MAP, 2000), and the majority of studies in the developed and developing world have used KAPB or other quantitative approaches. One problem in AIDS prevention is to truly understand a population's current beliefs (Venier and Ross, 2000), and qualitative approaches offer a very effective method to investigate themes in beliefs (MAP, 2000). Sexual behavior and risk-taking is also mooted and not a well-understood topic. Many past studies have been done in a theoretical vacuum, meaning

difficulties arise in generalizing and comparing past studies because several lines of inquiry have been followed in investigating and preventing risk behavior (Graber, Brooks-Gunn, & Galen, 1998; Varga, 1997). Research on sexual behavior and risk-taking has been heavily concentrated in the West, complicating any attempt to make assumptions or hypotheses in this study's investigation of male adolescents in sub-Saharan Africa.

Most of the research on adults and adolescents, for example, has been quantitative work focusing on variables that contribute to risk-taking. This does not penetrate the thoughts, beliefs, and possible misperceptions in respondents in their particular context. The use of different variables, different terminology, and different modes of investigation means results and findings are hard to compare or generalize. Studies highlighting the effect of gender, ethnicity, or race are popular, and have shown differing degrees of risk perception, or "optimism" versus "pessimism" between differing education levels, races, and between genders (see Zimmerman, Feist-Price, Ebreo, Cupp, & Donohew, 2000). One study conducted among American adolescents found that risk perception, extroverted personality factors, older age, and being male were highly correlated with high risk-taking (Gullone and Moore, 2000). Another study of American university students found that situational temptation, self-efficacy (ability and intention to perform action), and perceived costs and benefits of unprotected sex determine condom use the most (Parsons, Halkitis, Bimbi, & Borkowski, 2000). In this same study females were more likely than males to perceive negative outcomes of unprotected sex. Perceiving that friends engage in risk behavior, that friends would not support safe sex, and not knowing someone of a similar age with an STD all increased chances of engaging in unsafe sex in another study of American adolescents (Boyer, Shafer, Wibbleman, Seeberg, Telile, Lovell, 2000). Many studies highlight the importance of risk perception on risk-taking behavior (Moore and Rosental, 1992). Others have found that age, and especially age at first intercourse, is an important determinant of protective behavior. Denial of the personal relevance of the disease is of course a serious threat to risk perception and hence adequate protection. A study of Israeli male adolescents found that lack of condom use was associated with high levels of denial and low responsibility for protecting against infection (Ben-Zur, Breznitz, Wadi, & Berzon, 2000).

4. Youth and the South African HIV/AIDS Environment

Sexual activity in South Africa begins on average anywhere from 13-15 years old (Richter, 1996). In a recent 1999 survey, Study of Transition to Adulthood Survey among Adolescents in Durban, 50.2% of 14-22 year old respondents were sexually active (Medical Research Council [MRC], 1999). 13 years into the South African heterosexual epidemic few South African adolescents can claim to have not heard of HIV/AIDS (Crewe, 2000). In the Durban survey, 99.4% of respondents had heard of HIV/AIDS, and 94% knew one could transmit HIV through sexual intercourse. Few could be entirely ignorant of how to prevent HIV infection and South Africa is therefore a largely "AIDS-aware" population, tough this is not translating into behavior change (Crewe, 2000). This is reflected, for instance, in condom use. 49% of those sexually active in the Durban survey did not use condoms during last intercourse with their current partner (MRC). Statistics in risk-taking behavior are reflected in the high seroprevalence rate among South African youth. 60% of HIV infection in South Africa occur before the age of 25 (Abt Associates, Inc., 2000), and indeed hospitals are receiving infections as young as 13 years old.

The high prevalence rate and the aforementioned early onset of sexual activity increase the chances of infection among adolescents. Indeed, in high seroprevalence 'epicenters', most new infections occur during adolescence (Venier & Ross, 1998). Exacerbating this risk is the fact that fewer seropositive youth are identified than in other age cohorts (Rotherman-Borus & Futterman, 2000). Although this age group presents a wonderful 'window of opportunity' to generate awareness and stop risk-taking behavior before it begins (Kinghorn, 1998), Life Skills and HIV/AIDS programs in schools have been hampered by cultural taboos on the discussion of sex and administrative bungling. Indeed, even where interventions are implemented, they are often limited and poorly coordinated (Maart, 1998).

Adolescents, and adolescent males in particular, are prone to experimentation and risk-taking. Though adolescents around the world are educated on health-promoting behaviors, they often engage in a "personal fable" of invulnerability that can lead them to take risks (Greene, Krcnor, Walters, Rubin & Hale, 2000). Several factors are said to further negatively effect sexual decision-making and risk-taking of youth in South Africa: lack of basic knowledge of the human reproductive system, poor institutional support (Buga, Amoko, & Ncayiyana, 1996; Wood, Maepa, & Jewkes, 1997), nobody to talk to about sexual health issues, and fear, coercion, and peer pressure (Maart, 1998).

Awareness campaigns are implemented in a lackluster fashion in South Africa and this poor implementation means consequent gaps in knowledge are often filled by dangerous myths and misperceptions (Jackson and Harrison, 1999). Adolescents in South Africa are aware of HIV/AIDS, but they are also encountering fast-spreading urban and rural myths not to be underestimated for their confusing and adverse affects on efforts at protection (Preston-Whyte, 1999). Among the more notorious current myths are that HIV/AIDS can be cured by having intercourse with a virgin and the myth that HIV doesn't inevitably lead to AIDS, given false credence by President Thabo Mbeki's public musings on the topic. Anecdotal evidence suggests these myths and misperceptions are proving a disaster for HIV prevention in rural clinics in South Africa ("SA AIDS workers", 2000). News of biomedical breakthroughs, such as AZT and the Virodene scandal in South Africa (see Sidley, 1998), can also lead to a false sense of security and consequent risk-taking (Bajos and Marquet, 2000).

South Africa's feeble efforts at awareness have contrasted sharply with countries such as Uganda (Museveni, 1997; Rwomushana, 2000). South Africa, for this reason and those discussed above, has had the fastest growing epidemic among 15-19 year olds in the world. Recent evidence suggests a decrease in incidence, however (Whiteside & Sunter, 2000). 1 5 0 young people under 15 are infected with HIV/AIDS every day in South Africa (Maart, 2000). Recent efforts such as a sexual education television program, *Love Life*, aside, the 1990s has been called the lost decade for South African youth because of the lost opportunities for guidance, especially concerning HIV/AIDS awareness (Everatt, 1998).

5. Research Needs: Focus on Adolescent Males

Men, and adolescent men especially, are more prone to risk-taking that endangers their own health, including sexual risk-taking (World Health Organization [WHO], 2000). The socialization of young men in many parts of the world includes constant pressure and encouragement to be daring and virile (WHO, 2000). This is tragic in the context of HIV, as it leads to the equation of masculinity with multiple STD episodes, many sexual partners, and unprotected intercourse (Varga and Mellon, 2000), all of which can increase the chance of contracting HIV. At the end of 1999 there were 10 million men living with HIV in sub-Saharan Africa, while there were 7.5 million in the rest of the world (UNAIDS, 2000).

Much has been written about why women in sub-Saharan Africa have a higher prevalence of HIV and continue to take risks in the face of the HIV epidemic. Firstly, it is biologically easier for a man to transmit HIV to a woman (UNAIDS, 2000), but in sub-Saharan Africa women's social and economic position has also been seen to place them in a difficult negotiating position with men concerning sex and protection. Power in the relationship (Adams & Marshall, 2000; Maharaj 2000), cultural norms (Campbell, Mzaidume, and Williams, 2000), and economic dependency (LeFranc, Wyatt, Chambers, Eldemire, Bain, & Ricketts, 1996; Schneider, Steinberg, & Isselmuiden, 2000; Susser & Stein, 2000) put women in a difficult position to negotiate when and where to have sex and if protection is used. This has been exacerbated by the fact that few HIV/AIDS or reproductive health interventions have been targeted at men (Maharaj, 2000). Only recently are researchers and health practitioners discovering, after years of aiming most interventions in sub-Saharan Africa at women, that women's lack of control over sexual negotiations and decision-making is seriously hampering their efforts. Gender inequality has been identified by some as the number one obstacle to women protecting themselves from infection with HIV (Susser & Stein, 2000).

Surprisingly, given the popularity of blaming African males for the spread of the epidemic and its impact on women, the extent of the epidemic amongst African males, and their critical role in preventing HIV transmission, they have not been, comparatively, the focus of much research (Varga & Mellon, 2000; WHO, 2000). If men and adolescent men control virtually every aspect of sexual decision-making and negotiations as recent research has shown, then surely more research needs to be devoted to determining barriers to protection amongst men. Adolescent men, especially in sub-Saharan Africa, are one of the least studied cohorts in the HIV/AIDS literature. This therefore represents a serious gap in knowledge relating to HIV prevention, another reason being that youth is a time when gender roles, awareness and understanding of sex and relationships are formed (Varga & Mellon, 2000). Varga and Mellon (2000) carried out an extensive review of the literature on sub-Saharan African adolescent males, and even among these scarce studies, few go beyond the KAPB method to investigate barriers to protection. The question of why males continue to have unprotected sex with the possibility of HIV infection, and especially adolescent males, has not been considered in sub-Saharan African research often. What is understood is that men's behavior is constrained by culture, social norms and tradition just as women's is (WHO, 2000).

What research has been done, however, has ignored male perceptions and heavily concentrated on issues of sexual negotiation, male dominance and chauvinism. This has been done as an answer to work showing that females often engage in unprotected sex because of the resistance or abuse of them by males. Extrapolating male adolescent behavior from studies of women, however, is problematic. It's not enough to present the argument "males don't want to practice safe sex, so HIV is spreading". Qualitative work dealing with micro-level barriers to protection among males has been neglected in sub-Saharan Africa, South Africa included.

6. Research in South Africa

Past research, while slim compared to that in developed countries, has illustrated a number factors endemic to sub-Saharan and South Africa that impact risk-taking and present barriers to protective behavior. Considering the extent of the HIV/AIDS epidemic in South Africa, the research is sparse. As in the rest of sub-Saharan Africa, rarely has there been research that has focused exclusively on males, especially adolescent males.

Many studies have found access to condoms difficult for many South African adolescents. Cost and distance have found to be prohibitive in some instances. The nearest clinic was found to be 25km away for some young people in one study (Q.A. Karim, S.S.A. Karim, Preston-Whyte & Sankar, 1992), and many young people do not have enough money to buy over-the-counter condoms. Ill-chosen nursing advice and harassment has also presented a barrier. For instance, one study in the Cape Peninsula found nurses to be recommending injectable forms of contraception at the expense of condoms (Flisher, Ziervogel, Chalton, Leger, & Robertson, 1993).

Communication with partners is one aspect that can either dangerously or positively affect one's risk perception and self-efficacy. Many choose to take risks instead of facing the embarrassment or punishment of having to discuss HIV with their partners. Discussing HIV may means risking destabilizing intimate relationships (Varga, 1997) or provoking punishment in the case of women. Trust and fidelity in the relationship are of paramount importance (Pelzer, 1999). To request a condom is to show distrust or accusation of infection with an STD (Q. Karim, S.S.A. Karim, Preston-Whyte & Sankar, 1992; Varga, 1997). This is largely because of marketing campaigns in the past that promoted condoms as a defense

against STD and HIV infection, giving them a stigma because of this association with STDs. This problem of trust is exacerbated by the long incubation period of HIV infection. The lack of symptoms can reinforce the idea that one is safe with their partners (Varga & Makubelo, 1996).

The "fertility conundrum" is another barrier to the consistent use of condoms (Preston-Whyte, 1999: 143; see also Buga et. al, 1996). The importance placed on fertility for African men and women and the expectation that women become pregnant has been stated as a significant obstacle. Married men and women often have many children for the insurance and care children provide in old age. It is not only a problem amongst married adults, however. Single women in long-term relationships, teenagers, and girls sometimes feel pressured to get pregnant to avoid the label of "barren", and to prove their maturity (Preston-Whyte, 1999). These factors and the social acceptability of teenage pregnancy have led to high levels of unprotected sex and thus high levels of teenage pregnancy. In one study by Q.A. Karim, S.S.A Karim, Preston-Whyte, & Sankar (1992: p. 109), a male participant stated, "I will not use a condom – my girlfriend must get pregnant". In the same study, it was expressed that condoms were also a ploy by the white government to reduce fertility in blacks. Preston-Whyte (1999) calls the "fertility conundrum" the single greatest obstacle to condom use in sub-Saharan Africa.

Previous studies in South Africa have also echoed findings from the rest of sub-Saharan Africa (see above) that young men often use emotional and physical coercion in sexual relationships. Jackson and Harrison found that many young male adolescents consider sex as equivalent to life, and that they consider it absolutely necessary from a young age (1999). They are also under the pressure of peers and social norms that encourage them to engage in multiple sexual relationships to prove their virility (Wood, Maforah, & Jewkes, 1998). The desirability and acceptability of attaining *isoka* (Zulu equivalent of a Casanova) status and the consequences of being *isishimane* (one or no girlfriends) have been observed as barriers to safe behavior (Varga, 1997). A possessive and chauvinistic attitude towards women has been seen to fuel the problem of male violence and disregard for safety and respect (Varga, 1997). One study in the mines of South Africa found that an extreme attitude of *machismo* has led males to consider protection as feminine (Campbell, Mzaidume, & Williams, 1998). This attitude that "men don't use condoms" has also been reported among adolescent males in Cape Town (Q.A. Karim, S.S.A. Karim, Preston-Whyte, and Sankar, 1992).

Physical discomfort, inconvenience, and reduction of pleasure have also been barriers that South African males have stated (Campbell, Mzaidume, and Williams, 1998; Meedu & Pelzer, 2000). Condoms are seen as a barrier to full pleasure in sex. In the same Campbell study "flesh-to-flesh" was seen as necessary for a healthy "blood/sperm" balance, with condoms seen as forcing sperm to be retained in the body and possibly leading to physical and mental problems. Adolescents have also expressed these reservations about condoms, especially about reductions in pleasure (Q.A. Karim, S.S.A. Karim, Preston-Whyte, and Sankar, 1992).

Leclerc-Madlada (1 997) has found that many young Zulu South Africans who are infected with HIV are knowingly infecting others. Ongoing political violence and high levels of crime were seen to engender a situation where young people who suspect they are infected sleep with as many a possible to spread the infection (Leclerc-Madlada, 1997). One reason given was that these young people did not want to die alone.

Jackson and Harrison highlight the gap between awareness and safe behavior in one article. Although "awareness" is said to be high in South Africa, they discovered several gaps in functional protective knowledge and several myths that could dissuade young men and women from protecting themselves. Young men wanted to know what was wrong with using condoms for two rounds, 30% of students thought oral contraceptives could prevent HIV, and 39% thought that if you have sex with multiple partners, but a month apart between each one, you were protected from HIV. Q.A. Karim, S.S.A. Karim, Preston-Whyte, and Sankar (1992) also point out dangerous misperceptions. One misperception was that the condom could slip off and be left in a woman's vagina, leading to injury or death. Others were that the condom dangerously restricts blood flow to the penis and that they can be washed and re-used.

Other research has pointed to rapid urbanization and cultural change as putting today's South African adolescent township males at a crossroads between patriarchal traditions and the need to protect oneself in an environment of HIV/AIDS. This often leads to confusing and conflicting messages regarding sex and relations with young women (Varga, 1997). Traditional means of sexual education and sex such as *ukusoma* (thigh sex) have fallen away, not to be replaced and leaving black South African township adolescents vulnerable and often caught between two worlds (Jackson & Harrison 1999; Nash, 1990; Webb, 1995).

7. Methods

7.1 Sample and Venues

In order to identify possible attitudes, beliefs, perceptions, and practices that serve as barriers to protective behavior from HIV, focus groups were conducted among secondary school black Zulu-speaking adolescents in Durban townships: 1 in Inanda, 1 in Umlazi, and 2 in Clermont. Mixed open-ended and closed-ended questionnaires of 53 questions were also administered to black Zulu-speaking adolescents in two schools, one in Inanda and one in Umlazi. These schools were chosen because they were in townships and they granted permission for the research most expediently.

The two focus groups in Clermont were convened through snowball sampling, one being done in a library in KwaDabeka, Clermont, and the other in a private residence. Snowball sampling was used for these focus groups because secondary schools were on holiday at this point in the research, making it more difficult to locate young men for questioning. The other focus groups in Umlazi and Inanda were done at the school during school hours. It was exam time, and the teachers selected the participants for the study after they had completed the day's activities. Teachers were advised that students chosen at ransom from different classes were preferred. The questionnaires were administered to a convenience sample at the two schools. Young men were chosen at random by their teachers and told to go into a classroom for the questionnaire. All students in this study had received some degree of life skills/ HIV/AIDS education in their schools, though the extent is not known. Permission to conduct the focus groups and questionnaires in the schools was received from the KwaZulu-Natal Department of Education and the Durban-North District. Participants were aged between 15 and 23.

7.2 Data Collection

Focus groups and questionnaires were used to acquire qualitative data for this study. This author found only two examples of focus group research looking at micro-level barriers to condom use in South Africa in the past ten years, one in 1992 (Q.A. Karim, S.S.A. Karim, Preston-Whyte, and Sankar) and one in 1999 (Jackson and Harrison). Focus groups were utilized for a number of reasons. They engender different results from individual interviews, as they empower individuals to more fully express ideas through group

support and reassurance (Shedlin & Schreider, 1995). The multiple meanings and understandings produced by group interaction, importantly, mean multiple explanations for their behavior and attitudes are more easily articulated (Schedlin & Schreider, 1995). Focus groups also empower individuals and groups to have a voice (Race, Hotloh, and Parker, 1994), an aim entirely appropriate for this neglected, but often spoken-for cohort in the South African HIV/AIDS literature. So it was thought focus groups would produce differing insights to previous studies. Though their generalizibility and suitability is questioned by some (Shedlin & Schreider, 1995) and supported by others (Kaplowitz & Hohn, 1998), focus groups are always a useful tool in areas of study where there are vying hypotheses that are not well-established. The focus groups were semi-structured and a relaxed atmosphere was ensured. The main topics discussed in the focus groups and queried in the questionnaires were risk perception, opinions of condoms, opinions and beliefs concerning sex and HIV/AIDS, and opinions about multiple partners. The questionnaires were conducted as a means of comparison. The questionnaires included questions about general awareness of HIV/AIDS, as well as attitudes and opinions concerning sex and HIV/AIDS. They were designed to flow logically and, as Labaw (1980) prescribes, go from less sensitive questions to more personal due to the sensitivity of the topic. A closed-ended question about an attitude concerning HIV/AIDS or women was often followed by a request to explain why the respondent felt that way. A few of the respondents to the questionnaire misunderstood the meaning of some questions and gave unrelated or inappropriate answers, despite the availability of a Zulu translation to the questionnaire and a translator to help. Thematic analysis of the focus group and questionnaire data is used to identify possible barriers to protective behavior. Salient themes are identified and discussed.

Though theories of behavior related to HIV are illustrated above, this study exists in somewhat of a theoretical vacuum. It is intended to act as a compliment to other quantitative studies and KAPB surveys done in South Africa, including a recent survey of Durban adolescents that demonstrate risk-taking behavior is still pervasive. Its exploratory and descriptive nature indeed precludes the tight boundaries of a theoretical framework, given the tradeoff between prior theorizing and exploring anew (Charmaz, 1990).

8. Results

8.1 Characteristics

Questionnaires were administered to 56 black Zulu-speaking adolescent males, ages 15-23, mean age 18. Each school had approximately 300 students, and approximately 30 questionnaires were given at each school. 30 of the participants were in 12^{th} grade (54%), 9 in 11^{th} grade (25%), 14 in 10^{th} (16%), and 3 in 9^{th} (5%). 42 (75%) answered yes to the question "Have you ever had sex?" while 14 (25%) answered no. Four focus groups were conducted among 26 black Zulu-speaking adolescent males, ages 15-21, mean age 18. All were unmarried. One in the questionnaires and one in the focus groups reported having fathered a child.

8.2 Barriers to Protection: Themes

A number of themes in possible barriers to protection emerged from an analysis of the qualitative data. Some of these themes were evident in both the focus groups and questionnaires, though since the questionnaires were given simultaneously with the focus groups, their content prevented corroborating some of the surprising comments made in the focus groups.

8.2.1 Trust 1: Trusting girls through observation

Almost all respondents in the questionnaires stated their condom use was not consistent and everyone in the focus groups agreed theirs' was not consistent. One reason the subjects chose not to use condoms with some girls was what they believe is their ability to judge which girls are infected and which are not. All agreed in the focus groups and questionnaires that one can not tell who is and is not infected simply by looking at them, and most stated that someone might be infected for up to 10 years before showing signs of sickness. There still emerged, however, a consensus that one can judge which girls are to be 'trusted' and which are not. "I used a condom because I didn't trust her" was a common response in the focus groups and in the questionnaires to a variety of questions on past condom use. There exist strategies whereby girls are deemed uninfected and "trusted". Consider the following statement:

"...it depends, if you trust the lady or not. If I trust the lady, I want to feel how deep she is. If she is having many boyfriends, that is when I'm using condoms. Like my neighbor. I can't use a condom with my neighbor. I trust her..."

One strategy, it emerged, as in this statement and others in the focus groups and questionnaires, is that girls from respondents' areas are deemed safer, since they can more often be seen and their "lifestyles" observed. If they are thought to have many boyfriends that "follow" them, then it is likely they are sleeping with many men and a condom might be used. A common answer, therefore, on whether it was "cool" to be *isoka* (casanova) was "no, you can't know the conduct of all your girlfriends".

Consequently, virgins were seen as "safe" and as not requiring the use of condoms both in the questionnaires and in the focus groups. It is safe to use "meat to meat" because the assurance that no previous sexual encounters would have led to infection. One respondent in a focus group even felt compelled to sternly warn others that virgins can also have HIV, because sex is not the only way one may contract the virus. As one respondent in a focus group suggested to much agreement, the world of these young males is filled with treacherous women. Girls "try to act honest but they are dangerous" and they try to "act like" virgins, but the male must "show them" that they are not a virgin. In other words, many women are seen as adversaries within the context of HIV/AIDS. They are out to fool these young men into thinking they can be trusted, but these young men must constantly be on guard for infected women who posture as safe. Thus these young men must observe girls to judge if they are 'safe' and uninfected by HIV.

8.2.2 Trust 2: Condoms, sexual negotiation and the relationship

Most respondents stated they did not discuss HIV/AIDS with their partners. In the focus groups many agreed this is awkward and that there is 'no time' for discussing HIV/AIDS when one wants sex. Many respondents were glad if their girlfriend requests a condom, but most agreed this rarely or never happens. The most common reason cited for this lack of initiative on the girlfriend's part was that they are "too embarrassed" to ask. For these young men suggesting the use of a condom was seen as a possible demonstration of lack of trust. They also said suggesting a condom was like accusing their girlfriends of

being infected with an STD. A common answer, consequently, as to why a condom is not used is that both partners trust each other. The consequence of suggesting the use of a condom sometimes was insult to the partner, and in some cases cancellation of sex. The following encounter as recounted by one young man was considered common during sexual decision-making:

Some girls say, 'hey! Why you want to use this thing! I am not infected. Why don't you trust me?' Sometimes you have to say, 'ah, yes darling, let us not use this fucking thing'.

Many also stated, besides trust, that some girls prefer it "flesh to flesh" and tell them that having sex with a condom, as the oft-used cliché has it, is like "eating a sweet with a wrapper". However, nearly none of the males expressed reservations about using condoms because of reduction in pleasure, though some said applying a condom before sex was certainly an inconvenience.

8.2.3 Multiple Partners

Most of the respondents in the questionnaires and in focus groups stated it was dangerous to have many partners in the context of HIV/AIDS, but not wrong. As to whether it was cool to be *isoka* (casanova), some respondents said yes, because of the fame an *isoka* might receive in the townships. Most, however, agreed that to be *isoka* in the face of the HIV threat is risky and indeed stupid. One respondent on a questionnaire offered the following explanation indicative of the transition in male beliefs in townships:

To be *isoka* was good in the time...King Shaka was alive. There was no disease, so to be *isoka* was good. Now ooh! It is dangerous because there is a lot of disease like AIDS.

Many of the respondents did, however have more than one girlfriend they currently have sex with. In the focus groups many stated that when there is more than girlfriend, there is one long-term girlfriend with whom a condom is not used, but with the others condoms are used.

8.2.4 Distrust of condoms

There were several reasons condoms are distrusted by these young men -- or there are several reasons they allow these fears to overcome any sense of responsibility for protecting themselves. Perhaps the

greatest source of confusion, and a question that was brought up repeatedly, was the fact that some condoms are bought in stores and some are provided free. Many were convinced that this must mean the condoms provided at clinics or local libraries are thus of are inferior quality to brand name condoms bought in stores, the most commonly cited being *Lovers Plus*. Stories thus circulate that the free condoms must be old, susceptible to breakage, or somehow of some lower quality. One focus group even agreed that if they didn't have the money to buy *Lovers Plus*, then they didn't use condoms at all.

I want to know about condoms in the shop. In the shop maybe they are costing R11 and then you get a condom free, you know?...is these things, like the same? Maybe this thing is less thick because you get it free, you know.

One potentially dangerous rumor that has received wide circulation is that the free condoms carry HIV. Opinion was divided in the focus groups over whether this could be true, but two respondents to the questionnaires availed themselves of every opportunity to claim that all effort at protection was futile because condoms carry HIV. These condom myths also fit neatly into the various conspiracy theories, dealt with below, that account for a large part of these young men's narratives of HIV. One respondent in a focus group suggested Americans have discovered condoms were permeable to HIV because of their shape. Condoms are more "square" in shape, but the HIV moves in a "round" shape, thus slipping through.

In addition to a distrust of free condoms, many reported still being embarrassed at retrieving condoms from clinics or libraries. Nurses were reported as being rude and accusing them of being too young to need condoms. However, all of the young men in focus groups stated they still retrieved or would retrieve condoms, despite these obstacles.

8.2.5 A Cure for HIV/AIDS Infection

One other barrier to protection could be false comfort engendered by news of "cures" or an overly optimistic interpretation of biomedical advances. News of traditional healers curing, and not just treating (the correct Zulu interpretation was ensured) HIV was widespread. As to why someone believed this, one respondent on a questionnaire stated, "my parents tell me about it every day". These stories are circulating everywhere, and whether respondents believed in a cure or not, news of treatments and cures generally

confused them. A cure provided by an African potato was mentioned by three of the focus groups. One suggested an *inyanga* in Umlazi had this cure but was guarding his secret because it was sent from his ancestors to him for his exclusive use.

Most agreed that today's drugs did not have a cure, but many had hope that a cure could be discovered soon. Many in the groups kept insisting that there must be a cure in America or one being held by the South African government. These beliefs also fit quite neatly into their conspiracy theories. One group came to the conclusion there was simply too much money for there not to be a cure. Another group pointed out that TB once was not curable but now was, so why not HIV/AIDS? Confusion predominated on the idea of a cure, as the following participant's response illustrates:

Some people say AZT and another one – oh, it is a combination of AZT and another one. You take it in the morning and in the evening. And the doctor says in the radio – he say it can cure somebody who has AIDS or just minimize the effects.

Many were being taught there was no cure, but at the same time fast-circulating myths in these townships about cures and media accounts of drug treatments were leading to confusion and false optimism.

8.2.6 Skewed Risk Perception

Most respondents did not acknowledge the personal relevance of the possibility of HIV infection. When they did acknowledge it, it was usually as a result of having forgotten to use a condom on some past occasion. The most common answer as to why some of their friends were at risk was because "they sleep with many girls without using the condom". While there was optimism that a cure exists or is currently in development, there also emerged in the focus groups a pessimism regarding ability to protect against HIV; a perception of it as an all-encompassing, pervasive threat. Almost all on the questionnaires marked infection rates among young people in KwaZulu-Natal as being above 50%, which was the highest choice. In the focus groups there was a general consensus that infection levels were somewhere between 70 and 80% among "young people" in KwaZulu-Natal.

In the questionnaires and in the focus groups it emerged the threat of HIV lingered everywhere for many of these young men. From kissing a girl with bleeding gums, getting a haircut from a razor that has been used on HIV-infected people, oranges which are injected with HIV, to sugar daddies spreading HIV among young women in their schools, threats lurk everywhere for these young men:

I know about some AIDS. That some oranges were injected so that they carry AIDS.

And you believe this is a threat?

Yes, because people are still buying the oranges!

It also emerged in the focus groups that many have rationalized the high prevalence and incidence rates amongst blacks as the result of any number of conspiracies. These conspiracies range from a white South African racist plot to ethnically cleanse blacks, a developed country plot to make money from selling expensive drugs to African people living with HIV/AIDS, to a fulfillment of a biblical prophecy. The role of these conspiracy theories in these young men's narratives of HIV is not to be underestimated. Some expressed a fatalistic attitude in the face of such an onslaught that make their efforts at protection seem futile or the control of the virus unmanageable. One focus group blamed the spread of the myth that sex with virgins can clear HIV infection on whites:

And I think it can happen that white people brought HIV to kill blacks. White people can do that because of apartheid. And lots of black people who drive BMWs were paid by whites to sleep with the virgin girls to cure AIDS...And in the meantime they're spreading it!

One group agreed that the South African government was perhaps allowing the virus to spread:

But look, they give black people condoms with AIDS so that black people are reduced...I think the government can do that because if the country is down on its worth, even the population of that country can die. No jobs, no food. It's better that those few people which can die.

Others agreed perhaps that it was a plot of American drug companies to sell more drugs to sick people and therefore increase profits. Most agreed, with a few dissenters, that blacks were the victims of a deliberate plot to spread the HIV virus.

9. Discussion

The objectives of this study were to identify possible beliefs, attitudes, sexual practices, or perceptions of HIV that could act as barriers to protective behavior. Firstly, it must be stated that all respondents did not answer in ways leading to the misperceptions and possible barriers above. There were also informed individuals extremely knowledgeable of the HIV/AIDS problem, and the findings of this study therefore do not indict all young township men with ignorance of and misperceptions about HIV/AIDS.

Past studies have extrapolated male and male adolescent behavior from studies of females, leading to the conclusion that males use coercive strategies and abuse to force females into sexual relationships and unsafe sex. Most, however, did not attempt to explain why males continue to take risks when knowledge of the pervasiveness of HIV and AIDS was so widespread. While this study may be the first in South Africa to focus exclusively on adolescent township males, it also fills some of the huge lacuna concerning why young males might continue to take risks. All of the noted barriers are not easily grouped exclusively under one HIV/AIDS-related behavior or epidemiological theory or even their categories (e.g. - individual, social, environmental, structural, etc). But these respondents in this study have answered as to how they as individuals interpret the threat of HIV/AIDS and sex today in South Africa. These possible barriers to HIV/AIDS preventive behavior have been noted, and hopefully these attitudes, practices, and perceptions can and will be addressed in future research and interventions.

Most males in this study agreed that coercion was wrong, and few admitted to actually using any form of coercion, outside of teasing, to impel girls to have sex or unprotected sex. This is not to imply findings from previous studies are erroneous. The transition from patriarchal norms highlighted by Varga (1997) was clearly evident in some of the responses of these young men. Many respondents pointed out that times were changing and what may have been acceptable treatment of women even only a few years ago was no longer acceptable. In contrast to the study by Varga (1997), however, where being *isoka* was socially acceptable and considered a birthright, many of the young men in this study considered it risky and stupid. And while only a few young men stated they should always make the decision to use a condom because "the man is boss", many stated they wouldn't mind if the woman requested a condom, though it

rarely happens. Notably absent from these young male's reasons for having unprotected sex was the want of children. Most greeted this idea as ridiculous at their age, though many stated their sexual partners sometimes expressed the desire for a child.

The answer of why some young Zulu township males continue to take risks finds parallels in research from around the world, but also has reasons that are wholly specific to South Africa and the South African HIV/AIDS environment. This study can perhaps be generalized for Durban townships, but differing cultural, social and environmental contexts may lead to other findings in other parts of South Africa and sub-Saharan Africa. One barrier to protection perhaps lies in their strategies for identifying uninfected females. Observation of young women and consideration of virgins as "safe" is one ploy to avoid HIV. While some laughed off such presumptuous assumption of diagnostic power and insisted a blood test was the only way, the number who judged their own ability to judge if a girl can be 'trusted' points to a serious misunderstanding of who, meaning what type of person, can be infected. Future interventions amongst young males must stress that they in no way have the ability to decide who and who is not infected, or "trusted" and "safe". It must be pointed out that even " the girl next door" can be infected with HIV. Distrust of the quality of clinic condoms and the prohibitive cost of over-the-counter condoms was also a dissuading factor. As for condoms being faulty, these seem to be either connected with conspiracy theories or are a ploy to shirk responsibility for using them.

The belief in the availability of a cure from traditional healers is understandable. Traditional healers are consulted by 85% of black South Africans (Beyond Awareness Campaign, 1999). Many herbal remedies exist that treat some of the visible symptoms like loss of appetite or running stomach. This has led many well-known *inyangas* (traditional healers), like PT Mtolo of KwaZulu-Natal, to state unequivocally that they have a complete cure for HIV infection (Beyond Awareness Campaign, 1999). The number of males who believed healer's claims in three different townships around Durban reveals how pervasive and misunderstood stories of HIV cures are. Their optimistic attitude towards a biomedical cure could be engendered by the news of AZT and vaccine trials (see Beresford, 2000), such as the well-publicized trial in Hlabisa, KwaZulu-Natal, that are constantly circulating in the South African media. Advertisements for HIV drug treatments have been found to engender more comfort with risk-taking, for example, in the

United States (Collins, 1996). Perhaps it is also widespread fear and disillusionment with the very severity of the epidemic that has led many young men to believe that something so horrible and threatening must have a cure.

A fatalistic attitude for many is engendered by high risks and perceived conspiracies and ploys to spread the disease. These fast-spreading urban myths are aided by the weakness of South African sex and HIV/AIDS education, which often does not connect sex and HIV infection explicitly (Jackson and Harrison, 1999). Myths about whites spreading the disease are understandable. In terms of absolute numbers and percentages, HIV infection amongst blacks far outnumbers whites or any other race group (Whiteside, 2000). The history of subjugation, forced removals, and terrorist campaigns by South African security forces at the hands of a white NP government during 50 years of apartheid is of course well known and commonly discussed among young black South Africans. Current internecine racism and inequality is also commonly discussed. This author can attest to this. A visit to a *shebeen* (bar) or corner in Soweto or Clermont townships, for example, by myself, a white American male, inevitably always led to a discussion of past injustices and present racism and race relations.

As in the study by Jackson and Harrison (1999), the striking thing about the findings of this study was to what extent correct HIV/AIDS prevention information could possibly be rendered useless or harmful by fast-spreading myths and lack of continuous reinforcement of correct knowledge. Where most knew that one could not identify an infected person by simply looking at them, many believed through close observation that they could identify safe sexual partners. Where it was known condoms could prevent HIV, they were sometimes not trusted because of stories of their faultiness. So no matter what correct information a young person may have about HIV/AIDS, there are possibly myths or misinformation that can debunk this information in their minds. Future HIV/AIDS interventions need to take cognizance of this. They must identify and keep up with myths, misinformation, and strategies used by young adults and identify their falsity and danger to young people before they are allowed to grow stronger and more truthful in their minds.

These findings also highlight the danger of relying exclusively on quantitative HIV/AIDS awareness questionnaires to judge HIV/AIDS awareness and design interventions. While more expedient and

efficient than qualitative research, they do not reveal the dangerous misperceptions that may lie between given choices for answers. Asking a respondent simply yes or no about whether they believe in a cure, for example, is not going to reveal the multifaceted answers and often well thought-out narratives and theories that a qualitative investigation will. Also, asking respondents if they use a condom doesn't reveal how correctly they use it. For example, two respondents in focus groups in this study said they had heard of couples who pinch holes into condoms to release the fluid. More qualitative investigation is thus essential and urgent in generating a deeper understanding of the attitudes, beliefs, perceptions, and practices of young people concerning sex and HIV/AIDS.

10. Conclusion

The identification of barriers to protective behavior is of urgent need in South Africa, given the scope of the epidemic and evidence that behavior change can lead to lower incidence and prevalence. The influences on risk behavior are myriad and varied, and many are beyond an individual's control. This does not, however, preclude qualitative research into beliefs, attitudes and perceptions of the HIV virus, since the individual is the final interpreter of their environment. Past research on risk behavior has tended to be concentrated in the developed world and when it is done in sub-Saharan Africa, on females. It has also tended to be quantitative, not fully penetrating perceptions of, attitudes about and narratives of HIV. Neglected cohorts such as adolescent males, which are already susceptible to and able to spread infection, need immediate attention. These findings demonstrate some of the possible reasons that young black Durban township males may continue to take risks. As HIV/ Life Skills programs continue to be implemented in KwaZulu-Natal secondary schools, these findings should serve to show that the attitudes, beliefs, and perceptions of young South Africans are dynamic just as the epidemic is, and need to be fully penetrated. A tailored message should be directed at them. Awareness alone does not translate into behavior change. Unless young people are fully understood, HIV/AIDS awareness campaigns are likely to be inappropriate and ineffective.

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Appendix

Focus group guide questions

Box 1 contains the guide questions used in the focus groups. They were not necessarily asked in this order, and often other follow-up questions were asked based on how the respondents answered. After an extensive literature review and consultation beforehand with others in the respondents' cohort, the following questions were decided upon. A Zulu-speaker was always available to translate.

Box 1

- Firstly, is there anything anyone would like to say about HIV/AIDS before we get started?
- Does everyone believe in HIV and/or AIDS?
- Are there many people infected with HIV/AIDS in KwaZulu-Natal? What about in your community/ school?
- How can one be infected with HIV?
- How can one prevent being infected with HIV/AIDS?
- Is there a cure or treatment for HIV/AIDS?
- Who do you talk about HIV/AIDS with?
- Is there anyone you know who is at risk of being infected with HIV? Why?
- Are you at risk of being infected with HIV? Why?
- How do you protect yourself from HIV infection?
- Whose responsibility (between male and female) is it to protect from HIV infection? From pregnancy? Why?
- Can you get condoms easily? Are you comfortable carrying them around? Why or why did you not use them the last time you had sex? Were you aware of the possibility of infection with HIV at this time?
- What difference is there between the times you use condoms and the times you don't? Do you use them with some girls and with others not?
- Can you tell is a girl is infected with HIV? Do you think you're safe with certain girls? Why? Are there certain girls that aren't safe?
- Does using a condom mean you are less of a man? Is there any other reason you don't like using condoms? Any other stories you have heard about condoms?
- Who has a girlfriend? Anyone have more than one? Is it cool to be *isoka* and have more than one girlfriend to have sex with?
- Do you want to have a child? Does your girlfriend want to get pregnant?
- Can you discuss HIV with your girlfriend?
- What do you do if a girl does not want to have sex?
- What is your reaction if she asks you to use a condom? How does she react if you ask her to use a condom? Would you use one if she asked?
- Have you ever heard anything that has confused you about HIV/AIDS?
- Have you ever heard anything about HIV/AIDS that you didn't believe?

HIV/AIDS Questionnaire

Box 2 contains the questions in questionnaire given to the 56 students. Zulu translations of parts of the questionnaire were also available, as well as Zulu speakers to translate questions where there was difficult with the English.

Box 2

1) School _____ 2) Age _____ 3) Grade _____

4) Have you ever repeated a grade? YES NO

5) Do you enjoy school? YES NO

6) From which sources do you most often hear about HIV/AIDS? (Tick 3)

School _____ Newspapers _____ Parents _____ Other family members _____ Radio _____

TV _____ Magazines _____ Community leaders ____ Government _____ Friends _____

Other sources or programmes (please write) _____

7) How many times a week does your class discuss HIV/AIDS and/or sexual health with teachers in your school?

0 times ____ 1 time ____2 times ____ 3 times _____ 4 times or more ____

8) Is there anyone you can ask questions about HIV/AIDS and get advice/answers that you trust and believe?

YES NO

9) If yes, who is this person?

Friend _____ Teacher _____ Parent ____ Other person in family _____ Nurse _____

Other _____

10) What is HIV? What is AIDS? What is a sexually transmitted disease (STD)?

HIV _____

AIDS _____

STD _____

11a) Are many young people infected with HIV/AIDS in KwaZulu-Natal?

YES NO DON'T KNOW

11b) Are many adults infected with HIV/AIDS in KwaZulu-Natal?

YES NO DON'T KNOW

11c) About what percentage (%) of people are infected with HIV/AIDS in KwaZulu-Natal? (Please tick one)

0%_____ 2% _____ 5% _____ 10% _____ 15% _____ 20% _____ 30% _____ 40% _____
Above 50% _____

12a) Do you know someone who is infected with HIV/AIDS? YES NO

12b) Do you know someone close to you who has died of HIV/AIDS? YES NO

13) Please tick all ways YOU believe someone can be infected with HIV/AIDS.

POSSIBLE WAY OF BEING INFECTED
Sexual intercourse ___ Blood transfusion ___ Mosquito bite ___ Mother-to-child Breast-feeding baby ___
Sharing cup or plate with infected person ____ Hugging or kissing an infected person ____

Other (please write) _____ Other (please write) _____

Other (please write) _____

14) Does a person infected with HIV always know that they are infected? YES NO DON"T KNOW

15) How can a person know they are not infected with HIV/AIDS? _____

16) Is it possible that HIV infection would not show up on a medical test after someone has been infected for two weeks?

YES NO DON'T KNOW

17) How can a person know they are NOT infected with HIV/AIDS? _____

18) If someone has been infected with HIV for 3 years, is it possible they could still look, feel, and act like a normal healthy person?

YES NO DON'T KNOW

19) How long can someone be infected with HIV before they look and appear sick? _____

20a) Is there a cure (not just treatment) for HIV/AIDS? YES NO DON'T KNOW

20b) If yes, please explain.

21a) Are you at risk of being infected with HIV/AIDS? YES NO DON'T KNOW

21b) Why or why not?

22a) Can you protect yourself from HIV/AIDS? YES NO DON'T KNOW

22b) Why or why not?

23) Please tick all ways you believe you can PROTECT yourself from HIV/AIDS infection.

Male condom ____ Female condom ____ Not having sex ____ Pill, ____ Sangoma or inyanga _____

Other (please write) _____ Other _____

24) Do you know where to get condoms? YES NO

25) Do you ever have any problem getting condoms? YES NO

26) Do you feel uncomfortable carrying a condom around? YES NO

27) Does having an STD increase the chance of being infected with HIV/AIDS?

YES NO

28) Define sex.

29) Have you ever had sex? YES NO

30) Why did you first have sex? (if answer is NO, please go to question 34)
For love _____ Curiosity _____ Friends put pressure on you _____ It was forced _____

Other (please write) _____

31a) Did you use a condom the last time you had sex? YES NO

31b) Who makes the decision to use a condom for sex most of the time? YOU GIRLFRIEND BOTH

32a) Do you now have sex with more than one girlfriend? YES NO

32b) If yes to 32a, do you use condoms with all girlfriends? YES NO

32c) Do you think there is a possibility of infection with HIV/AIDS infection with your girlfriends?

YES NO DON'T KNOW

32d) Why or why not?

32e) Are there some girlfriends you wear condoms with more and some less?

YES NO

32f) Why or why not?

33a) How often do you drink alcohol before sex?
Never ____ Rarely _____ Sometimes _____ Most of the time _____ Always _____

33b) If yes to 33a, would you say it sometimes makes you "forget" to use a condom?

YES NO

34) Do you know how to use a condom? YES NO

35) Can one be infected with HIV/AIDS the first time they have unprotected sex?

YES NO

36) Is it taking a risk on being infected with HIV/AIDS to have unprotected sex with many partners?

YES NO

37a) Does using a condom mean you are less of a man? YES NO

37b) If yes, then why?

38a) Does your girlfriend(s) request you to use a condom? YES NO

38b) If yes, then why?

38c) If no, then why not?

39) Do you want your sexual partner or girlfriend to become pregnant while you are in school?

YES NO

If yes, please explain.

40a) Should you discuss contraception (protection from pregnancy) with your girlfriend?

YES NO

40b) Do you discuss contraception with your girlfriend? YES NO

40c) Whose responsibility is it to ensure that a girlfriend does not become pregnant during sex?

BOYFRIEND GIRLFRIEND BOTH

41) Is it cool to be an isoka and have sex with many girlfriends? YES NO

Please explain your answer.

42) Whose responsibility is it to protect against HIV/AIDS in a sexual relationship?

BOYFRIEND GIRLFRIEND BOTH

43) Do you talk about HIV/AIDS with your girlfriend/ sexual partner? YES NO

Why or why not?

44) If your girlfriend/ sexual partner requested that you use a condom, would you? What would be your reaction? Explain.

45) If your sexual partner/ girlfriend says no to sex, what do you do?

46) Have you punished a girlfriend for not wanting to have sex with? YES NO

How?

47a) Can you always know if your girlfriend is infected with HIV? YES NO

47b) If yes, how can you know?

48) If you think your girlfriend is not infected, would you still use a condom?

YES NO

49) If you request to use a condom what reaction do you get from your girlfriend?

50) If you knew you were infected with HIV would you tell anyone? YES NO

51) Have you been tested for HIV infection? YES NO

52) Has anything you have heard or seen on the radio, TV, newspapers, or in your community or family confused you about HIV/AIDS?

53) Do you think you can protect yourself from infection with HIV/AIDS? YES NO

Why or why not?