CONTRADICTIONS, TENSIONS AND DILEMMAS MITIGATING THE ADOPTION OF RISK REDUCING SEXUAL BEHAVIOUR IN THE RURAL EASTERN CAPE, SOUTH AFRICA

by

TENDANI GABAKAIWE

Submitted in fulfilment of the academic requirements for the degree of

Master of Social Science (Research Psychology)

School of Applied Human Science
Discipline of Psychology
University of KwaZulu-Natal
Pietermaritzburg
South Africa

December, 2015

DECLARATION

I hereby declare that the research work reported in this thesis is the result of my own original investigations except where acknowledged. It has not been submitted for any degree or examination at other university.

This work is based on research supported by a National Research Foundation (NRF) Thuthuka Grant, grant number: 73647. Any opinion, finding and conclusion or recommendation expressed in this material is that of the author(s) and the NRF does not accept any liability in this regard.

Tendani Gabakaiwe
Signed…….
Date…….

Supervisor: Dr. Mary van der Riet
Signed……
Date……

ACKNOWLEDGEMENTS

I wish my sincere gratitude to Dr. Mary van der Riet for her excellent supervision, criticisms and guidance throughout the process of completing this project. The feedback she gave greatly enriched this project. I am most grateful for the time you devoted in reading, commenting and correcting my work.

I am grateful for data I got from the broader project supported by National Research Foundation. I extend my gratitude to the research team of the broader project, Dr. Mary van der Riet, Dumisa Sofika, Olwethu Jwili, Dalindyebo Zani, and Sizwe Ngqiyaza for their hard work in data collection, data transcriptions and data translations. I also pass thanks to research participants for their voluntary willingness to participate in the large project.

My special thanks to my fiancé Nicholas Christopher Mbangiwa who has been my source of inspiration. His constant support, motivation, patience and love have assisted in the completion of this study. I would also like to thank my family and friends, who constantly extended their support during difficult times.

ABSTRACT

Despite considerable effort to prevent HIV and increase awareness about the HIV and AIDS epidemic, many South Africans continue to engage in risky sexual behaviours, putting themselves at a greater risk of HIV infection. This study explores this lack of sexual behaviour change. The study aims to understand sexual activity dynamics in *Ematyholweni*, a rural area in South Africa. It focuses on the tensions and dilemmas in the positions that men and women in *Ematyholweni* take in relation to safe sex practices. It also explored how these tensions and dilemmas relate to contradictions in the sexual activity system and the state of contradiction in the activity system.

The study used a qualitative research design. It used existing data from a broader NRF funded project. A purposive sampling technique was used in order to meet the objectives of the study. The data was collected using semi-structured interviews and focus group discussions. Data collection was conducted from 2012 to 2013. This study sampled 47 interviews transcripts. This sample consists of 22 men and 25 women in the age range 18 to 60 years. It also sampled 6 male focus groups and 7 female focus groups also aged between 18 and 60 years old. The study used an activity theory framework to guide the development, analysis and interpretation of this study. This model helps with identification of tensions and contradictions in an activity system and therefore helps with understanding the potential for change and transformation within an activity system. It used thematic analysis and activity system analysis as complementary analytic tools.

Data analysis highlighted that all participants were aware of the risk of HIV and HIV prevention measures. However, dilemmas that they experience in sexual activity, and the related tensions and contradictions do not lead to sexual behaviour change. Sexual activity was linked to a way of achieving gendered identity, making it problematic to effect behaviour change. However, the mediating artefact of the conceptual system of HIV risk is stronger for women than for men. The contradictions within women's activity systems are at a mature stage and near crisis, while men's activity systems are at an early stage of maturity and lack crisis. This lack of crisis in the activity system of men helps to understand lack of sexual behaviour change.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER 1: INTRODUCTION

1.1 Introduction

HIV and AIDS continue to be a major social and health problem worldwide. Every day, throughout the world, people are affected and infected by HIV. It was estimated that, in 2011, 34 million people were HIV positive in the world, with sub-Saharan Africa being the worst affected area (World Health Organization [WHO], 2012). Of the 34 million HIV-positive people in the world, 23 million are from sub-Saharan Africa (WHO, 2012). South Africa is no exception to other sub-Saharan African countries threatened by HIV and AIDS. HIV and AIDS has laid an enormous burden on the South African health system, devastated families and communities, reduced individual life expectancy, increased the child mortality rate and also increased the number of orphans (Gouws & Karim, 2010).

Despite considerable effort to prevent HIV and increase awareness about the epidemic, it continues to spread. According to Ndegwa, Wanderi and Mwisukha (2012), between 75% and 85% of HIV-positive adults and adolescents in the world are infected with HIV through unprotected sex. Despite the availability of condoms and the knowledge that they are the most effective way to prevent HIV infections, they are still used inconsistently (Bird, Harvey, Beckman, Johnson & The PARTNERS Project, 2001; Burgard & Kusunoki, 2009). Burgard and Kusunoki (2009, p.5) argued that "simply knowing that condoms are available and effective is not enough" to prevent the spread of HIV infections. Preventing HIV transmission still remains a major challenge (Shisana et al., 2014).

Since 2002, the Human Science Research Council (HSRC) has conducted four South African national HIV surveys which helped in understanding the extent of the HIV pandemic in South Africa as well as changes in the pandemic (Shisana & Simbayi, 2002; Shisana et al, 2005; Shisana, Zungu & Pezi, 2009; Shisana et al., 2014). The 2008 national HIV survey indicated a change in the prevalence of HIV with signs of a decrease in prevalence (Rehle et al., 2010). For instance, it indicated that HIV prevalence among youth aged 15 to 24 years decreased from 10.3% in 2005 to 8.6% in 2008. However, the 2012 survey indicated a significant increase in the number of people living with HIV. South Africa has the largest number of people living with HIV in the world (Shisana et al., 2014). According to the 2012 South African national HIV survey (Shisana et al., 2014), 6.4 million people in South Africa were HIV positive.

The survey indicated a significant increase of almost 1.2 million people living with HIV in South Africa. In the year 2008, there were 5.25 million South Africans estimated to be living with HIV and this had increased to 6.4 million by the year 2012 (Shisana et al., 2014). This figure represents a quarter of the people living with HIV in sub-Saharan Africa and 18% of infected people in the world (Shisana et al., 2014).

HIV and AIDS preventive interventions have been based on cognitive theories and models such as the health belief model (Becker, 1974), the theory of reasoned action (Ajzen & Fishbein, 1980) and social cognitive theories (Bandura, 1977). These theories and models share the assumption that individual knowledge and perception of risk are the main contributing factors to health behaviour (Parker, 2004).Therefore, HIV and AIDS-prevention programmes have focused on providing correct information to people based on the theory that HIV information or knowledge will reduce the spread of HIV (Caldwell, 2000; Parker, 2004). These prevention interventions have involved giving pamphlets and talks about how to keep safe from HIV and AIDS, promoting condom use (including giving people condoms for free), encouraging people to be faithful to one partner, and delaying first sexual activity (Marston & King, 2006).

The results of these interventions in African communities have been disappointing, as research indicates that HIV still continues to spread regardless of increased awareness (Burgard & Kusunoki, 2009; Kelly, Parker & Lewis, 2001; Shisana et al., 2014). Callanan (2006) argues that knowledge-based programmes have proved insufficient in effecting behaviour change. Although education is vital, it has not yet produced the desired effect of altering the behaviour of those at risk of HIV infections (Caldwell, 2000; Callanan, 2006). The question is: why do people continue to engage in risky sexual practices which expose them to the risk of HIV and AIDS despite the knowledge and information of HIV and AIDS available to them? People know about HIV and AIDS but they still do not change their behaviour to avoid infection.

As suggested above, there has been recognition in the HIV and AIDS field that although many health behaviour theories add value to understanding health behaviour, they do not provide an adequate framework to bring about sexual behaviour change (Airhihenbuwa, Makinwa, Frith & Obregon, 1999; Parker, 2004; Van der Riet, 2009). The behaviour change approach based on these theories does not match the reality in most contexts.These theories tend to focus on the individual's cognitive processes in relation to knowledge, without considering contextual

factors (Airhihenbuwa et al., 1999; Parker, 2004). It is assumed that people have ready answers when asked why they indulge in risky sexual behaviours. However, sexual activity is a complex behaviour "deeply embedded in individual desires, social and cultural relationships, and environmental economic processes" (UNAIDS, 1999, p.5). Thus, Van der Riet (2009, pp.38-39) argues that sexual activity is a complex behaviour which needs "more multidimensional, interdisciplinary and comprehensive perspectives which simultaneously consider individual, social and cultural spheres which are assumed to account more appropriately for this complexity".

The conception of the origin of sexual behaviour as being in cognitive processes cannot adequately describe such complex behaviour, which is influenced by social context, cultural context and economic context. According to Kelly et al. (2001, p.8), "when we act, our schemata of possible actions are prefigured and whilst we may strategize our actions, the character of social life makes it such that even the originality of our actions arises in a situated way". Therefore, an examination of individual cognition ignores the dynamics within sexual relationships and is over simplifying. Kelly et al. (2001, pp.2-3) argue that sexual activity is not an individual decision-making process; they say "it cannot be assumed that we [individually] choose to be sexually active in the ways that we are sexually active, or that sexual activity is only the outcome of individual decision-making processes".

This study shifts away from the assumption that sexual activity is an individual decision-making process to the conceptualisation of sexual activity as a complex and socially embedded activity. According to Engeström (1999), activity theory conceptualises the relationship between the context and the individual as dialectical, and he sees the two as inseparable. He argues that individual behaviour cannot be understood apart from social and cultural contexts; individual behaviour is thus 'situated' in these contexts. Van der Riet (2009, p. 45) argues that "framing the relationship between the individual and society as dialectically interactive and inseparable might lead to a better understanding of how contextual factors determine responses to the HIV and AIDS epidemic, and how they limit people's ability to change their sexual behaviour".

Besides this 'situatedness' of human activity, Van der Riet (2009) highlights the significance of the notion of 'activity' in activity theory. The key assumption of activity theory is that "human consciousness and higher mental functioning are *derived* from socially organised practical

activity" (Van der Riet, 2009, p. 79). In this way, our ability to think and act takes place through our involvement in practical social activity (Van der Riet, 2009). Van der Riet (2009, p. 59) comment that the fact that the "human mind develops within human social activity means that it can only be understood within the context of the meaningful, goal-oriented, and socially determined interaction between human beings and their material environment". This focus on activity is significant for the focus of this study, because it could potentially allow an understanding of how and why people engage in risky sexual behaviours. It does not focus only on what people know (i.e. an aspect of their cognition), but on the full complexity of sexual activity. Focusing on the sexual activity provides a holistic way to understand human sexual behaviour. According to Postholm (2008), a focus on activity helps to focus on a whole complex phenomenon rather than on just a few aspects that are part of the complex phenomenon.

Understanding the complexity of sexual activity and the complex social contexts of HIV and AIDS therefore requires an analysis of the activity. This is a key issue in a move away from most of the theoretical frameworks which underpin HIV and AIDS interventions. The question is: what kind of approach to the research process could be adopted to focus on activity? To try to understand the dialectical interaction between the individual and context, Engeström (1987) generated a model of human activity – the activity system. Van der Riet (2009) argues that this model provides an important advance in understanding the relationship between the context and the individual compared to that which is dominant in the HIV and AIDS field. Through this model (see Figure 2.2 in Chapter 2), activity in its dynamic relations is analysable as a contextual and mediated phenomenon.

According to Engeström (1999), an activity system conceptually bounds the social and material resources that interact to enable and constrain what individuals and social groups are able to accomplish. It offers a way to understand what an individual does in relation to his or her context, and the nature of the relationship between the subject and the context. In relation to the problem of this thesis (the lack of behaviour change despite knowledge of HIV and prevention), activity system analysis could assist in understanding the relationship between the individual and society, and the dynamics of risky sexual behaviour. The application of activity system analysis in the present study is based on Van der Riet (2009).

A critical component of an analysis of an activity system involves understanding, firstly, the components of the system, but most importantly the relationships between these components. Engeström (1987) argues that the activity system is dynamic rather than static. There are tensions and contradictions in every activity system, and between activity systems (Engeström, 1987). The terms 'contradictions' and 'tensions' used in the framework of activity system analysis differ from the everyday use of these words and are critical to the process of examining the research problem of this study. These will be elaborated in much greater detail in other sections, but in essence, Engeström (2001, p.137) argues that 'contradictions' are "historically accumulating structural tensions within and between activity systems", while 'tensions' are a small component of contradictions. The term 'dilemmas' will be used to refer to specific situations that illustrate tensions and contradictions. In analysing these tensions, one is able to understand the status of the activity system, and the potential for change and transformation (Engeström, 1987). Van der Riet (2009) argues that understanding the state of the system, and the potential for change and transformation, assists in understanding the problem of lack of behaviour change, and potentially assists in conceptualising HIV and AIDS interventions. Thus, analysing activity in relation to the activity system helps to understand the way(s) in which behaviour change takes place or does not take place. Understanding the contradictions, tensions and dilemmas can assist in understanding how change is possible or does not happen.

1.2 The structure of the dissertation

The second chapter of this dissertation, following this introduction, provides a literature review that is relevant to the area of interest. The literature review is made up of three sections: the first section discusses the socio-cultural factors that contribute to risky sexual behaviours, the second section discusses the theoretical framework of this study and thirdly, the aim and rationale of this study are explained.

Chapter Three describes the methodology employed in conducting this study. This section outlines the sampling process, data collection methods and data analysis, validity and reliability of data, ethical considerations, and dissemination of the results and data storage.

Chapter Four presents the results generated from the analysed individual interviews and focus groups. The results will be presented in two sections: the first section presents thematic analysis of the data and the second section presents the results of the study after data analysis

using Engeström's (1987) model of activity an activity system. The fifth chapter, the discussion chapter, discusses the results presented in the previous chapter. The last chapter, Chapter Six, provides a conclusion, discusses the limitations and the strengths of the study and presents recommendations for future research and interventions.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of literature and the theoretical framework applicable to the research question. It begins by showing how socio-cultural factors contribute to a lack of condom use. Campbell (2004) argues that socio-cultural factors define appropriate behaviours in relationships and therefore enlighten relationship expectations. The second section will focus on activity theory, the theoretical perspective relevant for this study. It is used to illustrate how one can understand lack of sexual behaviour change. Finally, this chapter will present the aim and rationale of this study.

2.2 Socio-cultural factors

The literature shows that despite knowledge about HIV and AIDS, people continue to be infected with the disease (Caldwell, 2000; Callanan, 2006; Parker, 2004). Campbell (2004) argues that an individuals' behaviour, including whether to use condoms in a sexual relationship, is shaped by the social context in which they live. There are various reasons for low condom use which are interlinked with socio-cultural beliefs around sex (Campbell, 2004). Socio-cultural factors may act as barriers to safe sex practice or may enable individuals to engage in safe sex, in relation to the social context in which a person lives (Govender, 2008). Indeed, social and cultural factors are considered crucial in shaping sexual experiences (Campbell, 2004; 1997; Govender, 2008; Marston & King, 2006; Parker, 2004). Sexual activity "will always be interpreted through and mediated by existing social systems of meaning that tell us how to act" (Parker, 2001, cited in Govender, 2008, p. 26). Crockett, Raffaelli and Moilanen (2003) argue that long before people engage in sexual activity, they have already developed sexual scripts which provide guidance on sexual interaction. People learn about sexual behaviour through interaction with their social environment (Crockett et al., 2003). However, HIV prevention has concentrated on the individual as the target for interventions, ignoring the context in which risky behaviour occurs (Corbett, Dickson-Gómez, Hilario & Weeks, 2009).

In order to understand how sexual behaviour change is possible (or does not happen), socio-cultural practices related to masculinity and femininity as well as gender inequality and poverty are discussed, followed by the dynamics governing relationships such as expectations to demonstrate fertility, trust and love, peer pressure, attitudes towards sexual risk and condoms,

and alcohol intake. The next section will discuss how the notions of masculinity and femininity influence the nature of sexual activity.

2.2.1 Masculinity and femininity

Masculinity and femininity play a critical role in shaping people's sexual lives and choices (Shefer, 2003). Each society has norms, values and beliefs which lie behind, and are reflected in, people's sexual behaviours (Shefer, 2003). Therefore, ideals of masculinity and femininity differ from one social context to another. According to Shefer (2003), masculinity in heterosexual relationships means that the male partner controls sexual decision-makingwhile women do as they are told. Men are commonly socialised to prioritise their sexual desires, and to initiate and control sexual activity (Campbell, 1995). In contrast, femininity in heterosexual relationships often means that women are socialised to be submissive and passive in sexual interactions (Shefer, 2003). Holland, Ramazanoglu, Sharpe and Thomson (2004) describe emphasised femininity as 'unsafe' as it places women at risk of sexually transmitted infections.Gavey, McPhillips and Doherty (2001) argue that as long as dominant norms of femininity are associated with passivity and submissiveness to male needs and desires, assertive negotiation of condom use will always be difficult for women. Furthermore, men are expected to be promiscuous while women are expected to place value in steady relationships (Campbell, 1995).

Hollway (1984) termed these dynamics the male sex drive discourse and the have-hold discourse. The male sex drive discourse positions men as having a high sexual drive which they are not expected to control (Hollway, 1984). The have-hold discourse positions a woman's role as needing to maintain a relationship as it provides a woman with power and status among her peers and within the community (Hollway, 1984). These elements of masculinity and femininity play a critical role in the individual's capacity to practice safe sex (Reddy, 2004). Jewkes (2009) noted that having a sexual partner is vital to South African women. Women's social status commonly depends on "the ability to have (and keep) a male partner" (Jewkes, Levin & Penn-Kekana, 2003, p. 126). Chimbiri (2007) argues that women often engage in unsafe sexual practice because they fear that if they decline unsafe sex, they might lose the relationship.

Although there is variation in forms of masculinity, Lindegger and Quayle (2009) argue that there is consistency in the construction of masculinity in relation to risky sexual behaviours.

Lindegger and Quayle (2009) mention the following behaviours as elements of masculinity related to HIV transmission: multiple sexual partners, use of alcohol before sex, unprotected sex and sexual violence. Lindegger and Quayle (2009) argue that men in general recognise the significance of these behaviours as indicators of successful masculinity. Therefore, they feel pressure to achieve them and thus safer sex messages, which entail one sexual partner and promote condom use, may be felt as a threat to their notion of masculinity (Lindegger & Quayle, 2009). According to Lindegger and Quayle (2009), in South Africa a man who fails to have multiple sexual partners is often given names such as 'cheesehead'. Thus, aspects of masculinity, including having multiple partners and being sexually knowledgeable, continue to challenge HIV and AIDS-prevention interventions (Reddy, 2004).

Frank, Esterhuizen, Jinabhai, Sullivan and Taylor's (2008) study found that boys in the Eastern Cape in South Africa defined masculinity as having multiple partners and having control over one's girlfriend. Young men who did not have girlfriends were pressurised by their peers to be sexually active (Frank et al., 2008). Zakwe (2005, in Lindegger & Quayle, 2009) stated that the inability of young men to demonstrate that they can have multiple sexual partners often results in shameful experiences. In a similar study, Wood and Jewkes (2001) also found similar results in a township in South Africa where the number of girlfriends a boy had gave him status.

Sathiparsad, Taylor and De Vries's (2010) study in rural South Africa revealed that young men strive for masculine identity by exposing themselves to sexual risks, in this way proving their manhood. Sathiparsad et al.'s (2010) study found that in sexual interactions men are more worried about proving their manhood than the need to protect themselves from HIV infections. Similarly, in Reddy's (2004) study, which explored young South African adults' sexual identity constructions within the context of HIV and AIDS, it was revealed that young women and young men conform to traditional aspects of femininity and masculinity. These notions of masculinity and femininity are associated with high-risk sexual behaviours (Reddy, 2004).

The notions of femininity and masculinity maintain unsafe sexual behaviours that need to be challenged in order to reduce vulnerability to contracting HIV (Reddy & Dunne, 2007). Reddy and Dunne (2007) argue that, without a major challenge to the constructions of masculinity and femininity, HIV and AIDS interventions are unlikely to make a significant impact. They argue that masculinity and femininity are not fixed or stable, so they can be challenged and changed (Reddy & Dunne, 2007).

The notions of masculinity and femininity discussed above have created unequal power dynamics between men and women. The following section discusses the impact of power imbalances between men and women in their sexual interactions in relation to HIV and AIDS.

2.2.2 Gender, HIV and inequality

HIV and AIDS prevalence is not equally distributed across genders. In South Africa, in line with the global distribution, more women are infected than men (Jewkes, 2009). This raises the question of how gender is a contributing factor to the spread of HIV and AIDS.

Gender studies on sexuality have indicated many ways in which gender norms generate conditions of greater HIV risk (Jewkes, et al., 2003; Pettifor, Measham, Rees & Padian, 2004). According to Pettifor et al. (2004), patriarchal social arrangements have resulted in gender dynamics that give power and privilege to men while at the same time restraining the autonomy of women. These gender power dynamics have led to the belief that men should be in control of women's sexuality (Mash, Mash & De Villiers, 2010). Blanc (2001, p. 189) describes this power as "the relative ability of one partner to act independently, to dominate decision-making, to engage in behaviour against the other partner's wishes or to control a partner's actions". Ngubane (2010) argues that in South Africa, men are socialised to control women, while women, on the other hand, are socialised to be submissive towards men. Pettifor et al. (2004) argue that women are at a greater risk of HIV infection than men because of these power dynamics within the relationships.

The gender power imbalance decreases the power that women have over the practice of safer sex (Holland, Ramazanoglu, Scott, Sharpe & Thomson, 1990; Stein, 1990). Men's control over women in sexual relationships is seen as normal by many communities (Holland et al., 1990). Women are thus not usually in a position of power to dictate how sexual interaction happens (Pettifor et al., 2004). Mash et al. (2010) argue that safe sex behaviour, particularly condom use, is not simple because it has to be negotiated between unequal partners. According to Van der Riet (2012, p. 33), "condom use is a male-controlled method and has to be negotiated", therefore, it makes it difficult for women to manage the risk of HIV. Van der Riet (2012) argues that the power of the male partner within the sexual activity system compromises HIV risk reduction.

In South Africa, women still struggle to negotiate condom use because of the power dynamics in their relationships (Ackermann & De Klerk, 2002; Jewkes et al., 2003; Mash et al., 2010; Pettifor et al., 2004). In Blanc's (2001) study in KwaZulu-Natal, young women found it challenging to initiate and negotiate condom use but used condoms when initiated by the male partner. This limited and unequal sexual power is significantly linked with inconsistent condom use (Pettifor et al., 2004). According to Mash et al. (2010), condom use in relationships increases when power is shared equally by sexual partners and decreases when a man is in control of the relationship. Shabane (2011) argues that this suggest that men have a significant role to play in determining the future of the HIV and AIDS epidemic. However, HIV-preventive strategies are usually based on gender-neutral interventions which fail to recognise the impact of power imbalance on women's ability to dictate safe sex (Jewkes et al., 2003).

In addition, men are usually expected to be older than their female partners in romantic relationships (Langen, 2005). Age difference is an indicator of power imbalance especially in patriarchal societies (Burgard & Kusunoki, 2009; Jewkes et al., 2003; Langen, 2005). The older the person is, the greater the respect he/she obtains from their juniors (Langen, 2005). Thus, in relationships, the younger partner usually respects and yields to the older partner (Langen, 2005). Pettifor et al. (2005 cited in Frank et al., 2008) found that in South Africa, girls aged 15 to 19 years had partners up to more than five years older than they were. Research indicates that people in relationships with older partners are less likely to use condoms (Burgard & Kusunoki, 2009; Johnson et al., 2010; Luke, 2005; 2006). Langen (2005) argues that age difference is a form of power imbalance that affects decisions regarding negotiation of safe sex practices.

Having looked at gender and inequality, I turn to one of the most recognised social factors linked with HIV and AIDS, poverty.

2.2.3 Poverty

There has recently been an increased focus on understanding how poverty is related to HIV and AIDS (Shisana et al., 2009). Poverty is argued to play a catalytic role in increasing sexual risk (Shisana et al., 2009). According Shisana et al. (2009), underprivileged people are more likely to make decisions based on their basic needs than on the risk of HIV and AIDS, thereby exposing themselves to HIV infection. They argued that poor contexts generate devastating circumstances, limiting an individual's ability to practice safe sex**.** For example, economic

needs may lead a person to exchange sex for economic benefits as a way of subsistence. This may mean that sex happens on the terms of the economic provider, increasing the likelihood of risky sexual practices (Shisana et al., 2009). In addition, in South Africa, unemployed individuals have a higher HIV prevalence than individuals who have jobs (Shisana et al., 2009). However, Williams et al. (2002) found that employed people who stay for long periods of times away from home are more likely to contract HIV than other employed people.

The economic dependence of women has been argued by many studies to be a driver of HIV infections (Holland et al., 1990; Jewkes et al., 2003; MacPhail & Campbell, 2001). Shisana et al. (2009) argue that an individual may have vast knowledge about HIV but not practice what they know because of their financial circumstances. Many women who are economically dependent on their partners find it difficult to dictate condom use (Jewkes et al., 2003). In a cross-sectional household survey of women aged 18 to 49 in three South African provinces, Jewkes et al. (2003) found that women who faced financial constraints were less likely to suggest condoms. They felt they could not risk losing their partners (their financial providers) by refusing unprotected sex. This makes it clear that vulnerability to HIV infection is increased by poverty.

Kelly and Parker (2000) say an older boyfriend provides status as well as gifts and financial assistance that no one in the family can provide. Eaton et al. (2003) argue that in this kind of relationship, sex happens on the terms of the male partner because of the gifts and financial assistance he is providing and this sex often occurs without the use of a condom. Jewkes (2009) argues that young women often engage in a relationship with an older man to fulfil financial needs. Eaton et al. (2003, p. 162) argue that "from a woman's perspective, protection from possible illness may be a lower priority than meeting immediate economic needs". This is an indication that financial circumstances may encourage an individual to engage in sex for money and gifts.

The next section will discuss how the expectation of fertility is important in most African societies. This suggests that HIV-prevention strategies might fail to address safety in sexual relationships, particularly for people who are married.

2.2.4 Condom use in marriage

The goal of marriage in most African societies is perceived as being to have children (Preston-Whyte, 1999). Condoms are thus rarely used in marriage relationships due to the desire and social pressure to have children (Adejoh & Uchenna, 2011; Preston-Whyte, 1999). Obviously, condom use will prevent a married woman from becoming pregnant. According to Leclerc-Madlala, Simbayi and Cloete (2009, p. 16), "condom use is seen as a 'waste' of sperm and that this conflicts with the emphasis on fertility in African culture". Therefore, even when men and women are informed or have knowledge about how to prevent HIV infection, the need to have children may put them in a dilemmatic situation. The expectation that the couple should have children may outweigh the fact that one of the partners may be HIV positive (Preston-Whyte, 1999).

Several studies have found that condoms are less common in marriage relationships (Adejoh & Uchenna, 2011; Bauni & Jarabi, 2003; Maharaj & Cleland, 2005; Preston-Whyte, 1999). As argued above, condom use within marriage relationships is viewed as inappropriate as it is commonly seen as being in conflict with social norms that regulate marriage (Chimbiri, 2007). Therefore, condom use in marriage is usually viewed in moral terms (Adejoh & Uchenna, 2011). Bauni and Jarabi (2003, p. 64) argue that the use of condoms is "complicated by concerns by religious groups who contend that condoms symbolise complacency, immorality and moral decadence and their use is committing a mortal sin".

Chimbiri's (2007) study found that the general perception among married people in Malawi was that condom use interferes with the marriage 'purpose' of pleasure and child-bearing. Maharaj and Cleland's (2005) study also found widespread disapproval of condom use within marriage because of its strong association with infidelity. The study found that only 14% of married men and 17% of married women reported consistent or 'occasional' condom use in KwaZulu-Natal, South Africa. Bauni and Jarabi (2003) found that even though men have power over sexual decision-making, they also feared requesting that their wives use condoms as this could create suspicion of an outside relationship. Maharaj and Cleland (2005) argue that most HIV-prevention strategies have ignored the protective needs of married people despite the great risk of infection due to infidelity. Chirwa, Malata and Norr's (2011) study of married couples aged between 20 and 53 years old in Malawi found mutual fidelity and HIV testing as the main HIV-prevention strategies among married couples. The next section will discuss discourses of trust and love which may limit the ability of partners to negotiate safe sex within

sexual relationships.

2.2.5 Construction of trust and love

Studies suggest that people in certain relationships do not use condoms because of their trust in each other (Hattori, Richter & Greene, 2010; Moore & Halford, 1999; Reddy, 2004; Rosenthal, Gifford & Moore, 1998). According to Rosenthal et al. (1998), sex is a way of strengthening and maintaining a relationship, while unprotected sex is a way of showing love and commitment to a sexual partner. Condom use is seen as inappropriate for love and committed relationships (Rosenthal et al., 1998). Therefore, consistent condom use faces resistance because of what unprotected sex means in the context of a committed relationship (Rosenthal et al., 1998).

Studies show that although relationships may begin with condom use, this stops once trust is gained (Flood, 2003; Hattori et al., 2010). In Moore and Halford's (1999) study in Melbourne, Australia of 400 heterosexual adults aged between 24 and 49, over 40% of participants agreed that if one loves and trusts one's partner, condom use is not necessary. According to Hattori et al. (2010), people (particularly young people) enter into relationships with the assumption that they are both HIV negative. People tend to trust that their partners would not knowingly infect them (Hattori et al., 2010). In addition, people enter into relationships with the expectation that their partner would be faithful to them, even though this does not always happen. This suggests that people in stable relationships could be at an increased risk of HIV infection. Requesting and negotiating condom use in these relationships usually implies a lack of trust in a committed or regular relationship (Chimbiri, 2007; Manuel, 2005). Even though people in committed relationships are aware of the risk of HIV infection, the issue of trust mediates their decisions regarding safe sex practices. The belief that condom use means lack of trust is significantly associated with low condom use (Burgard & Kusunoki, 2009).

Reddy et al.'s (2000) study of STI clinic attenders in South Africa, which sampled 1,473 patients, found that 35% of women and 43% of men believed that the use of condoms symbolised mistrust. Manuel's (2005) study explored the factors that hindered urban youth in Mozambique from having safer sex (in the context of HIV and AIDS). The study found that one main barrier to condom use was that participants believed that condoms were not necessary in stable relationships where there is love and trust (Manuel, 2005). This makes it difficult to negotiate condom use in long-term relationships. However, research indicates that women are

becoming more concerned about sexual safety (Van der Riet, 2012) but cannot insist on condom use due to what Hollway (1984) called the have-hold discourse.

Reddy's (2004) study in KwaZulu-Natal, South Africa, found that young women engage in unsafe sexual practices to prove love and ensure the continuation of the relationship. Reddy (2004) argues that the need to be loved is the principal reason women engage in risky sexual activities. Similarly, Rosenthal et al. (1998) interviewed heterosexual women and men in Australia and it was revealed that unprotected sex is constructed within the discourse of love. In their study, women and men viewed unprotected sex as a way of increasing their chances of a long-term relationship. As a result, partners do not ask each other to engage in condom use, thereby putting their lives at HIV risk (Shabane, 2011).

The next section will discuss the most recognised dynamic governing youth relationships, peer pressure.

2.2.6 Peer pressure

South African studies indicate that among the youth, peer pressure is one of the factors influencing risky sexual behaviour (Campbell, Foulis, Maimane & Sibiya 2005; Selikow, Ahmed, Flisher, Mathews & Mukoma, 2009). Brook, Morojele, Zhang and Brook (2006) argue that in South Africa, negative peer pressure is the strongest mediating predictor of high-risk sexual behaviour among the young people, especially for young men. Bhana and Petersen (2009) say that during the adolescent stage, there is a strong need for peer group affiliation as it helps in identity development. However, peer group affiliation can also impact on sexual behaviour. For example, research indicates that peers with friends who are sexually active are more likely also to be sexually active (Bhana & Petersen, 2009). Furthermore, Marston and King (2006) found that peers with friends who do not use condoms are more likely not to use condoms themselves. MacPhail and Campbell's (2001) study found that adolescents who were sexually inexperienced or who were using condoms were not approved of by their peers.

Brook et al. (2006) noted that young men are more influenced by their peers than young women. In terms of sexual behaviour, peer pressure among young men is about proving manhood, while for young woman peer pressure is more about sexual experience (Bhana & Petersen, 2009). Having multiple sexual partners as a young man provides status as well as admiration (Eaton et al., 2003). Eaton et al. (2003) noted that sexually active boys and girls

often exclude others who are sexually inexperienced from their discussions. However, Eaton et al.'s (2003) study indicated that boys and girls whose friends approve of delaying being sexually active are more likely also to delay sexual initiation. Thus, peer pressure may also be a positive influence.

Another major factor recognised to contribute to HIV risk is the low perception of risk.

2.2.7 Perception of risk

Research indicates that many youth in South Africa under-estimate their risk of contracting HIV (Eaton et al., 2003; Harrison, Xaba & Kunene, 2001). The denial of vulnerability is often higher in men than in women (MacPhail & Campbell, 2001). According to Lindegger and Quayle (2009), the denial of vulnerability is one of the elements of masculinity making it hard for men to admit to vulnerability to contracting HIV. Harrison et al.'s (2001) study found that many young men were involved in risky behaviour because they thought their risk was low. In the interviews, it was clear that they assessed the risk of contracting HIV based on trust and the duration of the relationship (Harrison et al., 2001).

MacPhail and Campbell's (2001) study found similar rates of perception of risk among young people in the community of Khutsong in South Africa. The majority (70%) of both young men and young women did not see themselves as vulnerable to the risk of HIV, although they engaged in risky sexual behaviours (MacPhail & Campbell, 2001). Also, Anderson, Beutel and Maughan-Brown's (2007) study found low HIV risk perception among youth in Cape Town. Low perception of risk of HIV is linked with increased risk of HIV infections (MacPhail & Campbell, 2001).

The next section will discuss attitudes towards condom use.

2.2.8 Attitudes towards condom use

The literature suggests that descriptions and feelings about condoms are consistently negative (Browne & Minichiello, 1994; Flood, 2003). These descriptions include 'wearing condoms decreases penile sensation', 'it's like eating sweets unwrapped', and 'it's unnatural and uncomfortable' (Browne & Minichiello, 1994; Flood, 2003). These descriptions seem to suggest that these participants would not use condoms in their sexual relationships. Several studies argue that for most men, having sex is for pleasure purposes and condoms reduce

sexual pleasure (Flood, 2003; Mash et al., 2010; Varga, 1997). This increases women's vulnerability to HIV infection because women do not request that their partner uses a condom because of the concern about their partner's sexual pleasure. In Varga's (1997) study of youth from Durban, South Africa, 47% of women said their partners frequently rejected condoms, justifying that they reduced sexual pleasure. Holland et al.'s (1990) study found that in long-term relationship, women usually start using a contraceptive pill as a sign of commitment in the relationship and condom use is then stopped. In more committed relationships, the main concern is prevention of pregnancy rather than of sexually transmitted diseases. This also shows that people value unprotected sex (Eaton et al., 2003).

As discussed above, condom use is often associated with negative connotations such as lack of trustworthiness, infidelity, promiscuity, multiple partners and casual partners, and it is not easy to change people's perceptions on this matter (Burgard & Kusunoki 2009; Preston-Whyte, 1999). Several studies suggest that condom use is becoming more acceptable in casual relationships but is often more difficult to implement and is seen as inappropriate for a 'longer term' relationships (Burgard & Kusunoki, 2009; Maharaj & Cleland, 2005; Preston-Whyte, 1999; Varga, 1997). Maharaj and Cleland (2005) argue that HIV awareness and prevention campaigns have managed to increase condom use in the above-mentioned behaviours but fail to address condom use in married and cohabiting couples although many HIV infections happen in these relationships. These couples are expected to be faithful to each other and go for regular HIV testing (Chirwa et al., 2011). Although there has been a rise in the number of individuals who present for HIV testing, the rates of couple-testing are still very low (Van der Linde, 2013).

There is a close link between the use of alcohol and risky sexual behaviours. The next section discusses the use of alcohol as an opportunity for risky sexual behaviours.

2.2.9 The use of alcohol

The link between alcohol use and HIV transmission is well documented. According to Leclerc-Madlala et al. (2009), in South Africa alcohol has been used for cultural rituals and celebrations such as weddings and childbirth. These celebrations are also used broadly for sexual networking (Pattman, 2001, cited in Leclerc-Madlala et al., 2009). In social settings where there are few recreational centres, these celebrations, and their accompanying alcohol use, may provide an opportunity for recreation and social interaction (Leclerc-Madlala et al., 2009).

Various studies have found that alcohol intake increases unsafe sexual practices (Erinosho, Isiugo-Abanihe, Joseph & Dike, 2012; Fisher, Bang & Kapiga, 2007; Morojele et al., 2005). These studies indicated that when a person drinks alcohol, there is a decreased likelihood that he/she will use condoms correctly and consistently. Thus, alcohol use increases the chances of risky sexual behaviours. This literature suggests that alcohol use might be a key factor to understanding and influencing HIV transmission.

The discussion of the above socio-cultural factors does not imply that they operate in isolation. These socio-cultural may modify and interact with each other. For example, gender inequality and poverty, in relationships where there is unequal sexual power and the male partner is the financial provider, women's ability to dictate safe sex is often limited (Jewkes et al., 2003).

Although the above set of contextual or socio-cultural issues have added value to an understanding of sexual behaviour, the HIV and AIDS field has recognised that a focus on these factors alone does not offer a sufficient framework to change sexual behaviour (Van der Riet, 2009). Van der Riet (2009) argues that the main problem with a focus on the context is the conceptualization of context as something surrounding the individual and 'causing' behaviour. The context is thus treated as the container of behaviour and this ignores the social dynamics and the dialectical interaction between the individual and society (Van der Riet, 2009). For instance, the social ecological model proposed by Bronfenbrenner (1979) arguably take into account the socio-cultural context and the relationship between the individual and society, however fails to account for the analytically inseparable and dialectical relationship between the individual and society. This approach is apparent in most of the HIV and AIDS research. Geertz (1973, p.ii) argues that:

> In this conception, man is a composite of 'levels', each superimposed upon those beneath it and underpinning those above it. As one analyzes man, one peels off layer after layer, each such layer being complete and irreducible in itself, revealing another, quite different sort of layer underneath.

He termed this approach a "stratigraphic" conceptualisation. The problem with this perspective is that the individual and society are identified and treated as separate entities. Van der Riet (2009) argues that once the individual and social factors are separate, it is difficult to understand the process of behaviour change and develop more comprehensive and effective

interventions. Therefore, there is a need for another way of understanding behaviour change, in which the individual and society are conceptualised as dialectically interactive and inseparable. Activity theory therefore provides an alternative conceptualisation for understanding behaviour change (Van der Riet, 2009).

The purpose of the following section of the literature review is to provide a theoretical framework for this study. This study adopted the conceptual framework of activity theory (Engeström, 1987). It is a practical framework which can be used to understand the complex and dynamic problems of human practice (Postholm, 2008). Unlike most HIV and AIDS theories which focus on cognitive process, activity theory focuses on activity. Activity theory conceptualises the relationship between the context and the individual as dynamic, dialectically interactive and analytically inseparable (Engeström, 1999). Individuals cannot decide on their own actions because their actions are related to the society in which they live (Engeström, 1999). This helps us understand why behaviour change theories have been ineffective in the HIV and AIDS field. This theoretical approach presents a key move away from most of the theoretical frameworks which traditionally underpin HIV and AIDS interventions. Van der Riet (2009) argues that the problem is not about what people know about HIV and AIDS or the variables causing the behaviour, but the fact that sex is a complex and socially embedded phenomena. As Van der Riet (2009) argues, activity theory helps to assess the HIV and AIDS problem in a holistic way, providing a particular understanding of the relationship between the individual and society; it does not concentrate on the social context only or only on the individual, but on the dialectical relationship between the individual and the social context.

Kelly et al. (2001) argue that there is a challenge in studying sexual activity as well as developing models of behaviour changes in the sexual domain because sexual activity is not a unitary phenomenon. Sexual activity is a complex behaviour, embedded in individual, social, cultural and economic relationships (UNAIDS, 1999). It is "about deeply hidden power inequities and long-established cultural meanings about identity and roles, which create the contradictory personal and societal expectations through which men and women negotiate their sexual encounters" (Browne & Minichiello, 1994, p. 232). There are many reasons people provide for wanting to have sex and they are different in each case (Kelly et al., 2001). The HIV and AIDS field has been focusing on changing individual behaviour, particularly the individual's understanding of risk, but this has had no significant effect on behaviour change. In order to understand a lack of sexual behaviour change and the complexity of sexual

behaviour, Engeström's (1987) model of human activity was used to analyse and interpret the data collected in this study. The following section will begin by looking at how activity theory understands human behaviour and then discuss the concept of contradictions in activity systems.

2.3 Theoretical framework

2.3.1 Activity theory

The basic assumption of activity theory is that the relationship between society and the individual is dynamic, dialectical and inseparable (Engeström, 1999). This means that the individual and society are interactive and interdependent. This theory provides a non-dualistic conceptualisation of the relationship between individual and society (Van der Riet, 2009). It rejects the view of the individual and society as separate entities, arguing that both mutually constitute each other (Engeström, 1999). It provides a radical move away from the well-known theoretical frameworks in the HIV and AIDS field. It understands "human behaviour as being part of complex and continuously collectively constructed systems of activity" (Engeström, 1993, p. 66). Engeström (1996 cited in Van der Riet, 2009, p. 79) argues that to "understand human behaviour, analysis must be grounded in actual concrete, everyday activities and the rules and structures of the social world which organise and constrain that activity".

In contrast to most HIV and AIDS theories which focus on cognitive processes, activity theory focuses on activity. Activity theory expands the unit of analysis from the individual to the activity (Engeström & Miettinen, 1999). The way in which individuals see and comprehend reality is through the activity and the social relations in which they participate. Our cognitive processes develop out of our participation in collective activities in society (Van der Riet, 2009). Therefore, the activity of the individual should not be viewed in isolation but should be seen as socially bound (Ditsa, 2003). According to Engeström (1987), human activity is a collective, systemic formation with complex mediational structure (Daniels, 2008).

Vygotsky (1978) argued that all human actions are mediated by artefacts and they are inseparable from the social context in which the actions take place. This means that human consciousness develops through interaction with artefacts and others in the environment (Vygotsky, 1978). Mediation is thus a central feature of human activity (Vygotsky, 1978). This notion of mediation is illustrated by the triangular representation of the mediated act in Figure 2.1 below. According to Vygotsky (1978), people understand the world by the use of tools and

signs. Vygotsky (1978) argues that the relationship between the individual and the society is always mediated by artefacts such as tools and signs.

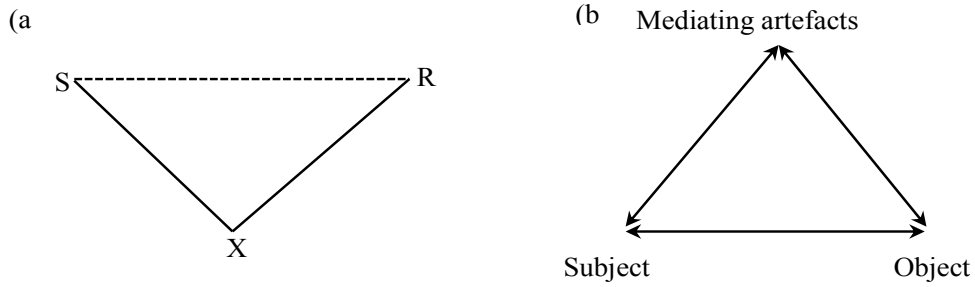

Figure 2.1. (a) Vygotsky's (1978) model of a mediated act and (b) its common reformulation (adapted from Engeström, 2001, p. 134).

In Figure 2.1, diagram (a) represents the direct relationship between stimulus and response. 'S' is the stimulus mediated by 'X' and 'R' is the resultant response. Diagram (b) represents the common reformulation as conceptualised by Vygotsky (1978). The subject is related to the object and this relationship is mediated by mediating artefacts.

Therefore, this theory challenges the idea that cognitive processes exist only inside the heads of individuals; rather it argues that our consciousness exists "in the interaction between the individual and the objective forms of culture" (Miettinen, 2006a, p. 6). The individual can "no longer be understood without his or her cultural means" (Engeström 2001, p. 134). In addition, the social context can "no longer be understood without the agency of the individuals who use and produce artefacts" (Engeström, 2001, p. 134). Thus, in terms of activity theory, sexual activity "is only analysable as distributed in the activity between humans and their artefacts" (Cole & Engeström, 1993, cited in Van der Riet, 2009, p. 59).

According to Miettinen (2006a, p. 6), through socialisation, people internalise "language, theories, technical artefacts as well as norms and modes of acting" and therefore cannot be separated from their cultural means. Activity theory highlights the social nature of behaviour which suggests that sexual behaviour cannot be understood as a purely biological or individual process. Individual behaviour can only be understood as joint, collective activity (Miettinen, 2006a). Therefore, in activity theory, sexual practices would be understood in relation to the broader notion of sexual activity.

In activity theory, the minimal way to understand human behaviour is the activity system (Engeström, 1987). Engeström (1987) thus generated an analytic model of human activity - an activity system. It is a dynamic unit used to analyse human activity. This is reflected in the diagrammatic representation contained in Figure 2.2 below. The relations between the subject and the object are not direct but rather mediated by several factors such as tools, rules, the division of labour and the community (Engeström, 1987). In addition to Vygotsky's (1978) mediated act, Engeström (1987) introduced rules, division of labour and community to the activity system model.

The activity system, as proposed by Engeström (1987), consists of the following components: subject, object, tools, rules, division of labour, community and outcome. In this model (depicted in Figure 2.2 below), activity is analysable as a contextual and mediated phenomenon, in terms of its inner dynamic relations (Engeström, 1987). Therefore, an activity system reveals the dialectical relationship between the individual and society in the rules and structures of the social world (Engeström, 1996). Postholm (2008, p. 40) argues that "in the activity system, context is not reduced to something that just surrounds it, but is interwoven in the actions, becoming a single process". Van der Riet (2009) argues that this counters the dominant behaviour change theories in the field of HIV and AIDS.

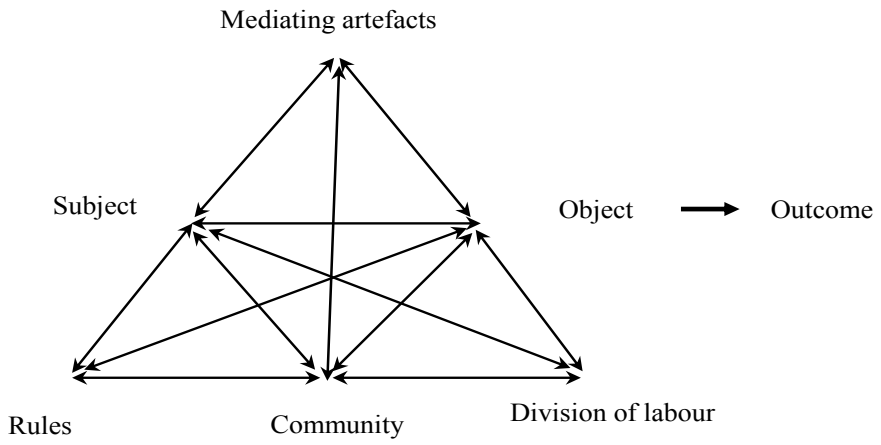

Figure 2.2. The activity system model (adapted from Engeström, 2001, p. 135).

The components of the activity system may be described as follows: The 'subject' in this model is the individual or group of individuals whose activity is being analysed or who are involved in the central activity (Engeström 1999), for example, the participants of the study. The 'object' is the motive of the activity being presented, for example, attaining sexual pleasure. Object

refers to “raw materials” which are changed into outcomes by subjects “with the help of physical and symbolic, external and internal tools” (Engeström 1999, p. 67). An example of an outcome of sexual activity is pregnancy. ‘Mediating artefacts’ refer to everything used in the transformation process, including both material tools and tools for thinking (Engeström, 1999). For example, a condom is a material tool, while HIV knowledge could be classified as tool for thinking.

‘Rules’ are formal and informal regulations that prescribe action and interaction within activity system (Engeström 1999). For example, in many contexts, women do not initiate sexual interaction, it is the prerogative of the male partner. This is an example of an informal rule, or rather, a norm. Another informal ‘rule’, or expectation in sexual relationships, is that partners should be faithful to each other. This is of course not a ‘rule’, as it is not written down or prescribed anywhere, but it is an expectation in the relationship. ‘Community’ refers to all participants in the activity system with a common object (Engeström 1999), for example, other young men in the same context who also engage in sexual activity to demonstrate a particular identity investment. ‘Division of labour’ refers to the sharing of roles and responsibilities according to their vertical and horizontal dimensions (Engeström, 1999). The horizontal dimension refers to the division of roles in the activity, for instance women are usually responsible for sexual safety in a relationship. The vertical dimension refers to hierarchical power relations and authority (Engeström, 1999), for instance men often initiate and control sexual activity.

In this thesis, activity system analysis helped in understanding the relationship between individuals and society, as well as the dynamics of risky sexual behaviour (as was done by Van der Riet, 2009). This allowed a deeper understanding of the context in which sexual activity takes place. Activity system analysis involves first understanding the components of the system (this means how the data fits into the seven components of the sexual activity system), and then how the components of the activity system interact with each other. This analysis leads to understanding the tensions and contradictions inherent in the system; these concepts will be discussed in the next section.

2.3.2 Contradictions, tensions and dilemmas

As already stated in Chapter 1, the terms contradictions and tensions used in the framework of activity system analysis differ from the everyday use of these words. In activity theory, the

term ‘contradictions’ refers to “historically accumulating structural tensions within and between activity systems” (Engeström, 2001, p. 137). Virkkunen and Kuutti (2000, p. 302) define them as “fundamental tensions and misalignments in the structure that typically manifest themselves as problems, ruptures and breakdowns in the functioning of the activity system”. ‘Tensions’ are a small component of contradictions. A ‘dilemma’ refers to difficult choices between two alternatives (Engeström, 1996). Dilemmas are specific situations that illustrate tensions. For instance, women may want to insist on condom use with their partners but, if they do, they may be suspected of infidelity by their sexual partner. Roth and Lee (2007) argued that contradictions are historically accumulated and should not be equated with a tension or a dilemma. Although they are source of tensions and dilemmas, they cannot be equated with them. Therefore, tensions and dilemmas are expressions of developing contradictions (Miettinen, 2006b). Contradictions are understood as accumulating tensions in an activity system that aggravate turbulence and lead to transformation (Engeström, 1987).

According to Engeström (1999), there are four types of contradictions in the activity system: primary contradictions, secondary contradictions, tertiary contradictions and quaternary contradictions. The primary contradictions exist within components of an activity system (Engeström, 1999); for example, for a mediating artefact to manage the risk of pregnancy, people have condoms and injectable contraceptives. These can be in tension because when one uses injectable contraceptives one may be reluctant to use condoms. The secondary contradictions are between the components of an activity system (Engeström, 1999), for example, the tension between the object and the outcome of sexual activity. People may experience tension between having sexual pleasure and the negative consequences of getting an STI, including HIV and AIDS (Van der Riet, 2009). Tertiary contradictions are between components of different activity systems (Engeström, 1999), for example, the tension between the objects of the sexual activity system of men and the sexual activity system of women. The quaternary contradictions are in the interaction between the changing central activity and its neighbouring activities (Ditsa, 2003). For example, “a primary care doctor, working on a new holistic and integrated basis, refers the patient to a hospital operating strictly on a traditional biomedical model” (Ditsa, 2003, p. 218).

Contradictions are important concepts in activity theory and they are most critical to the process of examining the research problem of this study: the lack of behaviour change despite knowledge of HIV and prevention. The concept of contradictions is critical because it becomes

an important element in the process of analysing a system and understanding where the potential sources of change are. Contradictions are important to the understanding of the working of an activity system (Van der Riet, 2009). Therefore, understanding the contradictions in an activity system is important for understanding the system itself (Barab, Barnet, Yamagata-Lynch, Squire & Keating, 2002). In order to understand contradictions and their transformations, there is a need to analyse the activity (Engeström, 1999).

Contradictions are inherent and inevitable in every activity system (Engeström, 1987). Therefore, like other systems, sexual activity systems are not stable and harmonious. In activity theory, contradictions are acknowledged and identified as useful tools of analysis (Barab et al., 2002). Engeström (2001) argues that contradictions are significant in an activity system because they are the driving sources of change, innovation and development. They are opportunities to change a predominant practice. Engeström (2001) says any essential transformation in the activity system has initially emerged as a tension and contradiction.

Engeström (2001) argues that internal tensions and contradictions within an activity system are aggravated over time and eventually lead to crisis which results in a new activity system. Tensions and dilemmas imply a possibility of change (Miettinen, 2006b). Van der Riet (2009) argues that for an activity system to change, tensions must manifest as essential dilemmas. Latent and weak tensions do not create essential dilemmas and do not lead to change (Van der Riet, 2009). A tension is weak if it has not lead to a significant contradiction in a system. Therefore, tensions and contradictions are mechanisms which can assist in understanding how change is possible (or has not happened) in a sexual activity system. In order for transformation to occur in an activity system, tensions and contradictions must be identified and then change develops (Engeström, 1999). According to Miettinen (2006b, p. 175) "transforming them into a recognized problem requires conscious reflection by the participants and a call for remediation and innovative solutions". By focusing on contradictions, activity system analysis enables us to gain some explanatory insights into safe sex practices and barriers to transformation. Therefore, focusing on contradictions is central to understanding sexual behaviour change or lack of sexual behaviour change in the context of HIV and AIDS. The next section presents the aim and the rationale of this study.

2.4 Rationale and aims for the study

2.4.1 Rationale

In order to prevent HIV and AIDS and sexually transmitted infections, there is interest in

studying high-risk sexual behaviours. The 2012 South African National HIV Survey indicated that HIV and AIDS continue to spread in South Africa despite concerted efforts to prevent it (Shisana et al., 2014). The survey indicated a significant increase of almost 1.2 million people living with HIV in South Africa between 2008 and 2012. Thus, changing behaviour in response to HIV and AIDS remains a significant problem in South Africa. It also indicates that attempting to prevent the spread of HIV and AIDS by educating people about the risks and promoting a change in risky sexual behaviours is not enough to reverse the HIV pandemic (Rohleder, Swartz, Kalichman & Simbayi, 2009). HIV and AIDS remain a problem and a most challenging disease, especially in developing countries (Parker, 2004). To develop appropriate interventions that can address HIV prevalence and prevent transmission of HIV infection, an understanding of sexually risky behaviours is crucial.

It is critical to understand why there is a lack of behaviour change in response to the HIV-prevention interventions already put in place, especially as a remedy for HIV in terms of medication or vaccines still seems far away. To address the challenges posed by STIs and the HIV pandemic, researchers have focused on cognitive theories and models to inform prevention programmes (Protogerou, Flisher, Aarø & Mathews, 2012). These theories focus on the assumption that sexual behaviour is an individual decision-making process. However, other authors such as Parker (2004) question their applicability, arguing that cultural and community factors are crucial in understanding HIV transmission. There has been increasing awareness that contextual factors affect individual behaviour (Parker, 2004). However, there has also been recognition that neither cognitive nor context-based theories provide an adequate framework for understanding sexual behaviour change (Van der Riet, 2009).

Consequently, there is a need for a conceptual framework which incorporates the dialectical relationship between the context and individual. In terms of understanding sexual behaviour change, there is a need for a theorisation of activity "in which people continually shape and are shaped by their social contexts" (Roth & Lee, 2007, cited in Van der Riet, 2009, p. 75). Thus, this study focused on activity theory. It is the only theory that provides a conceptual framework for the dialectical link between the individual and society (Engeström, 1999). Activity theory thus provides an alternative lens for analysing sexual activity in the context and community that supports it. There are limited studies (Engeström, 1996; Van der Riet, 2009; 2012) that have applied activity theory specifically to health issues. Activity theory may provide a more

comprehensive and effective understanding to guide interventions aimed at changing high-risk sexual behaviour.

The findings of this study might be beneficial to South African HIV and AIDS programmes which are aimed at preventing the spread of HIV and AIDS. It could contribute to the important body of knowledge of HIV and AIDS. It could also assist policy makers and non-governmental organisations to apply appropriate interventions by providing empirical data on why people continue to engage in risky sexual practices regardless of their awareness of the negative consequences.

2.4.2 Aims of the study

The main reason for this study was to find out why people continue to engage in risky sexual practices which expose them to the risk of HIV and AIDS, despite knowledge and information about HIV and AIDS. The study sought to understand a lack of sexual behaviour change in response to HIV and AIDS using the framework of activity theory (Engeström, 1987). This study use secondary data from a broader NRF project exploring people's responses to HIV and AIDS. The participants in this study were from a rural area in the Eastern Cape, called *Ematyholweni*. This is discussed in more detail in Chapter 3.

This study analysed the way in which people in *Ematyholweni* talk about sex, sexual relationships, and their response to HIV and AIDS. It focused on the tensions and dilemmas in the positions that men and women in *Ematyholweni* take in relation to sexual activity and relationships. The main aim was to understand the different dilemmas and tensions within sexual relationships related to condom use and safe sex practices. It also explored whether and how these tensions and dilemmas relate to contradictions in the sexual activity system. Understanding the relative state of contradictions in the activity system assisted in conceptualising HIV and AIDS interventions in similar contexts.

2.4.3 Research questions

1. What are the dominant dynamics around sexual activity and risk-reducing sexual behaviour in *Ematyholweni*?
2. What is the response to HIV and AIDS among people in *Ematyholweni*?
3. What is the response of people in *Ematyholweni* to condom use?
4. What tensions and dilemmas occur in the activity system of sex of people in

Ematyholweni?

5. What is the state of contradiction in the activity system of sex among people in *Ematyholweni*?

This chapter explored literature related to the study. It presented literature on socio-cultural factors that may act as barriers to safe sex practices, activity theory as a theoretical framework of this study and the principle of contradictions in this theory. It finally presented the aim and rationale of this study.

The next chapter will discuss the methodology employed in this study. It outlines the research design, sampling, the data collection and the data analysis procedures. It also discusses the steps for ensuring the validity and reliability of the study. It also explains in detail the ethical consideration of this study.

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter presents the methodology of this study. In the first section, this chapter presents the research design of the study. The second section describes the process of sampling and recruitment. The third section provides detail on the procedures for data collection, while the fourth section details the procedures of data analysis. The fifth section documents the techniques used to strengthen the research quality of this study. The sixth section presents the ethical considerations of the study and the final section provide details on dissemination of the results and data storage.

3.2 Research design

According to Polit and Beck (2004, p. 49) a research design is:

> a blueprint, or outline, for conducting a study in such a way that maximum control will be exercised over factors that could interfere with the validity of the research results. The research design is the researcher's overall plan for obtaining answers to the research questions guiding the study.

A qualitative research design was used in this study. Qualitative research designs play a very important role in social science research. 'Qualitative research design' "is an umbrella term covering an array of interpretative techniques which seek to describe, decode, translate and otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world" (Van Maanen, 1983, p. 9). It is a research design that uses words in data collection and data analysis. According to Maxwell and Boyle (1995, p. 279), "it is more appropriate for the exploration of motivation, meaning and contradictions in behaviour". Silverman and Marvasti (2008) argue that qualitative methods are crucial for exploring people's everyday behaviour. Silverman and Marvasti (2008) also argue that, when compared with quantitative designs, a qualitative design offers a deeper understanding of social phenomena.

Qualitative research was employed in this study because the researcher wanted to understand sexual activity within its particular context. The researcher was concerned with the meaning and underlying lived experiences of the sexual activity of participants. Answering the research questions relied heavily on uncovering the participants' subjective views and experiences of

sexual practices. A qualitative approach was chosen over a quantitative approach because of the need to focus on obtaining the subjective and contextual views of the participants, and the need to provide a detailed description of their social reality. The use of this approach allowed a deeper understanding of the phenomenon of sexual behaviour. The qualitative approach is usually difficult to validate because findings are seen as subjective and thus not based on rigorous investigations (Van der Riet & Durrheim, 2006). However, Silverman and Marvasti (2008) argue that it is possible to objectively explore the subjective as long as one carefully chooses methods which are appropriate to the topic and the model.

3.3 Sample

3.3.1 Research context

The sample of this study was drawn from a larger National Research Foundation-funded qualitative project in the rural Eastern Cape entitled *Activity Theory and Behaviour Change*. This means the present study used secondary data from the broader project database. The broader study explored people's responses to HIV and AIDS in *Ematyholweni*, a rural community in the Eastern Cape. The name of the research site is a pseudonym ('*Ematyholweni*') which was used to protect its identity and the anonymity of the study participants.

Kelly's (2000) study found that youth aged 15 to 30 in an area very similar to the research study site were involved in unsafe sexual activities including unprotected sex, early sexual initiation and extreme age differentials between partners. Van der Riet's (2009) study, also in a similar context, identified similar dominant dynamics in sexual activity. These dynamics included a concern with pregnancy (rather than HIV) as a risk of sexual activity, an awareness of HIV but a lack of condom use and a strong link between identity and sexual activity (Van der Riet, 2009).

Ematyholweni is a relatively undeveloped rural area, characterised by high unemployment with many residents relying on social grants and pensions. It consists of 14 villages and people from all of the 14 villages were included in the sample. The research site residents are mostly black, *isiXhosa*-speaking people. *Ematyholweni* has both traditional leadership and democratic leadership. There is one chief, one democratically elected councillor, and each village has a Residents Association with a chairperson. This study site was selected due to fact that the study coordinator Dr. Mary van der Riet, had worked in the research site for several years and had an

ongoing relationship with the community.

Although I was not part of the broader project, for clarity about the secondary data which I used, I now describe the recruitment, sampling and data collection process use for the broader project.

3.3.2 Recruitment

Ethical clearance for the larger study was granted in 2011 by the University of KwaZulu-Natal's Humanities and Social Science Research Ethics Committee (see Appendices 1 and 2 for approval letters). Ethical clearance for this study was granted in 2013 by the University of KwaZulu-Natal's Humanities and Social Science Research Ethics Committee (see Appendix 3). The chief and Residents Association chairpersons acted as gatekeepers and granted the permission to carry out the research in their community.

As part of the larger project, a letter was written to the chief (see Appendix 4A, English version and 4B, *isiXhosa* version) seeking permission to carry out the research in the community. A meeting was also held with the chief to explain the purpose of the research. The study aims and benefits were clarified to the chief and he granted permission for the study.

Access to participants was gained through the chairpersons of the residents associations. The researchers verbally informed (in *isiXhosa*) the chairpersons about the purpose of the study and requested assistance in the recruitment of participants for the study. A key informant whom the research team had known for many years also assisted in recruitment for the study. Potential participants were approached by the key informant and the researchers. The researchers informed them about the objectives and the rationale of the study, topics to be covered in the research process, as well as the time the interviews/focus groups would take. The contact information of those who agreed to take part in the study was recorded and arrangements were made for their interview/focus group sessions. The researchers also used soccer tournaments and other community gatherings such as choir practices as sites for participant recruitment.

In the case of children (participants aged 10 to 17 years), parents or guardians were visited in their homestead to ask if their child could take part in the study. Parents were verbally (in *isiXhosa*) informed in detail about the purpose of the study, the procedures and the potential benefits of the child taking part in the study. Parents who agreed that their child could

participate in the study signed the consent form (see Appendix 5A, English version and 5B, *isiXhosa* version). The researchers also explained the purpose of the study to the child and gained assent from him/her as well. These children only participated in the research study if they wanted to participate.

3.3.3 Sample characteristics for the larger project

The larger project used non-probability sampling techniques in which participants' selection of participants is not random (Durrheim, 2006). The study used purposive sampling in order to access residents of a rural area in the Eastern Cape. Purposive sampling is a selection method whereby the purpose of the study, that is, the research questions and study objectives, and the researcher's knowledge of the population guide the selection process (Durrheim, 2006). This allows the researcher to include only participants who suit the needs of the study; for example, this study involved sampling of both men and women who grew up in *Ematyholweni* or had been residing there for a number of years.

This study also used convenience sampling in which participants were selected based on their availability, accessibility and willingness to participate (Durrheim, 2006). These sampling techniques usually result in small samples that are not representative of the entire population. However, these methods are fast, inexpensive and easy to use as the sample is readily available (Durrheim, 2006). Although the sample size is small, this is balanced by the ability to capture the richness of the individual cases (Silverman & Marvasti, 2008). Silverman and Marvasti (2008) argue that, in a qualitative study, a suitable sample size is one that sufficiently answers the research question.

The sample consisted of both men and women. The sample was drawn from a wide age range (from 10 to 60 years) to see if there were differences or similarities in how different age groups respond to the HIV and AIDS epidemic. This provides diverse perspectives on risky sexual behaviours. The total sample entailed 75 people who participated in individual interviews and 20 focus groups of 4 to 14 participants each. Individuals were sampled for interviews according to the following age groups: 18 to 25; 26 to 34; 35 to 45; 46 to 60. Focus groups were divided into single sex groups, as well as six age groups as follows: 10 to 13; 14 to 17; 18 to 25; 26 to 35; 36 to 45; 46 to 60. This was done to reduce power differences between participants (for example, adult and child) so that they could be comfortable with each other in group discussions.

3.4 Data collection methods and procedures

The broader study used both interviews and focus groups in order to access complementary views of the phenomenon (Lambert & Loiselle, 2007). The combination of interviews and focus groups was also used for pragmatic reasons. For instance, someone unwilling to take part in an interview may be willing to participate in a focus group discussion (Kitzinger, 1995). Therefore, the combination of these methods assisted in accessing many participants because individuals could choose the method most convenient to them (Lambert & Loiselle, 2007). The other reason for combining these methods was for triangulation purposes. Triangulation of data methods provides different views about the same phenomenon and therefore contributes to the credibility of the findings (Lambert & Loiselle, 2007). Furthermore, integrating interviews and focus groups served the purpose of data confirmation (Lambert & Loiselle, 2007).

3.4.1 Interviews

Individual semi-structured interviews were used for the study as they are a means to access participants' perspectives on the phenomenon under investigation. Lambert and Loiselle (2007) argue that interviewing is a powerful way to understand another person. Therefore, through interviews one may be able to identify and understand tensions and dilemmas obstructing the adoption of risk-reducing sexual behaviour. Maxwell and Boyle (1995) argue that interviews are a means of exploring taboo topics such as sexual relationships. Sexual topics are still seen as a taboo, especially in rural South Africa, so an interview provides a private setting for a conversation where one can speak freely about sex.

A semi-structured interview was used so as to ensure that the interview had a specific focus and addressed the research question while also allowing a back-and-forth conversation between interviewer and interviewee. This was to ensure the interviewee did not feel pressurised by the process and was also to create an environment for the interviewee to feel comfortable about disclosing information on a personal matter. Semi-structured interviews allowed the researcher to ask additional questions, to explain and rephrase questions, to clarify participants' responses and probe deeper in a given situation where relevant (Parahoo, 2014). Thus, the goal of the semi-structured interviews was to enable open and detailed discussion (Kelly, 2006; Parahoo, 2014).

Although interviews contribute to generating in-depth data, the accuracy of participants' reports of their inner experiences may be problematic. Fielding (1994) notes that interviewees may decide to hold back certain descriptions or exaggerate them, particularly if the 'truth' is inconsistent with their preferred self-image. Interviewees may answer the questions to impress the interviewer or to say what they think the interviewer wants to know, not truly reporting their experiences (Fielding, 1994). Lambert and Loiselle (2007) state that even though the researcher may adopt a neutral role, the interviewee may be influenced by certain characteristics of the interviewer. According to Fielding (1994), this has raised the issue of whether interviewee-interviewer characteristics (i.e. age, race, gender) should be matched when conducting a study. In this study, the interviewers were matched with the participants in terms of race and gender in order to counter this issue. Participants were also advised not to answer questions that they were not comfortable with. They were also re-assured of the confidentiality of their responses; that is, whatever was said in the conversation would not be traced back to them.

A set of guiding questions were used for the interviews (see Appendix 6A, English version and 6B, *isiXhosa* version). Before the data collection of the larger project began, the research team drafted the interview guide. I was not part of this process because data was collected before I started my research project. The interview guide was developed in relation to the research questions. Literature on the topic was consulted to assist in framing suitable questions in accordance with the study aims and objectives. The guide was to provide a level of consistency between interviews. It was not used to impose on the conversation but to assist the researchers to gather information specifically related to the research objectives. It was developed using a semi-structured style with open-ended questions to allow the researchers to explore additional questions if necessary.

This interview schedule was translated into *isiXhosa,* the mother tongue of the participants, by members of the research team who are *isiXhosa*-speakers. A back-translation (Chen & Boore, 2010) method was used to ensure the accurate translation of the interview schedule. Back-translation is a method in which translators translate a document previously translated into another language back into the original language (Chen & Boore, 2010). The English interview schedule was translated into *isiXhosa* by one researcher. A second researcher then translated the schedule back into English to check on the accuracy of the translation. The interview schedule was translated into *isiXhosa* to ensure that participants could express themselves adequately

without struggling with misunderstanding or the issue of using translators. It was believed that mother-tongue interaction could contribute to the richness of data.

The procedures taken in conducting the interviews for the broader study are presented below. I was not part of this process because data was collected before I started my research project. The interviews were held on a one-on-one basis in a quiet place in the participant's residence. This was to ensure that the participants felt comfortable with the environment. Researchers also translated all consent and information sheets into *isiXhosa*. One researcher translated consent forms and information sheets into *isiXhosa* then another researcher, fluent in both English and *isiXhosa* translated the consent forms and information sheets back into English to ensure the accuracy of the translation.

3.4.1.1 Conducting the interview

To gain assent from participants, researchers verbally explained (in *isiXhosa*) the research to the participants. Participants were also given an information sheet (see Appendix 8A, English version and 8B, *isiXhosa* version) that explained the objectives, the rationale of the study and the participant's rights in taking part in the study. The information sheet was written in both English and *isiXhosa* to ensure that participants understood their rights concerning participation. The participants were then given the opportunity to consent to participate in the study. They were informed that their participation was voluntary, that they had the right to freely choose to be part of the study and that they had the right to withdraw from the study at any time without any negative consequences. This was to ensure that participants understood their roles and rights in the research process. Participants were assured that their identity would be kept confidential as their responses would not be able to be traced back to them. They were informed that their names would be protected with the use of pseudonyms.

Participants who agreed to take part in the study were allowed to choose a date and time when the interview could take place. Those who were immediately available to be interviewed were given consent forms (see Appendix 9A, English version and 9B, *isiXhosa* version) to sign before the interview could begin. They were also informed that the interview would be audio-recorded to avoid loss of data and were asked for their consent to record the interview. If they agreed, another consent form (see Appendix 10A, English version and 10B, *isiXhosa* version) to record the interview was signed. Then the researcher facilitated the interviews guided by an interview schedule (see Appendix 6A, English version and 6B, *isiXhosa* version). The

interviews lasted approximately an hour. After the interview, participants were compensated with R30 for their time and participation.

3.4.2 Focus groups

Stewart and Shamdasani (1990), argues that focus groups are very important because they allow researchers to observe and understand attitudes and behaviour in a context. Kitzinger (1995, p. 299) states that focus groups "tap into the many different forms of communication that people use in day-to-day interaction, including jokes, anecdotes, teasing and arguing". They are more appropriate for discussion of sensitive topics because the shyer participants can be encouraged to participate (Kitzinger, 1995). This was certainly important for the study because the discussion of sex is a sensitive issue in the South African context. It was significant for this study to use data from focus groups because focus groups discussions assist in exploring social norms and social behaviours around risky sexual behaviours. Van der Riet (2009) argues that focus groups may potentially illustrate the dynamics in the social world of the participant.

However, group dynamics pose some ethical issues. For instance, the presence of other participants in the group discussion compromises confidentiality (Kitzinger, 1995). However, participants in the focus groups were asked to sign a confidentiality pledge (see Appendix 11A, English version and 11B, *isiXhosa* version).

Prior to data collection, the research team drafted the focus group schedule (see Appendix 12A). The schedule was used as a guide for the topics to be covered during the discussion. It included the following: dynamics of relationships, risks in sexual activity and knowledge about HIV and AIDS. The focus was on how people in *Ematyholweni* respond to and manages the risk of HIV and AIDS. This semi-structured focus group schedule was prepared in English and then translated into *isiXhosa* (see Appendix 12B) by members of the research team. A back-translation method was used to ensure the accurate translation of the focus group schedule. The procedures taken in conducting the focus groups for the larger study are presented below. I did not take part in the data collection because the project was ongoing and some data had already been collected before my research project. In addition, I do not speak *isiXhosa.*

3.4.2.1 Conducting focus groups

Potential participants were approached by the key informant and the researchers. When the participants had agreed to participate in a focus group discussion, a date and time were arranged for the focus group discussions. Participants were transported by the research team to places where the focus groups were conducted. Before data collection began, researchers verbally (in *isiXhosa*) explained the research to the participants. Information sheet (see Appendix 7A, English version and 7B, *isiXhosa* version) that explained the objectives and rationale of the study and participant's rights in the study was given out and read to the participants.

The information sheet was written in both English and *isiXhosa* to ensure that participants fully understood their rights in participating. The participants were then given the opportunity to consent to take part in the study. They were told that their participation was voluntary (that they had the right to freely choose to be part of the study) and that they could withdraw from the study at any time without any negative consequences. This was to ensure that participants understood their roles and rights in the research process. Participants were assured that their identity would be kept confidential as their responses would not be traced back to them.

Participants who agreed to participate in the focus groups for the study were given consent forms (see Appendix 13A, English version and 13B, *isiXhosa* version) to sign before the focus group discussions could begin. Participants were asked to choose pseudonyms for transcription purposes. They were given name tags with those pseudonyms for easy identification during the discussions. They were also told that the discussion would be audio-recorded to avoid loss of data and their permission to allow the recordings was obtained. When the participants had agreed, another consent form (see Appendix 10A, English version and 10B, *isiXhosa* version) to record the focus group discussions was signed by each participant. Since the presence of other participants in the group discussion compromises confidentiality (as discussed above), participants were asked to sign a confidentiality pledge (see Appendix 11A, English version and 11B, *isiXhosa* version) to promise that they would not discuss the issues under discussion with anyone who was not part of the discussion. They were warned that there is a limit to the guarantee of confidentiality in a group; thus they were encouraged to discuss and reflect on issues which occurred generally in their community, rather than revealing personal experiences.

Participants were then divided into single sex groups to avoid limiting conversation in front of participants of the opposite sex. The participants were also grouped by age categories as follows: 10 to 13; 14 to 17; 18 to 25; 26 to 35; 36 to 45; 46 to 60, to allow easy dissicusions among members of the same age group. The number of participants per focus group depended on the availability of participants. Some of the focus group participants also participated in the semi-structured interviews and the two data collection process did not happen sequentially. After all these measures had been implemented, the researchers facilitated the discussions in *isiXhosa* guided by the focus group schedule (see Appendix 12). The discussions lasted approximately two hours. After the discussion, participants were given R30 to compensate them for taking part in the research.

3.4.3 Data processing

As already stated above, the individual interviews and focus groups discussions were audio-recorded. They were translated from *isiXhosa* to English during the transcribing process. I was not involved in translation and transcription of the data because I do not speak *isiXhosa*. I had access to electronic (soft) copies of the translated data. The data was transcribed using a simplified version of the Jefferson transcription conventions (see Appendix 14). This notational system was used to record actions which are more than just words, such as pauses and silences. This transcription and translation was done by the research team, as well as by additional research assistants who were fluent in both English and *isiXhosa.* The use of different transcribers might have affected the consistency between the transcripts. However, back-translation process was employed to ensure the accurate translation of the participants' discussion (Brislin, 1970). In this study, the *isiXhosa* recording was translated into English by one researcher. A second *isiXhosa*-speaking researcher then translated part of this transcript back to *isiXhosa* to check on the accuracy of the translation. Despite being time consuming, back-translation is the best way to ensure the accuracy of the translation (Brislin, 1970).

3.5 Characteristics of the sample for this study

As stated above, I was not involved in the recruitment, data collection, transcribing and translation of the broader study. The sample of this study was drawn from a broader NRF project described above. The advantage of this was that the data was readily available to use. The disadvantage was that secondary data does not offer direct involvement in the data collection and processing, which might help to confirm the research results directly with the participants. However, research assistants of the broader project were readily available to assist

with clarity and interpretation of data where it was not easy to understand. This data was used because it focused on issues related to the aims of this study such as HIV risk behaviours and the management of risk in relation to HIV and AIDS.

The sample of this study was selected from the broader dataset using purposive sampling. The sample consisted of men and women aged between 18 and 60 years. This age range was essential to this study because most people are sexually active at this age and are at risk of contracting HIV and AIDS (Johnson et al., 2010). By selecting data from sexually 'experienced' participants, it was expected that rich research data would be generated. I had access to 47 transcripts of interviews and thirteen transcripts of focus groups. This study used all of the 47 transcripts of the interviews I had access to. The demographics of the participants in the interviews used in this study are presented in the tables below.

Table 3.1. Demographics of the semi-structured interview participants for this study

Age category	**Men**	**Women**	**Total**
18-25	4	6	10
26-34	8	10	18
35-45	4	6	10
46-60	6	3	9
Total	22	25	47

This study also sampled transcripts of the focus group discussions due to interest in shifting away from the assumption of sexual behaviour as individual decision-making, to the conceptualization of sexual activity as a socially embedded activity. This study sampled focus groups to explore how social norms limit or facilitate an individual's ability to practice safe sex**.** I sampled thirteen focus groups using the same criteria as those used in sampling the interview data. That is men and women aged between 18 and 60 years, because most of these people are sexually active at this age and are at risk of contracting HIV and AIDS. I did not use the focus group material for the younger participants in the broader study (age 10-17) because the focus group discussions were not as detailed as those from the older participants. Five focus groups of the age group 18 to 25 years old (three with female youth and two with male youth) were sampled. Another four focus groups of the age group 26 to 35 (two with women and two with men) were sampled. Two focus groups of the age group 36 to 45 years old (one with women and one with men) were also sampled. The last two focus groups to be sampled

were of the age group 46 to 60 years old (one with women and one with men). This selection of different age groups across both genders was done to explore age and gender dynamics in response to HIV and AIDS (see Tables 3 and 4).

The demographics of the participants in the focus groups used in the current study are presented in the tables below. Thirteen focus groups were sampled (6 of males and 7 of females) with a total number of 89 participants (45 men and 44 women).

Table 3.2. Demographics of male focus groups for this study

Men		
Focus groups age category	**Number of focus groups**	**Number of participants per group**
18-25	1	7
18-25	1	14
26-34	1	7
26-34	1	5
35-45	1	6
46-60	1	6
Total	6	45

Table 3.3. Demographics of female focus groups for this study

Women		
Focus groups age category	**Number of focus groups**	**Number of participants per group**
18-25	1	9
18-25	1	6
18-25	1	6
26-34	1	7
26-34	1	4
35-45	1	6
46-60	1	6
Total	7	44

3.6 Data analysis

The data of this study was analysed by employing two methods as complementary analytic tools: thematic analysis and activity system analysis. Below is a detailed account of how these methods were employed.

3.6.1 Thematic analysis

Firstly, this study was concerned with identifying the dominant dynamics around sexual activity and risk-reducing sexual behaviour in *Ematyholweni*, as well as the response to HIV and AIDS among people in *Ematyholweni*, and for this I used thematic analysis. Thematic analysis is an important method of reporting participants' perspectives on, experiences about, and meanings related to the phenomenon under study (Braun & Clarke, 2006). Terre Blanche, Durrheim and Kelly (2006) argue that thematic analysis goes beyond summarising content; it involves classifying and unfolding both implicit and explicit concepts within the data. Below, I explain the steps I took in the process of analysing data using thematic analysis.

I read through the transcribed interviews and focus groups many times to familiarise myself with the text to the point of knowing where particular quotes occur in them. Kelly (2006) refers to this as immersion in the data. This helped me to understand the overall meaning in the text. I listed everything that came into my mind when thinking about the texts I was studying. This yielded an initial list of themes which facilitated an understanding of the overall idea of what was in the data. I looked for patterns that emerged in the whole data set and then I highlighted these with different colours in order to group data with similar information under one theme. This helped to group data into themes, patterns and similarities that could be seen at a glance. Following this, I developed mind maps showing how the themes I had generated related to one another. In this process I tried to identify which themes were predominant in the data. According to Strauss and Corbin (1990) this process ensures that the themes are exhaustive and mutually exclusive. The process of identifying themes involved writing a detailed analysis of each theme. Subsequently, I started to think about what the data was saying about the phenomenon I was studying, reflecting on my research questions. Finally, appropriate extracts were selected to illustrate key findings.

3.6.2 Engeström's model of the activity system

Thematic analysis was only a preliminary step. The main step was analysing the data using activity theory concepts and principles. Activity theory provides a particular understanding of

behaviour and the relationship between the individual and society (Van der Riet, 2009). It conceptualises the relationship between the context and the individual as dialectical and sees the context and the individual as inseparable (Engeström, 1987). This analysis was operationalised by adopting Engeström's (1987) model of the activity system. This model was mainly concerned with identifying tensions and dilemmas that occur in the activity system of sex for the people in *Ematyholweni*; it was used to understand the state of contradiction in the activity system of sexual behaviour among people in *Ematyholweni.* Below, I explain the whole process of analysing the data using Engeström's (1987) triangular model of the activity system.

In employing this analysis, I reviewed all the transcripts and analysed them using the pre-determined categories derived from Engeström's (1987) model of the activity system and the principle of contradictions. Engeström's (1987) model of the activity system consists of components which mediate the activity. The analysis involved analysing the data in relation to the activity system and its components. These components are: subject, object, outcome, rules, community, division of labour and tools. The activity system of sexual activity was created by categorising the data into these components of the activity system (as was done by Van der Riet, 2009).

I drafted and redrafted possible models of the activity of sex. I firstly identified how the data fitted into the seven components of the sexual activity system. I started with identifying the subject, then the object, and the outcome, followed by other components of the activity system; tools, rules, community, division of labour. Analysing small segments of data helped me to grasp the subjects' views of the components. I described the activity system of sex in terms of its components, for example: subject (unmarried man), object (sexual pleasure), outcome (HIV; reputation), rules (peers' expectation to be sexually active), community (peers), division of labour (who initiates the activity) and tools (condoms; safe sex messages).

During the analysis of the sexual activity systems of participants, the data indicated that, because of different dynamics related to these aspects, there was a need to have different activity systems for different types of relationships and the different genders. The analysis of the data was divided into four sexual activity systems: married man, married woman, unmarried man and unmarried woman. This was done to explore relationship type and gender dynamics in response to HIV and AIDS.

I then re-read the data several times with all these components in mind, looking at the extracts that depicted the presence of contradictions. In identifying contradictions, I looked for tensions and dilemmas faced by the participants within the activity system of sexual activity in the research context. As I read through the transcripts, I noted and marked extracts that indicated that a tension or a dilemma was present. A detailed description of these tensions and dilemmas was developed. These tensions and dilemmas were grouped according to the components involved in the contradiction. They were also grouped according to Engeström's (1987) classification of types of contradictions in an activity system. Lastly, the research questions guided the interpretation of these contradictions.

3.7 Research quality

According to Golafshani (2003), in qualitative research, reliability and validity are conceptualised as trustworthiness. They are about honesty and the truth of the data (Silverman & Marvasti, 2008). The goal of trustworthiness is to accurately report the experiences of the participants. Below, I discuss the strategies I have used to strengthen the trustworthiness of this study.

3.7.1 Credibility

According to Polit and Beck (2004, p. 751), credibility is "a criterion for evaluating integrity and quality in qualitative studies". It is the extent to which one can be confident about the truth of the findings (Ulin, Robinson, Tolley & McNeil, 2002). Silverman and Marvasti (2008) argue that one of the major threats to the credibility of qualitative research is 'anecdotalism'. According to Silverman and Marvasti (2008, p 259) anecdotalism occurs when presentation of research findings "depend on a few well-chosen examples" that hold-up the researcher's argument. Silverman and Marvasti (2008) argue that anecdotalism can be avoided by presentation of deviant cases and by adopting a constant comparative method in the process of data analysis. In addition, it can be avoided by engaging in comprehensive data treatment and by using the refutability principle (Silverman & Marvasti, 2008). This study used these methods, as well as triangulation, to prevent the occurrence of anecdotalism.

All the individual interviews and focus groups sampled for this research project were analysed and even the deviant cases were presented in the results. All data fragments were repeatedly reviewed and analysed until generalisation applied to every piece of data selected for this study (Silverman & Marvasti, 2008). According to Silverman and Marvasti (2008), this is what is

meant by comprehensive data treatment. Silverman and Marvasti (2008, p. 261) argue that qualitative researchers must attempt to "refute their initial assumptions about their data in order to achieve objectivity". An attempt to refute my assumptions about the data was made to avoid jumping to easy and interesting conclusions. Evidence of some interesting data was subjected to every possible test such as finding another case to test out a temporary hypothesis and by using comprehensive data treatment.

This study also used triangulation to enhance credibility. Triangulation refers to a situation where the researcher combines different methods to study the phenomena (Silverman & Marvasti, 2008). The study used two data collection methods: individual interviews and focus groups discussion. The triangulation of data methods provided different perspectives on the phenomenon and therefore contributed to the credibility of the findings (Lambert & Loiselle, 2007). Furthermore, the data analysis was also conducted using two methods - thematic analysis and then using Engeström's (1987) model of the activity system - which increased the credibility of the results.

3.7.2 Confirmability

Confirmability refers to the ability to confirm that the researcher has been able to maintain objectivity in data analysis in a way that the results could be verified by others (Polit & Beck, 2004). In an attempt to maintain confirmability of the results, the researcher ensured that the conclusions reached were supported by the analysed data. Confirmability is also strengthened by providing a very clear trail of the analytic procedure, and this has been demonstrated in detail in reporting on the analysis in the results section of the thesis.

3.7.3 Dependability

Dependability refers to the consistency of the results if the study was to be replicated (Polit & Beck, 2004). In attempt to ensure that the results of this study were dependable, the research questions were clearly stated and also logically connected to the research methodology and objectives. This study has been clear about the context of the study, the study population and the circumstances under which the data has been collected. This will make it easier for another researcher to replicate this study, as the details of the research and the methods of generating the information have been well documented. Furthermore, the data extracts and quotes that are provided in the results chapter include both the researcher's question and the responses from the participants, which show how the responses were obtained from the participants.

3.7.4 Transferability

Generalisability, which in qualitative research is called transferability, is the degree to which the results of the study are applicable to the population (Kelly, 2006). According to Arber (1993, p. 70, in Silverman & Marvasti, 2008, p. 163), "the purpose of sampling is usually to study a representative subsection of a precisely defined population in order to make inferences about the whole population". However, this is not available in a qualitative study because the data is usually from a few cases which are not randomly selected (Silverman & Marvasti, 2008).

However, Silverman and Marvasti (2008) argue that it is possible to generalise from a single case study because the basic structures of social order are present everywhere. They argue that the main aim of qualitative research is to intensively study particular cases, rather than to generalise. In this study, purposive sampling was used in order to enable transferability to a particular population. The research involved participants who grew up in or who have been residing in *Ematyholweni* for many years. A detailed description of the research participants, the research process and research context is provided so that the findings of this study can be transferable to similar context (Kelly, 2006).

3.8 Ethical considerations

Ethical issues are a main concern when one conducts a research. According to Orb, Eisenhauer and Wynaden (2001, p. 93), "ethics pertains to doing good and avoiding harm". Compared to a quantitative study, ethical challenges in a qualitative study may be complex due to the extent of the interaction between the participants and the investigator (Orb et al., 2001). A Research Ethics Committee plays an important role in scrutinising proposals for adherence to ethical research principles. In addition to ethical clearance, informed consent, confidentiality and respect for persons, which were explained earlier in this chapter, other crucial ethical principles include beneficence, non-maleficence, and justice.

3.8.1 Beneficence

This principle is about maximising the benefits and minimising potential harm to the participants (Emanuel, Wendler & Gray, 2000; Orb et al., 2001). This study was potentially of benefit to the participants because it provided participants with the opportunity to have conversations about HIV and AIDS and risky sexual behaviours. Participants potentially learned more about HIV and AIDS and sexuality because they were able to raise issues and

misconceptions about HIV and AIDS which were addressed by the researchers. In terms of indirect benefits, the findings of this research may help policy makers and non-governmental organisations to apply appropriate interventions within the study area.

3.8.2 Non-maleficence

This ethical principle refers to ensuring that participants are protected from harm during their involvement in the study (Emanuel et al., 2000). It is commonly referred to as the 'do no harm' principle and it involves the obligation not to inflict harm intentionally or unintentionally (Emanuel et al., 2000). This principle was compromised by the fact that safe sex is a private and sensitive topic in many South African rural contexts. A referral to psycho-social support services was arranged for participants who might experience unanticipated distress.

3.8.3 Justice

The principle of justice is concerned with "equal share and fairness" (Orb et al., 2001, p. 95). It ensures that the benefits and burdens of the research are fairly distributed across all participants (Emanuel et al., 2000). It is against the mistreatment and exploitation of participants (Orb et al., 2001). It also ensures that no participants are unfairly burdened during the research process. According to Van der Riet (2009, p. 115), researchers often benefit by acquiring a "degree, promotion, [or] publications, etc., while the life circumstances of the research participants remain the same". However, this study contributes to the study of behaviour change as well as the HIV and AIDS field. It is part of a broader project which aims to change sexual behaviuor in response to HIV/AIDS in *Ematyholweni.*

3.9 Dissemination of the study findings and data storage

Research participants were informed that the results of this study will be available in the final product of a thesis in the library at the University of KwaZulu-Natal. They were informed that the results of this study may also be presented at a postgraduate conference at the University of KwaZulu-Natal and other conferences. They were also informed that the findings of this study might also be published in relevant journals. They were further informed that the study site and participants' names would not be presented in any publications or presentations of the study.

I had access to soft copies of the data from research team members in the Discipline of Psychology; the data were stored in a password-protected computer. I also stored them on my personal computer in password-protected files. Soft copies will be deleted on completion of the

project.

3.10 Summation

This chapter provided a description the research methodology and procedures employed in both the broader project and the current study. It presented a detailed account of recruitment, sampling, data collection, data analysis and ways of ensuring trustworthiness in the study. This chapter also considered ethical principles, the dissemination of study findings and data storage. The next chapter presents the findings of this study**.**

CHAPTER 4: RESULTS

4.1 Introduction

This chapter presents the research findings. The data of this study was analysed using two methods as complementary analytic tools: thematic analysis and Engeström's (1987) model of the activity system. The chapter will begin by presenting the thematic results in order to provide a picture of the dominant issues around sexual activity and HIV and AIDS in the research site. The results of the thematic analysis begin by describing HIV and AIDS knowledge and responses, followed by the dominant dynamics around sexual activity and then present risk-reduction methods used by people in this study area. The second part of the results chapter presents the results of the data analysis using Engeström's (1987) model of human activity. This model was employed in analysing the data in order to understand how tensions and dilemmas relate to contradictions in the sexual activity system, as well as the state of contradictions in the activity system.

The results of the data analysis will be supported by extracts from the individual interviews and focus groups (see Appendix 15 for interview and focus group codes related to the organisation of data in the broader data set). The extracts and comments were chosen based on how well they represented the data, as well as their ability to answer the study questions. 'I' represents the interviewer and 'P' represents the participant's response. 'P' with numbers such as 'P1' or 'P2', represents participants in a focus group, while 'PPs' indicates multiple participants. The line numbering represents the exact line numbers from the transcribed individual interviews and focus groups in the broader data set. Text enclosed in square brackets provides explanatory information. All interviews and focus groups were transcribed using a simplified form of the Jefferson transcription conventions (see Appendix 14). The transcripts have been left in their uncorrected form, as they were translated and transcribed by the research team in the broader project.

The presentation of the findings begins by examining HIV and AIDS awareness, knowledge and response to HIV and AIDS and condom use among *Ematyholweni* residents.

4.2 Response to HIV and AIDS

4.2.1 HIV and AIDS knowledge

From the analysis of the data in this study, all participants were generally aware of HIV and AIDS and of the prevalence of HIV infection in their community. Many of the participants stated that they had seen and heard of people with HIV and AIDS and even of the deaths of HIV-positive people. However, most had a basic knowledge of how HIV is transmitted, its symptoms, how it is treated, how it is prevented, its potential consequences and where and how one can be tested for HIV. Their sources of HIV and condom knowledge were schools, radio, television, clinics, family members and friends. Clinics were the main source of knowledge about HIV and AIDS. All participants stated that unprotected sex was the main behaviour likely to transmit HIV infection while some mentioned that HIV may be transmitted through contact with the blood of an HIV-positive person. They also said HIV and AIDS is incurable.

The following extract provides evidence of what the majority of the participants stated as knowledge about HIV and AIDS. It is taken from an interview with a young woman in the age range 18-25 years old.

Extract 1

300 *P: You get it when you do not use a condom; as well as when someone is sick and they did*
301 *not explain that they had the disease, so you might touch them and not use gloves and that is*
302 *another way that you might get it, and also through an open wound, you know there are people who*
303 *like to fight, so you might try to save one of them and touch that open wound only to find that you*
304 *also have an open wound and that is how it might be transmitted.*

From the above extract, there is evidence of awareness that HIV is contracted through unprotected sex and through contact with blood from an infected person. The participant clearly specified how contact with blood from an HIV-positive person can lead to becoming HIV positive. She explained how the virus can be transmitted through an open wound. However, there is confusion about the mode of HIV transmission, as the participant stated that there is also the possibility of HIV transmission through touching (line 301) an HIV-positive person, which is not true. Participants also mentioned that having multiple sex partners increases the risk of contracting HIV. However, despite this, some men and women reported having multiple sexual relationships, although men were more likely to engage in these behaviours than women. This will be elaborated in much greater detail in sections 4.3.1 and 4.3.2.

Although all participants indicated a basic knowledge of HIV and AIDS, some male participants indicated several misconceptions and inaccuracies in their HIV knowledge. The next theme is on the misconceptions that were present in the research context.

4.2.2 Misconceptions about HIV and AIDS

Several people in the research context still seemed to have incorrect ideas about HIV and AIDS which may in turn lead to them engaging in risky sexual behaviours. In the young male (18-25) focus group, some of the participants believed that one could not contract HIV if one slept with an HIV-positive person for a short time.

Extract 2

175 *P:…you don't just get that thing in one*
176 *minute-*
...
187 *P: The plan is to tell yourself that that thing will never infect me in one minute..*

'*That thing*' in the above statement refers to HIV. Other young male participants in the same focus group argued that another method to prevent HIV is to bath immediately after sex. In the extract below, from the young men (18-25 years) focus group, participants explained how one could prevent the spread of HIV by washing immediately after sex or wiping one's private parts with a wet towel.

Extract 3

328 *P1: You have sex have sex and you don't wash, isn't it?*
329 *P2: Ja.*
330 *P1: And you stay, maybe you will wash around eleven.*
331 *P3: Late maybe at night, maybe she going home at night, it's spreading.*
332 *P1: After you have escorted her, you see, it's going then, it's increasing spreading, that*
333 *thing, that's all viruses they just doing their own thing.*
334 *P3: Because now it's going into your pores.*
335 *P4: You see, so then it's better that you just have a towel then, a wet towel where you*
336 *keep wiping yourself after you have done it.*
...
364 *P5: It's said that when you quickly wash after you have sex with this girl, you see if you*
365 *quickly wash, it could happen that you don't get affected when you quickly wash, take it out*
366 *and go and wash.*

Similarly, an unmarried man aged between 26 and 34 years, in an interview, also suggests wiping the private parts immediately after sexual activity to prevent HIV infection.

Extract 4

280 *I: mm s:o are there any ways to protect yourself without using condoms?*
281 *P: ... a way to protect yourself without using a condom?*
282 *I: mm to sleep with someone and protect yourself but not actually use a condom?*
283 *P: Do you mean is there another way =*
284 *I: = mm yes to sleep with someone but not to use a condom and still be safe =*
285 *P: = and still be safe?*
286 *I: Yes.*
287 *P: As in, is there a way for me not to use a condom but still be safe?*
288 *I: Yes mm*
289 *P: ... well my brother what do you think... perhaps if I am with my partner over*
290 *there and we are busy, then immediately after I am done I take a bucket and I wipe my thing*
291 [referring to his penis] *and then we have a conversation, suppose I then want to go again and*
292 *we do it again so immediately after I am done I wipe it, you see?*

There was one female participant in the age category 46-60 years who mentioned in an interview that she heard that one can get pills at the clinic that protect one from being infected.

Extract 5

110 *I: Is there another way to protect yourself that you have heard of except*
111 *for the use of a condom?*
...
122 *P: Oh okay I've heard of a way. You can go to the clinics and get;;; there*
123 *are these pills that people get. I've never went to get them but I hear that they are*
124 *there.*
125 *I: Okay, do you know what these pills are for?*
126 *P: They are there to protect you so you don't get this thing*.

These incorrect notions and information about HIV transmission were found mostly amongst men of all age groups.

Condom use is significant in reducing the risk of HIV. The next theme is on the responses to condom use in the research context.

4.2.3 Attitudes to condom use

Although many participants advocated that condoms were the number one way to protect them from the risk of HIV, there were a number of responses which indicated negative attitudes towards condom use. There was a general perception that men do not like condoms. In the extract below, from men (46-60 years) in a focus group, the participants say women usually initiate condom use but they are usually not successful at this because men "*want skin on skin*" (lines 440-441 and line 447), meaning that men want unprotected sex.

Extract 6

P1: Some of us do not want that condom, they say no I do not want that condom. I just want skin on skin.
I: Oh:
P1: I don't want no condom.
I: Is that usually an agreement or is it one person who says that I don't want it and therefore it will not be used?
P2: It is usually the woman who says me, I use a condom. then I say that I do not use a condom, I want skin on skin.
I: And then what happens?
P2: She will end up giving in.

Another example is found in the extract below, from an interview with a married woman (35-45 years). She explains that it is difficult for men to use a condom but she has to use it because she is scared of becoming ill due to infidelity (lines 336-341). She explains that for men to use condoms, one has to force them and give reasons for the use of a condom.

Extract 7

I: Okay, (.) so ehm you usually speak about those risks and what usually happens after that talk?
P: (.) It is hard for a male to use a condom=
I: =Yes.
P: And you see that you not in agreement about that thing.
I: Yes=
P: You realise that? (.) But then you end up using it, because you scared of these things, when you don't trust him, you going to be scared of sicknesses.
I: Oh, okay.
P: You end up 'condomising'.
I: Uhm, so, so after that talk he usually, I could say do he listen to you? Or ya
P: he listens to you with difficulty, but he ends up listening to you, yes.
I: Okay, okay (.) so it becomes hard maybe, maybe sometimes you cannot say there is a difference that you see, and would you say maybe there is visible difference in him?
P: When you speak to him about that?
I: Yes.
P: (.) There usually is a difference, because it's hard to condomise, they don't want to condomise, these men.
I:Ookay.
P: So a person has to do it by force because you telling him to do it and you tell him the reason for such.

In the following extract, a young woman (18-25 years) in an interview explains that her boyfriend does not like to even talk about condoms.

Extract 8

I: Ok ok. So he is a person that cannot talk about those things?
P: No, he can't.
I: Ok. but you didn't want to know why he doesn't want to?
P: To what?

91 *I: Like to talk about condoms and when you talk about protection from these diseases,*
92 *P: he doesn't want it.*

This is also found in the following extract from an interview with an unmarried woman aged between 35-45 years. She agrees that they have spoken about sex in their relationship because there is the possibility of infidelity. She tried to negotiate condom use with her partner, but he refused, justifying this by saying that he is unaccustomed to the use of condoms, saying "*I was not raised up to that, people using plastics*" (lines 50-51). The word "*plastics*" refers to condoms. He is arguing that when he grew up, there were no condoms and now it is difficult for him to agree to use condoms. There is a constant struggle between how he had sex before the introduction of condoms and now with pressure to use a condom.

Extract 9

38 *P: We even spoke about this in Johannesburg because there are lot of women in*
39 *Johannesburg. He'd also mention the fact that there are a lot of men in*
40 *Johannesburg. So we'd talk about sex. I'd say: if we are not going to be seeing*
41 *each other people it's best that when we meet we use a condom.*
42 *I: When you meet.*
43 *P: Xhosa people are very hard headed. Their views will never be the same as*
44 *white persons' views.*
45 *I: Uhhh*
46 *P: They will never agree to that. They'll ask you: where did you get that from?*
47 *Then I'd say: people are not trustworthy anymore.*
48 *I: uhhh, uhhh*
49 *P: For instance like now when we meet in ...I told him: we have not seen*
50 *each other let's use a condom. He'd reply: I don't know about that. I was not*
51 *raised up to that, people using plastics.*

One of the main reasons participants provided for not using condoms was that a condom reduces sexual gratification. In the following extract, from an interview with a young man aged between 18-25 years it is clear that condoms decreases sexual pleasure. He argues that he does not "*feel grand*" (line 100) and that when he uses a condom, he doesn't "*really feel*" what he is doing (line 102).

Extract 10

99 *I: Ok(h)ay* [laughs] *okay. Why is it you do not want to use a condom?*
100 *P: (I do not know man) ey I usually do not feel grand when I am using it.*
101 *I: Serious?*
102 *P: Yes I would realise that I do not really feel what I am doing.*

In another interview, an unmarried man aged between 26-34 years also argues that condoms reduce sensation in that "*you do not feel what you are doing*" (line 275), one does not "*feel it to the fullest*" (line 277). He argues that they should be used in casual sex only (lines 277-278).

Extract 11

274 *I: Okay, okay. What made you to want to stop using a condom?*
275 *P: A condom is... is... is... not: not: ... you do not feel what you doing.*
276 *I: Okay, okay.*
277 *P: You do not feel it to the fullest. It's like you could (.) only use it with a person*
278 *that you just met to protect yourself.*

An additional extract is taken from an interview with an unmarried man in the age range 26-34 years. He explains that he dislikes using condoms because he wants to be sexually gratified. The participant makes the statement: "*I want to experience its vitamins properly you know*" (lines 155-156) to emphasize the need for the enjoyment of sex. The participant believes that there is extra enjoyment associated with unprotected sex. He reasons that he wants unprotected sex so that he can enjoy sex. He equates a condom to a "plastic" (lines 158-159) to show the lack of enjoyment associated with condom use during sexual activity.

Extract 12

154 *I: What makes not to feel a condom?*
155 *P: I want it flesh to flesh you see. If I were to put it correctly, I want to experience its vitamins*
156 *properly you know.*
157 *I: Okay.*
158 *P: Because when it is in a plastic, we normally joke as guys that you cannot enjoy*
159 *something in a plastic.*

Some young women also justified the lack of condom use because condoms reduce sexual pleasure. In the extract below, from young women (18-25 years) focus group, participants argued that they also need sexual pleasure, or "niceness" (line 537) or the "soup" (line 542), and that is why they give in easily when their boyfriends refuse to use condoms. This shows that young women support the notion that sex should be pleasurable (line 548) not only for their male sexual partners, but also for them. However, participants were aware that condoms are vital in prevention of risk. This was embodied in P2's words when she argues that "*it's necessary that it must be used*" (line 549).

Extract 13

537 *P1: We both want the niceness.*
538 *P2: Yes, niceness on niceness.*
539 *P1: We also want the niceness, you see. Because you also want to, like if you really want to use a*
540 *condom, seriously you change and say we rather not do it then.*
541 *PPs: Yes, let's leave it.*
542 *P1: But we reckon huh uh let's endure because we want, this soup.*
543 *P2: this niceness ((laughs))*
544 *PPs: ((laughter))*
545 *I: ((laughs)) O(h)k so is using a condom not nice then?*
546 *PPs: Mhmm huh uh, it's not nice at all.*
547 *P2: And it's painful.*
548 *P1: It's very small pleasure, it's not a lot.*
549 *P2: ↓But it's necessary that it must be used.*

Some participants argued that putting on a condom at the beginning of each sexual activity slows down the process of engaging in sex. An example of this comes from a focus group of men in the age range 26-34 years.

Extract 14

1215 *P1: And you see condoms like, they slow down the process man.*
1216 *P2: Shit.*
1217 *P1: Serious, like when you are in the mood, it's like even though the condom is in the drawer, it is*
1218 *like it's too far.*

Many participants, particularly women, complained that condoms are uncomfortable. They complained that condoms cause abrasions (line 516) and bruising (line 118) on their private parts and also reduce the pleasure (line 519). An example of this comes from a focus group of young women in the age range 18-25 years.

Extract 15

514 *P1: We sometimes are the first ones that do not want to use it.*
515 *P2: Yes.*
516 *P1: Because when you put it there mos you see, there is this abrasion that you get and you feel*
517 *that hey...*
518 *P2: It's bruising you.*
519 *P1: And then you yourself don't feel the pleasure and you feel him about to climax and you are*
520 *not yet about to climax. And you get dry, when he puts on...*
521 *P2: a condom.*
522 *P2: But if it's skin on skin, you are*
523 *P2: you are grand.*

Another example of this comes from a focus group of women aged between 35-45 years. In this extract, one of the women complained that Choice condoms (a Choice condom is a free government-sponsored condom generally available at local clinics) cause a rash on her vagina. This highlights that condoms are linked with allergic reactions.

Extract 16

1001 *P3: I mean it even cause rash on your vagina, that Choice.*
1002 *PPs: <heh heh> ((shock))*
1003 *P4: Seems like you are really used to it (.)*
1004 *PPs: ((laughter))*
1005 *P4: She says it causes rash.*
1006 *PPs: ((laughter))*
1007 *P5: I don't understand, how does it cause rash?*
1008 *P3: It causes rash.*
1009 *P5: It doesn't cause rash, man.*
1010 *P6: People are not the same, man.*
1011 *P3: It makes me have rash. We will never be the same as people, it does cause rash on me.*

Some participants seemed to dislike the smell of the condom lubricant. In the extract below, from a focus group of young women (18-25 years), the participant argued that the "odour" of the lubricant on condoms has an unpleasant smell. This sugguest that, people may not use condoms because of this smell.

Extract 17

568 *P: It's that lubricant that makes you seem like you're gonna have this certain odour now, huh uh,*
569 *eish.*

Other participants indicated the possibility of condoms breaking at any time during sex; thus, they felt condoms are unreliable. In the following extract, from an interview with an unmarried man aged between 26-34 years, the participant says he must always do an HIV test because he does not trust condoms as they might break during sex. As he explains, "*I may be saying that I a wore it myself but*" (line 369), but he is afraid of it 'bursting'.

Extract 18

367 *P: Yes, they say that you must always get tested especially when you have done something*
368 *you know. Like I was saying that I just came back from "…" you can never know what*
369 *happens with a condom. I may be saying that I a wore it myself but...*
370 *I: Mm*
371 *P: But you can never be too sure because maybe it may just burst or something. ↑You must*
372 *always go man, you see.*

In the following extract, taken from a focus group of young men in the age range 18-25 years, the participants indicate that Choice condoms are the worst condoms as they break easily. This was a justification of why they were not using condoms, even when they are freely available to them. This indicates that people may not practice safe sexual behaviour (using condoms) because it takes away their enjoyment, reduces sensation, causes rash on their private parts and is uncomfortable.

Extract 19

145 *P1: And these Choice condoms are even worse.*
146 *P2: These Choice condoms are even worse; they even burst, these Choice condoms.*
147 *P3: They burst, these Choice condoms.*

The next section presents the major themes in the dominant dynamics around sexual activity that were revealed during data analysis. These include low acceptance of condom use in marriage, extramarital sex, multiple sexual partners, casual sex under the influence of alcohol, inter-generational sex, male control of sexual activity, fear of being 'left alone' and unprotected sex demonstrating love and commitment.

4.3 Dominant sexual activity dynamics

4.3.1 Low acceptance of condom use in marriage

The view held by many participants was that condoms are not supposed to be used within marriage relationships. The belief among participants was that sex within marriage is meant for procreation. In the extract below, from a focus group of young women in the age range 18-25 years, the participants believed married people do not use condoms within their marriage because of the need for children but use them in sexual engagements outside of marriage. The word "*umakhwapheni*" (line 984) is an *isiXhosa* term meaning in the armpit. This word is used to refer to a secret sexual partner outside of the acknowledged relationship.

Extract 20

981 *I: So according to you, do married people use condoms?*
982 *P: Nope, I don't think so.*
983 *I: Why are you saying that you don't think so?*
984 *P: Like, uh they use it only when a person has an* umakhwapheni *but when it is with their*
985 *wife, they don't use it because most of the time it's because they want children.*

Another example of this perspective comes from a focus group of young men aged between 18-25 years. These young men also argue that people in marriages do not use condoms because married people need to have children and family.

Extract 21

813 *I: Now people who are married, according to what you know, do they use condoms?*
814 *(.2).Those that are in marriage?*
815 *P1: No we don't reckon.*
816 *P2: No they don't use them, I think they don't use them.*
817 *I: Okay.*
818 *P2: Because children are wanted there.*
819 *I: Okay.*
820 *P2: Because they want a family there.*

In the extract below, from a focus group of women in the age range 26-34 years, participants agree that condom use is rare in marriage because it threatens child-bearing. The participant uses the statement, "*you are throwing away your seed*", meaning one is throwing away one's children. This statement emphasises the importance of having children in marriage in this community. Condoms are seen as inhibiting the ability to procreate.

Extract 22

483 *P1: It's very rare, it's non-existent. Any house you go into you won't find any.*
484 *P2: They say a marriage is a marriage by children, so by using a condom you are jeopardising*
485 *that, you are throwing away your seed.*

The view that married people are supposed to have children was also held by married people. An example of this is found in the following extract, from a focus group of married men aged between 46-60 years. According to the participant, married people have sex in marriage because they want to have children. If they do not bear children, there would be a concern of infertility in the family. This seems to be reflecting a social norm about fertility.

Extract 23

259 *I: All of you, okay. So do you have sex in your marriage?*
260 *P1: Yes we do have sex. Because if you not do that, then there will be trouble here in the family.*
261 *I: ((laughs)), Okay.*
262 *PPs: ((laughter))*
263 *P1: It will be like there is one of you who is infertile.*

Another example is found in the following extract, from a focus group of women aged between 46-60 years. The participant uses religious justifications for unsafe sex practice within marriage. She says married couples must have unprotected sex because they are "*allowed to by God*" (line 455) to have children.

Extract 24

455 *P: People who are married must have sex because they were allowed to by God. When God was*
456 *speaking in the book of Genesis telling them to procreate.*

This view makes it difficult for married people to negotiate condom use or make it happen. The participants felt that the introduction of condom use in the marriage relationship presented the suspicion that the other partner might have an outside relationship. Participants in the following extract, taken from a focus group discussion of women in the age range 46-60 years, explain how hard it is to introduce condom use to their husbands because *"it is his right to get this thing and he does not care how he gets it"* (lines 608-609) even if they suspect that he might be having an outside affair, because they would be accused of an outside affair (Line 612). '*This thing*' in the above statement refers to sex (line 608). P1 explains that the request for condom use as a married woman can lead to a fight with a husband and can also end up involving families. This suggests that condom use is not expected in a marriage relationship.

Extract 25

605 *I: So when he does not want to use a condom, does that mean that it will not be used?*
606 *P1: Even if he does not have the final word, but ultimately you will fight about it. Every time it*
607 *does not happen in the end you will fight and then it ends up being something big and it involves*
608 *families, that so and so is like this. Even if he does that he knows that it is his right to get this thing*
609 *and he does not care how he gets it*
610 *P2: And so here you are as a woman, you want to use a condom, what do you say to the man,*
611 *why do you want to use a condom as a married person?*
612 *P3: It's not easy because whenever you want to - use a condom, no I see that you are unfaithful. It's not*
613 *easy even though he sometimes does not come home or he comes late…*

Being accused of having an affair makes it difficult for those who know that their partners are not faithful to insist on condom use. Many married women are aware that their husbands are unfaithful and yet they continue to engage in unprotected sex with their husbands to maintain good relations. They are expected to stay in the relationship, regardless of these suspicions. The participant indicated that gender inequalities, in which a man controls sexuality, complicate negotiating safe sexual practices. In the following extract, a married woman in the age range

26-34 years explains how difficult it is for her husband to understand the need for safe sex practice. He only suspects her of having an affair (lines 89-90 and line 95).

Extract 26

I: s when you are already in a marriage. Mm, as married people, are you able to
speak to your husband about the risks of sex…?
P: ((laughs)) I talk about it, but then a man does not like to talk about those things. It
is usually you as the woman that usually talks about that.
I: m mm
P: Mm, but then eish, it becomes hard, it becomes hard ((shuffling)) for a man to
understand that=I mean a man understands that with much difficulty.
I: mm
P: That there are these diseases that you can contract through sex.
I: mm
P: And then your husband then just does not trust you then=he thinks that there is this
man that you are having an affair with when you keep on telling him that, yhu there is this
disease that is...
I: like this.
P: Eh, so rather let us use a condom most of the time.
I: mm
P: A:nd he thinks then that there is another man that you are having an affair with.

In the interviews and focus groups, there were reports of extramarital sexual relations within the research context which therefore exposed the couple to the risk of HIV infections. This issue is elaborated in detail in the following section.

4.3.2 Extramarital sex

Marriage usually assumes fidelity. In this study, some participants believed that, when one is married, there would be more trust and faithfulness between partners and therefore no need for protection in the form of condom use. In the following extract, from an interview with an unmarried woman aged between 35-45 years, the participant says it is essential to be worried about condom use when not married because the trust is low. She assumes that when people are married, the trust would be better. This is shown in lines 94-95: "*there's that trust bond*".

Extract 27

P: The next day I won't know what happened with him. You cannot trust each
other whilst you are not married. At least when you are married, there's that trust
bond.

However, there were reports that some married women and men have relationships outside the acknowledged one. In the following extract, from a focus group of women aged between 26-35 years, participants confirm that married people do have extramarital relationships even though

it is not supposed to happen. The perception among participants was that more men than women have extramarital relations (line 46).

Extract 28

1 *I: Ok, so do people who are married, or those who are not married, have girlfriends? Or let's*
2 *start with those that are married. Does it happen that I have a partner even when I am married?*
3 *Does it happen?*
4 *P1: mm*
5 *I: It happens?*
6 *P2: Yes, it happens.*
7 *P3: Yes, it happens.*
8 *P4: When you are married?*
9 *I: Yes.*
10 *P4: mm*
11 *P3: When a person is married...*
12 *P4: mm*
13 *P3: and they have their boyfriend...*
14 *P4: mm*
15 *P3: or others will have that girlfriend of theirs.*
...
42 *P2: It happens but by right it shouldn't be happening.*
43 *P3: By right, it's not something that should be happening.*
44 *I: Ok, ok who does it the most, women or men?*
45 *P3: It's the men.*
46 *PPs: It happens with the men.*

Some participants, particularly women, argued that marriage does not guarantee trust; therefore, married couples must be worried about protection. An example of this is in the following extract, from a focus group of women aged between 45-60 years. The participant emphasises that there is a need for protection in marriage because, even when married, there is infidelity.

Extract 29

71 *I: How many ways are there of being in a relationship?*
72 *I: Is our question understandable?*
73 *P: Married people today do not trust each other. Now you need to protect yourself. Because we*
74 *find that even though we say they are married they have other people that they are with whom*
75 *they are not married to. So you find that you do need to protect yourself.*

Another example is in the following extract from an interview of a married woman aged between 35-45 years. The participant points out that it is important to be concerned about protection and safe sex in marriage because there is always mistrust when married.

Extract 30

74 *I: Do you think that it is important when you are married to concern yourself*
75 *about ways to protect yourself as well as ways to have safe sex in your*
76 *relationship? Is it something that's important?*
77 *P: It is important.*
78 *I: Why?*
79 *P: It is important because when you are in married you always don't trust each*
80 *other. And that's a big issue, not trusting each other whilst being married.*

Another example is from an interview of a married woman aged between 35-45 years. She confirms that she and her husband talk about sexual risk because there is the possibility of sexual affairs outside the marriage relationship for either of the partners. She emphasises that there is no trust between partners even when married, saying "*there's no one trustworthy*" (line 282).

Extract 31

275 *I: Okay (.3) umm so (.3) here we go! Let's start here on these risks, as someone who is*
276 *married the risks of, of having sex do you speak about them in marriage?*
277 *P: Yes you do speak about the risk of having sex=*
278 *I: =Yes.*
279 *P: In marriage, because there are many sicknesses and you don't move around with this man*
280 *you not with him all the time he goes and you go, have you seen?*
281 *I: Yes.*
282 *P: There's no one trustworthy=*
283 *I: =Okay.*
284 *P: You realise that? You will never be fully trustworthy*

Although participants acknowledged that both married men and women may be involved in extramarital relations, many married women were concerned about the risk of HIV infection because of their partner's infidelity. An example of this appears in the following extract.

Extract 32

162 *I: Ok alright then. ((sighs)) h. Do you think, according to you now, is it important*
163 *that people in marriage should speak about safe sex in marriage. Is there a reason for them*
164 *to protect themselves when they are in marriage?*
165 *P: There is. There is a reason for you to protect yourselves when you are married*
166 *I: mm*
167 *P: (.1) You can't say that because you are married, now you can't protect yourself*
168 *now because another thing is that men, a man cannot be trusted*

In the above extract, a married woman aged between 26-34 years argues in an interview that there is need for protection in marriage because infidelity is common among men (lines 167-168).

Another example is found in the following extract from an interview of a married woman aged between 35-45 years. She agrees that it is vital to be aware of sexual risks and diseases, because her husband might be engaging in risky sexual practices in an outside relationship and therefore expose her to the risk of HIV infection.

Extract 33

88 *I: Okay, as a married person do you think that it is important to make yourself aware of all the risks and diseases that are out there?*
89 *P: Absolutely because the diseases are so terrifying because you could be sitting at home not doing anything. He comes in and out the house and with going out he meets someone and they have unprotected sex. And then he comes back home to me and ends up infecting me.*

Most married women were aware that their partners could be unfaithful so some advised their sexual partners to use condoms in an outside relationship. It could be argued that this was their management of sexual risk. An illustration of this is found in the following extract from an interview with a married woman aged between 35-45 years.

Extract 34

60 *P: I just explained to him the issues of cheating and that if he is cheating he should*
61 *please use a condom.*

These examples show the awareness and the acceptance of the possibility of sex outside the marriage relationship. In the extract below, from an interview with a married man aged between 46-60 years, the participant states that his wife asked him to use condoms because of the possibility that he may 'meet someone' (line 167).

Extract 35

163 *P:…There are the women.*
164 *who are really bent on protecting themselves. Uh, like my wife because I was not even cared*
165 *about condoms but it was the women who influenced me. They said you must use condoms*
166 *because you men are not honest. You say something to me here and then you turn around*
167 *and you have met someone else but you are going to say to me that you have not met*
168 *anyone.*

Although many married women were aware that their partners may have other partners, condom use amongst married people was not a norm in this context. An illustration of this is from an interview of a married woman aged between 46-60 years.

Extract 36

89 *I: So you never used a condom before?*
90 *P: No, I don't. ((laughter))*
91 *I: You don't even know how it looks?*
92 *P: We've never used it.*

There was normalisation and tolerance of men's extramarital relations. Men were perceived as people who cannot have one partner all the time, and men's sexual drive was seen as something that was difficult to control. In the following extract, a man in a focus group of men in the age range 46-60 years indicates that his wife knows that he may have sex outside marriage and therefore advises him to use condoms, stating "*you see a man has what are called* iminqweno[desires] *you see that"* (in line 369). This statement suggests that men are not able to control their sexual urges and this situation is expected of them.

Extract 37

392 *I: Ok, mm I see. but in marriage now do people talk now, like will the husband say to his wife*
393 *that there are such and such things out there, diseases, or maybe the wife, who is the one that*
394 *always speaks about these things and these things out there.*
395 *P: With me it is usually my wife who usually tells me that, no my husband, whatever happens,*
396 *you see a man has what are called* iminqweno [desires] *you see that, and she tells me that even if*
397 *you are out there and you are doing something there, please use a condom.*
398 *I: Ok.*
399 *P: Uh, and she tells me like that, that please, whatever happens please use a condom.*

Many married women have accepted this perception and are not challenging their husbands' infidelity. They do not seem to directly oppose their husbands' infidelity but rather advise them use condoms when engaging in sex with other sexual partners.

This normalisation of the expectation that men will have sex outside of their acknowledged relationship was not only common to married couples. Men in general were assumed to have multiple sexual relationships. This will be elaborated in the next sub-section.

4.3.3 Multiple sexual partners

Multiple sexual partners escalate the likelihoods of one contracting HIV. All participants in the study were aware that multiple sexual partnership increases the risk of sexually transmitted infections. Although participants indicated that there is this risk, they reported that some men and women were involved in multiple sexual relationships. In the following extract, from an interview of an unmarried woman aged between 26-34 years, the participant confirms that she

speaks to her partner about the risk of unsafe sex because there is the possibility of him having another partner outside the relationship. She agrees that they speak about the risk of unsafe sex because multiple sexual partnerships are 'common' among men (lines 51 and 58) and she often asks her partner to use condoms outside the relationship (line 54).

Extract: 38

45 *I: So in this relationship do you discuss the: risk of unsafe sex? Or do you speak about*
46 *them?*
...
51 *P: = Yes, we do speak about it because a man can have more than one woman and if he were to*
52 *meet one then he should use a condom.*
53 *I: He calls how?*
54 *P: He calls in a sense that he may have another woman.*
55 *I: Oh:*
56 *P: Yes so if he were to be with that other woman (.) then he must use a condom=*
57 *I: = Oh:*
58 *P: Because you never know, a man may have more than one woman.*

Another example is from an interview with a young unmarried woman in the age range 18-25 years. She agrees that she talks about the risks in a relationship and advises her boyfriend to use condoms with other partners.

Extract 39

59 *P: So I say to him if he does meet some other girl he must please use a condom.*

Another example is found in the following extract from a male focus group discussion aged between 46-60 years. One of the participants commented that if a man has many sexual partners, he is viewed as a "*very healthy man*" (line 816), while a woman with many sexual partners is given "*very bad names*" (line 818). The words "*very healthy man*" seems to indicate that having many partners among men was encouraged.

Extract 40

815 *P:... If you are a man and you have many women, like four, you*
816 *are taken as a very healthy man.*
817 *I: You are very healthy if you as one person have many people.*
818 *P: But if you are a woman and you have many men, then we will give you very bad names.*

It seems as if, in this context, it is expected that young men will also have multiple sexual partners. This was reflected in the young men's focus group discussion in the age range of 18-25 years. Young men equated having one sexual partner with the monotony of eating samp all

the time: "*You can't eat samp all the time*" (line 873, extract below), suggesting that a man needs to have diversity in sexual experiences. Sex with one sexual partner was perceived as unexciting. They also equated having one sexual partner with looking at only one side, like an axe: "*You will never look to one side like you're an axe man*" (line 872), which means a man should have multiple partners and not be like an axe, which can only cut on one side. They used the phrase "*You have to eat people*" (line 874) to indicate that engaging in sex with variety of sexual partners is necessary.

These young men indicated that having multiple partners was crucial to their identity. They stated that if one has multiple partners, "*it means that you are* 'udlalane*', you are* 'isibethi*'*" (line 878) which means one is a 'player'. Being a player gives one a good reputation amongst one's peers. However, the participants are able to associate multiple sexual partners with the risk of AIDS (lines 880-882). This does not turn into behaviour change because these young men believe that they have a sexual drive which needs to be satisfied: "*we are never satisfied*" (line 883). The following extract reflects young men's views on multiple sexual partnerships. It is from a focus group of young men aged between 18-25 years.

Extract 41

867 *I: So for people who are in relationships, that have a partner that they are in a*
868 *relationship with, does it happen that they have multiple partners? (.4) So when you have a*
869 *girlfriend mos?*
870 *PPs: Ja.*
871 *I: Is it that girl only?*
872 *P1: Huh uh you, you you will never look to one side like you're an axe man.*
873 *P2: You can't eat samp all the time, all these years you're eating the same thing.*
874 *P1: No, you have to eat people (.2)*
875 *I: You're saying that-*
876 *P1: You need to have many girlfriends you must not have one girlfriend.*
878 *P1: It means that you are* 'udlalane*', you are* 'isibethi*'.*
879 *PPs: ((laughing))*
880 *P3: Are(h)n't you a person who's looking for AIDS?*
881 *I: ((laughs))*
882 *P1: You are person who's looking for AIDS then ((laughing)), (unclear) that Azania there*
883 *P2: there are no relationships now, we just want to taste us, we are never satisfied.*

Failure to have a girlfriend or many girlfriends carried the risk of being looked down on and ridiculed by one's peers. An example of this is found in the following extract from the same focus group of young men aged between 18-25 years. The participant argued that no one would like to be labelled "*isishumane*" (line 506) because he will be the "*only one without a person*" (line 507). A man without girlfriends is perceived as shoemaker, *isishumane*, a person who

idles around repairing shoes and does not have a positive identity in the community. This term is used to define a man who does not have a girlfriend. The participant indicated that "*being called* isishumane" is derogatory for men (line 506).

Extract 42

506 *P: You will never like being called* isishumane*, if you are* isishume [unclear] *you are the*
507 *only one without a person, you see that's not right.*

Some young women also indicated acceptance of this behaviour. An example is found in the extract below from a focus group of young women aged between 18-24 years. The participants say that it is possible that, because of love, they would stay in a relationship with a young man even when they know that he is not faithful and has multiple partners. One of the participants used the word "endure" (line 634) to emphasise that she would put up with the relationship regardless of the circumstances. In lines 638-639, she shows that she tolerates this behaviour, and would 'share' (line 634) her partner, as long as she has an opportunity to see him.

Extract 43

627 *I: You said that maybe you are not happy (.) you see (.) but you are going to endure even*
628 *if he is wrong; how does that happen? What has he done maybe, that makes you continue to love*
629 *him?*
630 *P1: Maybe he is loved by other people.*
631 *I: You love other people?*
632 *P2: Him maybe he is loved by other girls.*
633 *I: Oh*
634 *P3: So you reckon that you are going to endure, you are going to share him because even you*
635 *love him also.*
636 *I: mm. And how do you do that?*
637 *(.)*
638 *P3: You do it in the sense that, if he gives you your time then there is no problem (.) when he*
639 *gives you maybe the time that you need him.*

Alcohol was seen as a facilitator of multiple sexual encounters. The theme below discusses this issue.

4.3.4 Alcohol and casual sex

Participants in this study reported that people tend to engage in casual sex particularly when drinking alcohol. In this study, casual sex can be understood as a brief sexual encounter. Men were expected to be sexually active when drunk and to use condoms with sexual partners they may possibly meet at the drinking places. An illustration of this is found in the extract below, from an interview of an unmarried man aged between 26-34 years. The participant indicated

that he always carries condoms when going to the tavern because there is a possibility that he would meet someone there and have sex with them.

Extract 44

282 *I: Mm mm] okay (.). Mm so (.) a condom is not something that you carry with you*
283 *and have all the time?*
284 *P: I usually carry a condom when I am going out to places where there is… you*
285 *see.*
286 *I: [Alright*
287 *P: Maybe] when I am going out to drink.*
288 *I: Okay.*
289 *P: When I am going to the tavern. Yes I carry it with me because you normally find*
290 *those things there.*
291 *I: Things that happen [there*
292 *P: That happen] there*
293 *I: Okay okay*
294 *P: And most of the time you will find out that you will not be able to bring that*
295 *person that you meet there back to your place.*
296 *I: [Mm*
297 *P: You see] so you will need to have a condom* (unclear).
298 *I: Mm okay. So does it happen that you go to her?*
299 *P: NO: like these things happen this way, you can meet a person there and finish*
300 *everything there.*
301 *I: Okay okay.*
302 *P: Because maybe she may have a partner where she comes from and I also have a*
303 *partner where I come from, so we cannot go to either of our places*.

This shows that condom use was acceptable, and associated with other partners. The following extract from an interview conducted with men aged between 46 to 60 years provides an example of this view. The participant in the extract agrees that safe sex is important, however only in 'outside' (line 162) relationships.

Extract 45

161 *So that is why I am saying that it is very important to protect yourself with that*
162 *person that you are doing it with, that person from the outside besides the one that you*
163 *have here in the house, make sure that you have the condom and you are using it.*

A tavern (a place where alcohol is consumed) was viewed as a place where people meet potential sexual partners whether they are in steady relationships or married. Although most of the participants said casual sex involved using a condom, there was evidence in the data that casual sex, and sex under the influence of alcohol was often unprepared, and therefore not safe sex. This presents a risk factor which increases the chances of being infected by HIV. The following extract presents an illustration of this; it is from an interview of a married man aged between 35-45 years. The participant explains how he ended up having unprotected casual sex

due to drunkenness. The statement "*without wearing it*" (line 593), means without using a condom.

Extract 46

583 *P: I met this chick there, now I am drunk, now, she loves me, I am drunk, I love her too*
584 *you see, AHH, we went to her house I bought her beer, what, what, what, I made her drink*
585 *straight, that woman, later I am not wearing anything=*
586 *I: =you not wearing anything.*
587 *P: I am not wearing anything, I wake up in morning, I think FUCK, what happened, I*
588 *don't know,…*
592 *…but I…*
593 *…know that this woman I slept with her, and I slept with her without wearing it…*

Another theme that surfaced in the collected data was the age difference between partners. The following section will look into inter-generational sex.

4.3.5 Inter-generational sex

It seemed as if it was a social expectation that a man should be older than his female partner in a relationship. These relationships usually had an age difference of about five to eight years at most. An illustration of this was found in the following extract from a focus group of men aged between 26-34 years. The participants explain that it is uncommon for a man to be in a relationship with a woman older than he is. If it happens that the woman is older than the man, it is normally unappreciated in the community. The participants used statements "*that's when people are going to start talking*" (lines 524-525) and "*then people start throwing their eyes up*" (line 529) to emphasise how it becomes uncomfortable to be in a relationship with a woman older than they are.

Extract 47

522 *P1: ((laughs))Then there is nothing funny about that that they don't say anything. For example at*
523 *my age I go out with a girl who is 18 years, no one will see that as strange. But when it comes to me,*
524 *being 30 years as I am, and I go out with a lady who is 42 years old, that's when people are going to*
525 *start talking.*
526 *P2: Even though you are passing the test though.*
527 *P3: The thing that has made many things change now, that now we are like five years older than*
528 *our girlfriends. But our fathers are like seven years older than our mothers, like it's true really. When*
529 *it comes to a woman who is older than the men, then people start throwing their eyes up. When it is*
530 *a woman who is younger, I don't know what made it like that because I don't think I know of anyone*
531 *who has wished that they could get someone who was older than them. Even a girl, once you date*
532 *her and she is fine and you find out that she is older than you, you become like huh uh, no man.*
533 *There is that concern. I mean for me that is.*

Another illustration is from an extract, from a focus group of women aged between 35-45 years. The participant confirms that it is common for women to be in relationships with older men but uncommon for men to date older women.

Extract 48

411 *P: No, I want to say that with us it happens here on the side of the girls, I have proof of*
412 *that. Where a small child goes out with an older guy but with the boys it's rare, it only*
413 *happens there in the townships.*

However, the data also indicate that some sexual relations in this research area are between a young man and an older woman. An illustration of this is found in the following extract from a focus group of women aged between 26-34 years. Participants argued that these relationships are due to "*security reasons*" (lines 341-342). They explained that their children are unemployed and possibly need financial assistance from older women. Participant 3 argued that the most common inter-generational relationships are "*mostly women in relationships with young men*" (lines 352-353). This could have been an exaggeration because these relationships are seen as inappropriate compared to when a man in a relationship is older than his female partner. The participant could be referring to something that is not common.

Extract 49

341 *P3: The one thing I see as the reason for young people going to older people is for security*
342 *reasons. Like maybe the woman has things, and so our children don't work mos, they don't have*
343 *anything. So the young man gets with this woman because she gives him everything that he needs as*
344 *a young man, you see, and so he gets with her even though he sees that she is my mother's age, but*
345 *she can afford all the things that I want she gives me so in that relationship you can see that it*
346 *depends on one benefitting.*
347 *I: Yes, one of them is dependent on the other.*
348 *PPs: Yes, yes, that's true.*
349 *I: Ok, maybe which one is more common here, is it a woman in a relationship with a younger*
350 *guy or is it a man in a relationship with a young girl?*
351 *I: According to here in Ematyholweni, or is it the same?*
352 *P3: The one which we have seen, and they can agree with me, it is mostly women in relationships*
353 *with young men, and we have seen that here, more than once.*
354 *P1: mm yes*

In the extract below, from a focus group of men aged between 46-60 years, participants agree that people engage in relationships with people who are considerably older than they are for financial purposes. Participant 3 (lines 193 to 195) argued that people get into relationships with older people because they want money. Thus, the need for financial support drives people into relationships with older people.

Extract 50

187 *P1: Yes that's the one thing that definitely happens. An older person is in a relationship with a*
188 *younger person and a younger person is in a relationship with an older person.*
189 *I: Do you agree with that?*
190 *PPs: ((laughter)))*
191 *P2: Yes I agree, it's like that.*
192 *I: P2 agrees, he says its like that. Oh so that happens. What makes that happen?*
193 *P3: It's two things. It can happen that me as an older person I am older than this child* [girl]. *This*
194 *child maybe wants money from me. And it can also happen that I as a younger guy, this woman has*
195 *money.*
196 *I: She has money, you want this money.*
197 *P3: Yes I want this money that she has.*
198 *I: mm. So it's money.*
199 *P3: It's the purse.*

Another illustration of this is from a focus group of men aged between 35-45 years, participants confirm that it is common for younger people to be in relationships with people who are older than they are. The participant explains that older people are able to buy younger people things they cannot afford and in the end the younger person would sleep with them.

Extract 51

103 *I: Does it happen that younger people are in relationships with people who are way older than*
104 *them or people who are way younger than them?*
105 *P: That does happen. With these children of today, these young children, we know that our*
106 *children believe in money now.You as an older person, you will keep buying her her things and she will*
107 *realise that, no man, other things I don't get from elsewhere, I get them from this old man. Yes,*
108 *and then she ends up sleeping with this old man.*

Some participants suggested that age difference may affect risk management between partners. In the extract below, from a focus group of women aged between 18-24 years, the participant suggests that if one is in a relationship with an older person, you may be fearful of telling him or her to use a condom.

Extract 52

127 *P:* [clears throat] *I think when a person meets with an older person, then this he or she*
128 *won't say it to this old person, maybe he or she is scared =*
129 *I: =yes*
130 *P: to tell him or her to use a condom.*

The data suggest that men were expected to be in control of the relationship. The next section will consider men's control of sexual activity.

4.3.6 Male control of sex

Gender inequalities in relationships were clear in the analysis of the data in the sense that a man is expected to control sexual matters while a woman is expected to be obedient and subservient. Many women, particularly married women, said it would be easier to use a condom when initiated by their partners. In the following extract from an interview of a married woman aged between 45-60 years, the participant admits that she would not ask her husband to use a condom but would welcome it if initiated by him.

Extract 53

234 *P: Yes I would never ask him that.*
235 *I: Ok ok.*
236 *P: Yes I would never say that to him.*
237 *I: Ok ok. (.) um, if he said that to you, what would you say? If said, wife let's use a condom. what*
238 *would you say?*
239 *P: No if it was up to me, I would welcome it.*
240 *I: You would welcome it.*
241 *I: I would welcome it.*

Another illustration of this is from an interview of a married woman aged between 35-45 years.

Extract 54

112 *I: So what would happen the day that you would hear your husband*
suggesting that you to use a condom?
113 *P: Him?*
114 *I: Yes.*
115 *P: We'd use it if he'd ask that we use it. Not a problem*.

This could indicate that women have acknowledged their powerlessness in sexual relationship. Their accounts illustrated that they had little power to negotiate safe sexual practices. In the following conversation with a married woman in the age range of 35-45 years, she is aware of her husband's infidelity and she realises that she is at risk of contracting HIV because of this behaviour. She tries to negotiate condom use with her husband but she is not successful. Her ability to initiate condom use was diminished by her husband's questioning.

Extract 55

355 *I: Okay, okay , umm, so because of the situation that you've just spoken about does that*
356 *perhaps, umm, make you think that it is important, umm, to talk about ways to protect your*
357 *selves during intercourse or maybe you don't speak about it as something that needs to be*
358 *there?*
359 *P: It is important that this be something that we speak about,[*
360 *I: uhh, uhh*

361 *P: but he doesn't want that. He asks: why is it as my wife*
362 *I: yes,*
363 *P: you ask that we use a condom?*
364 *I: use a condom]*
365 *P: What is it that you are trying to tell me? What are you telling me?*
366 *Then he doesn't agree.]*

It was clear that women's sexual relationships were led by the preferences of the male partner. In the above extract, a married woman cannot insist on condom use to her husband because he would not understand the reason for condom use when having sex with his spouse. Another example is found in the following extract, from an interview of a married woman aged between 26-34 years. She says she wishes to use condoms in her relationship but her husband does not want to use condoms, so she ends up powerless and gives in to not using them.

Extract 56

308 *P: So then I vote that if he says that he does not want it then no he does not want it. But then if*
309 *it is absolutely necessary, then I force him and tell him that it is necessary that*
310 *we use it. But if there is nothing forcing us, then he usually say huh uh, then I will eventually*
311 *end up giving in.*

However, some young unmarried women indicated having some power to negotiate safe sexual practices. This was evident from some young women's accounts as they seemed determined to insist on condom use with their male partners, regardless of their partner's preferences for or dislike of condoms. An example is found in the following extract from an interview of an unmarried woman aged between 18-25 years. She is determined to use condoms, even though her boyfriend does not like condoms. The participant portrays herself as a person who is able to insist on condom use and make it happen.

Extract 57

86 *P: He refuses... because he does not like condoms but we argue about that until he*
87 *eventually gives in and agrees to use one.*

Another example is in the following extract from an interview with an unmarried woman in the age range 18-25 years. She stresses that she cannot have sex with anyone without the use of condoms. She uses the statement: "*I will feel used*" (line 133-134) to show that she is in control of her sexual decisions and risk management.

Extract 58

133 *P: (.4) I cannot, I cannot sleep with anyone any more without using a condom. I will feel*
134 *used.*

The following extract is another example from an interview with an unmarried young woman in the age range 18-25 years. The participant indicated that she insists on condom use because she cannot trust her partner 'completely'. However, it should be noted that participants could be responding to questions in a socially desirable manner.

Extract 59

100 *P: I cannot trust him completely you see; and I cannot just say "I will not use a condom"*
101 *because he is my man.*

A sub-theme that is related to male control of sexual relations is women's fear of being left by their sexual partners. This theme is presented below.

4.3.7 Fear of being 'left alone'

Many of the women commented that if their male partner did not want to use a condom, it would not be used because they feared being 'left alone'. They argued that they could not refuse unprotected sex because it would send their men to other women who would welcome unprotected sex. The desire to maintain the relationship made them compromise on safety in sexual activity. Unprotected sex was seen as being like a requirement to hold on to a sexual partner. An illustration of this is found in the following extract from a focus group of young women aged between 18-24 years. The participants agree that it is important to them that they do not lose their partners but their partners are not interested in using condoms. They say their partners complained that condoms reduce pleasure and equate the use of condom to "*a sweet on its wrap*" (line 603, 609, and 611). Thus, if their partners do not want to use condoms, these women will agree to this.

Extract 60

599 *P1: Yes, we don't want to lose them to others, remember.*
600 *P2: = yes*
601 *P3: I don't want to be left, we don't like being left=*
602 *P2: =yes*
603 *P3: and then they say, 'yho', no you giving me a sweet while it still on its wrap'.*
604 *P4: that one=*
605 *P1: =let me go to that one that will=*
606 *P4: = give me skin on skin*

607 *P1: skin on skin*
608 *I: Okay*
609 *P2: and they don't want a sweet on its wrap=*
610 *P1: =They say it's tasteless*
611 *P2: They will tell, for real and say a sweet on its wrap, we don't want to eat it=*
…
719 *P5: Remember if her boyfriend says, 'no I don't want to use a condom', she too will agree*
720 *because she doesn't want him to leave her=*
721 *P1: =she'll agree because she doesn't want to be left alone*
722 *P5: You see?*
723 *I: Okay.*
724 *P1: She wants to be with someone.*
725 *P4: She wants her own guy, because if she uses a condom this one will leave her, go to the*
726 *next one who will open all and not use a condom you see?*

This was also illustrated in the extract below from a focus group of women in the age range 25-30 years. The participant says requesting a male partner to use a condom is uncomfortable because he is going to question her trust in him (line 1966) and threaten to leave and go to others who would trust him (line 1967). She reasons that in this circumstance, she would rather not use a condom because she fears that her partner will leave her.

Extract 61

1965 *P1: I said that for example a man scares you sometimes mos and he says that for*
1966 *example, you say can we please use a condom, hayi bo man don't you trust me. No kaloku, I will*
1967 *just leave you and go to other people that are going to trust me. Then you end up telling yourself*
1968 *that you will not wear a condom because you have that fear that he is going to leave you.*

Another participant in the same focus group explains that men "sometimes" (line 2534) have an outside affair if, as a woman, one insists on condom use every time. She explains that the male partner would leave the woman and go to another partner who does not insist on condom use. She reasons that the male partner would leave because he is not sexually satisfied (lines 2536-2537).

Extract 62

2534 *P2: Sometimes it's like a man who cheats who goes outside. Isn't you are a woman, you*
2535 *are always talking about a condom. He is going to go to that one that does not shout at him*
2536 *about a condom. That is why it happens it happens. Maybe the husband is going out to cheat;*
2537 *you are not satisfying him here in the house. All the time you want this sweet in its plastic.*

Another theme which links to the fear of being left alone was viewing unprotected sex as a way of showing love and commitment to a sexual partner.

4.3.8 Unprotected sex demonstrates love and commitment

The analysis of the data suggests that sex is viewed as essential in a relationship. Both the men and the women in this study indicated that sex was a way of showing commitment to a relationship. They pointed out that abstinence was not expected in a relationship and that sex was a necessity. In the following extract from a focus group with men in the age range 26-34 years, participants say sex is expected in a relationship and without it, they do not consider themselves as being in relationships. This was clearly embodied in the words of Participant 1, who says relationships without sexual activity are not considered serious: "*it's like there is nothing really between us*" (line 821), and Participant 2 who argues that sex is a means to show commitment, so without sexual activity, "*it's still a joke*" (line 822). These participants see relationships and sex as inseparable.

Extract 63

820 *I: If you have not yet had sex then*
821 *P1: it's like; there is nothing really between us.*
822 *P2: It's still a joke.*
823 *P1: I myself do not feel as if we are in a relationship until we have had sex. Then, when we have*
824 *had sex then I can tell anyone that no we are in a relationship with so and so.*
825 *I: Okay.*
826 *P1: I can't say that I am in a relationship with so and so without first going to the cross (sleeping*
827 *together))*

Participants believed that sex is inevitable in a relationship even if it may be delayed. In the following extract, from an interview of an unmarried woman aged between 26-34 years, the participant agrees that a relationship will always lead to a sexual activity.

Extract 64

74 *I: If you are in a relationship, will it always lead to sex?*
75 *P: It is a problem to be in a relationship because eventually it will end up at that point.*

This was also found in the extract below from a focus group of women aged 18-25 years.

Extract 65

72 *P1: Oh, there is no such thing where a person, a girlfriend dates a boyfriend and they don't*
73 *have sex.*
74 *P2: No, there is no such thing.*
75 *P1: There is no such thing, that here...*
76 *P2: We don't have that.*
77 *P1: We do not yet have such a thing here. A person, if I date a guy it necessar=it's not necessary*
78 *but in the end, its gonna happen; this thing of not having sex is rare.*

Many regarded sex as a way of assuring themselves of the relationship and showing their love to their partner. An illustration of this is in the extract below, from a focus group of men aged between 26-34 years.

Extract 66

812 *P1: Like for example we have that thing that if I am going out with O, I won't say that I am*
813 *dating O without having slept with O.*
814 *P2: I want to show you that I love you.*

Another example is found in the extract below, from a focus group of women aged between 26-34 years. The participant equated sex to love: "*love is sex now*" (line 290) and explains this is because sex happens only between people who are in love with each other.

Extract 67

290 *P1: Love is sex now, I don't see it any other way.*
291 *I: So sex and love are the same thing.*
292 *P1: Let me say it's the same thing.*
293 *I: uh huh*
294 *P1: Because if it was not the same thing, then everyone would be having sex with anyone. That*
295 *means it's made by love because you loved that person. That's the person you want to have sex with.*
296 *Then they say that you have feelings, that you are attracted to each other.*

Another example which indicated that sex was equated with showing love is found in the following extract from a focus group of women aged between 25-30 years.

Extract 68

284 *P: I will never, it will never know how much I really love him unless I sleep with him=*

Thus, sexual activity was linked with love. Denying the partner sex challenged the assumption that there was love in the relationship. Many women revealed that the need to express love was so significant that they were willing to compromise their sexual safety. They argued that the need to show love made it easy not to use a condom. They feared that insisting on condom use would risk loss of love. In the extract below from a focus group of young women in the age range 18-24 years, a participant explains that if she loves her partner, she will easily give in when he does not want to use a condom.

Extract 69

870 *P: I said that with the girl, ne, like you love this boy ne, and you don't want him to leave you*
871 *maybe you are going to ask for the condom. He is not going to be wanting to use it you see.*
872 *I: uh huh ((writing))*
873 *P: So you will end up giving in as well.*

Below is another example, an extract from young women in the age range 18-24 years in a focus group discussion. The participant reasons that people do not want to use condoms because they fear losing loved ones.

Extract 70

116 *P: I think as people don't want to use a condom it is because they don't want to lose the one*
117 *they love. He or she ends up putting him or herself under that risk=*

Overall, participants preferred condom-less sex despite their knowledge about HIV and AIDS prevention. Although condom use among many participants was not a norm, there were several strategies used by people in *Ematyholweni* to minimise the sexual risk. These included using condoms until trust is gained, asking the partner to use condoms with outside partners and going for HIV testing. These are discussed below.

4.4. Risk reducing behaviours adopted by population under study

4.4.1 Condom use until trust is gained

Condoms were generally perceived as a significant way to prevent HIV and AIDS among the participants. For many, the first sexual encounters with their current partners involved the use of condoms. An illustration of this is found in the extract below, from an interview of an unmarried man aged between 46-60 years.

Extract 71

136 *P: Ja like when we first met like, we hadn't yet trusted each other that what type*
137 *of person are you.*
138 *I: Ok ok.*
139 *P: And so we were using a condom.*

Participants indicated that as the relationship lengthens, condom use decreased. Although most of the relationships started with condom use, this diminished with time. Condoms were commonly used only during the first weeks or months of the relationship. It was evident throughout the data that men were the ones who determined when to stop using condoms. An

illustration is presented in an extract below, from an interview with an unmarried man aged between 35-45 years.

Extract 72

46 *P: No we had been in the relationship for six months when I decided that I should stop*
47 *using a condom because the relationship was stable, you understand.*

The following extract from an unmarried male participant in the age range 26-34 years is another example of how condoms are abandoned due to the length of the relationship.

Extract 73

261 *I: Mm. So do you use a condom all the time or?*
262 *P: No, I only used it for the first four months when we started dating.*
263 *I: Mm*
264 *P: We decided to stop using it and agreed.*

Participants indicated that within steady relationships, trust militates against using condoms. If there is an element of trust within the relationship, there is no worry about condom use and protection. In the extract below, a female participant from a focus group in the age range of 46-60 years says trust is crucial in a relationship. She says "*If they trusted each other, there wouldn't even be a need for them to be ensuring that they are protecting themselves*" (lines 737-739). She sees trust as the main 'risk-prevention' option. In her view, protection is important for people who are unfaithful to each other; that is what she means by "*walking separate paths*" (line 743).

Extract 74

735 *I: There is a question that I would like to ask that we have not yet asked but it's very*
736 *important. It needs your opinion. What does safe sex mean to people in long-term relationships?*
737 *P: The first thing is trust. It's very important for two people to trust each other. If they trusted*
738 *each other, there wouldn't even be a need for them to be ensuring that they are protecting*
739 *themselves. They would be sure that they trust each other, that I belong only to you and you only to*
740 *me. So there would be no need for condom use. There are people that do trust each other. I don't*
741 *want to say that people do not trust each other, there are people that trust each other. They know*
742 *how they can see that their wife or husband is trustworthy. I am trying to say that protection is*
743 *between people that know that they are walking separate paths in their relationships, so they will*
744 *need that protection but ultimately you do not know where they go. So rather you know where each*
745 *person is and not go separate directions, otherwise then that trust will be lost and that's when you*
746 *need protection.*

In long-term relationships, it was assumed that the degree of trust was high, significantly affecting decision-making about condoms. The introduction of condom use in a relationship

where condoms were not used previously presented an element of distrust and suspicion that the other partner might have an outside relationship. Both men and women said they would be suspicious of their partners if they introduced condom use. Many said they would need an explanation for the initiation of condom use. In the extract below, from an interview of a married woman aged between 46-60 years, the participant believes her partner would ask her why she wanted to introduce condom use and she also would ask the same question because she believes condom use is meant for people who do not trust each other. Unprotected sex was perceived as a sign of trust.

Extract 75

135 *I: If perhaps you have said to him "I think we should use a condom",*
136 *what do you think he would have said?*
137 *P: He'd first ask me why is it that I am suggesting that we use a condom?*
138 *Isn't it?*
139 *((Laughter))*
140 *I: I also don't know;;;*
141 *P: "↑Why is it now that you think we should use a condom?" He'll want*
142 *to know.*
143 *I: Alright.*
144 *P: "Why are you telling me to use a condom?"*
145 *I: What would you say if he were to ask you to use a condom?*
146 *P: I'd also ask him: "Why is it that you are asking me to use a condom"?*
147 *I: So what kind of people use these condoms?*
148 *P: People who do not trust each other.*

Another example is from an interview with an unmarried man in the age range 46-60 years; he says if his partner asked for condom use, he would ask his partner what has happened and what she could be suspicious of.

Extract 76

247 *I: mm. So now if she had to say that you must use a condom now, what would you*
248 *say?*
249 *P: I would say "No man, we haven't used a condom for so long. What happened now?"*
250 *I: Ok.*
251 *P: Or maybe, "What is it that you suspect maybe?"*

Requesting condom use raised concerns about trust in the relationship. If one of the partners suggests using condoms, the other partner would automatically assume that she or he is accusing her/him of having an outside relationship. An illustration is found in the extract below, from an interview of an unmarried woman aged between 26-34 years.

Extract 77

183 *I: How would you feel if he asked first that you guys should use a condom when you got*
184 *back?*
185 *P: I would also want a reason as to why we should use a condom. I wouldn't understand if*
186 *he were to suspect that I am cheating or something. I would like to know exactly why he says we*
187 *should now use a condom.*

Below is an extract from a focus group of men aged between 35-45 years. These men explain that in long-term relationships, there is 'too much' trust (line 348), as well as an acceptance that the trusted partner would not put the other at risk of HIV infections. As a result of this, requesting condom use leads to suspicion.

Extract 78

346 *I: Alright. People who are in long-term relationships, do they worry themselves about these risks,*
347 *like do they think about these risks and dangers?*
348 *P1: No, when they have gone out for a long time, it's the same like they trust each other too much*
349 *now and so they don't even think about putting each other at risk.*
350 *P2: Sometimes when you just come out and you want to use a condom now, she asks you*
351 *what's happening now, we were not using a condom before, what have you heard about me> then*
352 *there starts to be fights now in the house.*
353 *I: mm. Yes, what does it mean to protect ourselves when we have been in a long-term*
354 *relationship? Like what does that mean, what does safe sex mean for people in long-term*
355 *relationships?*
356 *P2: Um, the reason for that, if you have taken those steps, you find that the woman is*
357 *suspecting you.*

In the following extract from an interview with an unmarried man in age range 45-60 years, the participant explains how it was difficult for him to introduce condom use in his relationship because his girlfriend thought that he was accusing her of "*doing inappropriate things*". This may have been interpreted to mean that she may have another relationship in addition to the acknowledged one. The participant explained that every time he introduced condom use, the girlfriend felt that he was undermining the trust in the relationship (lines 66-67).

Extract 79

51 *I: So this time you were still together, did you ever speak about sexual risks, like*
52 *the risks that you get from having sex?*
53 *P: mm mm Yes. we used to talk about those.*
54 *I: Ok, so maybe what did you used to say?*
55 *P: ((chuckles))*
56 *I: ((laughs)) What are those risks?*
57 *P: ((laughs)) No, I mean we didn't used to use a condom.*
58 *I: Yes.*
59 *P: Ja, otherwise it was her; she didn't even want to see a condom.*
60 *I: Ok.*
61 *P: She was saying that I am thinking badly of her.*

62 *I: Ja.*
63 *P: Because mos I met her when she was at that age and she was also just continuing*
64 *with her own life.*
65 *I: Ja.*
66 *P: So when I used to talk about that ,it became as if I don't trust her, like I suspect her*
67 *that she has something.*
...
76 *I: Ja ok, I hear you. So you were the one that raised the topic that we must use a*
77 *condom?*
78 *P: Yes, to such an extent that it became the main reason for our arguments.*
79 *I: mm mm*
80 *P: It became like I was suspicious of her or maybe she is doing inappropriate things.*

Another strategy that couples used to minimise the risk of HIV was going for HIV testing and disclosure of prior HIV status. For some participants, HIV testing was an alternative to the use of condoms in managing sexual risk.

4.4.2 HIV testing

HIV tests and disclosure of prior HIV status were reported as an HIV risk-reducing behaviour among participants. Participants said they were testing regularly to ensure that they knew their status. As soon as people found out that their status was negative, they stopped condom use. In the following extract from an interview of an unmarried man aged between 26-34 years, the participant explains that HIV testing is another way to practice safe sex if one does not want to use condoms. He says people could get tested to find out if they are "*clean*" (lines 90 and 93) meaning HIV negative; if so, then they can stop the use of condoms.

Extract 80

85 *I: Mm okay (.) so in your knowledge, are there any other ways of practising safe sex*
86 *without using a condom?*
87 *P: Yes there but I do not know how safe it is. That would be to go get tested first if ever we*
88 *do not want to use a condom.*
89 *I: Okay.*
90 *P: We could go get tested to see if she clean and I am clean. Even with that, we cannot just*
91 *test once. We have to at least go again.*
92 *I: So after you get tested for the second time and the results come out negative?*
93 *P: And they come out saying we are clean?*
94 *I: Yes, you are clean; what is going to happen after that, because you do not want to use a...*
95 *P: A condom.*
96 *I: Yes.*
97 *P: With us, even with the person who will be testing us, let us say a nurse, we would have*
98 *told her that we intend on stopping using condoms.*

Another extract of this view is from an interview of an unmarried man aged between 26-34 years. The participant agrees that they talk about the sex risk in their relationship and says he mentioned HIV testing to his partner as an alternative to the use of condoms. However, he emphasises that if sex happens outside the relationship, then they must use "*gloves*" (line 200), meaning condoms.

Extract 81

198 *I: Mm ok...ok so when you* [and your girlfriend] *talk about* [sex-related] *risks, who*
199 *is the person that usually initiates the discussion, when you talk about risks?*
200 *P: ... <You mean like when people do not use "gloves"* [condoms]*>?*
201 *I: Yes.*
202 *P: Hmm well yes uh >I have sometimes mentioned it myself< in fact I asked her "Ok*
203 *we can use these 'plastics'* [condoms] *but perhaps if we were to get tested together, we could*
204 *then stop using them. You can then stop using them, but only if you know that you will not be*
205 *doing anything elsewhere or if you do as long as you use 'gloves'. I might not be here and*
206 *you may want to do something with someone else, just make sure you use 'gloves'" She went*
207 *there but she did not tell me that she was going; she only showed me the results after she had*
208 *been there. She was not actually the first one to show me that, I had also seen it with the first*
209 *one that I had been with at the time that she was pregnant. I guess she had been tested there*
210[at the clinic] *and –*

Many of the participants seemed to have started to substitute condom use with HIV testing. They go for testing to avoid the use of condoms. An example of this is presented in the extract below from an interview of an unmarried man aged between 26-34 years; he indicated that he and his partner went to be tested because they were tired of using condoms. This extract also shows that people prefer injectable contraceptives to prevent pregnancy (lines 190-191).

Extract 82

189 *P:...After four months (.) I suggested that we*
190 *go get tested together because I was tired of using a condom. She will continue to go*
191 *for her injection* [unclear].
192 *I: Oh okay, okay. So you did not want to use a condom anymore?*
193 *P: Yes, I did not want to use a condom.*

The following extract, from a focus group of young women aged between 18-24 years also indicated that people go for testing to avoid condom use. They claim that condom use is "*not nice*" (line 1261); therefore, it is better to get tested and not use condoms.

Extract 83

1254 *I: Ok what makes you, let's* [say] *here you are, you are having sex now and you say that it is*
1255 *chafing you. What do you think you could do that is better than telling him to stop using the*
1256 *condom?*

1257 *P1: You must go and test you see. That thing is right when you are like, you are going to stop*
1258 *using the condom but you are going to go and test first because isn't they say you must test how*
1259 *many times again?*
1260 *P2: Three.*
1261 *P1: mm Because a condom is really not nice so rather you go and test then. So that you*
1262 *cannot condomise then.*

Not knowing one's partner's status meant that you cannot be sure if your partner is negative. In the following extract from an interview of a young man aged between 18-25 years, he reveals that he has tested but he uses condoms "*all the time*" (line 77) because they have not been to "*get tested together*"(lines 77-78). He reported that he was aware of his own status but does not know his partner's status. This suggests that the participant would continue to use condoms until they both tested.

Extract 84

74 *I: Ok, ok, ok so (.3) ok do you use condoms when you, when you have sex?*
75 *P: Yes we use them.*
76 *I: O:k, ok how often perhaps, all the time when you sleep together or some of the time?*
77 *P: (.2) Ya let me say hayi all the time we use it, just because we have not yet gone to get*
78 *tested together*
79 *I: You have not yet gone to get tested?*
80 *P: No (.2) I go alone, you see.*
81 *I: And does she go?*
82 *P: On that part, I do not know, which is why I say I cannot be sure and so that's why I use a*
83 *condom.*

Disclosure of prior HIV test results decreased condom use. Participants who knew their own and their partner's HIV status were reluctant to use condoms. They used this knowledge as a justification for not using condoms. In the following extract from an interview of an unmarried man aged between 35-45 years, the participant showed his girlfriend the HIV test results which indicated that he was negative and then asked the girlfriend about her HIV results which she indicated were negative. He then decided not to use condoms (lines 36-37).

Extract 85

30 *I: Ok=o=ok eh* [pauses] *so now as people who have decided to get into this relationship,*
31 *did you perhaps discuss the options that are available in a relationship regarding sexual intercourse?*
32 *P: mm uh... The first time that she came to my house, I tried to come to an understanding*
33 *with her about that and I requested that we use a condom before we 'see' each other, you know*
34 *that I had recently had some blood drawn* [tested]*, uh at the end of January and I found that*
35 *everything was fine, so we continued, you understand, and she did not have problem with that so I*
36 *then asked whether she had been to get her blood drawn and I showed her my results which*
37 *indicated that I was fine, you understand. She then said that her results were at her home and I did*
38 *not ask her to produce them. So I then decided that I did not need a condom and we had sexual*
39 *intercourse without a condom.*

Another illustration of this was found in the extract below from an interview of an unmarried man aged between 26-34 years. The participant says his girlfriend got tested for HIV when pregnant and showed him the results (lines 200-201). He was then motivated to go and test for HIV himself and found that he was HIV negative so decided to stop using condoms with her (line 202) but use them outside the relationship (line 203).

Extract 86

200 *P: Yes when she was pregnant, when she came back from the clinic, she showed me the*
201 *results and so this one* [his current girlfriend] *showed me her results as well, so I also decided to go. I*
202 *found that I was negative but I was told to return after a certain time. I figured that I could stop*
203 *using protection and that we could just do it but when I am with someone else. I use protection. It*
204 *happens occasionally when I go out or I meet someone else, somewhere else but I use protection. Like*
205 *I said to her, if something like that were to happen with her, she ought to use protection. I will*
206 *not really know what happens but the choice is hers. Just like I know that with other women, I will use*
207 *protection, she must also know that with other men, she must use protection.*

However, many women reported having gone for HIV testing due to pregnancy, rather than because they were initiating finding out about their HIV status. This is found in the following extract from an interview of an unmarried woman aged between 18-25 years.

Extract 87

396 *P: Me... I got tested now when there was the possibility that I was pregnant... °I was*
397 *pregnant you see.°*

Another example is found in the extract below, from an interview of an unmarried woman aged between 35-45 years.

Extract 88

427 *I: What made you to get tested?*
428 *P: The reason why I got tested is because I got pregnant with my child in 2006.*

Some women explained that their male partners depended on them finding out their status and then inferred their own HIV status from them. An example comes from the following extract taken from an unmarried woman in the age range 26-34 years. Knowing their partner's status was an excuse not to go for testing.

Extract 89

314 *I say he must go and get tested and he says if he did have it then I would also have it*
315 *seeing as I got tested when I was pregnant. He then says that means he does not have it.*

As already stated, the above thematic analysis was a preliminary step to provide a picture of the issues surrounding sexual activity in the research area. The next section presents the analysis of the data using Engeström's (1987) model of human activity. The main aim of this study was to analyse the data using Engeström's (1987) model of human activity to understand and explain the lack of sexual behaviour change in response to HIV and AIDS. This model allows for a deeper understanding of the complexity of sexual activity.

4.5 Data analysis using Engeström's model of the activity system

Engeström (1987) argued that an understanding of complex human behaviour requires an analysis of the activity. Therefore, understanding the complexity of sexual activity requires an analysis of sexual activity. To analyse the activity, Engeström (1987) generated a model of human activity - the activity system. Engeström's (1987) model of the activity system (see Figure 2.2) was used in the analysis of the data to understand sexual activity in the research context. Analysing activity in relation to the activity system helps to understand the way in which behaviour change takes place, or does not take place. Activity system analysis assisted in identifying the circumstances in which sexual activity and unsafe sexual practices could be understood. It also helped in recognising actions which may not be easily identified and understood through using other analytical methods. Engeström's (1987) model allows a deeper understanding of data. It allows the data to be analysed in terms of contextually embedded activity.

Using Engeström's (1987) model as an analytic tool, I described the activity system of sex in terms of its components: *subject* (the individual whose activity is being analysed), *object* (the motive of the activity), *outcome* of the activity (the results or consequences of the activity), *tools* (material or conceptual instruments), *rules* (norms and conditions which constrained sexual activity), *community* (the main reference point for subjects), *division of labour* (roles, responsibilities and power in the sexual activity). I first identified the subject and object, and then outcome, followed by an examination of the relations of the subject and the object as mediated by other components of the activity system, including tools, norms, rules, community and division of labour. This model allowed me to map the complex sexual behaviour in the research setting. The analysis of the data indicated the need to have different activity systems for different types of relationships and genders because of the different dynamics related to these aspects. The presentation of the study results is thus divided into four sexual activity systems which are as follows: unmarried man, unmarried woman, married man and married

woman. These systems emerged as significant for analysis because each of these categories presented different dynamics, thereby indicating the complexity of sexual activity.

The second step involved identifying the tensions and dilemmas faced by the participants in the sexual activity systems that indicated that contradiction was present. I focused on pinpointing how each component of the activity system affects the subject as they attempt to obtain the object and, eventually, the outcome. This helped with identifying the tensions within and between the components of the system and between activity systems. According to Engeström (1987), an activity system could experience four types of contradictions: primary, secondary, tertiary and quaternary contradictions. In the present study, three types of contradictions were identified: primary, secondary and tertiary contradictions.

As already stated above, the presentation of the study results is divided into four sexual activity systems. Each presentation begins with a brief description of the adapted Engeström's (1987) model. It then provides the model, followed by a brief description of the nature of the contradictions within and between the components of the activity system. The 'lightning lines' indicate the presence of tensions in the activity systems. Reference was made to theme sections and extracts which represent the tension(s) or contradiction(s) within and/or between activity systems. After this, there is a description of the contradictions between activity systems.

4.5.1 The sexual activity system of an unmarried man

This section draws on the accounts of unmarried men. The activity system in Figure 4.1 below captures the sexual activity system of an unmarried man in the rural research site. It is used to highlight the key components of the activity system and dynamics between them.

In the unmarried man's activity system of sex, there were several objects that were identified throughout the data. It was clear from the participants' accounts that the following were the objects of the activity system: being sexually active, sexual experience and sexual pleasure. For instance, many unmarried men complained that condoms reduce sexual pleasure. This was most clear in section 4.2.3, particularly extracts 10, 11 and 12 above, where male participants emphasised the need for sexual gratification.

The finding regarding rules includes peers' expectations that one must have a relationship, have multiple sexual partners and have sex in a relationship. This was evident in extracts 38, 40 and

41 above, where participants confirmed that for men, multiple sexual partnerships are common and indeed expected. It was also clear from the findings that unmarried men controlled sexual activity. This aspect relates to the division of labour component of the activity system. For instance, they were in control of whether condoms were used or not used in the activity. This was evident in extracts 53, 54, 55 and 56 above, which illustrate how women are submissive to their partner's sexual needs and desires.

The community of this activity system consisted of other unmarried men. An analysis of the relationship between the subject and the object of the activity system revealed identity as an outcome of sexual activity. Most unmarried men were sexually active, as those who were not in sexual relationships were ridiculed and called names such as *isishumane* (a reference to a 'shoemaker'), as stated in extract 42 above. Being sexually active was a source of identity or reputation among their peers. However, identity, the outcome of this activity, is affected by other negative outcomes of the activity system, such as HIV. The tools that mediated the activity were condoms, safe sex knowledge and messages, and HIV testing. This is evident in extracts 71, 72, and 73 above, where participants said that they commonly use condoms at the beginning of the relationship but for some, once they tested negative for HIV, condom use was no longer necessary (see extract 83 above).

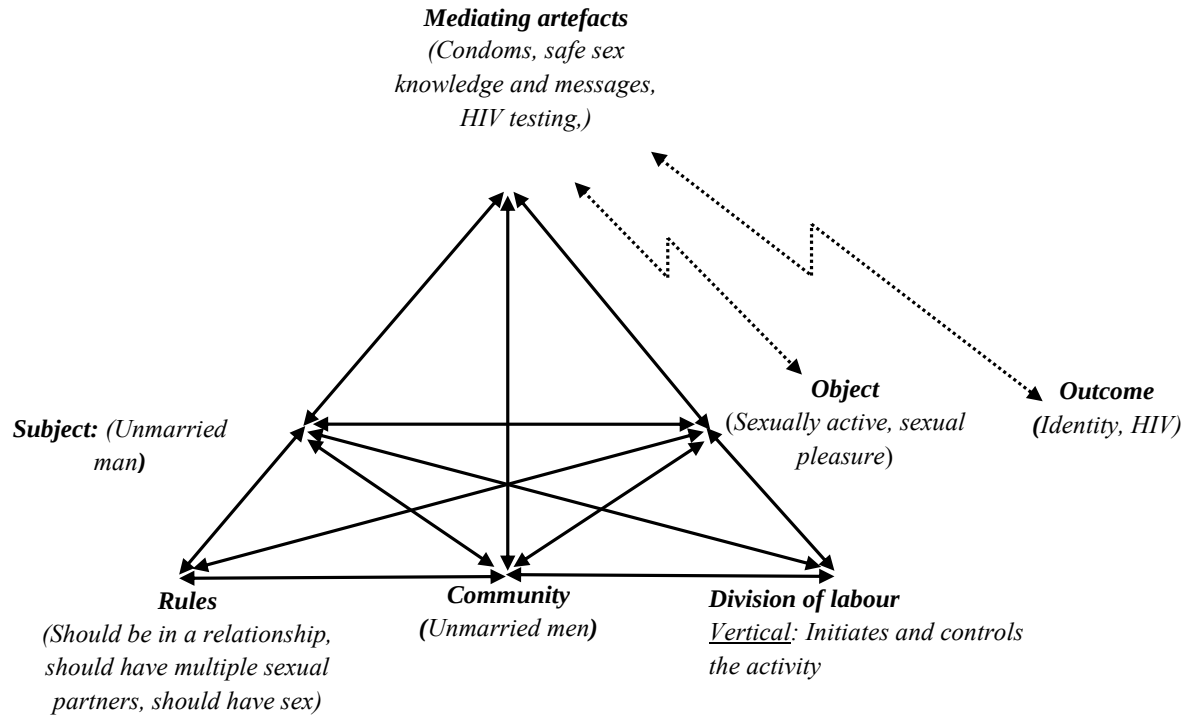

Figure 4.1. The model of sexual activity system of an unmarried man.

An examination of the data suggested the presence of tensions in the activity system of sexual activity of an unmarried man. The major tension noted from analysis of interviews and focus groups is between safe sex knowledge (and messages which encourage abstinence) and the expectations of an unmarried man to be sexually active and to engage in multiple partners. As suggested above, the number of sexual partners an unmarried man has, provided him with power and status among peers. The extract reflecting this tension is extract 42 above where a participant argued that "*you will never like being called* isishumane".

Despite information and knowledge on how to prevent HIV infection, the need to demonstrate virility amongst peers may prevent unmarried men from rejecting risky sexual behaviours. This becomes a dilemma for unmarried men: an unmarried man can stay away from sexual relationships, but he might not want to because he is concerned about how he will be perceived by his peers. This tension presents a secondary contradiction between the components of the mediating tools (safe sex knowledge and messages) and components of the norms/rules, which expect unmarried men to be sexually active and have multiple partners. It is a weak tension because many unmarried men seem to be sexually active and involved with multiple partners. This was seen most clearly in section 4.3.3 (extracts 40 and 41), where participants argued that

having multiple sexual partners gives one a good reputation. An unmarried man is aware of the advantages of staying away from sexual relationships but has much at stake in terms of his status.

There was also tension between the component of the mediating tool of the condom and the object of the activity, sexual pleasure. For unmarried men in this study, having sex was for pleasure purposes and condoms were seen to reduce sexual pleasure. This was most clear in extracts 10, 11 and 12 (in section 4.2.3) above, where male participants argued that condoms reduce sensation. It seems most unmarried men felt that condoms reduce the pleasurable sensations of sex. This creates a dilemma because unmarried men are aware of condom use as protective health behaviour and may not practice safe sexual behaviour if it takes away their gratification. The decrease in sensation when using condoms creates a barrier against actively choosing protected sex.

This tension is a manifestation of a secondary contradiction between the component of the mediating tool of the condom and the object of the activity, sexual pleasure. The tension is also weak because many unmarried men are not willing to use condoms consistently, particularly with their regular partner, because they decrease sexual pleasure. Long-term relationships were considered risk free because known partners were considered safe partners. This was most clear in extracts 71, 72 and 73 in section 4.4.1 above, where participants indicated that they had used condoms only at the beginning of the relationship because they did not yet know each other.

4.5.2 The sexual activity system of an unmarried woman

The activity system in Figure 4.2 below illustrates the sexual activity system of an unmarried woman. It captures the unmarried woman as the subject engaged in sexual activity to show love and to hold on to the sexual partner as the objects. An analysis of the relationship between the subject and the object of the activity system revealed identity as an outcome of sexual activity. The more predominant outcomes of this activity were reputation among peers (identity) and the negative outcome of being infected by HIV. Unmarried women engaged in sexual activity to hold on to sexual partners, as is seen in the use of the sentence "*I don't want to be left alone*" (sections 4.3.7 and 4.3.8 above). They did this because having a sexual partner provided them with status and power among their peers. From the analysis of the transcripts, norms that guide this activity include holding on to a sexual partner and having sex in a

relationship. This was most clear in the sections 4.3.7 and 4.3.8 above, where female participants indicated their fear of insisting on condom use because this may lead to loss of a partner.

The analysis shows that the tools which mediate this activity include condoms, injectable contraceptives, safe sex knowledge and messages, and HIV testing. Many unmarried women mentioned being on injectable contraceptives to prevent pregnancy. An example of was seen in extract 82, where the participant preferred the use of injectable contraceptives to prevent pregnancy to the use of condoms. Unmarried women were concerned about the risk of HIV infections, as stated in section 4.3.7. They mentioned HIV testing as way of knowing each other's status and used this knowledge as a justification for non-use of condoms. This was most clear in extract 89, where the participant indicated that she had known her HIV status during pregnancy. This activity is situated in the community of unmarried women. Unmarried women were submissive to their male sexual partners in the activity, as seen in section 4.3.7; their sexual activity was governed by their male sexual partner's desires. For instance, many unmarried women raised the idea of condom use, but in most cases it was not used if the male partner was against its use. These aspects relates to the division of labour component of the activity system.

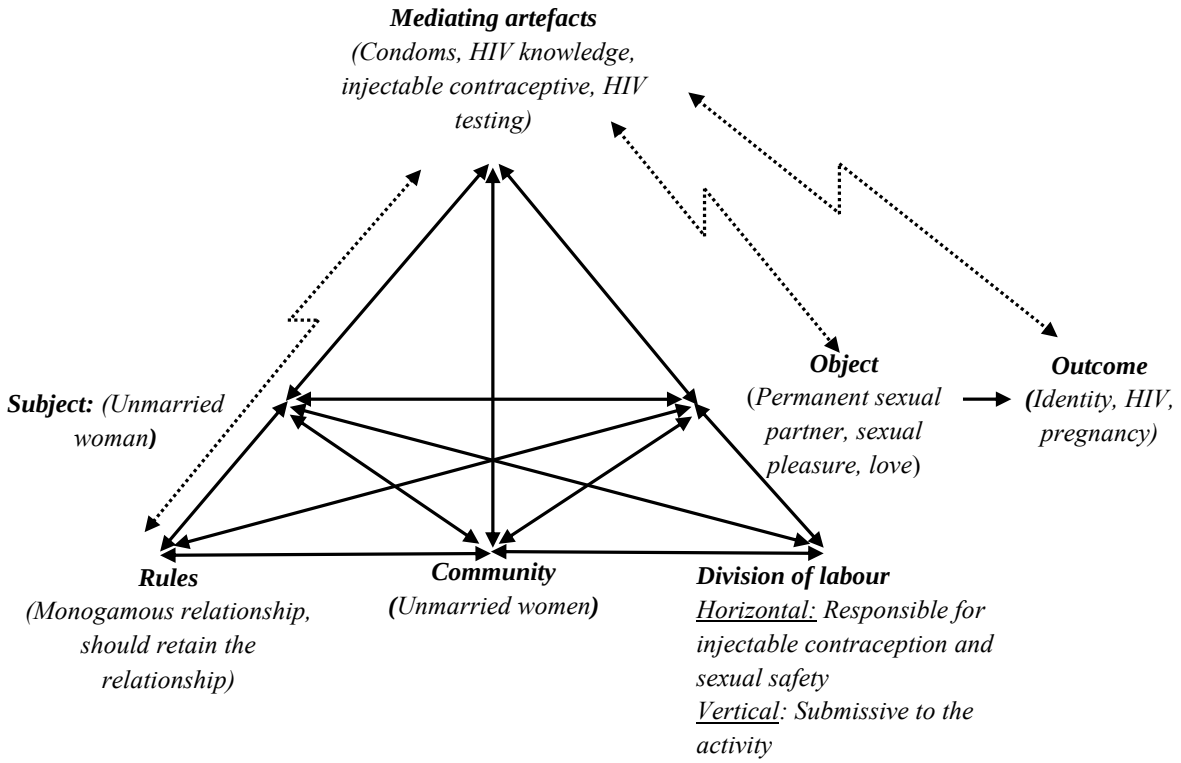

Figure 4.2. The model of sexual activity system of an unmarried woman.

The analysis suggested the manifestation of tensions in the activity system of sexual activity of the unmarried woman. The unmarried woman is faced with tension between the object of the activity, love, and the mediating tool, the use of condoms. For unmarried women, sex was viewed as a way of showing love and commitment to the partner. This was evident in extracts 67 and 68 above, where participants suggested that love and sex are the same things by saying "*I will never know how much I really love him unless I sleep with him*". Thus, condom use was perceived as inappropriate when having sex with someone with whom one is in love.

Insisting on the use of condoms challenged the unmarried women's expression of love to their partners. This was evident in extracts 69 and 70, where participants indicated fear of jeopardising the possibility of love through insisting on condom use. This creates a dilemma as it might mean that couples discontinue the use of condoms in order to show love to one another. This tension is a manifestation of the underlying secondary contradiction between the object of the activity, love, and the mediating tool of the condom. It is a significant tension because many unmarried women perceived themselves at great risk of HIV infection due to their partner's infidelity (as stated in extract 38 above) but felt that they could not insist on

condom use because it may lead to them losing this partner.

There was also a tension between the object of the activity (having a permanent partner) which is tied to woman's identity, and the mediating tool of the condom. For many unmarried women in this study, losing a sexual partner means loss of power and status within their peer group. So, in most cases they avoided condom use, and the confrontations related to this, in order to maintain a steady relationship; this is seen in section 4.3.7 (extracts 60, 61 and 62) and section 4.3.8 (extracts 69 and 70) above. Although many women showed concern about the risk of HIV infections, they were also concerned about maintaining a stable relationship. This presents a dilemma as the risk of losing a sexual partner may outweigh the risk of HIV infections. This tension is a manifestation of the underlying secondary contradiction between the object of the activity (having a permanent partner) and the mediating tool of the condom. It is a major tension because unmarried women recognise the risk of HIV infection due to unprotected sex but cannot insist on condom use because condom use compromises their desire to have a relationship.

Another tension was between the component of the mediating tool of the condom and the component of the norm of 'trust' in a long-term relationship. In long-term relationships, unmarried couples come to trust that their partner will be faithful and therefore the couple might not use condoms. This was most clear in extracts 72, 73 and 74 in section 4.4.1 above. In these relationships, the risk of HIV infection is not seen as great and there is a belief that the trusted partner would not put the other at risk in this way. Requesting condom use, in these relationships, is associated with unfaithfulness. This makes initiating and negotiating condom use a dilemma for people in these relationships because it threatens this trust which is assumed. This was seen in extracts 78 and 79 above.

However, it was clear that infidelity was common in this community, particularly among men (as was most clear in sections 4.3.3 and 4.3.2), suggesting that people in long-term relationships might be at high risk of HIV infections. This tension is a manifestation of the underlying secondary contradiction between the component of the mediating tool of the condom and the rule/norm component of 'trust' in long-term relationships. It is a weak tension because long-term relationships are still relationships where partners trust each other and do not use condoms.

4.5.3 The sexual activity system of a married man

The activity system in Figure 4.3 below illustrates the sexual activity system of a married man. The subject in the analysis is a married man. From the analysis, a married man is engaged in the activity with the object of having children and sexual gratification. This was most clear in extracts 20, 21, 22, and 24 in section 4.3.1 above, where many participants argued that marriage is meant to produce children. Married men did not specifically mention sexual pleasure as the object of the activity; however, it was clear that sexual activity was not always for procreation but also for pleasure purposes.

The tools available for mediating this activity were condoms, HIV testing and safe sex knowledge and messages. As stated in section 4.2.1 above, all married men in this study indicated awareness of HIV and AIDS, and HIV prevention, and where and how one can be tested for HIV. The findings regarding the norms and rules that guide this activity are that a married man should have children in a relationship, should not use condoms with their wives and can have relationships out of the acknowledged relationship. These aspects were evident in section 4.3.1, where participants argued that condoms are inappropriate for married couples because marriage is meant to produce children and in section 4.3.2, where married women acknowledged their husbands' outside relationships. The community of this activity includes other married men.

An analysis of the relationship between the subject and the object of the activity system highlighted identity as the significant part of the outcome of sexual activity. The ultimate outcomes of this activity are masculine identity and becoming HIV positive. Sexual activity produces a virile identity for men. According to many participants, a married man demonstrates his virility through having children. As was seen in section 4.2.6 above, it was clear from the participants' accounts that the married man was responsible for controlling the activity. Married women indicated yielding to their husbands' sexual desires, even if there was a risk of HIV infection. This aspect relates to the division of labour component of the activity system.

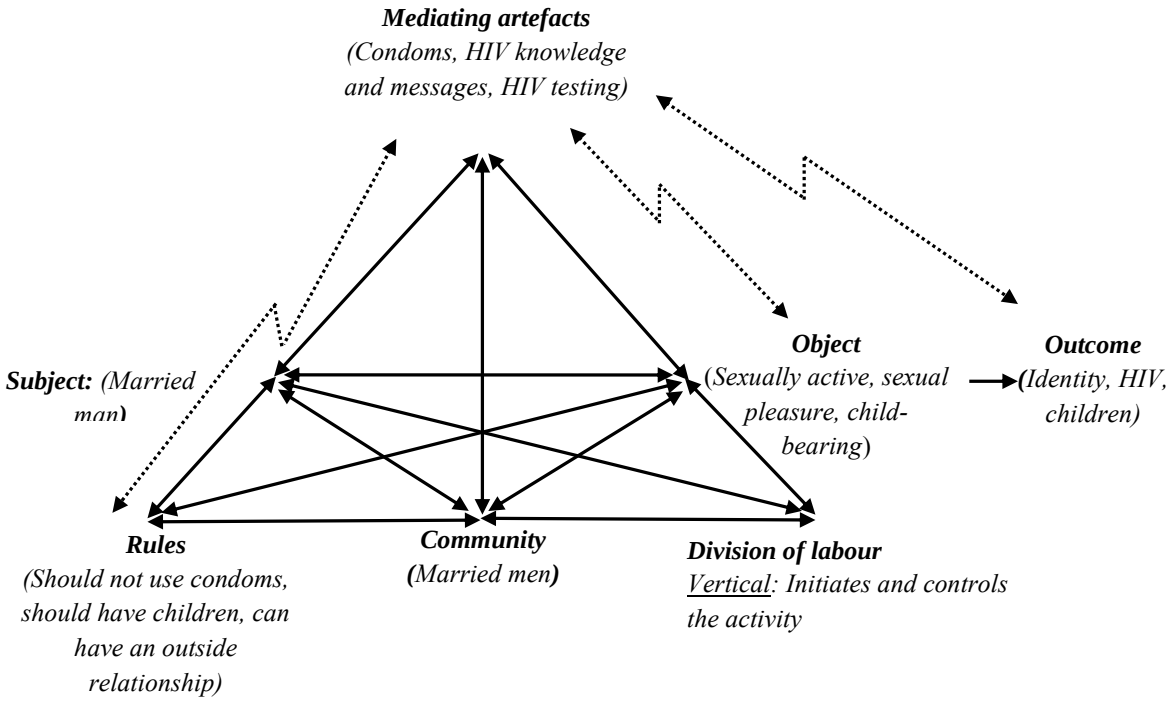

Figure 4.3. The sexual activity system of a married man.

The data suggested the presence of tensions in the sexual activity system of a married man. The first tension is between the object of the activity, child-bearing, and the mediating tool of the condom and this tension relates to identity and reputation. This study reveals that the status of married men depends on child-bearing ability; this was seen in section 4.3.1 (particularly extract 23) above, where the participant explains that without child-bearing, there would be a concern of infertility. However, condom use, which is meant to prevent HIV infections, also prevents child-bearing. This creates a dilemma for a married man because he is expected to have children.

Many participants, both men and women across all ages, argued that condoms are inappropriate for married couples because marriage is meant to produce children; this was seen most clearly in the statements that 'marriage is children' in extracts 20, 21, 22, and 24. This makes it difficult for people in marriage relationships to negotiate condom use. The expectation that the couple should have children may outweigh the risk of HIV infection. Fertility and procreation in marriage are highly valued, and condom use prevents conception. This tension generates a secondary contradiction between the object of the activity, child-bearing, and the

mediating tool of the condom. However, this tension is weak because condom use is not a norm in marriage relationships. The tension is not significant enough to create a crisis in the system because the activity continues without much disturbance.

Another tension is within the rules and norms, between 'trust' and the tolerance of an outside relationship. Marriage is assumed to be about trust and therefore people view condom use as inappropriate in marriage relationships. A trusted partner is perceived as safe and risk free, and it is believed that he or she would not put the other partner at risk of HIV infections. However, there were many comments that countered the view that people in marriage can be trusted, particularly husbands. This was most clear in section 4.3.2 (extracts 29, 30, 31, 32 and 33), where most married women argued that there is a need for married couples to be concerned about sexual safety because of a lack of trust in their partner.

The risk of HIV infections in marriage was associated with infidelity. Married men were assumed to have sexual relationships outside of marriage and this seemed to be tolerated because some married women even advised their husbands to use condoms if they had an outside relationship (as illustrated in extracts 34 and 35). The possibility of another sexual partner put the couple at high risk of HIV infections. This creates a dilemma for married men because they are expected to be trusted partners but they also know that their infidelity is tolerated and accepted. This tension presents a primary contradiction within the rules/norms, between the trust and the tolerance of an outside relationship. This tension is a weak tension because the activity continues without much disturbance. Married men continue to engage in sexual activities with people outside of their marriage (as illustrated in section 4.3.2).

4.5.4 The sexual activity system of a married woman

The activity system in Figure 4.4 below illustrates the sexual activity system of a married woman. The married woman is the subject of the analysis. From the analysis, the objects of this activity are to retain the relationship and to have children. Married women in this study argued that they put up with the risk of HIV infections to maintain a good relationship (see extracts 25 and 26 above). The tools identified to mediate this activity were condoms, HIV testing, and safe sex knowledge and messages. Married women were aware of HIV and AIDS and its prevention strategies. Some indicated having talked to their husbands about the use of condoms in outside relationships (as illustrated in extracts 34 and 35). Some said that they had done HIV testing.

An analysis of the relationship between the subject and the object of the activity system highlighted identity (related to having children) as significant outcome of sexual activity. However, being infected by HIV was also an outcome of the activity. A married woman's identity is attached to child-bearing and keeping her marriage. This was most clear in section 4.3.1 in which participants justified non-use of condoms by referring to the expectation of child-bearing in marriage. The informal rules for this activity were that married women should have children, they should be trustworthy (that is, not engage in sex with other partners outside of the marriage relationship) and should not use condoms with their husbands. This was most clear in extracts 20, 21, 22, and 24, where participants argued that condoms are inappropriate for married couples because marriage is meant for children. The community for the subject of this activity includes other married women. It was clear from the participants' accounts that a married woman was submissive to her husband in the activity (see section 4.2.6 above). Women's other 'role' was to take responsibility for initiating condom use, evident in extract 6 in section 4.2.3. These aspects relates to the division of labour component of the activity system.

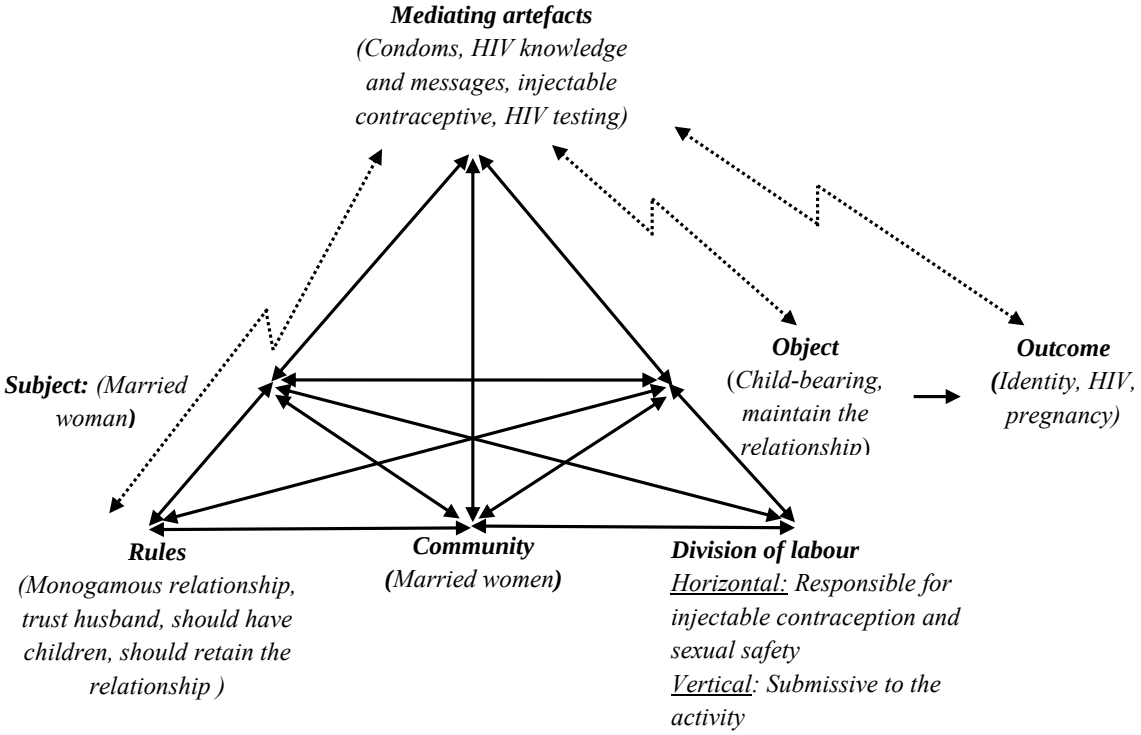

Figure 4.4. The sexual activity system of a married woman.

From the analysis of the data, the following tensions were observed in the sexual activity system of a married woman. The first tension is between the object of the activity, child-bearing, which relates to identity, and the mediating tool of the condom. Child-bearing is viewed as a critical part of marriage. For many married women, their identity is tied to their ability to bear children. Being able to bear children provides a married woman with a positive social identity. If she does not bear children, there is usually a concern about infertility. This is evident in extract 23 in the words of the participant who stresses the need for sex in marriage relationships: "*it will be like there is one of you who is infertile*".

Many participants, both men and women, believed that condoms are not supposed to be used in marriage as marriage is meant for procreation (extracts 20, 21, 22, 23 and 24 above). Condoms were seen as inappropriate for married couples. This presents a dilemma, because condom use is necessary for protection against STI infections but also to prevent pregnancy. This tension is a manifestation of a secondary contradiction between the object of the activity, child-bearing, and the mediating tool of the condom. However, this tension is weak because condom use is still not seen as acceptable in marriage.

There was also a tension between the informal rule of 'trust' and the mediating tool of the condom. Married couples were assumed to have more trust in each other than unmarried couples. This was most clear in extract 27, where it was argued that it is important to be worried about condom use with a partner to whom one is not married because you cannot trust one another when you are not married. Due to the fact that marriage is about trust, fidelity was assumed; therefore, condom use was seen as not necessary. This creates a dilemma, because suggesting condom use threatens the trust of the partners in each other.

Many married women may perceive themselves to be at risk of contracting sexually transmitted infections. However, it is difficult for them to negotiate condom use, even when they see the need, because suggesting condoms would raise the possibility of mistrust (as seen in extracts 25 and 26 above). Thus, married women tend to avoid suggesting condom use in their sexual relationship and they continue to engage in unsafe sex practices in order to maintain the relationship and not threaten it in any way. This tension is a manifestation of a secondary contradiction between the informal rule or expectation of trust and the mediating tool of the condom. It is a significant tension because many married women expressed a concern about lack of trust in marriage, particularly due to their husbands' infidelity. This was

seen most clearly in extracts 29, 30, 31, 32, where many married women argued that marriage does not guarantee trust. They emphasised that married couples need to use condoms because one cannot guarantee that one's partner is being faithful.

4.5.5 Tertiary contradictions

From the analysis of the data, tensions were also observed between the sexual activity systems of men and women. The man's sexual activity system is connected to that of the woman's sexual activity system with all of its components; therefore, neither activity system can be studied in isolation. The tensions that manifest between the two sexual activity systems are tertiary level contradictions. The apparent tension is between the objects of the man's sexual activity system and the objects of the woman's sexual activity system. Men identified their objects of the activity system as being sexually active, obtaining sexual pleasure and procreating. Women identified their objects as desire for a relationship, desire for love and procreation. These objects, although different, are geared towards the outcome of identity. For both men and women, identity is the most essential outcome of the sexual activity system. If the objects of men are sexual pleasure and being sexually active while for women they are being in a relationship and being loved, then there is clearly a tension between the activity systems.

Maintaining the relationship was the key identity object for women because many risked HIV infections to hold on to their partners. This is most evident in sections 4.3.7 and 4.3.8, which reflect that women have great concern for sexual safety but risked HIV infection because they were concerned about maintaining the relationship. The mediating artefact of the conceptual system of HIV risk seems to be stronger for women. Although many women attempted to initiate condom use, they did not persist in their request when their male partner refused to use a condom, because the man had more power in the relationship.

The power dynamics within the division of labour in which men control the sexual activity and women submit to male control had an effect on how sex happens. Even though the mediating artefact of the conceptual system of HIV risk is strong for women, it does not affect the man's sexual activity system because women have less power in the activity. This means that these contradictions are in an early stage of maturity because the woman's sexual activity system does not create a crisis for the male partner which would generate a change in the system. The power dynamics within the division of labour sustain the tension between the objects of a

man's sexual activity system and the objects of a woman's sexual activity system.

The analysis highlights some distinctions between married and unmarried people. In both married and unmarried people there was a significant power difference between a man and a woman. However, a married man had more power and authority than an unmarried man in the sexual relationship. This was evident in cases where married women felt it would be difficult for them to request the use of a condom or negotiate condom use with their partner (as seen in extracts 53 and 55 above). The participants indicated powerlessness in initiating condom use with their husbands because the husband is in control of how sex happens. However, with unmarried couples, many women attempted initiating condom use even though few said managed to make it happen (as seen in extracts 57, 58 and 59 above).Thus, the contradictions within married people's sexual activity systems are in an early stage of maturity and are relatively stable compared to unmarried people's sexual activity systems.

4.6 Summation

This chapter presented the results of this study. The results showed that people in *Ematyholweni* are aware of the risk of HIV and AIDS and also have a basic knowledge about HIV and AIDS and prevention. However, dilemmas that they experience in sexual activity, and the related tensions and contradictions, do not lead to sexual behaviour change. It was evident that women experience many more dilemmas than men in their sexual activity systems. The results show that the main risk-reducing behaviour among participants was the assumption of trust. Assuming that they could 'trust' their partner meant that condoms would not be used; however, this was problematic because the data also indicated the presence of infidelity.

Other issues that mediated condom use were related to identity formation. Sexual practices reflected what it means to be a 'proper' man or woman: their reputation. These present different positions when it comes to sexual interactions. These gender-appropriate positions were revealed in a number of ways including tolerance and acceptance of male infidelity, and yielding and submitting to the male partner's control. The male partner's attitude towards condom use was the key hindrance to condom use.

Chapter 5 will discuss these results in more detail in relation to the aims of the study, previous findings in the field of HIV and AIDS and behaviour change, and also in relation to the framework of this study, activity theory.

CHAPTER 5: DISCUSSION

5.1 Introduction

This study examined the tensions, dilemmas and contradictions militating against the adoption of risk-reducing sexual behaviour among *Ematyholweni* residents. It intended to explore the response to HIV and AIDS among *Ematyholweni* residents. The main aim was to understand the different dilemmas and tensions within sexual relationships as they related to condom use and safe sex practices. It aimed to explore whether and how these tensions and dilemmas relate to contradictions in the sexual activity systems.

The findings will be explained, integrated and compared to the studies and information in the literature review. This chapter will attempt to show how and why people in *Ematyholweni* continue to engage in risky sexual practices. Activity theory provides a helpful theoretical basis through which to understand tensions and contradictions within the activity system, as well as the lack of behaviour change.

The discussion will be divided into three sections. The first part of the chapter discusses HIV and AIDS awareness, knowledge and response to HIV and AIDS among the residents of *Ematyholweni*. This section focuses on whether people know about HIV and AIDS and prevention, and their responses to this knowledge. The second section will focus on the dominant sexual behaviours among people in *Ematyholweni*. The third section will discuss the risk-reducing behaviours among people in *Ematyholweni.* This section will elaborate on tensions and dilemmas within sexual relationships related to condom use and safe sex practices, and how these tensions are related to contradictions.

5.2 Response to HIV and AIDS and condom use

Condom use still remains the most effective HIV and AIDS preventive strategy (Bird et al., 2001; Erinosho et al., 2012S). The findings of this study revealed that there was awareness of HIV and AIDS among participants. They were also aware that condoms were the best method of protection against HIV and AIDS infections, as well as against pregnancy. Many of the participants seemed to know and acknowledge this by calling it the "*number one way"* to protect themselves. These results are similar to those of MacPhail and Campbell (2001), Preston-Whyte (1999) and Maharaj and Cleland (2005), who also reported that people see condom use as the main form of HIV prevention. However, this acknowledgment did not mean

that condoms were used in relationships.

The results of this study show that people, especially men, do not like to use condoms. If people do not like condoms, particularly men, there is little possibility that they would be used within a sexual relationship (Flood, 2003). Men of all ages and young women said condoms reduced sexual pleasure; were uncomfortable and caused rashes on their private parts; they also said condoms were unreliable as they can break during sexual intercourse. These complaints have been widely documented in previous studies (Browne & Minichiello, 1994; Chimbiri, 2007; Flood, 2003) and were used by some participants in the present study as reasons for not using condoms. According to Flood (2003), problems such as rupturing of condoms during sexual intercourse decrease confidence in this method and discourage its use.

The study also found misconceptions and inaccuracies, held particularly by men, about HIV and AIDS. For instance, some men believed that HIV infections can be prevented by washing immediately after sex. This incorrect notion might lead people to think that they are not at risk of HIV infection; therefore, they might engage in risky sexual behaviours. The next section discusses the dominant sexual behaviours among people in *Ematyholweni* to provide a picture of sexual risk in this community.

5.3 Dominant sexual behaviours in *Ematyholweni*

Although people in *Ematyholweni* are aware of the risk of HIV and AIDS, their dominant sexual behaviours include risky sexual behaviour such as multiple sexual partners, extramarital relations, casual sex, inter-generational sex and unprotected sex. Despite the awareness of HIV risk, people are not responding to the safe sex messages. These issues are discussed below.

5.3.1 Demonstrating reputation and virility

Sexual activity is a very important element of manhood (Frank et al., 2008; Van der Riet, 2009). For many men in this study, sexual activity was related to the social construction of manhood. Sex was about their reputation. Men in this study demonstrated their manhood through being sexually active, having multiple sexual partners, not using condoms and having children. Having a variety of sexual partners was perceived as important for the reputation of men. In the research context, having multiple sexual partners positioned them as 'proper' men. Men with multiple partners were termed '*udlalane*' or '*isibethi*' (players) and this gave them power and status amongst their peers. These terms were used to compliment men with multiple

sexual partners. This is consistent with Varga's (1997; 1999) studies in KwaZulu-Natal where a man demonstrating multiple sexual conquests was termed *'isoka'*, giving him a positive social status.

This shows that men often feel the pressure to engage in sex and multiple sexual partnerships in order to uphold the desired image of manhood. This desire is often felt as if it is an individual and personal desire but it does not originate within the individual but in the system (Van der Riet, 2009). Seeing one's peers having multiple sexual partners makes it seem normal and desirable. Reddy and Dunne (2007) argue that a man's failure to have sexual experiences can lead to stigma within peer groups. This was reflected in this study by the use of the *isXhosa* term *isishumane* (a shoemaker), a belittling and shameful name for a man not having sexual partners or having just one sexual partner (Van der Riet, 2009). Thus, men who did not have multiple sexual partners were stigmatised and ridiculed by their peers. However, the notion of manhood associated with multiple sexual partners exposes men to an increased risk of HIV (Reddy, 2004).

According to Hollway (1984, p. 232), "men's sexuality is understood through the male sex drive discourse: they are expected to be sexually incontinent and out of control - 'it's only natural'". Having multiple sexual partners enables men to be positioned as subjects in the male sex drive. Male sexuality is seen as natural and therefore cannot be inhibited. Participants believed that men's infidelity was common and inevitable. Men were perceived as people who are unfaithful and unable to be with only one woman. This presents dilemmas and tensions for men's sexual safety. Safe sex messages which encourage abstinence and one sexual partner may be felt as inappropriate for their concept of manhood. These tensions are within the outcomes of the activity, namely identity and HIV. Thus, many men's sexual health is limited by the construction of masculinity because they want to be perceived as 'proper' men.

According to Leclerc-Madlala et al. (2009), multiple sexual partnerships have been recognised as one of the key behaviours that increase vulnerability of people to HIV infection in South Africa. It is common even when people are married (Van der Linde, 2013). The results showed that in *Ematyholweni*, there was tolerance and acceptance of men's multiple sexual partnerships, which was perceived as part of manhood. There was a common belief among both men and women that men are naturally programmed to need sex and cannot control their natural sexual urges. This shows that people draw on the male sex drive discourse in which

men are seen as having a high sex drive which they are unable to control (Hollway, 1984).

Eaton et al. (2003) argue that women implicitly endorse male multiple sexual partners as they often do not expect to be the only sexual partner and they do not question this. The findings of this study show that approval of this behaviour creates tensions and dilemmas within the norms/rules of the sexual activity system, according to which the male partner is expected to have an outside partner and also to be monogamous. It was difficult for women to question, confront and challenge their male sexual partners about their outside partners even when they suspect infidelity. It can be argued that positioning men as always wanting sex exposes both men and women to the risk of HIV infection.

Multiple sexual partnerships were also influenced by alcohol consumption. For many people, entertainment usually involves alcohol consumption. The majority of men in this study said it was easy for them to engage in sexual relations with other partners in places where alcohol was consumed. This is consistent with several studies (Erinosho et al., 2012; Fisher et al., 2007; Morojele et al., 2005) which found that alcohol intake increases risky sexual behaviour. Some men said they leave their primary partner at home and find themselves being sexually involved with other partners when drunk. There was a belief among participants that when men are drunk, they could not control with whom, how and where they had sex.

Most of men said that they used or would use condoms with a casual partner. This is consistent with Varga (1997) and Preston-Whyte (1999), who found that casual sexual relations were not seen as genuine relationships; therefore, it was easy to negotiate and use condoms. Erinosho et al. (2012, p. 121) argue that "alcohol is a catalyst for risky sexual behaviour" as it may impair the judgment required to make decisions about safe sexual practice. There was substantial evidence in the data that casual sex, and sex under the influence of alcohol, was unprepared and therefore not safe sex. Although most of the participants said casual sex involved using a condom, it did not always happen. This exposed them and their primary partner to the risk of HIV. Thus, alcohol misuse might affect sexual decision-making and alcohol could be understood as mediating condom use for those who consume it.

Linked to the notion of manhood, was the 'manly' desire for condomless sex. Condomless sex was seen as something that men needed, a basic necessity for men, making consistent condom use problematic in relationships. Many men resisted the use of condoms because they dislike

the way condoms interfered with sexual pleasure. This relates to the male sex drive discourse, in which sex is meant to relieve men's sexual urges. The position of a woman in the male sex drives discourse "is as the object that precipitates men's natural sexual urges" (Hollway, 1984, p. 233).

Most men perceived sex as a source of pleasure and condoms were seen to reduce pleasure associated with sexual activity. This is consistent with most of the literature in which men complain that condoms reduce sexual sensation (Browne & Minichiello, 1994; Chimbiri, 2007; Flood, 2003). Even though issues of pleasurable sex were more pronounced in men, some young women also expressed the need for sexual pleasure and raised complaints about the way condoms interfered with sexual satisfaction. This reveals a tension between the object of the activity, sexual pleasure and the mediating tool of the condom. The need or desire for sexual pleasure may outweigh the risk of HIV infections.

Although married couples did not mention having sex for pleasure, they did not use condoms in their marriage. The main reason was that they need to have children because not having children would affect their identity. A man's virility (and a woman's fertility) is demonstrated through procreation. This finding is consistent with that of Adejoh and Uchenna (2011), Chimbiri (2007), Maharaj and Cleland (2005) and Preston-Whyte (1999), who found that the need and desire to have children in marriage is in conflict with the use of condoms. Some people believe that marriage was invented by God and therefore sex in marriage should be 'natural' (Chimbiri, 2007). Van der Riet (2009, p. 197) argues that "doing' sex is about producing yourself". Married men were against condom use because their reputation and identity as virile is impeded through the use of condoms. Thus, the desire to demonstrate the ability to have children seems to override the concerns about the risk of HIV infections. There was a clear and significant tension between the use of condoms and identity.

The participants' arguments, particularly women, indicated that management of risk was complicated by power dynamics within relationships. The section below discusses how power dynamics constrain risk management.

5.3.2 Management of risk

Men are often in control of decisions made about sexual activity and the management of risk. The analysis of the sexual activity systems illustrated some of the dynamics of sexual

interaction in the division of labour component, specifically the vertical dimension. The vertical dimension of the division of labour focuses on the dynamics of power between subjects of the activity. There was a difference in power between men and women within the sexual activity systems. Overall, men had more power and control over sexual activity.

The unequal power dynamics clearly had implications for women's ability to negotiate and make safe sex happen. In many sexual interactions, men persuaded their female partner to have unprotected sex and did not accept their partner's reluctance. Women were more likely to request condom use but their requests were often rejected by their partners. Thus, Harrison et al. (2001) argue that some HIV-prevention strategies (such as condom use) may not be suitable for many women, as they do not control their own sexuality. Unlike other HIV-prevention strategies, condom use has to be negotiated between potentially unequal partners (Mash et al., 2010; Van der Riet, 2012).

Mash et al. (2010) argue that the power dynamics within relationships play a critical role in the transmission of HIV and AIDS. The results of this study show that decisions about using or not using a condom were controlled by men. Their needs and desires mainly governed the sexual activity. Many women said it would be easier to use a condom if initiated by the male partner. Similarly, in Harrison et al. (2001) and Stein (1990), women said it would be easier to refuse sex than negotiate condom use with their partner. This shows that in relationships of unequal power, women find it difficult to confront their partners about using condoms (even if they see the need) and they are therefore at risk of HIV infection.

Women also tend to honour a relationship (this will be discussed in more detail in section 5.3.3) and the only way they perceive they can preserve the relationship is to be submissive to male control (Hollway, 1984). Thus, they find it difficult to propose condom use because of the social norm which calls women to be submissive to their male partners. They cannot make condom use occur because men are the more powerful partners in sexual interactions.

In addition, the findings of this study showed that most women are in relationships with men who are older than they are. Burgard and Kusunoki (2009) argue that age difference between sexual partners is likely to affect the power distribution and decisions about sex. Several studies show that when young people (particularly young women) are in relationships with older partners, they are less likely to use condoms (Burgard & Kusunoki, 2009; Johnson et al.,

2010; Luke, 2005; 2006). Therefore, an inter-generational relationship introduces the potential for unsafe sex practices.

Furthermore, if a young person is in a relationship with an older partner, the older partner usually has more power in terms of economic status. Thus, confronting this older partner about using condoms might become very difficult and create a dilemma because the younger person does not want to jeopardise the financial and material gains from the relationship (Burgard & Kusunoki, 2009). The literature highlights women being in relationships with older men. However in this study some young rural men are involved in sexual relationship with older women. Participants explained that these young men are in these relationships for financial gain. Shisana et al. (2009) argue that poor individuals are more likely to make decisions based on their basic needs rather than on the risk of HIV and AIDS, thus exposing them to HIV infection.

Management of sexual risk is vital in the context of HIV and AIDS. In this study, relationships were considered very significant for a woman's identity; as a result, a woman has to find a balance between managing the risk of HIV infection and maintaining a relationship. The following subsections elaborate on these issues.

5.3.3 Fear of loss of partner

In this study, fear of losing a partner was the most significant barrier to condom use for the majority of women. For example, many women in this study, married or unmarried, expressed concern about being at risk of HIV infection due to their partner's infidelity. However, they continued to engage in unprotected sex with their partners to ensure continuation of the relationship. They feared that suggesting condom use would imply that they were not 'decent' women or create suspicion that they were having an affair outside the acknowledged relationship. This might result in the loss of the relationship.

One might ask why this is so significant. How could a relationship be more valuable than protection of one's health? Hollway (1984) would argue that women are drawing on the have/hold discourse to explain their investment in relationships. Although women are worried about sexual safety, they are still worried about keeping up the relationship. For many women, obtaining and keeping a sexual partner was a significant pursuit because a relationship is a crucial part of a woman's social identity. Keeping a man affirms one's feminine identity

(Hollway, 1984). The man is positioned as the object of the have/hold discourse (Hollway, 1984). A woman in a relationship has a positive social status, a reputation and also has power amongst her peers (Hollway, 1984).

The ability to maintain a relationship has personal and social rewards. This is what Hollway (1984) refers to as investments. According to Hollway (1984), people enlist certain discourses because they provide some pay-off for them. Women in this study invested in maintaining a relationship because, in this community, a relationship is seen as an essential part of a woman's identity. Thus, their investment is in their own identities (Hollway, 1984). They have invested in maintaining a relationship even if this sometime means the risk of HIV infection.

Many women were reluctant to engage in unprotected sex but they were trapped by their desire to maintain the relationship. They feel they cannot leave the relationship, yet they cannot take the necessary steps to protect themselves. This is a clear tension between being in a relationship and having to engage in unprotected sex. The women raised concerns about sexual safety, but were unable to insist on condom use because they feared being 'left alone'. Hattori et al. (2010) also found that women may refrain from insisting on condom use if they recognise this would keep the relationship stable. Rosenthal et al. (1998) argue that it may seem rational for women to refuse sex or to have unprotected sex in the light of the HIV and AIDS pandemic, but the refusal of sex or insistence on condom use may be more threatening than the risk of HIV infection. The risk of HIV is in tension with that of a woman's reputation.

In attempting to secure and maintain a relationship, women prioritise men's sexual needs and desires and this has implications for their ability to negotiate safe sex practices (Jones & Oliver, 2007). Having the positive social reputation of being linked to, and keeping, a partner restricts them in terms of acting upon their sexual safety. There is a gap between a woman's aim to practice safe sex and her ability to carry this out (Holland et al., 2004; Jones & Oliver, 2007). Many women indicated "*giving in"* to the male partner's desires. This illustrates their use of the male sex drive discourse to justify their actions. Women prioritised what their partners desired and expected, in order to ensure the continuation of the relationship. They focused on satisfying their partner's sexual needs in order to hold on to them, despite their awareness of the risk of HIV.

This dynamic creates tensions and dilemmas for women who have accepted their partner's claims that condoms reduce sexual pleasure, believe that condom use implies multiple sexual partners, and believe that insisting on condom use would lead to suspicion of outside affairs, but who on the other hand recognise the risk of HIV infection. These tensions are between the mediating tool of the condom and the object of keeping a man. These tensions and dilemmas are indicative of underlying contradictions within women's sexual activity systems. These contradictions hinder the adoption of risk-reducing sexual behaviour.

Another issue related to fear of losing your partner was that condomless sex symbolised love and commitment to the sexual partner. This is discussed in detail below.

5.3.4 Showing love and faithfulness

The majority of women in this study indicated that they engaged in unprotected sex to show their love and faithfulness to their partners. This is consistent with several studies (Corbett et al., 2010; Rosenthal et al., 1998; Manuel, 2005) which found that showing love and commitment to a sexual partner were legitimate reasons for unprotected sex. Being in love and being faithful are the defining features of the have/hold discourse (Van der Riet, 2009). The non-use of a condom is equated to showing love and faithfulness; therefore, if one partner kept on requesting condom use, this was interpreted as lack of love or not being faithful, and this therefore threatened the relationship.

Condom use was associated with many meanings, making them difficult to be consistently used in relationships. Some men refused the request to use a condom by accusing their partners of infidelity, using the notion of being faithful as a way to repel condom use. By accusing their partners of being unfaithful, they have recruited the have/hold discourse. This presents dilemmas and tensions between the norms/rules and mediating tool of condoms in the sexual activity system, because in a committed relationship, the suggestion of the safe sexual practice of using condoms is tied to a lack of love or to not being faithful to the partner. Once sex is constructed in terms of love and faithfulness, safe sexual practice becomes a dilemma (Rosenthal et al., 1998).

This illustrates how consistent condom use faces resistance because of what unprotected sex means in the context of a committed relationship (Rosenthal et al., 1998). Many participants, particularly women, recognised their risk of HIV but could not insist on condom use because it

calls their love and/or faithfulness into question. Thus, condomless sex was used by many women as a strategy to show their love in order to maintain the relationship. In this research site, this exposes the couple to risk of HIV infection because there is always a possibility of infidelity, especially for men.

Although some people reported using condoms to prevent the transmission of HIV, in most cases they were not used consistently. This put people at risk of HIV infections. This study reveals that unprotected sex remains a critical issue, particularly in regular relationships. There are some strategies people have in place to attempt to ensure sexual safety. Couples minimised sexual risk through maintaining fidelity, assuming 'trust' between partners and finding out if the partner was HIV negative. These are discussed below.

5.4 Risk-reducing sexual behaviour in *Ematyholweni*

5.4.1 Trust

The most common strategy to address the risk of HIV in *Ematyholweni* was the assumption of trust. Condom use was associated with casual sex and where there was trust, it was believed that condoms were not necessary. Many participants said they minimised the risk of HIV infection by using condoms with a new partner until they gained the trust of the partner. Participants indicated that the longer the duration of the relationship, the more they gained trust in their partner. They explained that they used condoms at the beginning of the relationship because they had not yet known each other and therefore there was no trust. This is consistent with other studies which found that unprotected sex was a way of showing trust and commitment to a sexual partner (Bird et al., 2001; Flood 2003; Hattori et al., 2010; Manuel, 2005; Reddy & Dunne, 2007; Rosenthal et al., 1998). Knowing each other provided partners with a sense of safety about the risk of HIV infection; therefore, there was no need to worry about safe sex practices, including the use of condoms.

A trusted partner was perceived to be a safe partner. The more partners trusted each other, the lower the likelihood that condoms were used. Assuming that there was 'trust' in a relationship led to a presumption of monogamy in a relationship and diminished the worries and concerns about safe sex practice. Trust in a relationship was thus understood as a substitute for condom use. After the couple had established trust, they tended to stop the use of condoms. Participants believed that their partners would not knowingly place them at risk for HIV and AIDS. This perception has been reinforced by previous HIV and AIDS campaigns which encouraged

condom use only with an outside partner (Manuel, 2005). HIV-prevention campaigns have considered casual relationships to be a higher risk than steady relationships.

Married people were assumed to have more trust in each other than unmarried couples. There was an assumption that when one is married, there is no need to be worried about the use of condoms because there is fidelity. Those in marriage relationships were expected to maintain fidelity and not use condoms. This finding is consistent with that of Chirwa et al. (2011), Chimbiri (2007), Maharaj and Cleland (2005) and Preston-Whyte (1999), who found that condoms were less acceptable in marriage. Condom use within marriage relationships was viewed as inappropriate.

Despite the expectation of marital fidelity, results show that some married couples did not maintain fidelity, particularly husbands. The finding that married men were more likely to engage in extramarital relations than their wives is consistent with other studies (Bauni & Jarabi, 2003; Chimbiri, 2007; Chirwa et al., 2011; Maharaj & Cleland, 2005). The norm of marital fidelity created tensions and dilemmas which made it difficult for married couples to negotiate condom use, even though one partner might feel vulnerable to the risk of HIV infection from their partner.

This dilemma is captured in the finding that although some married women commented that they felt at risk of HIV infection due to their husband's infidelity, they continued to have unprotected sex with him. This means that, despite awareness of HIV and AIDS, most married couples continue to practice unprotected sex rather than threaten the relationship by implying that someone is being unfaithful. Jewkes et al. (2004) argue that women are often aware of the risk within sexual relationships but find it hard to negotiate condom use because of cultural expectations and norms. In this research area, the lack of condom use is a risk factor because there is a possibility of sex outside relationships, particularly for men. The majority of participants spoke of monogamy as an ideal in a relationship but they also acknowledged the reality of multiple sexual relationships.

Due to the fear of suggesting condom use and also the preference for condomless sex, some participants suggested HIV testing instead. The next section discusses HIV testing.

5.4.2 HIV testing

HIV testing was another HIV-prevention strategy among *Ematyholweni* residents. The majority of the participants reported having tested for HIV as they argued that knowing one's status is crucial in the prevention of HIV transmission. These results are consistent with those of Van der Linde (2013), who showed an increase in the number of people who know their HIV status in South Africa.

Participants indicated having been motivated by the desire to stop using condoms and the need to prove to their partners that they were safe; this was in order to continue having unprotected sex because it is pleasurable and preferable sex. The results show that finding out that one's partner was HIV negative lessened the worries and concerns about safe sex practices and condom use. Negative HIV tests were seen as permission to continue risky behaviour. Hattori et al.'s (2010) study similarly found that knowing that one's partner was HIV negative strengthened the trust that the partner would not knowingly infect them. However, it could be argued that lack of condom use in this research area is problematic because sex outside relationships is possible, and even common, particularly for men.

The discussion above underpins the argument that safe sex practices do not entail a simple step learnt from knowledge and information about HIV and AIDS (Kelly et al., 2001; Van der Riet 2009). The issues raised above reveal the complicated nature of sexual activity. This study did not only describe sexual activity in *Ematyholweni* but also used Engeström's (1987) model of activity system. This model facilitates the identification of tensions and contradictions and thereby assists in understanding the potential for change in the activity system of sex in *Ematyholweni*. This model illustrates how systemic tensions impact on sexual behaviour change following the introduction of safe sex practices. The next section looks at the status of contradictions and the possibility for change in sexual activity systems.

5.5 Potential for change in the activity system of sexual activity

According to Engeström (1987), tensions and contradictions manifest themselves through dilemmas, breakdowns and disturbances, and the analysis of these could reveal potential for change in an activity system. Engeström (1987) argues that every activity system has internal tensions and contradictions. These accumulate over time and eventually lead to an overall crisis in the activity system (Engeström, 1987). The crises in the activity system eventually lead to new forms of the activity, thus leading to transformation (Van der Riet, 2012). Therefore,

tensions and contradictions are significant to the activity system because they are the driving force of change, innovation and development (Engeström, 2001). Thus, activity systems "are inherently characterised by constant construction, renewal and transformation of the components of the system" (Engeström, 1996, cited in Van der Riet, 2012, p. 34). Van der Riet (2009) argues that tensions and contradictions in the system are highly significant in understanding the problem of lack of behaviour change in response to the HIV and AIDS epidemic.

Drawing on the data, there were numerous tensions and dilemmas identified; these are indicative of underlying contradictions in the sexual activity systems. The analysis of both married and unmarried men's sexual activity systems revealed two types of contradictions: primary and secondary contradictions. The primary contradictions arise within the outcomes of the sexual activity systems: identity (reputation) and the risk of HIV. Men were aware of the risk within sexual relationships but they continued to draw on normative constructions of manhood. Men focused on developing a virile identity despite their awareness of the risk of HIV. The mediating artefact of the conceptual system of HIV risk appears to be weak in their sexual activity systems. Despite the awareness of HIV risk, men are not responding to the safe sex messages they receive.

There is another primary contradiction within the rules/norms of these sexual activity systems: the expectation of trust in a relationship and the possibility of an outside relationship. Trusting one another was the most acknowledged 'risk-prevention' option but tolerance and acceptance of male multiple sexual partnerships undermined this norm. Secondary contradictions arise between the object of the activity, that is, to obtain sexual pleasure, and the tool of the activity (the condom). Men were aware that condoms were the best method of protection against HIV infections but the desire for sexual pleasure hindered the consistent use of condoms.

The analysis of both married and unmarried women's sexual activity systems also reveals primary and secondary contradictions. The primary contradictions arise within the outcomes of the activity: identity (reputation) and the risk of HIV. The secondary contradictions arise between the mediating tool of the condom and the object of the activity, which is, maintaining the relationship. Women's main goal was to attract and keep a man (which is a reputational object) because a relationship is an important part of a woman's social identity. Trying to maintain a relationship limits women in terms of acting upon their sexual safety. For instance,

most women took the risk of HIV infections seriously; they were concerned with the protection of their health. The mediating artefact of the conceptual system of HIV risk appears to be stronger in their activity system. In response to this, they raised the idea of condom use, but in most cases this was refused by the male partner. The women's response was to prioritise keeping the relationship, rather than responding to their fear of the risk of HIV infection.

Tertiary contradictions between men's sexual activity systems and women's sexual activity systems were also detected. There were tensions between the objects in the sexual activity systems of men and women and also in the division of labour. The objects of men are sexual pleasure and being sexually active; for women, the objects are being in a relationship and being loved. This clearly leads to a tension between the men's and the women's sexual activity systems. In the division of labour, women were responsible for sexual safety but had less power to fulfil this obligation. The unequal power dynamics clearly led to tensions between the sexual activity systems of men and women, because men were not as concerned about sexual safety as women.

Engeström (1996) argues that it is in the identification of the tensions and contradictions within an activity system that change can be facilitated. Tensions and contradictions are vital because they contain the potential for the transformation of the activity (Engeström, 1996). Identifying tensions and contradictions enables an understanding of why certain changes cannot be fully achieved (Van der Riet, 2009). Van der Riet (2009, p. 209) states that "it is the strength, or status, of these tensions and contradictions which is critical in understanding the nature of change in the activity system". If tensions and contradictions are weak and not severe enough, change is not possible or does not happen in the system (Van der Riet, 2009).

It was clear that a range of tensions and contradictions exists in the sexual activity systems. The analysis of women's sexual activity systems reveals that contradictions within these systems have become aggravated forms of contradictions. The mediating artefact of the conceptual system of HIV risk has become strong for both married and unmarried women; thus, there is a strong tension between the practice of safe sex and unsafe sex for women. HIV has generated many tensions and contradictions with other components within these sexual activity systems. Women are concerned about the protection of health and take the risk of HIV infections more seriously but they are restrained by their desire to maintain the relationship.

This means that the contradictions within their activity system are at a mature stage.

However, there were differences between the married woman's sexual activity system and the unmarried woman's sexual activity system. Although married women had a strong mediating artefact in terms of the conceptual system of HIV risk, their activity system is not in a crisis; it is still stable because condom use is not a norm in marriage relationships. For unmarried women, it could be argued that their activity system is near crisis. The system is unstable because the results show that some unmarried women, particularly young women, have begun to deviate from the norm of unprotected sex. This opens up the possibility for change. It was easier for some unmarried women to request condom use and make it happen in sexual encounters. Engeström (2001, p. 137) says "as the contradictions of an activity system are aggravated, some individual participants begin to question and deviate from its established norms. In some cases, this escalates into collaborative envisioning and a deliberate collective change effort".

As already stated above, the woman's sexual activity system is connected to that of the man's sexual activity system with all of its components, and men control the activity. Although, there is a strong tension for women between the practice of safe sex and unsafe sex, it does not create a crisis for the man's sexual activity system because of the division of labour in which the male partner controls the activity and the woman submits to his desires. Thus, these contradictions are inadequate to effect a change in the system because the mediating artefact of the conceptual system of HIV risk is weak for both married and unmarried men.

There is a tension between the practice of safe sex and unsafe sex for men but this tension can be perceived as latent rather than apparent. The tension is not significant enough to create a crisis in the system. For the activity to change, this tension needs to manifest as a strong tension in both partners or women need to question the status quo and refuse sex. This lack of crisis in the man's sexual activity system throws light on the lack of behaviour change in response to HIV and AIDS.

Van der Riet (2009) argues that the relationship between the outcomes of the activity system of sex, in particular the production of self, is critical in understanding the lack of sexual behaviour change. The analysis of activity systems revealed that sexual activity is interconnected with identity formation. For both men and women, identity was a significant outcome of sexual

activity. Identities are constructed in dynamic social interaction with other individuals (Campbell, 1997). Particular gender identities are central outcomes of the sexual activity system. This creates significant tensions and dilemmas in the management of sexual safety and also limits the potential for change in the activity system.

Both men and women invest in their own identities (Hollway, 1984). Men focused on developing a virile identity while women prioritised keeping the relationship. Van der Riet (2009) argues that men and women take up certain positions in relation to particular sets of gender-differentiated discourses, making it very problematic to generate change in the activity system. Campbell (1997) argues that the meaning of sexual activity depends on the contextual discourses of sexuality. Participants' risky sexual practices were rationalised by drawing on the male sex drive discourse and the have/hold discourse. According to Hollway (1984), the practice of gender-differentiated discourses re-produces gender identities. These discourses "set the parameters through which desire is produced, regulated and channelled" (Henriques, Hollway, Unwin, Venn & Walkerdine, 1984, p. 220).

There was acknowledgement of HIV as the negative outcome of sexual activity among both men and women. Condom use was also acknowledged as the most effective strategy to prevent the transmission of HIV and AIDS. However, the introduction of condoms in the sexual activity system has led to tensions related to the outcome of identity. Condom use "does not enhance the reputation of either the male, or the female subject; rather, it is stigmatizing to one's identity" (Van der Riet, 2009, p. 196). Although many women requested the use of condoms and felt the need to use condoms, this was often over-ridden by the outcome of identity. Condom use symbolised unfaithfulness and therefore threatened the relationship. On the other hand, for men, sexual interaction was about virility and conquest, and condom use did not enhance this reputation.

5.6 Summation

The data analysis indicated that most people knew that HIV is potentially transmitted when condoms are not used or used intermittently. However, the findings of this study indicate that condoms are used at the beginning of the relationship but not necessarily later on in the relationship. People's use of condoms declined with an increase in the duration of the relationship and condom use was, furthermore, not acceptable in marriage relationships. The majority of participants, particularly men, resented the use of condoms and refused to change

their risky sexual practices, regardless of the knowledge they had about HIV and AIDS and its prevention strategies. Thus, the knowledge they have often does not translate into behaviour change.

From the analysis of sexual activity of both married and unmarried men and women it is clear that several tensions and dilemmas exist in their systems of sexual activity. However, these tensions and contradictions are very weak in the men's activity systems. Therefore, the activity systems of men are stable. However, women's activity systems might be near crisis but constrained by the desire for the relationship. They are further constrained by the division of labour because women have less power. The analysis of the sexual activity systems in relation to tensions and contradictions revealed resistance to change in the system. Both men and women invest in their own identities by drawing on gender-differentiated discourses (Hollway, 1984), making it very difficult, if not impossible, to generate change in the activity system.

This chapter discussed the results of this study. It has shown the tensions and dilemmas inherent in the activity system of sex. The next chapter draws conclusions about the study, discusses the strengths and limitations of the study and finally makes recommendations based on the study results.

CHAPTER 6: CONCLUSION

6.1 Introduction

This chapter concludes the study and discusses the study strengths and limitation and, finally, makes recommendations.

6.2 Conclusions from the study

Numerous studies have shown that despite the progress in awareness, knowledge and information about HIV and AIDS, and the prevention of HIV and AIDS, people continue to engage in risky sexual practices which expose them to the risk of HIV and AIDS (Bird et al., 2001; Maharaj & Cleland, 2005; Ndegwa et al., 2012). This study explored why people continue to engage in risky sexual practices despite the risk of HIV and AIDS. It intended to understand the dynamics of the activity system of sex in *Ematyholweni*. It focused on the tensions and dilemmas in the positions that men and women in *Ematyholweni* take in relation to sexual activity and relationships. It aimed to understand the different dilemmas and tensions within sexual relationships related to condom use and safe sex practices. It also explored whether and how these tensions and dilemmas relate to contradictions in the sexual activity system. It assumed that understanding the relative state of contradictions in the activity system would lead to understanding the potential for change and transformation, and thereby potentially assist in conceptualising more effective HIV and AIDS interventions (Van der Riet, 2009). This study partially replicated Van der Riet's (2009) study, which illustrated how one can understand lack of sexual behaviour change through the use of an activity theory framework.

The study sampled individual interviews and focus group discussions from a broader NRF project exploring people's response to HIV and AIDS in *Ematyholweni*. The data from individual interviews and focus group discussions helped to identify and understand the dynamics of sexual activity in *Ematyholweni*. The study used an activity theory framework to better understand lack of sexual behaviour change despite increased awareness of the risks of unprotected sexual activity. This framework informed the analysis of this study. Thematic analysis and Engeström's (1987) model of human activity were used as complementary analytic methods in order to allow for a deeper understanding of the context in which sexual activity takes place.

Men and women seemed to take up positions aligned with particular sets of gender-differentiated discourses around sexuality: the male sex drive discourse and have/hold discourse. Drawing on these discourses enabled them to rationalise unsafe sex practices. This illustrates that barriers to safe sex are socially constituted, thereby illuminating the dialectical relationship between the individual and context.

The non-use of condoms was perceived, particularly among female participants, as a means to maintain and secure a primary relationship. It was clear that men demonstrate their virility through the quest of obtaining multiple sexual partners and the non-use of condoms, as well as through their control of sexual interactions.

In terms of risk reduction, participants mentioned trusting one another as the most socially welcomed 'risk-prevention' option, although, as many participants acknowledged, condom use remains the key risk-reduction strategy. However, this study suggests that the need to practice safe sex creates tensions and dilemmas which make it difficult for sexual partners to use condoms. It was clear that women experienced more tensions and dilemmas in their sexual activity system related to sexual safety than men.

In order to identify the tensions and dilemmas in sexual activity, the activity systems of married and unmarried men and women were drawn and described. The analysis of sexual activity systems revealed primary, secondary and tertiary contradictions. However, these contradictions were insufficient to effect a change in the system. The mediating artefact of the conceptual system of HIV risk is strong for women and still relatively weak for men. The nature of the interconnectedness of the two systems in the activity of sex means that both systems would have to experience significant contradictions in the activity system of sex to be in crisis. However, the contradictions within sexual activity systems of both married men and unmarried men are in an early stage of maturity. This means that men's sexual activity systems are stable.

The contradictions within married women's sexual activity system were shown to be at a mature stage, but not in a crisis, and therefore also stable. For unmarried women, the contradictions are at mature stage and near crisis. This means unmarried women's sexual activity system is unstable; however, this is insufficient to effect a change in the system. For change to occur, the mediating artefacts of the conceptual system of HIV risk need to be strong for both men and women. Also, if women resist engaging in sex with their partners, this would

lead to a crisis in the men's sexual activity system and eventually the collapse of the activity system.

Despite their knowledge about HIV and AIDS and its negative consequences, and the protective value of condoms, people continue to engage in risky sexual behaviours. The findings of this study suggest that the HIV and AIDS field must develop new approaches to tackle new HIV infections. Evaluating tensions and contradictions within activity systems may reveal opportunities for change in a sexual practice.

6.3 Limitations and strengths of this study

There are four criteria for ruling on the quality of qualitative research. These are discussed below in relation to the limitations of this study.

6.3.1 Credibility

Credibility deals with how the research findings are congruent with reality (Polit & Beck, 2004). The first limitation of this study is that the data collection was conducted using *isiXhosa*, the mother-tongue language of the participants, and then translated into English during the transcribing process. This process may have been affected by the use of different transcribers which might also have affected the consistency of the use of transcription conventions. These factors might have affected the quality of the transcripts and therefore affected the credibility of the results. However, back-translation was done to improve the credibility of the translation and the transcripts.

6.3.2 Dependability

Dependability refers to the consistency of the data if another researcher replicates this study (Polit & Beck, 2004). Due to the sensitive nature of the topic, participants may have constructed their answers in a social desirable way. The researchers' own gender and age could have also limited the communication process during interviews and focus group discussions. Participants may have constructed their answers in relation to the gender or age of the researcher. For, instance, the youngest research participants may have been reserved in stating their views to a researcher who was older than them, while on the other hand, the older research participants also could have been reserved in declaring their views to a researcher who was younger than them. This may mean that the results of this study cannot be replicated because of the dynamics of data collection. However, the study has been clear about the

methodology employed, explaining how the research process happened to make it easier for another researcher to replicate it. For instance, participants were classified into different age groups in focus groups, and participants in groups and interviews were matched with the same gender of researchers in individual interviews.

6.3.3 Confirmability

Confirmability refers to the ability to maintain objectivity in the analysis of the data (Polit & Beck, 2004). Themes are constructions of the researcher expressed in the participants' narratives. The inference of themes must be consistent with the participants' accounts. It might be argued that the researcher found what she wanted to find because qualitative data can always be interpreted in a way that satisfies the researcher. In this sense, the possibility of bias in the interpretation of the results is acknowledged. However, confirmability was ensured by describing clear analytic procedures and ensuring that the conclusions reached were supported by participants' statements.

6.3.4 Transferability

Transferability refers to the generalisability of the results of the study to other settings and populations (Kelly, 2006). The results of this study cannot be generalised due to lack of probability sampling and small sample size. However, they can be transferred to similar contexts, because the study has been clear about the context of the study, the study population and the circumstances under which the data has been collected and analysed.

6.4 Strengths of the study

This study also had the following strengths. The first strength was the analysis of tensions and dilemmas in the sexual activity systems. This study has brought the nature of tensions and contradictions in the sexual activity systems of the participants in rural Eastern Cape setting to the fore. The use of focus groups in data collection also provided participants with the opportunity to have conversations in which they could talk about HIV and AIDS, and risky sexual behaviours, with others. These conversations may empower them to change their actions and lead to change in the activity systems. The research team stayed in the research area before and while collecting data. This helped with the establishment of trust between them and the participants. The prior engagement in the site helped the research team to compare data collected and observed while in the field. Thus, it helped with the clarification and verification of data. In terms of the present study, the research team was also readily available to assist with

clarification of the data where it was not easy to comprehend. Another strength of this study is that deviant cases were incorporated in the results section to refute initial evidence. This is a useful way of strengthening the rigour and increasing credibility of the results.

6.5 Recommendations

6.5.1 Programmes

It seems that there are still misconceptions about condoms and HIV and AIDS, particularly among men. For example, inaccurate beliefs, such as that HIV can be prevented by washing after sex, must be challenged. Therefore, health care providers should continue with provision of education and information about HIV prevention to address any misconceptions about condoms and HIV and AIDS. Programmes aimed at developing HIV and AIDS knowledge should contain consistent and coherent prevention messages.

The results of this study suggest that trust significantly affects safer-sex practices within relationships. Interventionists promoting HIV prevention need to reconceptualise condom use as an activity between partners who trust one another. The importance of condom use in every sexual encounter should be highlighted, even in long term "monogamous" relationships.

6.5.2 Future research

This study is one of the very few studies which used an activity theory framework in the field of HIV and AIDS. Therefore, one of the recommendations of this study is a call for more studies to be conducted using an activity theory framework in this field, particularly focusing on tensions and contradictions of sexual activity systems. Understanding these systems, leads to a better understanding of resistance to change and the potential for change, this could contribute to conceptualizing and developing better HIV and AIDS interventions.

Although women know that they are at heightened risk of HIV infections, they still participate in risky sexual behaviour. This finding requires further and more detailed investigation.

6.6 Conclusion

This study explored why people continue to engage in risky sexual practices which expose them to the risk of HIV and AIDS, despite knowledge and information about HIV and AIDS, and HIV prevention. An application of the activity theory framework assisted in understanding the relative state of contradictions in the sexual activity. All participants were aware of the risk

of HIV, and aware of HIV prevention measures. Nevertheless, dilemmas that they experience in sexual activity, and the related tensions and contradictions are not significant enough to lead to sexual behaviour change.

REFERENCES

Ackermann, L. & Klerk, G. W. D. (2002). Social factors that make South African women vulnerable to HIV infection. *Health Care for Women International*, *23*(2), 163-172.

Adejoh, I. & Uchenna, O. M. (2011). Condom use in Nigeria: An evaluation. *Current Research Journal Economic Theory*, *3*(1), 10-13.

Airhihenbuwa, C. O., Makinwa, B., Frith, M. & Obregon, R. (1999). *Communications framework for HIV/AIDS: A new direction*. Geneva: UNAIDS/Penn State.

Ajzen, I. & Fishbein, M. (1980). *Understanding attitudes and predicting social behaviour*. Englewood Cliffs, NJ: Prentice-Hall.

Anderson, K. G., Beutel, A. M. & Maughan-Brown, B. (2007). HIV risk perceptions and first sexual intercourse among youth in Cape Town, South Africa. *International Family Planning Perspectives*, *33*(3), 98–105.

Auerbach, J. D., Parkhurst, J. O. & Cáceres, C. F. (2011). Addressing social drivers of HIV/AIDS for the long-term response: conceptual and methodological considerations. *Global Public Health*, *6*(3), 293-309.

Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice-Hall.

Barab, S. A., Barnet, G. M., Yamagata-Lynch, L. C., Squire, K. & Keating, T. (2002). Using activity theory to understand the contradictions characterizing a technology-rich introductory astronomy course. *Mind, Culture, and Activity*, *9*(2), 76-107.

Bauni, E. K. & Jarabi, B. O. (2003). The low acceptability and use of condoms within marriage: Evidence from Nakuru District, Kenya. *African Population Studies*, *18*(1), 51-65.

Becker, M. H. (1974). The health belief model and sick role behavior. *Health Education & Behavior*, *2*(4), 409-419.

Bhana, A. & Petersen, I. (2009). HIV and youth: A behavioural perspective. In P. Rohleder, L. Swartz, S. C. Kalichman & L. C. Simbayi (Eds.), *HIV/AIDS in South Africa 25 years on* (pp. 55-68). New York: Springer Science and Business Media.

Bird, S. T., Harvey, S. M., Beckman, L. J., Johnson, C. H. & The PARTNERS Project. (2001). Getting your partner to use condoms: Interviews with men and women at risk of HIV/STDs. *The Journal of Sex Research*, *38*(3), 233-240.

Blanc, A. K. (2001). The effect of power in sexual relationships on sexual and reproductive health: An examination of the evidence. *Studies in Family Planning*, *32*(3), 189-213.

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

Brislin, R. W. (1970). Back-translation for cross-cultural research. *Journal of Cross-Cultural Psychology*, *1*(3), 185-216.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press.

Brook, D. W., Morojele, N. K., Zhang, C. & Brook, J. S. (2006). South African adolescents: Pathways to risky sexual behavior. *AIDS Education & Prevention*, *18*(3), 259-272.

Brown, J., Sorrell, J. & Raffaelli, M. (2005). An exploratory study of constructions of masculinity, sexuality and HIV/AIDS in Namibia, Southern Africa. *Culture, Health & Sexuality*, *7*(6), 585-598.

Browne, J. & Minichiello, V. (1994). The condom: Why more people don't put it on. *Sociology of Health & Illness*, *16*(2), 229-251.

Burgard, S. & Kusunoki, Y. (2009). *Gender and condom use among black South African young people*. Population Studies Center, University of Michigan.

Caldwell, J. C. (2000). Rethinking the African AIDS epidemic. *Population and Development Review*, *26*(1), 117-135.

Callanan, P. (2006). *"Damned if I do and damned if I don't": Women's dilemmas in the face of HIV/AIDS in sub-Saharan Africa* (unpublished doctoral thesis). University College Cork, Ireland.

Campbell, C. (1995). The social identity of township youth: An extension of Social Identity Theory (Part 1). *South African Journal of psychology*, *25*(3), 150-159.

Campbell, C. (1997). Migrancy, masculine identities and AIDS: The psychosocial context of HIV transmission on the South African gold mines. *Social Science &Medicine*, *45*(2), 273-281.

Campbell, C. (2004). Creating environments that support peer education: Experiences from HIV/AIDS-prevention in South Africa. *Health Education*, *104*(4), 197-200.

Campbell, C., Foulis, C. A., Maimane, S. & Sibiya, Z. (2005). The impact of social environments on the effectiveness of youth HIV prevention: A South African case study. *AIDS care*, *17*(4), 471-478.

Chen, H. Y. & Boore, J. R. (2010). Translation and back-translation in qualitative nursing research: Methodological review. *Journal of Clinical Nursing*, *19*(1-2), 234-239.

Chimbiri, A. M. (2007). The condom is an 'intruder' in marriage: Evidence from rural Malawi. *Social Science & Medicine*, *64*, 1102–1115.

Chirwa, E., Malata, A. & Norr, K. (2011). HIV prevention awareness and practices among married couples in Malawi. *Malawi Medical Journal*, *23*(2), 32-37.

Corbett, A. M., Dickson-Gómez, J., Hilario, H. & Weeks, M. R. (2010). A little thing called love: Condom use among high-risk primary heterosexual couples. *Perspectives on Sexual and Reproductive Health*, *41*(4), 218–224.

Crockett, L. J., Raffaelli, M. & Moilanen, K. L. (2003). Adolescent sexuality: Behavior and meaning. *Faculty Publications Department of Psychology*, *245*, 371-392. Retrieved from http://digitalcommons.unl.edu/psychfacpub/245

Daniels, H. (2008). *Vygotsky and research*. New York: Routledge.

Ditsa, G. (Ed.). (2003). *Information management: Support systems and multimedia technology*. London: Ideal Group Inc.

Durrheim, K. (2006). Research design. In M. Terre Blanche, K. Durrheim & D. Painter (Eds.), *Research in practice: Applied methods for the social sciences* (pp. 33-59). Cape Town: University of Cape Town Press.

Eaton, L., Flisher, A. J. & Aarø, L. E. (2003). Unsafe sexual behaviour in South African youth. *Social Science & Medicine*, *56*(1), 149-165.

Emanuel, E. J., Wendler, D. & Gray, C. (2000). What makes clinical research ethical? *The Journal of the American Medical Association, 283*(20), 2701-2711.

Engeström, Y. (1987). *Learning by expanding. An activity-theoretical approach to developmental research*. Helsinki: Orienta-Konsultit.

Engeström, Y. (1996). Developmental studies of work as a test bench of activity theory: The case of primary care medical practice. In S. Chaiklin & J. Lave (Eds.), *Understanding practice: Perspectives on activity and context* (pp. 64-103). Canada: Cambridge University Press.

Engeström, Y. (1999). Activity theory and individual and social transformation. In Y. Engeström, R. Miettinen & R. L. Punamäki (Eds.), *Perspectives on activity theory* (pp. 19-38). Cambridge: Cambridge University Press.

Engeström, Y. (2001). Expansive learning at work: Toward an activity theoretical reconceptualization. *Journal of Education and Work*, *14*(1), 133-156.

Engeström, Y. & Miettinen, R. (1999). Introduction. In Y. Engeström, R. Miettinen & R. L. Punamäki (Eds.), *Perspectives on activity theory* (pp.1-16). Cambridge: Cambridge University Press.

Erinosho, O., Isiugo-Abanihe, U., Joseph, R. & Dike, N. (2012). Persistence of risky sexual behaviours and HIV/AIDS: Evidence from qualitative data in three Nigerian communities.

African Journal of Reproduction Health, 16(1), 113-123.

Fielding, N. (1994). Varieties of research interviews. *Nurse researcher*, *1*(3), 4-11.

Fisher, J. C., Bang, H. & Kapiga, S. H. (2007). The association between HIV infection and alcohol use: A systematic review and meta-analysis of African studies. *Sexually Transmitted Diseases, 34*, 856–863.

Flood, M. (2003). Lust, trust and latex: Why young heterosexual men do not use condoms. *Culture, Health & Sexuality*, *5*(4), 353-369.

Frank, S., Esterhuizen, T., Jinabhai, C. C., Sullivan, K. & Taylor, M. (2008). Risky sexual behaviours of high-school pupils in an era of HIV and AIDS. *South African Medical Journal*, *98*(5), 394-398.

Gavey, N., McPhillips, K. & Doherty, M. (2001). "If it's not on, it's not on": Or is it? Discursive constraints on women's condom use. *Gender and Society*, *15*(6), 917-934.

Geertz, C. (1973). *The interpretation of cultures.* London: Hutchinson.

Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report*, *8*(4), 597-607.

Govender, N. (2008). *Social factors affecting HIV protective behavior among male Pakistani migrants residing in greater Johannesburg and surrounding areas* (unpublished master's thesis). University of the Witwatersrand, Johannesburg.

Gowns, E. & Karim, Q. A. (2010). HIV infections in South Africa: The evolving epidemic. In S. S. A. Karim & Q. A Karim (Eds.), *HIV/AIDS in South Africa* (pp. 55-73). Cambridge: Cambridge University Press.

Hattori, M. K., Richter, K. & Greene, J. (2010). Trust, caution, and condom use with regular partners: An evaluation of the trusted partner campaign targeting youth in four countries. *Social Marketing Quarterly*, *16*(2), 18-48.

Harrison, A., Xaba, N. & Kunene, P. (2001). Understanding safe sex: Gender narratives of HIV and pregnancy prevention by rural South African school-going youth. *Reproductive Health Matters*, *9*(17), 63-71.

Henriques, J., Hollway, W., Unwin, C., Venn, C. & Walkerdine, V. (1984). *Changing the subject: Psychology, social regulation and subjectivity*. London: Methuen

Holland, J., Ramazanoglu, C., Scott, S., Sharpe, S. & Thomson, R. (1990). Sex, gender and power: Young women's sexuality in the shadow of AIDS. *Sociology of Health & Illness, 12*(3), 336-350.

Holland, J., Ramazanoglu, C., Sharpe, S. & Thomson, R. (2004). *The male in the head: Young people, heterosexuality and power* (2nd ed.). London: Tufnell Press.

Hollway, W. (1984). Gender difference and the production of subjectivity. In J. Henriques, W. Hollway, C. Urwin, C. Venn & V. Walkerdine (Eds.), *Changing the subject: Psychology, social regulation and subjectivity* (pp. 227–263). New York: Routledge.

Jewkes, R. (2009). HIV and women. In P. Rohleder, L. Swartz, S. C. Kalichman & L. C. Simbayi (Eds.), *HIV/AIDS in South Africa 25 years on* (pp. 27-40). New York: Springer.

Jewkes, R, K., Levin, J. B. & Penn-Kekana, L. A. (2003). Gender inequalities, intimate partner violence and HIV preventive practices: Findings of a South African cross-sectional study. *Social Science and Medicine, 56,* 125-134.

Johnson, S., Kincaid, L., Laurence, S., Chikwava, F., Delate, R. & Mahlasela, L. (2010). *Second national HIV communication survey 2009: Findings from Eastern Cape Province*. Pretoria: JHHESA.

Kelly, K. (2000). *Communicating for action: a contextual evaluation of youth responses to HIV/AIDS. Summary of findings*. Sentinel site monitoring and evaluation project. Beyond Awareness Campaign/HIV/AIDS and STD Directorate, Department of Health, Johannesburg.

Kelly, K. (2006). Calling it a day: Reaching conclusions in qualitative research. In M. Terre Blanche, K. Durrheim & D. Painter (Eds.), *Research in practice: Applied methods for the social sciences* (pp. 370-386). Cape Town: University of Cape Town Press.

Kelly, K., & Parker, W. (2000). Communities of practice: Contextual mediators of youth response to HIV/AIDS. *Pretoria: Department of Health.*

Kelly, K., Parker, W. & Lewis, G. (2001). Reconceptualizing behaviour change in the HIV/AIDS context. In C. R. Stones (Ed.), *Socio-political and psychological perspectives on South Africa* (pp. 251-275). New York: Nova Science.

Kitzinger, J. (1995). Qualitative research: Introducing focus groups. *British Medical Journal*, *311*(7000), 299-302.

Lambert, S. D. & Loiselle, C. G. (2008). Combining individual interviews and focus groups to enhance data richness. *Journal of Advanced Nursing*, *62*(2), 228-237.

Langen, T. T. (2005). Gender power imbalance in women's capacity to negotiate self-protection against HIV/AIDS in Botswana and South Africa. *African Health Sciences*, *5*(3), 188-197.

Lave, J. (1996). The practice of learning. In S. Chaiklin & J. Lave (Eds.), *Understanding practice: Perspectives on activity and context* (pp. 3-32). Cambridge: Cambridge University Press.

Leclerc-Madlala, S., Simbayi, L. C. & Cloete, A. (2009).The sociocultural aspects of HIV/AIDS in South Africa. In P. Rohleder, L. Swartz, S. C. Kalichman & L. C. Simbayi

(Eds), *HIV/AIDS in South Africa 25 years on* (pp. 13-26). New York: Springer.

Lindegger, G. & Quayle, M. (2009). Masculinity and HIV/AIDS. In P. Rohleder, L. Swartz, S. C. Kalichman & L. C. Simbayi (Eds), *HIV/AIDS in South Africa 25 years on* (pp. 41-54). New York: Springer.

Luke, N. (2005). Confronting the 'sugar daddy' stereotype: Age and economic asymmetries and risky sexual behavior in urban Kenya. *International Family Planning Perspectives*, *31*(1), 6-14.

Luke, N. (2006). Exchange and condom use in informal sexual relationships in urban Kenya. *Economic Development and Cultural Change*, *54*(2), 319-348.

MacPhail, C. & Campbell, C. (2001). 'I think condoms are good but, aai, I hate those things': Condom use among adolescents and young people in a southern African township. *Social Science and Medicine*, *5* (11), 1613-1627.

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

Manuel, S. (2005). Obstacles to condom use among secondary school students in Maputo city, Mozambique. *Culture, Health and Sexuality: An International Journal for Research, Intervention and Care, 7*(3), 293-302.

Marston, C. & King, E. (2006). Factors that shape young people's sexual behaviour: a systematic review. *The Lancet*, *368*(9547), 1581-1586.

Mash, R., Mash, B. & De Villiers, P. (2010). 'Why don't you just use a condom?': Understanding the motivational tensions in the minds of South African women: Review article. *African Primary Health Care and Family Medicine*, *2*(1), 1-4.

Maxwell, C. & Boyle, M. (1995). Risky heterosexual practices amongst women over 30: Gender, power and long term relationships. *AIDS Care*, *7*(3), 277-294.

Mertens, D. M. (1998). *Research methods in education and psychology: Integrating diversity with quantitative and qualitative approaches*. California: Sage Publications.

Miettinen, R. (2006a). Epistemology of transformative material activity: John Dewey's pragmatism and cultural-historical activity theory. *Journal for the Theory of Social Behaviour*, *36*(4), 389-408.

Miettinen, R. (2006b). The sources of novelty: A cultural and systemic view of distributed creativity. *Creativity and Innovation Management*, *15*(2), 173-181.

Moore, S. & Halford, A. P. (1999). Barriers to safer sex: Beliefs and attitudes among male and female adult heterosexuals across four relationship group. *Journal of Health Psychology,*

4(2), 149-163.

Morojele, N. K., Kachieng, M. A., Mokoko, E., Nkoko, M. A., Parry, C. H. D., Nkowane, A. M., Moshia, K. M. & Saxena, S. (2005). Alcohol use and sexual behaviour among risky drinkers and bar and shebeen patrons in Gauteng province, South Africa. *Social Science and Medicine, 62,* 217–227.

Ndegwa, I. N., Wanderi, M. P. & Mwisukha, A. (2012). Factors influencing behaviour change for the prevention of the spread of HIV/AIDS among students in Githunguri division, Githunguri District, Kiambu County, Kenya. *International Journal of Business and Social Science, 3* (16), 313-324.

Ngubane, S. J. (2010). *Gender roles in the African culture: Implications for the spread of HIV and AIDS* (unpublished doctoral dissertation). Stellenbosch University: Western Cape, South Africa.

Orb, A., Eisenhauer, L. & Wynaden, D. (2001). Ethics in qualitative research. *Journal of Nursing Scholarship*, *33*(1), 93-96.

Parahoo, K. (2014). *Nursing research: Principles, process and issues*. UK: Palgrave Macmillan Limited.

Parker, W. (2004). *Rethinking conceptual approaches to behaviour change: The importance of context*. Johannesburg, South Africa: CADRE. Retrieved February 18, 2014 from http://www.cadre.org

Pettifor, A. E., Measham, D. M., Rees, H. V. & Padian, N. S. (2004). Sexual power and HIV risk, South Africa. *Emerging Infectious Diseases*, *10*(11), 1996-2004.

Polit, D. F. & Beck, C. T. (2004). *Nursing research: Principles and methods*. Philadelphia, PA: Lippincott Williams & Wilkins.

Postholm, M. B. (2008). Cultural historical activity theory and Dewey's idea-based social constructivism: Consequences for Educational Research. *Critical Social Studies*, *1*, 37-48.

Preston-Whyte, E. (1999). Reproductive health and the condom dilemma: Identifying situational barriers to HIV protection in South Africa. *Resistances to Behavioural Change to Reduce HIV/AIDS Infection*, *13*, 139-155.

Protogerou, C., Flisher, A. J., Aarø, L. E. & Mathews, C. (2012). The theory of planned behaviour as a framework for predicting sexual risk behaviour in sub-Saharan African youth: A critical review. *Journal of Child & Adolescent Mental Health*, *24*(1), 15-35.

Reddy, S. (2004). Safe sex or safe love? Competing discourse within the context of HIV/AIDS. *Alternation*, *11*(2), 440-453.

Reddy, S. & Dunne, M. (2007). Risking it: Young heterosexual femininities in the South

African context of HIV/AIDS. *Sexualities*, *10*(2), 159-172.

Rehle, T. M., Hallett, T. B., Shisana, O., Pillay-van Wyk, V., Zuma, K., Carrara, H. & Jooste, S. (2010). A decline in new HIV infections in South Africa: Estimating HIV incidence from three national HIV surveys in 2002, 2005 and 2008. *PloS One*, *5*(6), 11094.

Rohleder, P., Swartz, L., Kalichman, S. C. & Simbayi, L. C. (2009). *HIV/AIDS in South Africa 25 Years On*. New York: Springer.

Rosenthal, D., Gifford, S. & Moore, S. (1998). Safe sex or safe love: Competing discourses? *AIDS Care: Psychological and Socio-Medical Aspects of AIDS/HIV*, *10*(1), 35-47.

Roth, W. M., & Lee, Y. J. (2007). "Vygotsky's neglected legacy": Cultural-historical activity theory. *Review of educational research*, *77*(2), 186-232.

Sathiparsad, R., Taylor, M. & De Vries, H. (2010). Masculine identity and HIV prevention among young male youth in rural South Africa. *Journal for Social Sciences*, *25*(2), 159-168.

Selikow, T., Ahmed, N., Flisher, A. J., Mathews, C. & Mukoma, W. (2009). I am not 'umqwayito': A qualitative study of peer pressure and sexual risk behaviour among young adolescents in Cape Town, South Africa. *Scandinavian Journal of Public Health, 37*(2), 107-112.

Shabane, P. M. (2011). *Gender, sex, power and inequalities: An investigation of African femininities in the context of HIV and AIDS* (unpublished master's thesis). University of KwaZulu-Natal, Pietermaritzburg.

Shefer, T. (2003). Heterosexuality. In K. Ratele & N. Duncan (Eds.), *Social Psychology: Identities and Relationships* (pp. 289 – 302). Cape Town: Juta and Company Ltd.

Shisana, O. & Simbayi, L. (2002). *Nelson Mandela/HSRC Survey of HIV/AIDS*: *South African National HIV Prevalence. Behavioural Risks and Mass Media Household Survey 2002*. Cape Town: Human Sciences Research Council (HSRC) Press.

Shisana, O., Rehle, T., Simbayi, L. C., Parker, W., Zuma, K., Bhana, A., Connolly, C., Jooste, S. & Pillay, V. (2005). *South African national HIV prevalence, incidence, behaviour and communication survey*. Cape Town: HSRC Press.

Shisana, O., Rehle, T., Simbayi L. C., Zuma, K., Jooste, S., Zungu, N., Labadarios, D., Onoya, D., Davids, A. & Ramlagan, S. (2014). *South African National HIV Prevalence, Incidence and Behaviour Survey, 2012.* Cape Town: HSRC Press.

Shisana, O., Zungu, N. & Pezi, S. (2009). Poverty and HIV and AIDS. In P. Rohleder, L. Swartz, S. C. Kalichman & L. C. Simbayi (Eds.), *HIV/AIDS in South Africa 25 years on* (pp. 89-104). New York: Springer.

Shuell, T. J. (1986). Cognitive conceptions of learning. *Review of Educational Research*, *56*(4), 411-436.

Silverman, D. & Marvasti, A. (2008). *Doing qualitative research: A comprehensive guide*. Los Angeles, CA: Sage.

Stein, Z. A. (1990). HIV prevention: the need for methods women can use. *American Journal of Public Health*, *80*(4), 460-462.

Stewart, D. W. & Shamdasani, P. N. (1990). *Focus groups: Theory and practice*. Newbury Park, California: Sage.

Strauss, A. & Corbin, J. (1990). *Basic of qualitative research: Grounded theory procedures and techniques*. Newbury Park, California: Sage.

Terre Blanche, M., Durrheim, K. & Kelly, K. (2006). First steps in qualitative data analysis. In M. Terre Blanche, K. Durrheim & D. Painter (Eds.), *Research in practice: Applied methods for the social sciences* (pp. 320-344). Cape Town: University of Cape Town Press.

Ulin, P. R., Robinson, E. T., Tolley, E. E. & McNeill, E. T. (2002). *Qualitative Methods: A field for Applied Research in Sexual and Reproductive Health.* North Carolina: Family Health International.

UNAIDS. (1999). *Sexual behavioural change for HIV: Where have theories taken us?* Geneva: UNAIDS.

Van der Linde, I. (2013). Plenary Session 3, 20 June 2013 - *HIV/AIDS in South Africa: At last the glass is half full*. Human Sciences Research Council. Retrieved March 3, 2015 from http://www.hsrc.ac.za/en/media-briefs/hiv-aids-stis-and-tb/plenary-session-3-20-june-2013-hiv-aids-in-south-africa-at-last-the-glass-is-half-full.

Van der Riet, M. (2009). *The production of context: using activity theory to understand behaviour change in response to HIV and AIDS* (unpublished doctoral thesis). University of KwaZulu-Natal, Pietermaritzburg.

Van der Riet, M. (2012). Working with historicity: tracing shifts in contraceptive use in the activity system of sex over time. *PINS, 43*, 23-39.

Van der Riet, M. & Durrheim, K. (2006). Putting design into practice: writing and evaluating research proposals. In M. Terre Blanche, K. Durrheim & D. Painter (Eds.), *Research in practice: Applied methods for the social sciences* (pp. 81-89). Cape Town: University of Cape Town Press.

Van Maanen, J. (1983). Reclaiming qualitative methods for organisational Research: a preface. In J. Van Maanen (Ed.), *Qualitative methodology* (pp.9-18). London: SAGE Publications.

Varga, C. A. (1997). Sexual decision-making and negotiation in the midst of AIDS: Youth in

KwaZulu-Natal, South Africa. *Health Transition Review*, *3* (7), 45-67.

Virkkunen, J. & Kuutti, K. (2000) Understanding organizational learning by focusing on "activity systems". *Accounting, Management and Information Technologies 10(4)*, 291-319.

Vygotsky, L. S. (1978). *Mind in society: the development of higher mental processes*. Cambridge, Mass: Harvard University Press.

Williams, B. Gouws, E., Lurie, M. & Crush, J. (2002). *Spaces of vulnerability: Migration and HIV/AIDS in South Africa* (Series No. 24). Cape Town: Idasa.

Wood, K. & Jewkes, R. (2001). 'Dangerous' love: Reflections on violence among Xhosa township youth. In R. Morrell (Ed.), *Changing men in Southern Africa* (pp. 317-336). Pietermaritzburg: University of Natal Press.

World Health Organization (WHO). (2012). *HIV/AIDS* (Fact sheet). Retrieved 18 March, 2013 from http://www.who.int/mediacentre/factsheets/fs360/en/index.html.

Appendix 1: Ethical clearance letter 1 for broader study

UNIVERSITY OF
KWAZULU-NATAL
INYUVESI
YAKWAZULU-NATALI

Research Office, Govan Mbeki Centre
Westville Campus
Private Bag x54001
DURBAN, 4000
Tel No: +27 31 260 3587
Fax No: +27 31 260 4609
Ximbap@ukzn.ac.za

9 November 2011

Dr M van der Riet (24839)
School of Psychology

Dear Dr van der Riet

PROTOCOL REFERENCE NUMBER: HSS/0695/011
PROJECT TITLE: Activity theory and behavior change

FULL APPROVAL NOTIFICATION – COMMITTEE REVIEWED PROTOCOL

This letter serves to notify you that your application in connection with the above was reviewed by the Humanities & Social Sciences Research Ethics Committee, has now been granted **Full Approval** following your responses to queries previously raised:

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach/Methods must be reviewed and approved through an amendment /modification prior to its implementation. Please quote the above reference number for all queries relating to this study. PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

Best wishes for the successful completion of your research protocol

Yours faithfully

Professor Steven Collings (Chair)
Humanities & Social Sciences Research Ethics Committee

Appendix 2: Ethical clearance letter 2 for broader study

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

18 June 2012

Dr Mary van der Riet 24839
School of Applied Human Sciences

Dear Dr van der Riet

PROTOCOL REFERENCE NUMBER: HSS/0695/011
PROJECT TITLE: Activity theory and behavior change

Full approval notification- Amendment

This letter serves to notify you that your application for an amendment dated 6 June 2012, has now been granted full approval.

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

Best wishes for the successful completion of your research protocol.

Yours faithfully

Professor Steven Collings (Chair)

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

Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

Inspiring Greatness

Appendix 3: Ethical Clearance for this study

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

22 August 2013

Ms T Gabakaiwe 207503744
School of Applied Human Sciences
Pietermaritzburg Campus

Protocol Reference Number: HSS/0367/013M
Project title: Contradictions, tensions and dilemmas mitigating the adoption of risk reducing sexual behavior amongst youth in the [redacted] South Africa.

Dear Ms Gabakaiwe

Full Approval – Expedited
This letter serves to notify you that your application in connection with the above has now been granted full approval.

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach/Methods must be reviewed and approved through an amendment /modification prior to its implementation. Please quote the above reference number for all queries relating to this study. Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

Best wishes for the successful completion of your research protocol

Yours faithfully

.....
Dr Shenuka Singh (Acting Chair)

/px

cc Supervisor: Dr Mary van der Riet
cc Academic Leader Research: Professor D McCracken
cc School Administrator: Mr Sbonelo Duma

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Acting Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban, 4000, South Africa
Telephone: +27 (0)31 260 3587/8350/4557 **Facsimile:** +27 (0)31 260 4609 **Email:** ximbap@ukzn.ac.za / snymanm@ukzn.ac.za / mohunp@ukn.ac.za
Website: www.ukzn.ac.za
Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

Appendix 4A: Letter to the Chief (English)

Dr M van der Riet
Psychology, Pietermaritzburg,
P/Bag X01, Scottsville 3209

Dear Nkosi

I have worked in the with various research projects since 1990. In 2000-2003 we conducted research about HIV/AIDS, youth, relationships and sexual health. I would like to consult with you, and seek your permission to continue the research in the *Ematyholweni*, over the next few years.

The focus of the research would be on seeing how responses to HIV and AIDS have changed in the *Ematyholweni*. It would look at what people know about HIV and AIDS, what they think about it and how they are responding to it. The team of people working on the project is from the University of KwaZulu-Natal, in Pietermaritzburg, and also staff and students from Fort Hare University.

The research would involve interviews and focus groups with young people, parents, church groups, traditional leaders, traditional educators, traditional healers, and the clinic staff. It would also involve workshops at which information collected in interviews and focus groups will be presented and discussed. The process of the research project is meant to include the residents of the *Ematyholweni* in understanding and analyzing this information. It might happen that because we are all discussing the research process and the information together, changes will come out of the workshop process.

We would like to work in a few villages in the *Ematyholweni*. Unfortunately because of time constraints it will not be possible to work in all of the villages. The project data collection would start in 2012, and might continue until the end of 2013.

The interviews and focus groups will be recorded so that the researchers can accurately capture what it is that people have said, and translate it into English. The workshop process will be filmed using a video camera, also to accurately record what people discuss. This information will then be transcribed (or written down) from the video recording.

The names of all of the people who participate in the interviews and focus groups will be kept confidential and known only by the research team. Each participant will be given a code number so that their views will remain private.

The information collected in the research process will also be used to write research articles, and to present at conferences so that other people may learn from the experience of our research. Some of the students and lecturers conducting the research will be using the research project to study for their degrees.

I will be happy to answer any questions that you have about the project.

Yours sincerely

Dr Mary van der Riet
Senior Lecturer, Psychology, UKZN

Appendix 4B: Letter to the Chief (*isiXhosa*)

Dr M van der Riet
Psychology, Pietermaritzburg,
P/Bag X01, Scottsville 3209

Nkosi

Ndike ndasebenza e-*Ematyholweni* ndisenza iinkqubo zophando ezininzi ukusukela ngo 1990. Ngo 2000-2003 senza uphando ngentsholongwane nesifo sikagawulayo, ulutsha, ezobudlelwane kunye nempilo ekwabelaneni ngesondo. Ndingathanda ukuba sidibane, ukuzo cela imvume yakho yokuba siqhubeke noluphando e-*Ematyholweni* kuleminyaka embalwa elandelayo.

Ingqwalasela yoluphando kukubona ukuba iimpendulo malungelana nesifo sikagawulayo sezatshintsha na e-*Ematyholweni*. Oluphando lizakujonga ulwazi labantu ngentsholongwane nesifo sikagaqulayo, iingcinga zabantu ngesisifo kunye nokuba bapendula/bayibona kanjani lemeko.Iqela labantu abasebenza koluphando basuka e Yunivesithi yaKwaZulu-Natal, eMgungundlovu (Pietermaritzburg), kunye nabasebenzi, nabafundi abasukae Yunivesithi yaseFort Hare.

Oluphando luquka, udliwano-ndlebe kunye nengxoxiswano nolutsha, abazali, amabandla, inkokheli zesintu, iingcibi, abanyangi/izangoma kunye nabasebenzi base kliniki. Oluphando luzoquka/bandakanya iimfundiso/imihlangano apho ulwazi oluqokelelwe kudliwano-ndlebe nakwiingxoxiswano,
lizokwandlalwa khona. Lenkqubo yoluphando yenzelwe ukuba abahlali base *Ematyholweni* babe nesabelo ekuqondeni nasekucalucaleni olulwazi.Kungezeka ukuba ngenxa yokuba sixoxisana sisonke kulenqubo yophando kunye nakwi ncukacha, utshintsho lungavela emhlanganweni.

Singathanda ukuqhuba oluphando kwiilali ezimbalwa zase*Ematyholweni*. Kodwa ngenxa yokuba ixesha esinalo lufutshane, asizukwazi ukuba sisebenze kuzo zonke iilali.Uqokelelo-lwazi loluphando luzokuqala ngonyaka ka 2012 futhi lungaqhubeka kude kuyophela unyaka ka 2013.

Iindliwano-ndlebe kunye nengxoxiswano zizoshicilelwa ukwenzela ukuba abaphandi babambe ngononophelo oko abantu abakuthethileyo, bakutolikele kwisingesi.Inkqubo

yemfundiso/yomhlangano izoshicilelwa kusetyenziswa i-video camera, kushicilelwe nyanisekileyo oko abantu abakuxoxileyo.Olulwazi luzokubhalwa phantsi lusuka/lusukela kushicilelo lwe-video.
Onke amagama abantu abazobe behlomla/bethatha ingxaxheba kudliwano-dlebe nakwi ngxoxiswano azogcinwa efihlakele azokwaziwa liqela lophando kuphela.Wonke umntu ezoba ehlomla uzonikwa inombolo ukuze izimvo zabo zihlale zifihlakele.
Ezi nkcukacha ziqokelelwe kule nkqubo yophando zisosetyenziswa ukubhala amanqaku azokwaziswa/bhengezwa kwi nkonfa ukwenzela ukuba abantu bafunde kumava oluphando. Abanye babafundi nabafundisi-ntsapho abaqhuba oluphando bazokusebenzisa lenkqubo yophando ukufezekisa/ukugqibezela izifundo zabo. Ndingathanda ukuphendula yonke imibuzo mayelana noluphando.

Ozithobileyo

Dr Mary van der Riet
Senior Lecturer, Psychology, UKZN

Appendix 5A: Parent/guardian consent form (English)

Dr M van der Riet
Psychology, Pietermaritzburg,
P/Bag X01, Scottsville 3209

Dear Parent/Guardian

As you know we are doing research on HIV and AIDS. We would like your child _____ to be part of a Focus Group discussion on HIV and AIDS and relationships. This means that she or he will be part of a small group talking about what they know about HIV and AIDS and relationships. By talking to the younger children in the *Ematyholweni* and finding out what they know about HIV and AIDS, it might provide us with a way to stop more people from getting the disease. This is not a test to see how much your child knows, but it is a way of finding out whether there is anything we can do for young children in preventing HIV and AIDS.

The focus group will be held at _____ (village & place of focus group).
It will be run by _____ (researcher's name). It will take 30 to 45 minutes.

In the group discussion we will ask them questions such as:

1. What do they know about relationships?
2. How do parents talk about relationships
3. What do their friends say about relationships?
4. What are some of the problems of having relationships at their age?
5. What do they know about HIV?
6. What do they think they can do about HIV and AIDS?
7. Are there any questions that they have about HIV and AIDS?

We would like to assure you that these questions are not harmful to your child in any way. If your child does not want to answer any of the questions he or she is free to be silent.

We will use a digital recorder to record the discussion so that the researchers can write down accurately what the children in the group said. This will also help us to translate it into English so that all the researchers can understand.

When we have finished the discussion, and when it has been written down, we will take that information and use it in the community workshops. The names of the children who participate in the focus group will not be known to anyone but the researchers. Each child will be given a code name or number (for example, Participant 1 Focus Group 2). This will mean that if anyone sees the written information from the focus group, they will not know which child said what.

Although we are asking your permission for your child to participate, we will also ask your child whether or not he or she would like to be part of the discussion. There will not be any negative consequences if your child does not want to participate in this focus group.

Do you have any questions about the research or about the discussion group? (There is more information about the research in the INFORMATION SHEET which the researchers will give to you).

Yours faithfully

Dr Mary van der Riet
Senior Lecturer, Psychology, UKZN

CONSENT FOR MY CHILD TO PARTICIPATE IN THE FOCUS GROUP

- I agree that my child _____ (name of child) can participate in this research
- I have had an opportunity to read and understand the information sheet given to me.
- The purpose of the study has been explained to me. I understand what is expected of my child in this discussion.
- I understand that my child does not have to participate if he or she does not want to. I understand that even during the discussion, he or she may withdraw from the group if he or she does not want to participate.
- I understand although all the participants will be asked not to talk about the details of what is discussed, it is not possible for us to guarantee this.
- I agree that the discussion can be recorded and that my child's name will not be revealed in the recording
- I understand that the information collected in this discussion will be kept safe
- I understand that the information collected may be used for student studies, for future research, for conference presentations and for journal articles. I understand that in all of this my child's name will not be mentioned. I understand that no identifying information about my child will be published.
- I have the contact details of the researcher should I have any more questions about the research.

Signature of Parent/Guardian: _____ Date: _____

Appendix 5B: Parent/guardian informed consent form (*isiXhosa*)

Dr M van der Riet
Psychology, Pietermaritzburg,
P/Bag X01, Scottsville 3209

Incwadi ebhekiswe kumzali

Njengoba usazi, siquba umphando ngesifo sikagawulayo, iHIV ne AIDS.Besicela umntwana wakho
u……..abelilunga kwezingoxo esiziqhubayo mayelana nalomba.Sifuna ukuba bathethe ngalentsholongwani, basiphe ulwazi abanalo ngayo, ukuba lentsholongwane ibachaphazela kanjani abantwana abangangaye apha e *Ematyholweni*.Ololwazi lungase lusincede ekubeni sifumane iindlela zokuba sikwazi ukufumana iindlela esingase sincede ukuze esisifo siyeke ukuchphazela abanye abantu, nokuba sikwazi ukufumana iindlela zokunceda ulutsha.

Iingoxiswano zizobanjwa e _____ (ilali ne ndawo).
Iingxoxiswano zizokube ziqhutywa ngu _____ (igama lomphandi). Zizokuthatha imizuzu eyi 30-40.

Kwingxoxiswano sizokubabuza imibuzo efana nokuba:
1. bazi ntoni ngokuthandana?

2. Bathetha kanjani/bathini abazali ngokuthandana?

1. iitshomi zabo/oontanga babo bathini ngokuthandana?

2. zeziphi iingxaki ezikhoyo abantu abalingana naye abadibana nazo ngokuthandana?

3. loluphi ulwazi abanalo ngeHIV?

4. Yintoni abacinga ukuba bangayenza ukutshintstha isimo seHIV?

5. Ikhona na imibuzo abanayo ngeHIV ne AIDS?

Siyakuthembisa ukuba lemibuzo ayizukumphatha kakubi umntwana wakho nangeyiphi indlela. Ukuba kukhona imibuzo angafuni ukuyiphendula uvumelekile ukuba angayiphenduli.

Sifuna ukusebenzisa irekoda ukuba siteyiphe lengxoxo ukwenzela sizobhala phantsi lengxoxo. Izosinceda ukuba siyitolike kwenzele izobhalwa phantsi ngabanye abaphandi.

Ezincukacha zalongxoxo sizokuzisebenzisa kwiingxoxiswano nabanye abahlali. Asizuwasebenzisa amagama wabantwana, awazuvezwa phakathi kwabantu.Abantwana sizokubanika ikodi.Abantu abafunda izinto abazithethile abazukwazi ukuba zithethwe Ngubani.

Nangona sicela imvume kuwe, sizomcela nomntwana wakho ukuba uyafuna na ukuthabatha umnxeba kulenqubo. Akuzuba miphumelelo emibi ukuba uthe akafuni.

Ikhona imibuzo onayo ngalenqubo? Iincukacha zalenqubo ziyafumaneka kwicwecwe lencukacha zenqubo yophando elifumaneka kwabaphandi.

Othandekayo

Dr Mary van der Riet
Senior Lecturer, Psychology, UKZN

Appendix 6A: Interview questions 18+ unmarried people who have been in/or are in relationships (English)

Process:
Introduction of the research process
Sign consent documents
Obtain permission for audio-recording
Complete demographic information sheet

RELATIONSHIPS

- **If not in a relationship currently, questions are about what happened in the last relationship**

1. Have you been in a relationship before?
2. Are you in a relationship at the moment? Are you married?
    a. Is it with someone in the area?
3. Tell me a bit about the relationship
    a. How did it start?
    b. How old is your partner?
    c. How long has it been going on for? How long have you been married?

HEALTH RISKS

- **If not in a relationship currently, questions are about what happened in the last relationship**

4. In your relationship, have you discussed the risks of sex? Why/ why not?
    a. If yes, what risks have you discussed?
    b. Who raised the question of the risks?
    c. What was said in the discussion?
    d. Did anything change because of the discussion?
5. Do you think it is important to worry about safe sex in your kind of relationship? Why/why not?
    a. Do you think it is important to practice safe sex in your kind of relationship? Why/why not?
6. Have you discussed with your partner how to prevent getting a sexually transmitted infection?
    a. Please tell me briefly about that discussion (why did it come up? What was the worry/concern? Who raised it?)
    b. If no, why have you not discussed this?
7. Can you discuss sex freely with your partner? Why, why not?

CONDOM USE

8. Have you ever used a condom in your relationship?
    a. If yes, can you explain when and why?
    b. Do you always use a condom?

c. If no, why not?
d. How do you feel about getting a condom? Why?
e. Where would you get a condom? Are there problems with getting condoms? Elaborate

9. Are there other ways of practicing safe sex without using a condom? Please explain
10. Can you freely suggest using a condom to your partner? Why/why not?
    a. What would his/her reaction be if you suggested using a condom?
    b. How would you feel if your partner suggested using a condom?
11. Do you carry a condom with you? Why/why not?
    a. What do you think about a woman carrying a condom around with her?
    b. What do you think about a man carrying a condom around with him?
12. The last time you had sex, did you and your partner talk about condom use? Can you tell me what happened?
13. The last time you had sex did you use a condom? Can you tell me what happened?

HIV QUESTIONS

14. Can you tell me briefly what you know about HIV/AIDS?
    Please note I do not want to know your status, you do not have to tell me anything about whether you are positive or negative.
15. Have you ever talked to anyone about HIV and AIDS?
    a. If yes, please elaborate?
    b. If no, why not? What stops you from talking about HIV?
16. Is there anything you would like to know about HIV?
17. Do you know anyone in *Ematyholweni* who is HIV positive? (please do NOT tell me their names)
    a. How do you know they are HIV positive?
18. If someone is HIV positive should they tell others? Why/why not?
    a. Do you know of anyone who is HIV positive?
    b. How are people who are HIV positive treated in the *Ematyholweni*?
    c. Should this change? Why/why not?

TESTING

19. What do you know about HIV testing?
    a. What do you think about it? Is it a good/bad thing? Why?
20. Do you know your own HIV status? **(PLEASE DON'T TELL ME YOUR STATUS, ONLY WHETHER OR NOT YOU KNOW YOUR STATUS)**
21. Did you check your partner's HIV status before getting into the relationship? Why/why not?
22. Have you ever been for an HIV test?
    a. If yes,
        i. Why did you go?
        ii. What did you feel about going for the test?
        iii. Where did you go?

iv. What was it like?
v. Have you been again? How often do you go?
vi. Would you go again? Why/why not?

b. If no, why have you not gone?
i. What would need to change for you to go? (under what conditions would you go for a test?)

23. If you have a partner do you know his or her HIV status?
a. If yes, how did you find out? (did your partner tell you? Did you go for a test?)
b. If no, why not?
i. Do you want to know?

24. Have you discussed going for a test with your partner? Why/ Why not?

TREATMENT

25. Can HIV be treated?
a. If yes, how?
b. If no, why not?
c. If you had HIV, how would you treat it?
d. Where would you go in *Ematyholweni*for treatment?

26. What do you know about anti-retroviral treatment (ARV's)? (What is it, what does it look like, how does it work?)

27. Would you take ARV's if you needed to? Why/why not?
a. If yes, where would you go to get them?
b. If no, what would stop you from taking them?

GENERAL

28. What can be done about HIV and AIDS in the *Ematyholweni*?

29. What can YOU personally do about HIV and AIDS in *Ematyholweni*?

Appendix 6B: Interview questions 18+ unmarried people who have been in/or are in relationships (*IsiXhosa*).

Appendix 6B Imibuzo lodliwano-ndlebe: Abantu abatsha

Isingeniso senkqubo yophando
Fumana imvume yoku qhubeka nodliwano-ndlebe
Fumana imvume yoku shicilela udliwano-ndlebe

1. Wakhe wathandana na?
2. Ukhona Umntu othandana naye ngoku?
    a. Ngumntu walapha?
3. Bendicela undixelele kancinci ngobubudlelwane benu?
    a. Iqale kanjani?
    b. Uneminyaka emingaphi?
    c. Lixesha elingakanani?
4. Kobubudlelwane benu niyaxoxa na ngentlobano zesini neengozi ezichaphazela impilo?
        a. Zeziphi iingozi enizixoxayo?
        b. Zivuswa Ngubani ezingxoxo?
        c. Nathetha ngantoni kulengxoxo?
        d. Lukhona utshintsho olubonayo ngenxayale ngxoxo?
5. Kubalulekile na ukuba nizikhathaze ngengozi ezichaphazela impilo kwiintlobano zesini?
        a. Kubalulekile na ukuba nizikhusele xanisenza isini?
6. Nakenaxoxa na nomntu wakho ngokuzikhusela kwizifo ezigqithiswa ngesini?
        a. Ndicela undichazele ngalongxoxo?
7. Ukuba zange nixoxe, kutheni?
        a. Ungaxoxa ngokuzikhusela ngokukhululekileyo na nomntu wakho? Ngoba?
8. Nake nayisebenzisa na icondom?
    a. Bendicela undichazele?
    b. Uyisebenzisa njalo na icondom?
    c. Ukuba hayi, ngoba?
    d. Uziva kanjani xakufuneka ufemene icondom? Ngoba?
    e. Ungayifumanaphi icondom xa uyifuna? Zikhona ingxaki ojongana nazo xaufuna icondom?
9. Zikhona na ezinye iindlela zokuzikhusela ungayisebenzisanga icondom xa uzolala nomntu?
10. ngokukhululeka na umntu wakho ukuba makasebenzise icondom?
    a. Angathini?
    b. Ungathini wena ukuba umntu wakho angatsho lonto kuwe?
11. Icondom uyayiphatha na kuwe? Ngoba?
    a. Ucinga ntoni ngabafazi/amantombazane aphatha iicondom?
    b. Ucinga ntoni ngamadoda/amakhwenkwe aphatha iicondom?
12. Ukugqibela kwakho ukulala nomntu wakho, naxoxa na ngokusebenzisa icondom? Bendicela undichazelel ukuba kwenzeka ntoni?
13. Ukugqibela kwakho ukulala nomntu wakho, nayisebenzisa na icondom?
14. Bendicela undixelele ulwazi onalo ngeHIV/AIDS? (Ungandixeleli isimo sakho sentsholongwane, andifuni ukusazi sona)
15. Ukhona Umntu owakhe waxoxa naye nge ntsholongwane iHIV ne AIDS?
        a. Ukuba Ukhona, Bendicela undichazele?
        b. Ukuba akekho, kutheni, yintoni ekwenza ungathethi ngayo?

16. Ikhona na into ofuna ukuyazi ngeHIV/AIDS?
17. Ukhona na Umntu omaziyo apha e*Ematyholweni* onentsholongwane kagawulayo?
    a. Wazikanjani ukuba unentsholongwane kagawulayo?
18. Kuyafuneka na ukuba axelele abanye abantu na Umntu oneHIV ukuba unayo? Ngoba?
    a. Unaye na wena umntu omaziyo oneHIV?
    b. Baphathwa kanjani abantu abane HIV aphe e*Ematyholweni*?
    c. Kufanele kutshintshe na oku? Ngoba?
19. Wazintoni ngokuhlolwa kweHIV?
    a. Yinto entle okanye embi?
20. Isimo sakho seHIV uyasazi na?
21. Umntuwakho wasihlola na isimo sakhe sentsholongwane ngaphambi kokuba nithandane?
22. Wakewahlolwa na
    a. If yes,
        i. Wasiwa yintoni?
        ii. Waziva kanjani xausiyakuhlola?
        iii. Wayaphi?
        iv. Kwakunjani?
        v. Wakhe waphinda futhi? Kangaphi?
        vi. Uyozeuphinde na? Ngoba?
    b. Ukuba hayi, kutheni ungaphindanga waya khona?
        i. yintoni ekunofuneka itshintshe ukuze uphinde?
23. Ukuba unaye umntu onaye, Ingaba uyasazi na isimo sakhe se HIV?
    a. Ukuba uyasazi, wasazi kanjani?
    b. Ukuba akunjalo kutheni?
        i. Uyafuna na ukusazi?
24. Nakenaxoxa na nomkakho/nomyeni wakho ngokuyohlolwa?
25. Iyatritwa na iHIV?
    a. Ukuba iyatritwa itritwa kanjani?
    b. Ukuba akunjalongo, kanjani?
    c. Ukuba uneHIV uyitrita kanjani?
    d. Ungayaphi e*Ematyholweni* xaufuna itritment?
26. Zisebenza kanjani? ziyintoni?
27. Ungazithatha na iARVs xakukho isidingo sokuba uzithathe? ngoba?
    a. Ungazithatha phi?
    b. intoni enokunqanda ukuba ungazithathi?
28. Yintoni enokwenziwa ngeHIV e*Ematyholweni*?
29. Yintoni onokuyenza ngeHIV wena apha e*Ematyholweni*?

Appendix 7A: Interview questions, married people (English)

Process:
Introduction of the research process
Sign consent documents
Obtain permission for audio-recording
Complete demographic information sheet

RELATIONSHIPS
1. How long have you been married?
2. Tell me a bit about how you met your husband/wife?
3. Do you have children?
    a. What are their ages?
4. Do you talk to your children about sex?
    a. If yes, at what age did you/do you talk to them? Can you tell me briefly what you say?
    b. Do you talk to them about the risks in sex?
        i. What kinds of risks?
        ii. What can they do about these risks?
    c. If no, why do you not talk to them?
5. Have you been in a relationship before?

HEALTH RISKS
6. As married people, have you discussed the risks of sex? Why/why not?
    a. If yes, what risks have you discussed who raised the question of the risks?
    b. What was said in the discussion?
    c. Did anything change because of the discussion?
7. Do you think it is important to worry about safe sex in your marriage? Why/why not
    a. Do you think it is important to practice safe sex in your marriage? Why/why not?
8. Have you discussed with your wife/husband how to prevent getting a sexually transmitted infection?
    a. Please tell me briefly about that discussion (why did it come up? What was the worry/concern? Who raised it?) If no, why have you not discussed this?
9. Can you discuss sex freely with your partner? Why, why not?

CONDOM USE
10. Have you ever used a condom in your marriage?
    a. If yes, can you explain when and why? Do you always use a condom? If no, why not?
    b. How do you feel about getting a condom? Why? Where would you get a condom? Are there problems with getting condoms? Elaborate
11. Are there other ways of practicing safe sex without using a condom? Please explain.
12. Can you freely suggest using a condom to your husband/wife? Why/why not?
    a. What would his/her reaction be if you suggested using a condom? How would you feel if your husband/wife suggested using a condom?

13. Do you carry a condom with you? Why/why not?
    a. What do you think about a woman carrying a condom around with her What do you think about a man carrying a condom around with him
14. The last time you had sex, did you and your husband/wife talk about condom use? Can you tell me what happened?
15. The last time you had sex did you use a condom? Can you tell me what happened?

HIV QUESTIONS

16. Can you tell me briefly what you know about HIV/AIDS (Please note I do not want to know your status, you do not have to tell me anything about whether you are positive or negative).
17. Have you ever talked to anyone about HIV and AIDS?
    a. If yes, please elaborate?
    b. If no, why not? What stops you from talking about HIV?
18. Is there anything you would like to know about HIV? Do you know anyone in *Ematyholweni* who is HIV positive? (Please do NOT tell me their names)
    a. How do you know they are HIV positive?
19. If someone is HIV positive should they tell others? Why/why not
    a. Do you know of anyone who is HIV positive? How are people who are HIV positive treated in the *Ematyholweni*? Should this change? Why/why not

TESTING

20. What do you know about HIV testing?
    a. What do you think about it? Is it a good/bad thing? Why?
21. Do you know your own HIV status? (PLEASE DON'T TELL ME YOUR STATUS, ONLY WHETHER OR NOT YOU KNOW YOUR STATUS) Did you check your husband/wife's HIV status before getting married? Why/why not? Have you ever been for an HIV test?
    a. If yes,
        i. Why did you go?
        ii. What did you feel about going for the test? Where did you go?
        iii. What was it like? Have you been again? How often do you go?
        iv. Would you go again? Why/why not?

b. If no, why have you not gone?
    i. What would need to change for you to go? (Under what conditions would you go for a test?)
22. If you have a husband/wife do you know his or her HIV status?
    a. If yes, how did you find out? (Did your partner tell you? Did you go for a test?) If no, why not?
        i. Do you want to know?
23. Have you discussed going for a test with your husband/wife? Why/ Why not?

TREATMENT

24. Can HIV be treated?

a. If yes, how?
b. If no, why not?
c. If you had HIV, how would you treat it?
d. Where would you go in *Ematyholweni* for treatment?

25. What do you know about anti-retroviral treatment (ARV's)? (What is it, what does it look like, how does it work?)
26. Would you take ARV's if you needed to? Why/why not?
    a. If yes, where would you go to get them?
    b. If no, what would stop you from taking them?

GENERAL

27. What can be done about HIV and AIDS in the *Ematyholweni*? What can YOU personally do about HIV and AIDS in *Ematyholweni*?

Appendix 7B: Interview questions, married people (*IsiXhosa*)

Process:
Isingeniso senkqubo yophando
Fumana imvume yoku qhubeka nodliwano-ndlebe
Fumana imvume yoku shicilela udliwano-ndlebe

RELATIONSHIPS
1. Lingakani ixesha seleutshatile?
2. Bendicela undichazele kancinci ukuba nadibana kanjani nomyeni wakho/nonkosikazi wakho?
3. Unabo na abantwana?
    a. Mingaphi iminyaka yabo?
4. Uyathetha na nabo ngokuthandana nentlobano zesini?
    a. Waqala nini ukuthetha nabo ngezizinto?
b. Bendicela undixelele kancinci ukuba uthini kubo?
    c. Uyathetha na nabo ngeengozi zentlobano zesini?
        i. Uthetha ngeziziphi iintlobo zenengozi?
        ii. Yintoni abanokuyenza bona ngezizingozi?
    d. Ukuba awuthethi nabo, kutheni ungathethi nabo?
5. Wena wake wanaye Umntu othandana naye?

HEALTH RISKS
6. Njengabantu abatshatile, niyaxoxa na ngengozi zeentlobano zesisni?
    a. Ukuba kunjalo, zeziphi iingozi enizixoxayo?
    b. Ngubani owavusa lombandela wezizingozi?
    c. Kwathiwani kulengxoxo?
    d. Khona uthsintsho owalibona ngenxayalengxoxo phakathi kwenu?
7. Xa ucinga, kubalulekile ukuba kuthethwe ngokulalana okukhuselekile emthsatweni?
    a. Xa ucinga, kubalulekile ukuba nizikhusele xanilala emtshatweni wenu?
8. Wakewaxoxa nomkakho/nomyeni wakho ngezifo ezigqithiselwa ngokulala?
    a. Bendicela undichazele kancinci ngalengxoxo?
    b. Ukuba akunjalo, kutheni?
9. Uyaxoxa ngokukhuleka ngentlobano zesini nomyeni/nomkakho?

CONDOM USE
10. Niyazisebenzisa na iicondom emtshatweni wenu?
    a. Ukuba kunjalo Bendicela undixelel ukuba wazisebenzisa nini, kutheni?
    b. Niyisebenzisa njalo na icondom?
    c. Ukuba akunjalongo, kungoba kutheni?
    d. Uziva kanjani xakufuneka uyofumana icondom? Ngoba?
    e. Uyfumanaphi icondom, zikhona ingxaki ojamelana nazo xaufuna icondom? Bendicela uchaze
11. Zikhona na ezinye iindlela zokuzikusela ungayisebenzisanga icondom? Ndicela undichazele
12. Uyakwazi na ukumcela umyeni wakho/umkakho ukuba manisebenzise icondom ukhululekile?
    a. Uye athini xausenza esisicelo?
    b. Ungaziva kanjani ukuba umkakho/umnyeni wakho angakucela ukuba nisebenzise icondom?

13. Uyayiphatha na wena icondom? Ngoba?
    a. Ucinga ntoni ngabafazi abaphatha iicondom?
    b. Ucinga ntoni ngendoda ehamba iphethe icondom?
14. Nathetha na ngokusebenzisa icondom? Bendicela undichazele ukuba kwenzeka ntoni?
15. Ukugqibela kwakho ukulala nomntu wakho, nayisebenzisa na icondom?

HIV QUESTIONS

16. Bendicela undixelele kancinci ngolwazi onalo ngentsholongwane ka gawulayo? (Andifuni kwazi ukuba upositive na)
17. Ukhona umntu owake wathetha naye nge AIDS
    a. Bendicea undichazele
    b. Ukuba akekho, kutheni engekho?
18. Kukhona na into oralela ukuyazi ngesisifo?
19. Kukhona na Umntu apha e *Ematyholweni* omaziyo ukuba upositive?
    a. Wazikanjani ukuba upositive lomntu?
20. Ukuba Umntu uneHIV okanye iAIDS, kufanele na abazise abanye abantu? Ngoba?
    a. Ukhona na Umntu omaziyo oHIV positive?
    b. Baphathwa kanjani abantu abanentsholongwane apha e*Ematyholweni*?
    c. Kufuneka itshintshe na lento?

TESTING

21. Loluphi ulwazi onalo ngokuhlolwa kwentsholongwane kagawulayo?
    a. Ucinga ntoni ngayo,yinto entle okanye ayintlanga? Ngoba?
22. isimo sakho seHIV uyasazi na? ndicela ungandixeleli ukuba sithini
23. Umyeni wakho, umkakho wamhlola na intsholongwane ngaphambilokuba nitshate?
24. Wena wake wayihlolelwa iHIV?
    a. Ukuba kunjalo
        i. Kwakutheni uzeuye
        ii. Wawuziva kanjani ngelixeshauyohlolwa?
        iii. Wahlolwa phi
        iv. Kwakunjani?
        v. Selekewaphinda, kangaphi?
        vi. Ungaphinda futhi uyohlolwa? Ngoba?
    b. Ukuba zange uphinde, kutheni?
        i. yintoni ekunofuneka itshintshe ukuze uphinde?
25. Ukuba unaye umfazi/inkosikazi, uyasazi na isimo seHIV sakhe?
    a. ukuba uyasazi, usazi kanjani?
    b. Ukuba awusazi, kutheni ungasazi?
        i. Uyafuna na ukusazi?
26. Nakenaxoxan nomkakho/nomyeni wakho ngokuyohlolwa?

TREATMENT

27. Iyatritwa na iHIV?
    a. Ukuba kunjalo, kanjani?
    b. Ukuba akunjalongo, kanjani?
    c. Ukuba uneHIV uyitrita kanjani?
    d. Ungayaphi e*Ematyholweni* xaufuna itritment
28. Uyazazi iARVs?
29. Ungazithatha na xakunesidingo sokuba uzithathe? ngoba?
    a. Ungayozithatha phi?

b. Yintoni enokunqanda ukuba ungazithathi?

GENERAL

30. Yintoni enokwenziwa ngeHIV e*Ematyholweni*?
31. Yintoni onokuyenza ngeHIV wena apha e*Ematyholweni*?

Appendix 8A: Information Sheet about the Research Project (English)

Dr M van der Riet
Psychology, Pietermaritzburg,
P/Bag X01, Scottsville 3209

INFORMATION SHEET ABOUT THE RESEARCH PROJECT

Dear resident of the *Ematyholweni*

You may know that I have conducted research here in the *Ematyholweni* before. That research was about HIV and AIDS and what you as residents of the *Ematyholweni* think about HIV and AIDS, and how you respond to HIV and AIDS. In that research we spoke to youth and parents about relationships, about sex, about sexual health, and about the risk of HIV and AIDS.

In this research project we want to show you some of the things that we found in that research, and find out what you think about those findings. We would like to hold a few workshops where we talk about the findings of that research.

It has been a number of years since that research project, and perhaps things have changed in the *Ematyholweni*. We would therefore also like to conduct more interviews, and focus group discussions with traditional leaders, young people, parents, traditional educators, traditional healers, church members and the clinic staff. In these interviews and focus group discussions we would ask you to talk about relationships, sexual health practices, and what you think about HIV and AIDS.

The interviews and focus groups will be recorded so that the researchers can accurately capture what it is that people have said, and translate it into English, so that all of the researchers can understand it.
Once we have held the interviews and focus groups, we will take the information, and make it confidential. Each person who participates will be given a code number, so that his or her name is not used. This means that you will not be able to know who said what in the interviews or focus groups.

This information will then be used in another workshop, where we can all discuss what people say about relationships, and sexual health. In this way, we hope to see what people in the *Ematyholweni* feel about the problem of HIV and AIDS, and what you feel can be done about

it. The workshop process will be filmed using a video camera, also to accurately record what people discuss. This information will then be transcribed (or written down) from the video recording.

Mary van der Riet, who you know has conducted research in the *Ematyholweni* before, is the leader of the project. She is now living in KwaZulu-Natal and is a lecturer at the University of KwaZulu-Natal. There will also be a few students and lecturers from the University of KwaZulu-Natal, and some from the University of Fort Hare, who are helping her with the research. Some of these people may do the interviews and focus groups, and they will be at the workshops. We will introduce all of these people to you.

The information collected in the research process will also be used to write research articles, and to present at conferences so that other people may learn from the experience of our research. Some of the students and lecturers conducting the research will be using the research project to study for their degrees.

We would like to do this research process in a few villages in the *Ematyholweni*. It depends on how much time we have. The project data collection would start in 2012, and might continue until the end of 2013.

We would like to invite you to participate in the research project. The more people who participate, the more different views we have of the problem. If you have any questions, then please let us know. You can talk to us directly, or you can call Mary on xxxx.

This project has been approved by the Ethics committee of the University of KwaZulu-Natal. If you have any questions about the ethical issues in this project, then you can contact Ms Carol Mitchell on xxxx, or Ms Carol Mitchell, School of Psychology, University of KwaZulu-Natal, Private Bag X01, Scottsville, Pietermaritzburg, 3201 or email xxxx.

Yours faithfully

Dr Mary van der Riet
Senior Lecturer, Psychology, UKZN

Appendix 8B: Information Sheet about the Research Project (*isiXhosa*)

UNIVERSITY OF
KWAZULU-NATAL
INYUVESI
YAKWAZULU-NATALI

Dr M van der Riet
Psychology, Pietermaritzburg,
P/Bag X01, Scottsville 3209

Ucwecwe lencukacha mayelana nenkqubo yophando

Mhlaliwase*Ematyholweni* othandekayo.

Ningazi ukuba ndakendenza inkqubo yophando apha *Ematyholweni* ngaphambili.Olophando lwalumayelana nentsholongwane kunye nesifo sikagawulayo, nokuba nina ningabahlali base *Ematyholweni* nicingantonina ngentsholongwane kunye nesifo sikagawulayo nokubanisithatha/nisibonakanjanina esisifo. Kolophando, saathetha/saathethisana nabantu abatsha, kunyenabazali mayelana nobudlelwane, ukwabelana ngosondo, ezempilo ekwabelaneni ngesondo, kunyenobungozi bentsholongwane nesifo sikagawulayo.

Kulenkqubo yophando, sifuna ukunibonisa ezinye zezinto esazifumanisayo kolwaphando futhi sive ukuba nina nicingantoni ngezozinto. Singathanda ukubamba iimfundiso/imihlangano, embalwa apho sizothetha ngesakufumanisayo kolophando.
Seyadlula iminyaka, emvakwalankqubo yophando, mhlawumbi nezinto sezatshintsha e*Ematyholweni*. Singathanda ukwenza/ukuqhuba olunye udliwano-ndlebe kunyeneengxoxiswano, neenkokheli zesintu, abantu abatsha, abazali, iingcibi,abanyangi, abezenkolo kunye nabasebenzi base kliniki. Kwezodliwano-ndlebe kunye neengxoxiswano, singathanda ukuba nithethe ngobudlelwane, indlela ezikhuselekileyo zesondo, nokubanicingantonina ngentsholongwane nesifo sikagawulayo.

Udliwano-ndlebe kunye neengxoxiswano zizokushicilelwa ukwenzela ukuba abaphandi babambenyanisekileyo oko abantu abakutshileyo/abakuthethileyo futhi bakutolikele kwisingesi ukwenzela ukuba bonke abaphandi bakuqonde/bakuve.

Emvakokuba sesilubambile udliwano-ndlebe kunye neengxoxiswano, sizothatha iingcombolo/inkcazelo/inkcukacha sizenzeimfihlelo.Wonke umntu othathaingxaxheba uzokunikwa inombolo ukwenzela ukuba igamalakhe lingasetyenziswa.Oku kuchaza ukuba angekewazi ukuba ubani utshontoni kwindliwano-ndlebe neengxoxiswano.
Ezingcombolo/olulwazi, luzokusetyenziswa nakweminye imihlangano, apho sizoxoxa ukuba abantu bathini nangezobudlelwane, kunye nezempilongesondo.Ngalendlela, sithemba ukubona ukuba abantu base *Ematyholweni* bazivakanjani ngalengxaki yentsholongwane nesifo sikagawulayo nokuba bacinga ukubayintoni enokwenziwa ngaso.Le nkqubo yemihlangano izoshicilelwa kusetyenziswa I video camera ukwenzela ukuba kushicilelwe nyanisekileyo oko abantu abakuxoxayo.Ezingcombolo zizokubhalwa phantsi zithathwakwi video recorder.

UMary Van der Riet, enimaziyo, owakewenza uphando apha e*Ematyholweni* ngaphambili, nguye umkhokheli wale nkqubo. Ngoku sengumhlali waKwaZulu-Natal futhi ungumfundisi-ntsapho eyunivesithi yakwaZulu-Natal.Kuzobekukho abafundi abambalwa kunye nabafundisi-ntsapho abaphuma eyunivesithi yakwaZulu-Natal, nabanye abasuka eyunivesithi yase Fort Hare, abancedisa ngophando. Abanye baba bantu bangenza iindliwano-ndlebe kunye neengxoxiswano, futhi bazobe bekhona kwiimfundiso/kwimihlangano. Sizokubazisa bonke ababantu kuni.

Ezinkcukacha ziqokelelwe kulenkqubo yophando zizosetyenziswa ukubhala amanqaku azokwaziswa/bhengezwa kwinkonfa ukwenzela ukuba abantu bafunde kumava oluphando.Abanye babafundi nabafundisi-ntsapho abaqhuba oluphando bazokusebenzisa lenkqubo yophando ukufezekisa/ukugqibezela izifundozabo.
Singathanda ukwenza le nkqubo yophando kwiilali ezimbalwa zase e*Ematyholweni*. Kuzokuxhomekeka uku[redacted]exesha elingakanini na. Uqokelelo lwencukacha luzoqala ngo 2012 futhi kungenzeka ukuba luqhubeke ukufikela ekupheleni kuka 2013.

Singathanda ukunimema ukuba nithathe inxhaxheba kulenkqubo yophando.Ukubanabantu abaninzi abathatha inxhaxheba kuzonceda ukuba kubekho imibono emininzi eyahlukeneyo ngalengxaki.Ukuba unemibuzo, sicela uqhagamshelane no Mary kulenomboro xxxx.

Ukhuseleko lwabathathinxaxheba kulenkqubo yophando beselijongwe lavunywa yikomiti yezophando yaseYunivesithi yaKwaZulu Natal. Kodwa ukuba unemibuzo ungathintana no Ms Carol Mitchell kulenombolo xxxx okanye Ms Carol Mitchell, School of Psychology, Private Bag X01 Scottsville, 3201 okanye email: xxxx.

Ozithobileyo,

Dr Mary van der Riet
Senior Lecturer, Psychology, UKZN

Appendix 9A: Consent form interviews (English)

Dr M van der Riet
Psychology, Pietermaritzburg,
P/Bag X01, Scottsville 3209

Consent form Interviews

Dear Participant

In this interview we will ask you some questions about relationships, sexual health and the risk of HIV and AIDS. We would like to find out what your experience is, and what you think about these things.
The interview will take about 1 hour.

Once we have held the interviews and focus groups, we will take the information, and make it confidential. This means that you will be given a code number, so that your name is not used and not linked to the statements that you make.

We would then like to use the information we get from all of the interviews and also from the focus groups in workshops with more people. Then we can all discuss what people say about relationships, and sexual health. In this way, we hope to see what people in the *Ematyholweni* feel about the problem of HIV and AIDS, and what you feel can be done about it.

The information collected in the research process will also be used to write research articles, and to present at conferences so that other people may learn from the experience of our research. Some of the students and lecturers conducting the research will be using the research project to study for their degrees.

If you participate in the interview, your views will help us to have a different perspective on the problem of HIV and AIDS.

If you agree to participate, but then at a later time you feel that you would like to withdraw from the interview, or not participate any more, that is fine. You can say so and we will stop the interview.
If you have any questions, then please let us know. You can talk to us directly, or you can call Dumisa Sofika on xxxx or Mary on xxxx.

Yours faithfully

Mary van der Riet
Dumisa Sofika

CONSENT TO BE INTERVIEWED

- I agree to participate in this research
- I have had an opportunity to read and understand the information sheet given to me.
- The purpose of the study has been explained to me. I understand what is expected of me in terms of my participation in this study and the time commitment I am making to participate in this study.
- I understand that my participation is voluntary and I know that I may withdraw from the study at any point, without negative consequences.
- I understand that the information collected in this interview will be kept safe
- I understand that my identity will remain confidential
- I understand that the information collected may be used for student studies, for future research, for conference presentations and for journal articles. I understand that in all of this my name will not be mentioned and that my participation in this research will be completely confidential. I understand that no identifying information about me will be published.
- I have the contact details of the researcher should I have any more questions about the research.

Signature of Participant:_____ Date:_____

Appendix 9B: Consent form interviews (*isiXhosa*)

Dr M van der Riet
Psychology, Pietermaritzburg,
P/Bag X01, Scottsville 3209

Ucwecwe lemvume yokuthabatha inxeba kudliwanondlebe

Kulodliwanondlebe sizokubuza imibuzo edibene nokuthandana, intlobano zesini kunye negozi ezidibene neHIV ne AIDS. Sufuna ukwazi kuwe ukuba ucinga ntoni ngezizinto.

Udliwanondlebe uzokuthatha iyure enye

Emvakodliwanondlebe nengxoxiswano sizokuthatha iincukacha sizenze imfimfihlo.Uzokinikwa inomboro eyiyikodi ukwenzela ukuba igama lakho lingaveli, kwaye nezinto ozithethile.

Sizosebenzisa ezoncukacha zalodliwanondlebe kwingxoxo nabanye abantu.Sifuna ukuxoxisana ngezinto ezifana nokuthandana nezinto ezichaphazela impilo. Sifuna ukuva ngani ukuba Nicinga ntoni ngezizinto nokuba Nicinga ukuba kungathiwani ngazo

Iincukacha ezivela kwezingxoxo esizozibambha zizokusetyenziswa ekubhaleni amaphepha azobhengezwa kwinkomfi naphambi kwabanye abantu nabaphandi.Abanye abafundi bazosebenzisa lenqubo ukuze bafumane iidigri zabo.

Ukuthabatha inxeba kwakho kulenqubo kuzonceda ukuba sifumane amava ahlukene ngalengxaki yentsholongwane kagawulayo nesifo sikagawulayo.

Ukuba uyavuma ukuba lilunga lalenqubo, kodwa mhawumbe uphinde uzivekungathi awusafuni ukuthabatha inxeba kulenqubo uvumelekile ukuba uziroxise kulenqubo.Ukuba sisinqweno sakho ukuziroxisa sizokuyekisa.

Ukuba unemibuzo ngalenqubo ungatsalela umnxeba ku Dumisa Sofika kule nomboro xxxx okanye u Mary kule nomboro xxxx.

Mary van der Riet
Dumisa Sofika

Imvume yokuthabatha inxeba kudliwanondlebe

- Ndiyavuma ukuthabatha inxeba kulenqubo
- Ndilifumene ithuba lokufunda ucwecwe lencukacha zalenqubo futhi ndiyaziqonda
- Ndiyichazelwe intloso yalenqubo. Ndinalo ulwazi lokuba kudingwa ntoni kum futhi ndiyazibophelela ukwenza ezozinto ezicelwe kum.
- Ndiyaqonda ukuba akunyanzelekanga ukuba ndithabathe inxeba kulenqubo, futhi ndingayeka nanini apho ndithande ukuyeka khona.
- Ndiyaqonda ukuba zonke incikacha eziqokelelwe kulenqubo zizogcinakala ziyimfihle
- Ndiyaqonda futhi ukuba mna ndizogcinakala ndikhuselekile kulenqubo
- Ndiyaqonda ukuba incukacha ezivela kwezingxoxo esizozibambha zizokusetyenziswa ekubhaleni amaphepha azobhengezwa kwinkomfi naphambi kwabanye abantu nabaphandi. Abanye abafundi bazosebenzisa lenqubo ukuze bafumane iidigri zabo. Ndiyaqonda ukuba kuyyonke lenqubo, igama lam lizohlala likhuselekile.
- Ndinazo iincukacha zabaphandi kulenqubo kwaye ndingabatsalela umnxeba nanini ukuze ndicaciselwe ngemibuzo endinayo nangezinto endingaziqondi.

Isityikityo:_____Date:_____

Appendix 10A: Consent for audio recording interview/focus group (English)

CONSENT TO RECORD INTERVIEW

In order to be able to understand clearly what you have said in this interview/focus group, and to remember it, we would like to record the discussion on this small digital recorder. We will then listen to the recording and write it down (transcribe it). It will also be translated into English. After we have written the information down, we will then delete the recording on the digital recorder.

We assure you that your name will not be linked to the recording, or the written information from the recording. We will give you a code name, using numbers, for example Participant 1_Interview 3. Or Focus group 3.

Do you agree that we can record the discussion?

If yes, then please sign here: _____ Date:_____

Appendix 10B: Consent for audio recording interview/focus group (*isiXhosa*)

Ucwecwe lemvume yokuqopha udliwanondlebe

Ukuze sikuqonde kakuhle, futhi sikukhumbule okuxoxwe apha sifuna ukuteypa ingxoxo yethu nge rekoda.Sizophinde siyimamele lengxoxo kulerekoda sibhale phantsi iincukacha zalengxoxo.Ingxoxo izotolikwa ukuze iviwe ngabanye abaphandi.Ukuqhiba kwethu ukwenza lonto sizokuyicima yonke into ekwi rekoda.

Siyakuthembisa ukuba igama lakho alizukuvela kwi rekoda nakwizinto ezibhaliwe ephepheni.Igama lakho sizokuligcina liyimfihlo ngokulinika inomboro.

Uyavuma na ukuba siyiqophe ingxoxo?

Ukuba uyavuma, ndicela ubhale igama lakho apha: _____ umhla ka:_____

Appendix 11A: Confidentiality Pledge (English)

Confidentiality Pledge

As a member of this Focus Group, I promise not to repeat what was discussed in this focus group with any person outside of the focus group. This means that I will not tell anyone what was said in this group.

By doing this I am promising to keep the comments made by the other focus group members confidential.

Signed _____ Date: _____

Appendix 11B: Confidentiality Pledge (*isiXhosa*)

Isibophelelo sokugcina ingxoxiswano iyimfihlo
Njengelunga labantu abakulengxoxiswano, ndiyathembisa ukuba andizukithetha ngaphandle kwalamagumbi izinto esizixoxe namhlanje.Andizukuzithetha namntu izinto esizixoxe apha. Izinto ezithethwe ngabanye abantu zizohlala ziyimfihlo.

Igama _____ Date: _____

Appendix 12A: Focus group questions for 18+ young people, unmarried, married, parents, older people (English)

Process:
Introduction of the research using info sheet
Signing of consent documents
Obtain permission for audio-recording
Get demographic information on sheet

QUESTIONS ABOUT RELATIONSHIPS

- Use YOUNG If under 30 and unmarried
- Use MARRIED if married participants

1. Do (young/married) people in *Ematyholweni* have boyfriends or girlfriends?
    a. What is it called when they do this? (Is it dating? /what is dating)
    b. Are there different ways of having a boyfriend or a girlfriend? (What kinds of relationships do young/married people in the *Ematyholweni* engage in?
        i. Can you describe them?
        ii. What words do they use to describe these relationships?
2. What kinds of activity do boyfriends and girlfriends engage in?
3. When do young people in *Ematyholweni* have a chance to meet? Can you give examples? 4. Do people sometimes have relationships with people who are much older/younger than them?
    a. What do you think about this? (Is this a problem? Why/why not?)
5. Are people sometimes forced to have relationships? Why?
6. Do young/married people in relationships have sex?
    a. Why do they have sex? What do you think they want from sex?
    b. If they don't have sex, why not?

RISKS IN SEX

7. Are there risks in having sex? What are these risks?
    a. Do people in relationships discuss the risks in sex?
        i. Can you give me an example of this discussion? (Who started it, what was said, what happened after the discussion?)
        ii. Who usually raises the issue of health risks in relationships?
8. How do people having sex protect themselves from these risks?
    a. If they protect themselves, can you explain how they do it?
    b. If they don't do anything, why not?
    c. Do they discuss the risks with their partners?
    d. Do men and women worry about for these risks in the same way?
    e. Do men and women take responsibility for these risks in the same way?
9. Do you think people in long term relationships are concerned with the risks in sex?
    a. Do you think they should be concerned?
    b. What does safe sex mean for a couple who has been going out for a long time?
10. Do people use condoms?
    a. If they don't use condoms, why not?
    b. If they use condoms:
        i. When do condoms get used?
        ii. Who raises the issue of using a condom? Why this person?
        iii. Where do they get them from?
        iv. What are problems with getting condoms?

11. Do people in marriages use condoms? Why/Why not?
12. Should married couples, or couples in long-term relationships use condoms? Why? Why not?
13. What do you think if a woman carries a condom with her?
14. What do you think if a man carries a condom with him?
15. Do people in relationships have more than one partner? Why
    a. Is this the same for men and women? Why?
16. Do married people have more than one partner? Why?
    a. Is this the same for men and women? Why?
17. Do women talk about sex? Why, why not? Who do they talk to?
18. Do men talk about sex? Why, why not? Who do they talk to?

Additional questions for PARENTS
19. Do parents talk to their children about sex?
    a. If yes, at what age does this happen?
        i. Can you tell me briefly what is said?
b. If no, why not?

HIV QUESTONS
20. Can you tell me briefly what you know about HIV/AIDS?
NB I do not want to know about your status so you do not need to tell me if you are positive or negative.
    a.What is HIV/AIDS?
    b. How do people get HIV/AIDS?
    c. Can you tell if someone has HIV/AIDS? How?
    d. Do you think AIDS is curable? Please elaborate
    e. Have you ever talked to anyone about HIV/AIDS?
        i. If yes, whom did you talk to?
        ii. What did you talk about?
        iii. If no, why not? What prevents you from talking about HIV and AIDS?
    f. What would you like to know about HIV and AIDS?

21. Do you know of anyone who has HIV/AIDS? /Are there HIV positive people in *Ematyholweni*?
    a. How do you know that they are HIV positive?
    b. How do you feel around that person?
    c. How are people who are HIV positive treated in the *Ematyholweni*?
    d. Do you think this should change? Why/why not?
22. If people are HIV positive, do they tell others? Why/why not?
    a. Should they tell others? Why/why not?
23. Do people in the *Ematyholweni* get themselves tested for HIV?
    a. If yes, why do they go?
    b. If yes, where do they go?
    c. If no, what prevents people from going?
    d. What would need to change for people to go for testing?
24. Do people in relationships have discussions about HIV testing?
    a. If no why not?
    b. If yes, what kinds of things are discussed?
25. Do people in relationships encourage each other to know their HIV status?
    a. If yes, why?
    b. If no, why not?

26. Do men and women go for testing?
27. What types of treatments are there for HIV positive people?
    a. Where do they go for that treatment?
    b. If there is medication, what do you know about it? (Where do you get it, what does it look like, how much does it cost?)
    c. If there is medication, how does it work?
    d. What do you know about anti-retroviral treatment (ARV's)?
    e. Do people take ARVs' if they need to?
    f. How do they do this? Where do they go?
    g. If they don't take them, what stops them from taking them?
    h. Do you think that people should get treatment for HIV?

That is all the questions we wanted to ask you. Do you have any questions about the research process, or about what we have been discussing? Thank you for participating in this focus group.

Appendix 12B: Focus group questions for 18+ young people, unmarried, married, parents, older people (*IsiXhosa*)

Process:

Isingeniso senkqubo yophando

Fumana imvume yoku qhubeka nodliwano-ndlebe

Fumana imvume yoku shicilela udliwano-ndlebe

QUESTIONS ABOUT RELATIONSHIPS

1. Ingabe abantu abatsha/abatshatileyo bayajola na apha e*Ematyholweni*?
    a. Ibizwa ngantoni/kuthiwa yintoni xa besenza lonto? (kuyathandanwa?/yintoni ukujola?)
    b. Ingabe kukhona iindlela ezihlukile zokuthandana? (zeziphi ezikhoyo iindlela zokuthandana apha e*Ematyholweni*?)
        i. Bendicela nindichazele ngezizindlela?
        ii. Ngawaphi amagama asetyenziswayo xakuthethwa ngoluhlobo lokuthandana/abathandana ngalo?
2. Abantu abajolayo zeziphi izinto abazenzayo?
3. Ulutsha luwafumana nini amathuba okudibana? Bendicela nindiphe umzekelo
4. Kuyenzeka na ukuba abantu bathandane nabantu abadala/abancinci kakhulu kunabo?
    a. Nina ngokubona kwenu nithini ngalento? (Niyibona iyingxaki, ingeyiyo ingxaki?)
5. Abantu banyanzelekile ukuba babenabantu ngamanyane amaxesha? Ngoba?
6. Ulutsha/abantu abatshatileyo abathandanayo bayazenza intlobano zesini
    a. Bazenzelani intlobano zesini? Ngokubona kwenu, yintoni abafuna ukuyifumana kwintlobano zesini?
    b. Yintoni eyenza abanye abantu bakhethe ukungazenzi intlobano zesini?

RISKS IN SEX

7. Ingaba ikhona imiphumo emibi okanye iingozi ekubeni nentlobano zesini? Yeyiphi lemiphumo emibi?
    a. Ingaba abantu xa bethandana bayaxoxa ngengozi eziphathelene nokuba neentlobano zesini?
        i. Ningandenzela imizekhelo yezingxoxo (Ngubani oyiqalayo lengxoxo, uye athini, kwenzekani emva koko?)
        ii. Ngubani umntu ovusa umbandela wokuzikhusela kwingozi ezichaphazela impilo kwizithandani?
8. Bazikhusela kanjani abantu abenza iintlobano zesini kwezi ngozi?
    a. Ukuba bayazikhusela, bazikhusela kanjani (cacisa)?
    b. Ukuba abazikhuseli, yintoni eyenza ukuba bangazikhuseli?
    c. Bayathetha na ngengozi nabantu babo?
    d. Abantu abangomama notata bazikhathaza ngendlela efanayo ngizingozi?
    e. Kungabe abantu abangomama no tata bathatha inxaxheba yokuzikhusela kwezingozi ngendlela efanayo?
9. Kungabe abantu abasebekunye ixesha elide bayazikhathaza na ngeengozi zentlobano zesini?
    a. Xa nicinga, kufanele na bazikhathaze ngalonto?
    b. Kuthetha ntoni xabezikhusela kwintlobano yesini abantu abasebekunye ixesha elide?
10. Bayazisebenzisa na iicondom abantu?
    a. Ukuba abazisenbenzisi, yintoni eyenza ukuba bangaziseenzisi?
    b. ukuba ziyasetyenziswa iicondoms

i. Zisetyenziswa nini?
ii. Ngubani ekuba nguye ovusa indaba yecondoms xakuzolalwa? Kutheni ingulomntu?
iii. Bazifumana phi ezicondoms?
iv. Zeziphi iingxaki ezikhoyo ekufumaneni iicondoms?

11. Bayazisebenzisa na iicondoms abantu abasemtshatweni? Bazisebenzisela ntoni/kutheni bengazisebenzisi?
12. Abantu abasebetshate ixesha elide kufanele bazisebenzise na iicondoms?
13. Nicinga ntoni ngomtu ongumama/ngentombi ephatha iicondom kuyo?
14. Umntu ongutata ophatha icondom kuye nicinga ntoni ngaye?
15. Umntu onaye umntu anaye kuyenzeka ukuba abe nabantu abaninzi ajola nabo? Kwenziwa yintoni?
    a. Kuyafana ko mama no tata?
16. Abantu abatshatile kuyenzeka ukuba babenaye abantu babebaninzi?
    a. Kuyafana na ko mama no tata?
17. Bayathetha na abantu abangomama ngetlobano zesini? Kwenziwa yintoni? Bathetha nobani?
18. Amadoda ayathetha na ngentlobano zesini? Ngoba? Bathetha nobani?

Additional questions for PARENTS

19. Abazali bayathetha nabantwana babo ngentlobano zesini?
    a. Bathetha nabo xasebe neminyaka emingaphi?
        i. Bendicela nindixelele kancinci ukuba kuthethwa ngantoni?
    b. Ukuba akunjalongo kwenziwa yintoni?

HIV QUESTONS

20. Bendicela nindixelele kancinci ngolwazi eninalo ngeHIV/AIDS?

NB Andifuni kukwazi ukuba umntu upositive okanye negative na

    a. Yintoni iHIV/AIDS?
    b. Ifumaneka kanjani iHIV/AIDS?
    c. Uyabonakala na umntu oneHIV/AIDS? Ubonakala njani?
    d. .Xanicinga iyanyangeka iAIDS? Bendicela nindichazele.
    e. Ukhona umntu owake wathetha naye ngeAIDS?
        i. Kwakungubani lomntu?/ngubani umntu ongathetha naye ngeAIDS
        ii. Nathetha ngantoni? Yintoni eningayixoxa nalomntu?
        iii. Ukuba akheko umntu ongathetha naye kutheni kunjalo?
    f. Loluphi ulwazi onothanda ukubanalo ngeHIV/AIDS?

21. Ukhona umntu omaziyo oneHIV/AIDS? Bakhona na abantu abaneHIV/AIDS apha e*Ematyholweni*?
    a. Nazi kanjani ukuba bapositive?
    b. Uzivanjani xa uphambi kwalomntu?
    c. Abantu abanengculaza baphathwa kanjani apha e*Ematyholweni*?
    d. Xanicinga kufanele itshintshe lento? Ngoba?

22. Ukuba abantu bapositive, kukhona abantu ababaxelelayo? Ngoba?
    a. Kunyanzelekile na baxelele abanye abantu? Ngoba?
23. Abahlali balapha e*Ematyholweni*bayayixilongelwa na iHIV/AIDS?
    a. Bazixilongela ntoni?
    b. Baxilongelwa phi?
    c. Yintoni ebavimba ukuba bangayi kuyoxilongwa?

d. Yintoni ekunofuneka ukuba itshintshe ukuze abantu bazise ukuyoxilongwa?

24. Bayaxoxa na abantu abathandanayo ngokuzixilongela iHIV/AIDS?
    a. Ngoba?
    b. Zeziphi izinto abazixoxayo ngokuxilongwa?
25. Abantu abathandanayo bayacebisana ukuba mabasazi isimo seHIV/AIDS sabo?
    a. Ukuba ewe, ngoba?
    b. Ukuba hayi, ngoba?
26. Ingaba amadoda nabafazi bayaya na ukuyoxilongelwa iHIV/AIDS?
27. Yeyiphi intlobo yetreatment ekhoyo eyenzelwe abantu abapositive?
    a. Ithathwa phi le treatment?
    b. zikhona na iipilisi ozaziyo, wazintoni ngazo (zinjani, zithathwa phi, ziyimalini?).
    c. Isebenza kanjani/isetyenziswa kanjani?
    d. Loluphi ulwazi eninalo nge ARVs?
    e. Abantu bayazitya na iARVs xebefanele bazitye?
    f. Bayenza kanjani, bayaphi?
    g. Ukuba abazityi, banqandwa yintoni ukuba bangazityi?
    h. Xanicinga kunyanzelekile ukuba bayifumane itreatment abantu abapositive?

Iphelile imibuzo ebesifuna ukuyibuza kuni. Ikhona imibuzo enifuna ukuyibuza na kuthi ngezizinto ebesizixoxa? Enkosi ngothatha umnxeba kule focus group**.**

Appendix 13A: Consent form Focus group (English)

Dr M van der Riet
Psychology, Pietermaritzburg,
P/Bag X01, Scottsville 3209

Consent form Focus group

Dear Participant

In this focus group we will ask you some questions about relationships, sexual health and the risk of HIV and AIDS. We would like to find out what your experience is, and what you think about these things.
The focus group discussion will take about 1 to 2 hours. Once we have held the focus groups, we will take the information, and make it confidential. This means that all of you who participate in the discussion will be given a code number, so that your name is not used and not linked to the statements that you make.

As a member of this group we will also you to sign a confidentiality pledge. This means that you will not tell other people outside of this discussion in this room what was said by other group participants. This will help all of you to feel that you can speak more freely. However, we cannot ensure that each of your does not speak about the focus group, so please be aware when you talk in the group that it might not be kept confidential. When you talk in the group perhaps you could make comments about what people generally do, rather than referring directly to yourself, or to specific people.

We would then like to use the information we get from all of the focus groups and also the interviews in workshops with more people. Then we can all discuss what people say about relationships, and sexual health. In this way, we hope to see what people in the *Ematyholweni* feel about the problem of HIV and AIDS, and what you feel can be done about it.

The information collected in the research process will also be used to write research articles, and to present at conferences so that other people may learn from the experience of our research. Some of the students and lecturers conducting the research will be using the research project to study for their degrees. If you participate in the focus group, your views will help us to have a different perspective on the problem of HIV and AIDS.

If you agree to participate, but then at a later time you feel that you would like to withdraw from the discussion, or not participate any more, that is fine. You can say so and we will stop the discussion to allow you to leave.
If you have any questions, then please let us know. You can talk to us directly, or you can call Mary on xxxx.

Yours faithfully,

Dr Mary van der Riet
Senior Lecturer, Psychology, UKZN

CONSENT TO FOCUS GROUP

- I agree to participate in this research
- I have had an opportunity to read and understand the information sheet given to me.
- The purpose of the study has been explained to me. I understand what is expected of me in terms of my participation in this study and the time commitment I am making to participate in this study.
- I understand that my participation is voluntary and I know that I may withdraw from the study at any point, without negative consequences.
- I understand that there is a limit to confidentiality in a focus group setting as the researcher cannot guarantee that the other participants will adhere to the conditions of the confidentiality pledge.
- I understand that the information collected in this focus group will be kept safe
- I understand that the information collected may be used for student studies, for future research, for conference presentations and for journal articles. I understand that in all of this my name will not be mentioned and that my participation in this research will be completely confidential in this regard. I understand that no identifying information about me will be published.
- I have the contact details of the researcher should I have any more questions about the research.

Signature of Participant:_____ Date:_____

Appendix 13B: Consent form Focus Group (*isiXhosa*)

Dr M van der Riet
Psychology, Pietermaritzburg,
P/Bag X01, Scottsville 3209

Ucwecwe lemvume yengxoxiswano

Kulengxoxiswano sifuna ukukubuza imibuzo ngobudlelwane bokuthandana, iintlobano zesini nentsholongwane nesifo sikagawulayo.Sifuna ukuva ukuba ucinga ntoni ngezizinto.

Ingxoxiswano izothatha ixesha elingangeyure ezimbini.Emvakodliwanondlebe nengxoxiswano sizokuthatha iincukacha sizenze imfimfihlo.Uzokinikwa inomboro eyiyikodi ukwenzela ukuba igama lakho lingaveli, kwaye nezinto ozithethile.

Njengane lunga leliqela labantu abakulengxoxiswano, sizokucela ukuba usayine incwadi eyisibophelelo semfihlo.Ukusayina kwakho eliphepha kuthetha ukuba awuzukuzithetha izinto esizixoxe kweligumbi, okanye ezithethwe ngabanye abantu ngaphandle kwalamagumbi, kwabanye abantu.Kodwa, asinasiqiniseko sokuba abantu abazukuzithetha ezizinto ngaphandle kwalamagumbi.Sicela nilumke ukuba igenzeka lento.Mhlawumbi endaweni yokuba uchaze izinto ngawe, ungenza umzekelo ngezinto ezenziwa ngabanye abantu.

Emvakoko, sifuna ukusebenzisa ezincukacha eziqokelelwe kulenqubo kwezinye ingxoxiswano, phambi kwabanye abantu.Kwezongxoxiswano kulapho esingathetha khona, sive ukuba abanye abantu bacinga ntoni ngezizinto, nokuba bacinga ntoni ngeHIV neAIDS nokuba ingathiwani.
Iincukacha eziqokelelwe kulenqubo zizosetyenziswa ngabafundi ukubhala amaphepa wabo we research, nokufumana iidigri zabo, futhi zizokubhengezwa kwiikomfa phambi kwabanye abantu ukubazisa ngalenqubo yoluphando.

Ukuba uthabatha umnxeba kulengxoxiswano esiyibambayo, amava wakho azosinceda ukuba sibenemibono emininzi ngalenxaki yeHIV ne AIDS.

Ukuba uyavuma ukuba lilunga lalenqubo, kodwa mlawumbe emvakwexesha uphinde uzive ufuna ukuroxisa inxeba yakho kulomba, kulungile.Kufuneka ukhululeke usixelele, sizokuroxisa.
Ukuba unemibuzo ofuna ukuyibuza ungatsalela umnxeba kuMary kule nomboro xxxx.

Ozithobileyo

Dr Mary van der Riet
Senior Lecturer, Psychology, UKZN

Ucwecwe lwemvume yokuthabatha inxeba kwingxoxiswano

- Ndiyavuma ukuthabatha inxeba kulenqubo
- Ndilifumene ithuba lokufunda ucwecwe lencukacha zalenqubo futhi ndiyaziqonda
- Ndiyichazelwe intloso yalenqubo. Ndinalo ulwazi lokuba kudingwa ntoni kum futhi ndiyazibophelela ukwenza ezozinto ezicelwe kum.
- Ndiyaqonda ukuba akunyanzelekanga ukuba ndithabathe inxeba kulenqubo, futhi ndingayeka nanini apho ndithande ukuyeka khona.
- Ndiyaqonda ukuba zonke incikacha eziqokelelwe kulenqubo zizogcinakala ziyimfihle
- Ndiyaqonda futhi ukuba ndizogcinakala ndikhuselekile kulenqubo
- Ndiyaqonda ukuba incukacha ezivela kwezingxoxo esizozibambha zizokusetyenziswa ekubhaleni amaphepha azobhengezwa kwinkomfi naphambi kwabanye abantu nabaphandi. Abanye abafundi bazosebenzisa lenqubo ukuze bafumane iidigri zabo. Ndiyaqonda ukuba kuyyonke lenqubo, igama lam lizohlala likhuselekile.
- Ndinazo iincukacha zabaphandi kulenqubo kwaye ndingabatsalela umnxeba nanini ukuze ndicaciselwe ngemibuzo endinayo nangezinto endingaziqondi.

Isityikito: _____ Date: _____

Appendix 14: Transcription conventions

	(.)	Just noticeable pause
	(.3), (2.6)	Examples of timed pauses
	↑word, ↓word	Onset of noticeable pitch rise or fall *(can be difficult to use reliably)*
A: B:	word [word [word	Square brackets aligned across adjacent lines denote the start of overlapping talk. Some transcribers also use "]" brackets to show where the overlap stops
	.hh, hh	in-breath (note the preceding fullstop) and out-breath respectively.
	wo(h)rd	(h) is a try at showing that the word has "laughter" bubbling within it
	wor-	A dash shows a sharp cut-off
	wo:rd	Colons show that the speaker has stretched the preceding sound.
	(words)	A guess at what might have been said if unclear
	( )	Unclear talk. Some transcribers like to represent each syllable of unclear talk with a dash
A: B:	word= =word	The equals sign shows that there is no discernible pause between two speakers' turns or, if put between two sounds within a single speaker's turn, shows that they run together
	word, WORD	Underlined sounds are louder, capitals louder still
	°word°	material between "degree signs" is quiet
	>word word< <word word>	Inwards arrows show faster speech, outward slower
→		Analyst's signal of a significant line
	((*sniff*))	Transcriber's effort at representing something hard, or impossible, to write phonetically

Appendix 15: Extract codes

Extract number	Interview or focus group code
Extract 1	20120615_18-25_F_OJ_(Z)_(1)
Extract 2	20120505_18-25_M_FG_DS_Z_(E)
Extract 3	20120505_18-25_M_FG_DS_Z_(E)
Extract 4	20120512_26-34_M_DS_S
Extract 5	20120615_46-60_DZ_S
Extract 6	20120617_46-60_FG_M_DZ_S
Extract 7	20120612_35-45_F_DS_T
Extract 8	20120618_18-25_DD_R
Extract 9	20120617_35-45_F_OJ_S_(E)
Extract 10	20120508_18-25_M_DS_K_(E)
Extract 11	20120510_26-34_M_DS_S_(E)
Extract 12	20120512_26-34_M_DS_S_(E)
Extract 13	20120614_18-25_FG_F_OJ_Z
Extract 14	20120617_26-34_FG_M_DS_OJ_R_(E)
Extract 15	20120614_18-25_FG_F_OJ_Z
Extract 16	20120618_35-45_FG_F_DS_OJ_R
Extract 17	20120614_18-25_FG_F_OJ_Z
Extract 18	20120512_26-34_M_DS_S_(E)
Extract 19	20120505_18-25_M_FG_DS_Z_(E)
Extract 20	20120614_18-25_FG_F_OJ_Z
Extract 21	20120505_18-25_M_FG_DS_Z_(E)
Extract 22	20120510_26-34_FG_F_DS_T_(E)
Extract 23	20120617_46-60_FG_M_DZ_S
Extract 24	20120616_46-60_FG_F_OJ_DZ_Z
Extract 25	20120616_46-60_FG_F_OJ_DZ_Z
Extract 26	20120616_26-34_F_OJ_Z
Extract 27	20120617_35-45_F_OJ_S_(E)
Extract 28	20120510_26-34_FG_F_DS_T_(E)
Extract 29	20120616_46-60_FG_F_OJ_DZ_Z
Extract 30	20120615_35-45_DZ_U
Extract 31	20120612_35-45_F_DS_T
Extract 32	20120616_26-34_F_OJ_Z
Extract 33	20120613_35-45_F_OJ_S
Extract 34	20120616_35-45_DZ_U
Extract 35	20120511_46-60_M_DZ_

List of extract codes continued below:

Extract number	Interview or focus group code
Extract 36	20120615_46-60_DZ_S
Extract 37	20120617_46-60_FG_M_DZ_S
Extract 38	20120510_26-34_FG_F_DS_T_(E)
Extract 39	20120511_18-25_F_DS_Y_(E)
Extract 40	20120617_46-60_FG_M_DZ_S
Extract 41	20120505_18-25_M_FG_DS_Z_(E)
Extract 42	20120505_18-25_M_FG_DS_Z_(E)
Extract 43	20130530_F_18-24_FG_OJ_Z
Extract 44	20120510_26-34_M_DS_S_(E)
Extract 45	20120615_46-60_M_DS_V
Extract 46	20120505_35_45_M_DS_Z (Married)
Extract 47	20120617_26-34_FG_M_DS_OJ_R_(E)
Exract 48	20120618_35-45_FG_F_DS_OJ_R
Extract 49	20120616_46-60_FG_F_OJ_DZ_Z
Extract 50	20120617_46-60_FG_M_DZ_S
Extract 51	20120620_35-45_ M_FG_DZ_Y
Extract 52	20130317_FG_18-24_F_OJ_Z.WMA
Extract 53	20120614_46-60_F_DZ_T
Extract 54	20120613_35-45_F_OJ_S
Extract 55	20120612_35-45_DZ_Z_(E)
Extract 56	20120618_26-34_F_OJ_Z
Extract 57	20120515_18-25_F_OJ_(Z)_(1)
Extract 58	20120511_18-25_F_DS_Y_(E)
Extract 59	20120515_18-25_F_OJ_(Z)_(1)
Extract 60	20130317_FG_18-24_F_OJ_Z.WMA
Extract 61	20130607_F_OJ_25-30_Z
Extract 62	20130607_F_OJ_25-30_Z
Extract 63	20120617_26-34_FG_M_DS_OJ_R_(E)
Extract 64	20120617_62-34_F_DZ_Z_(E)
Extract 65	20120614_18-25_FG_F_OJ_Z
Extract 66	20120617_26-34_FG_M_DS_OJ_R_(E)
Extract 67	20120510_26-34_FG_F_DS_T_(E)
Extract 68	20130607_F_OJ_25-30_Z
Extract 69	20130530_F_18-24_FG_OJ_Z
Extract 70	20130317_FG_18-24_F_OJ_Z.WMA

List of extract codes continued below:

Extract number	Interview or focus group code
Extract 71	20120615_46-60_M_DS_V
Extract 72	20120617_35-45_M_DZ_X
Extract 73	20120510_26-34_M_DS_S_(E)
Extract 74	20120616_46-60_FG_F_OJ_DZ_Z
Extract 75	20120614_46-60_F_DZ_T
Extract 76	20120615_46-60_M_DS_V
Extract 77	20120618_26-34_F_F_OJ_S_(E)
Extract 78	20120620_35-45_M_FG_DZ_Y[1]
Extract 79	20120615_46-60_M_OJ_V
Extract 80	20120512_26-34_M_DS_S_(E)
Extract 81	20120512_26-34_M_DS_S
Extract 82	20120510_26-34_M_DS_S_(E)
Extract 83	20130530_F_18-24_FG_OJ_Z
Extrac 84	20120510_18-25_M_DS_S
Extract 85	20120617_35-45_M_DZ_X
Extract 86	20120512_26-34_M_DS_S
Extract 87	20120615_18-25_F_OJ_(Z)_(1)
Extract 88	20120617_35-45_F_OJ_S_(E)
Extract 89	20120616_26-34_F_DS_Z_(E)