COMMUNITIES OF PRACTICE

Contextual mediators of youth response to HIV/AIDS

Sentinel Site Monitoring and Evaluation Project

Stage Two Report

BEYOND AWARENESS CAMPAIGN
HIV/AIDS AND STD DIRECTORATE
DEPARTMENT OF HEALTH

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SENTINEL SITE MONITORING AND EVALUATION PROJECT
Stage Two Report

COMMISSIONED BY
Beyond Awareness Campaign
HIV/AIDS and STD Directorate
Department of Health

NOVEMBER 2000

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COMMUNICATING FOR ACTION
A contextual evaluation of
youth responses to HIV/AIDS

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ACKNOWLEDGEMENTS
We would like to acknowledge the contribution of the sentinel site co-ordinators and research assistants who were the cornerstones of this research process. There are also many people we would like to acknowledge who contributed to data collection processes in each site, not least the participants who freely shared with us their views and experiences.

COMMENTS
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ISBN: 1-875017-39-9

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EXECUTIVE SUMMARY

SCOPE OF THIS STUDY

This research study is a follow-up to 'Communicating for action: A contextual evaluation of youth response to HIV/AIDS' (Kelly, 2000) which was based on a survey of youth response to HIV/AIDS in six sentinel sites across South Africa. 'Communities of practice: Contextual mediators of youth response to HIV/AIDS' is essentially a qualitative exploration of factors mediating some of the findings of the earlier study. These have previously been analysed and discussed at a descriptive, quantitative level only.

Field research for this study was undertaken between May and August 2000 at six sentinel sites in South Africa. The sites include rural and urban communities and and the study draws on a sample of 760 youth and young adults (15-30 years of age).

This research focuses on contextual factors which mediate youth response to HIV/AIDS within specific sites, each with its own unique dynamics. In this report province names are used in association with each site. It must be noted however that the differences between sites are *not specific* to the provinces where they are located. Rather, these differences relate to the specific contextual features of each site.

The data in the report is drawn from the following sources:

- qualitative analysis of responses to open ended questionnaire items collected in stage one of this project;
- further analysis of focus group material collected in stage one of this project;
- fourteen focus groups conducted with youth in these sites;
- twelve interviews conducted on sex communication and sexual debut;
- a focus group and interviews around a youth project in one site.

KEY FINDINGS

In general, the study confirms the validity of the previous quantitative study and opens up a number of new areas of investigation.

Key thematic areas of the report are the media environment, communication contexts, mediators of risk management and care and mobilisation trends.

Media environment

- ❑ Youth in all sites are well informed, through a wide range of sources, of the causes of AIDS, how HIV infection occurs and how it can be prevented. There is little evidence of youth having misconceptions about the facts relating to the spread and prevention of HIV infection.
- ❑ Whilst youth show evidence of being exposed to a wide range of key prevention oriented messages, by far the most prominent emphasis has been on condom use. There has been relatively little development of messages related to abstinence and 'secondary' abstinence; gender issues; the connection between STDs and HIV prevention; the promotion of voluntary counselling and testing; delaying sexual debut; and the problem of age differentials between sexual partners.

- There has been little development of positive images to support different or new repertoires of behaviour. The targeted behaviours have been constructed in the minds of youth as avoidance behaviours rather than as affirmative or positive concepts.
- There has been little done to address contextual determinants of behaviour. Youth development appears to have received little attention in the communities studied and thus the background factors mediating youth vulnerability appear to be largely unchallenged and unchanged. This study considers some of the contextual factors needing to be addressed in each of the following areas: sexual activity; sexual debut; age differentials between partners; factors affecting sexual negotiation and decision making; mediators of condom acquisition and use; sex partner turnover and abstinence; HIV/AIDS care and support.
- This study confirms that very little education about sexuality and HIV/AIDS is taking place in schools or churches. Formal sex education in most of the schools in the sites studied is conducted by health educators or nurses who visit schools, as well as through occasional, and mostly once-off, inputs by teachers.
- Youth are exposed to numerous myths about deliberate infection and about the origins of the epidemic. There are also numerous myths about ways of avoiding AIDS. However, there is little evidence of the respondents or their acquaintances internalising or acting upon these myths. It is therefore concluded that the existence of myths should not be emphasised as a strong mediating factor exacerbating the epidemic. Instead, such myths can be understood as a symptom of the struggle to make sense of the epidemic and to find a personal relationship to its psycho-social realities.
- The red ribbon has been accepted as a universal symbol of HIV/AIDS and has largely positive meanings attached to it. In some instances in rural areas however, wearing the red ribbon may imply a direct personal association with HIV/AIDS, rather than social involvement and concern.

Communication contexts

- Youth learn about sex mainly from peers, older siblings and infrequently from their parents. Parents typically only educate their daughters about sex at menarche, and this is usually a once-off activity in the form of warnings about the risks of pregnancy and AIDS, with the greater emphasis on the former. Sons do not typically receive similar inputs, and are for the most part left to their own devices in finding out about sex, which they do mostly from peers. There is very little evidence in lower socio-economic groups of fathers' involvement in sex education, apart from admonishments and threats. There is also little evidence of systematic sex education from any source, including cultural forms of sex education, churches or community based organisations.
- A case study is presented which explores sex communication in one of the sites, a remote rural area of the Eastern Cape. This shows that over the last forty years there has been a marked decrease in parental involvement in regulation of adolescent sexual activity. This coincides with higher levels of youth independence from parental control. The study points to the need to understand the changing sex communication context and shows the negative impact of injectable contraception on sex regulatory practices.

Mediators of risk management

In understanding mediators of risk it is important to note that youth are not uniformly at risk to HIV infection. Rates of condom use during last sex act range from 22% to 79% accross the six sites. The percentage who had had sex perfore ranged from 30% to 90% in the 15-30 year age group accross the sites. These, amongst other findings, draw our attention to the importance of not generalising about youth sexuality and risk taking behaviour. In addition, in spite of complex situations and contexts, youth are not ignorant of HIV/AIDS, and in situations where such contexts are conducive to action, many youth are proactive in relation to the disease.

The following aspects were reviewed with regard to mediators of risk management.

- The predominant risk avoidance behaviour being employed is the use of condoms, but there is a wide range of options being adopted by youth. These include reduction in number of sexual partners, more careful partner selection, abstinence and secondary abstinence, alternatives to sexual intercourse, HIV testing, and a range of idiosyncratic responses.
- Attention is given to the need to understand patterns of condom use in relation to profiles of actual risk and in relation to subjective estimations of risk exposure. Importance is given to understanding the use of condoms as a contraceptive measure as well as sexually transmitted disease (STD) prevention method. There is a need to appreciate the impact of female injectable contraceptive use on condom use and on male attitudes towards sexual health concerns. It is also suggested that not enough has been done to understand the factors which mediate the maintenance of condom use.
- With regard to the need for personal risk avoidance, a number of factors are identified which work against perception of youth vulnerability. In addition, a number of factors are identified which mediate the failure to act when there is high perception of personal vulnerability. Perception of vulnerability to risk in relationships is mediated by the following: the assumption that if there is love in a relationship, the risk of infection is lessened; the failure to acknowledge the impact of previous sexual histories and networks in evaluating risk; and the assumption that risk decreases during the course of a relationship, with youth who begin safer sex practices deciding to forgo safe sex practices as the relationship becomes more established.
- Factors influencing sexual negotiation and decision making are explored with a particular emphasis on courtship practices and expectations laid down within conventional courtship practice. These are seen to increase HIV infection risk, and need to be understood in the management of HIV infection risk.
- Regarding sex partner turnover, emphasis is given to the need to understand different patterns of practice, notably concurrent multiple partnering, rapid serial monogamy, and casual sex. These imply different intervention strategies.
- Factors mediating sexual activity amongst youth are examined, including the association of sexual activity with material favours, lack of youth recreational activities, and the changing context of parental influence.
- There is strong corroboration of the quantitative finding that the age of first sexual experience has dropped considerably in the last fifteen years. Factors mediating this change in a remote rural area are explored with particular attention given to the changing nature of parental regulation, the changing nature of sexuality in courtship, and most importantly, the impact of the widespread use of female injectable contraceptives on the self-regulation of male sexuality.

- Factors mediating high age differentials between sexual partners in the first sexual experience are explored with particular emphasis on socio-economic mediators. Also discussed are the acceptance of high age differentials as normative, as well as lack of awareness of the illegality of sex acts between young girls and older boys/men (statutory rape). In the first study these were shown to be prevalent to a disturbingly high degree.
- Abstinence is an appealing option for young women, but as an abstinence choice usually involves choosing not to have a boyfriend, and there is strong pressure for young women to have boyfriends, it is a difficult approach to adopt. It is noted that 'secondary' abstinence, meaning a decision to abstain from sex after having already been sexually active, is a spontaneous choice being made in some settings.
- There is little evidence of ready access to voluntary counselling and testing (VCT) in the sites studied and there is little understanding of the VCT process, especially in rural communities. There has been little promotion of VCT as a resource for those in monogamous relationships who wish to stop using condoms.

Care and mobilization contexts

- Youth attitudes towards people with HIV/AIDS are mixed but it appears that the predominant orientation is sympathetic. Although there is much uncertainty around how to approach and relate to people with HIV/AIDS it appears that exposure to people who are openly HIV positive or who have AIDS leads to replacement of feelings of avoidance with more positive and sympathetic feelings.
- It appears that youth are strongly moved by testimonies of those who have disclosed their HIV status, but there is very little evidence of this happening, especially in rural communities.
- Images of AIDS as an incurable fatal disease and the lack of support systems have created a poor context for wanting to know one's HIV status, or for revealing one's HIV status to others. There remains a generally fatalistic attitude towards HIV/AIDS which is framed by the understanding that without readily available therapies or social support there is little benefit in knowing one's HIV status.
- The study shows varying levels of community mobilisation around HIV/AIDS with urban environments having much greater levels of mobilisation across a broad front of organisations. However, there appear to be few examples of ongoing youth involvement in HIV/AIDS projects. HIV/AIDS remains a 'special issue', and although youth show an interest in being involved, there appear to be few initiatives in the researched communities which are primarily youth oriented and driven. There is certainly evidence of 'once-off' or special event involvement of youth, but little sustained involvement. A notable exception is detailed in the study and characteristics which have mediated this success in spite of institutional support are: integration of HIV/AIDS activism with learning of life skills; a youth friendly *modus operandi*; a committed mentor; assistance in defining objectives; clearly defined roles and objectives; a sense of being part of a broader, important social movement; a sense of being of assistance to the community; provision of a permanent venue; and, a team approach.

CONCLUSIONS

Whereas a broad spectrum of South African youth are aware of HIV/AIDS and are responding positively at both prevention and care levels, the response is inconsistent and not sufficiently self-sustaining and such change is largely 'experimental'. Until there is an understanding of the personal challenges involved in making specific changes, and until behaviour change programming addresses these issues, the progress that is being made will not be self perpetuating. There is also unlikely to be spread of behaviour change to those areas that are responding more slowly.

There has been little change in the background mediatory factors identified in this study and the youth who have changed are for the most part those who are less at risk and those whose life circumstances are most promising. There is clearly a need to connect HIV prevention efforts to youth development work, if the causal factors behind risk behaviour and HIV exposure are to change. This requires an integrated framework for youth development work as well as a strategic plan for improving the circumstances of youth. Unfortunately, at ground level, there appears to be little evidence of this.

INTRODUCTION

This research study is a follow-up to 'Communicating for action: A contextual evaluation of youth response to HIV/AIDS' (Kelly, 2000) which was based on a survey of youth response to HIV/AIDS in six sentinel sites across South Africa. 'Communities of practice: Contextual mediators of youth response to HIV/AIDS' is essentially a qualitative exploration of factors mediating some of the findings of the earlier study. These have previously been analysed and discussed at a descriptive, quantitative level only.

Behavioural outcomes of HIV/AIDS communication programmes are ultimately as much a product of the 'milling' of ideas within communities and social networks as they are a product of the content of messages targeted at the public. This research is designed to understand some of the social dynamics which underlie the reception context of HIV/AIDS communications, and to appreciate how this context should be engaged in the interest of promoting behavioural repertoires which are sustainable within the framework of everyday community realities. HIV risk exposure does not happen in a vacuum and we need to understand its context if we are to be successful in intervention efforts. Whereas much work in the field of HIV/AIDS education has been aimed at either shifting the ideas and practices of individuals or peer groups, it is important to understand the "location of peer groups within 'communities', 'social institutions' and systems of 'culture, politics, economics, and environment' " (Campbell, 1999, p.8).

COMMUNITIES OF PRACTICE

The term *practice* that is used in the title of this report is intended to refer to the social aspects of behaviour. Practice is what we do when we adopt previously established conventions of behaviour, through which we enact social roles and their attendant meanings (which are usually not of our own making or choice). Practices are, for the most part, not novel or new, but rather draw on established and often historically meaningful repertoires of action.

The concept of *communities of practice* is borrowed from the literature of activity theory (Wenger, 1999). This is a well chosen expression to describe the social nature of action. If we wish to understand HIV risk behaviour and the difficulties of changing such behaviour, we need to look at how practices are structured at the level of the social groups and institutions that constitute society.

Through this study it is hoped that some insights into features of community and interpersonal functioning can be developed which are useful for developing effective responses to the HIV/AIDS crisis. Campbell (1999) advocates the value of the concept of *social capital*, saying that "Concepts such as social capital, which focus on formal and informal networks at the local community level of analysis, represent an important intermediary stage between the micro-social individual and the macro-social levels" (p.9). The concept of social capital provides some indication of how a community activity is organised in order that the community may participate in development and change processes, and one important aspect of this are the horizontal networks of formal and informal community interaction. Without community communication networks being penetrated and mobilised in the interest of promoting HIV/AIDS prevention and care, there are likely to be limits to progress. Importantly, satisfactory levels of social capital imply the likelihood that health promotion interventions will be effective. This relies on the community having organisational entities and systems that support the desired responses, and which may be activated towards this end (Gillies, 1998).

The rural community in the Eastern Cape is a case in point. Whilst the community, relative to other sites, is lacking in exposure to mass and local media, a more fundamental and pressing need is for the community to begin to organise itself around HIV/AIDS issues. There are currently no HIV/AIDS committees in this community and there is very little social-level concern about HIV/AIDS. The low levels of adoption of prevention measures in this community seems to have as much to do with the lack of local activity in response to HIV/AIDS as it has to do with relatively poor media exposure of this community. By studying the community as a 'practice' environment we can hopefully identify some of the factors which have hitherto shaped the community response to HIV/AIDS. Once these are identified they can be addressed if they are obstacles, or built upon if they promise solutions.

All human activities are part of complex and "continuously collectively constructed" systems of activity (Engestrom, 1993, p.66). Sexual activity has multiple determinants and these are constantly changing rather than homogenous and stable. It is thus important not only to understand community frameworks as contexts of practice, but to understand the change processes these are undergoing in the HIV/AIDS context. We should ask 'How are values, norms and expectations adjusting in relation to HIV/AIDS and what is driving this change?'. Whereas a study such as the present one can easily settle for a snapshot in time, it is important to add an historical perspective to this so as to understand emerging trends in community practice. If we can grasp emerging trends and understand their mediators we can harness and support positive emerging trends and thereby marry emerging community transformation with intervention.

RESEARCH ORIENTATION

As Parker in Gillies (1996) comments sex research has always been a low priority in the social sciences, and the HIV/AIDS epidemic has raised the need for a clearer understanding of sexual behaviour. But he goes on to point out that "As the epidemic has continued to expand, dissatisfaction with current sexual behaviour research has increased" (p.137). In response to dissatisfaction with largely descriptive survey type research, there has been an increasing emphasis on contextual studies of sex practice, often using qualitative methods. The more recent trend according to Gillies (1996) is to combine large-scale knowledge, attitudes, beliefs and practices (KABP) studies with those that attempt to understand why the outcomes described in KABP studies are what they are. In keeping with this trend the present study has been modelled on the need to pursue both lines of enquiry. It has become clear from the descriptive survey study that much still remains unanswered and the present qualitative enquiry is intended to pursue some of the lines of enquiry and questions opened up previously.

Whereas quantitative methodologies provide us with descriptions of patterns and trends, qualitative study provides insight into why these patterns are present. The concept of 'mediators of change' is important here and refers to the conditions that shape behaviour. This study is designed to identify what some of these conditions are. For instance, there is little to go on in the first part of this study to explain the often considerable age differences between partners at sexual debut in some of the sites of study, but not in others. Working qualitatively we can begin to sort the pieces of the puzzle and hopefully make some progress in understanding what mediates these inter-site differences.

The practical significance of this is that it helps us to identify the issues that need to be addressed in developing a concerted and sustainable approach to HIV risk reduction. Such study could never be exhaustive and at most it might be hoped that

a study such as this one would identify some specific avenues for intervention and more refined understanding of questions that need to be addressed.

In the survey study a number of specific issues were shown to be in need of further research. Not all of these are thoroughly addressed in the present study, but certainly some progress is made in addressing many of these issues.

- In the area of sexual interaction and risk prevention the following issues were identified as needing to be better understood:
  - negotiation of HIV risk prevention measures which depend on how, where, and under what conditions sexual experience is 'negotiated';
  - conditions which sustain high levels of risk exposure;
  - factors associated with coercion and lack of choice in this context;
  - gender relationships in sexual negotiation;
  - sexual decision making with respect to abstinence and secondary abstinence;
  - maintenance and consistency of risk prevention practices;
  - the changing dynamics of early and childhood sexual experience;
  - the place of material transactions and favours associated with sexual practice and negotiation;
  - the relationship between condom use and birth control practices – especially injectable contraceptives;
  - the changes in sex practice around male initiation.
- In terms of care, the following issues were identified as needing to be better understood:
  - the relationship between attitudes to care and prevention behaviour;
  - the taboo on discussion of HIV/AIDS in family contexts in some sites;
  - the relationship between exposure to persons living with HIV/AIDS and care.
- In terms of both aspects detailed above (prevention and care), it was also suggested that it is important to identify the mechanisms and resources which are conducive to an enabling environment for HIV/AIDS prevention, care and support.

A further aspect that oriented this research is the lack of a theoretical base to HIV/AIDS education work and evaluation thereof. A great deal has been said about the problems associated with existing models for understanding behaviour change, but there has been little real innovation in this field and the many 'different' models are actually quite similar.

What is still required is a model of change processes which can be employed in developing communal and societal response to HIV/AIDS, and that addresses factors which distinguish between once-off changes and sustained changes. For this we need to understand the contexts in which change is initiated and sustained. Change is seldom an all-or-nothing event and does not necessarily take place in a consistent, linear, accruing and step-wise fashion. Inconsistency, reversal, and 'leaping ahead' into changes which are not supported by a sustaining context need to be taken stock of in building models for developing individual, communal and societal responses to HIV/AIDS.

Qualitative research is often spoken about as 'theory generating' and at the outset of this study it was hoped that the ideas generated would be fruitful in terms of theory development. Towards this end the study concludes by exploring the development of a theoretical framework for understanding the processes involved in bringing about so-called behaviour changes.

NOTE ON TERMS USED

Risk reduction practices refer to practices which directly or indirectly reduce the risk of HIV infection. *Care practices* refer to the relationship of individuals and society to those directly affected by HIV/AIDS. Care involves direct health care (for example, counselling, treatment, care of the ill) as well as creation of a climate for psycho-social well-being (for example, minimising discrimination and stigmatisation). Care also includes social mobilisation and advocacy around human rights and support for those who are infected or directly affected by HIV/AIDS.

THE STUDY

OBJECTIVES

The objectives of the Beyond Awareness Campaign Sentinel Site monitoring and evaluation programme as a whole are:

- to describe the exposure of youth in each of six selected sentinel sites in South Africa to HIV/AIDS media and to ascertain the levels of penetration of HIV/AIDS intervention campaigns in each of these contexts;
- to assess the HIV/AIDS knowledge, attitudes, beliefs and practices profile of youth in the six sentinel sites with respect to HIV prevention practices and care issues;
- to describe the cumulative effect of the range of HIV/AIDS interventions, both formal and informal, that are present in each context;
- to monitor changes within each context with respect to HIV prevention practice, and to understand factors which mediate existing HIV prevention and care practices in each context;
- to provide strategic insights to those implementing the Beyond Awareness Campaign, and other national, provincial and local HIV/AIDS communication campaigns. In particular, to identify enabling and reinforcing factors that promise to make the most marked and sustained difference in promoting HIV prevention behaviour and a culture of HIV/AIDS care;
- to identify the key indicators that are useful in discriminating between levels of risk exposure, risk reduction practices and different responses in relation to care.

The specific objectives of the second stage of this research programme are:

- to explore further the mediating factors which may explain the marked differences which were found between the sites, in areas of both prevention and care;
- to explore the range of cultural, community and other contextual factors which are important to address in understanding youth sexuality and prevention practice;
- to explore specific important issues particular to two sites which were identified as worthy of being investigated in depth;
- to explore factors which have made a difference in promoting preventive practices and which have changed care practices;
- to explore factors within communities which have constrained change;
- to explore the range of resources within communities which contribute most significantly to positive youth responses to HIV/AIDS;
- to explore possible avenues for intervention within communities that take into account the above factors.

THE SIX RESEARCH SITES

The six sites are:

A rural community, Eastern Cape: A cluster of villages in Amatole basin between Alice and Hogsback in the former Ciskei area; African population; remote; dirt road access; no electricity at the time of the study; limited piped water; migrant labour; no permanent health facilities besides a day clinic staffed by visiting nurses; few youth facilities; a high school and number of primary schools; tribal authority; agricultural area but little to no development or commercial interests in the area; housing in permanent brick and/or wattle and daub structures; multi-generational 'households' living in groups of clustered houses.

A rural community, KwaZulu-Natal: A rural ward in Macambini district on Empangeni side of Tugela river; African population; community members mainly employed in factory town 25 km away; strong tribal authority and few youth structures or facilities; electricity; clusters of houses in households situated on small plots on average about 100 m from each other; some small scale forestry and sugar cane; close to highway.

A peri-urban suburb, Western Cape: Rocklands, a community in Mitchell's Plain, outskirts of Cape Town; 'Coloured' area; low- to middle-income area; sampling limited to out of school youth; relatively high exposure to multiple sources of information; small houses close to each other.

An urban school, Gauteng: Private high school representing socio-economically advantaged youth of all races; good access to media; representing youth predominantly from LSM (living standards measure) 7-8 range; mostly live in suburbs of Johannesburg.

An urban township, Northern Cape: Galashewe, a peri-urban township on the outskirts of Kimberley; African population; typical South African township with houses ranging from shanties, to old government houses, to Reconstruction and Development Programme (RDP) houses and bonded houses.

A tertiary Institution, Northern Province: Students at a large tertiary institution; mainly African population; students mainly from Northern Province; sample of residence students staying away from home.

In the appendix tables are presented showing further demographic features of each site, which may be helpful in understanding the data presented in this study.

This research focuses on contextual factors which mediate youth response to HIV/AIDS within specific sites, each with its own unique dynamics. In this report province names are used in association with each site. It must be noted however that the differences between sites are not specific to the provinces where they are located. Rather, these differences relate to the specific contextual features of each site.

METHODOLOGY

The on-site research was managed by six site co-ordinators who have worked and/ or live in these communities.

Site selection

The following criteria were applied in selecting sites for the study as a whole:

- ❑ geographical spread;
- ❑ rural and urban representation;

- variation in terms of channels of HIV/AIDS information available to the community;
- stable community in sense of a likelihood that the community would retain its coherence over a number of years, and that the community could serve as a sentinel site on a longer term;
- variation in terms of socio-economic variables, education, race and culture;
- variation in terms of expected media access and exposure to HIV/AIDS education programmes;
- convenience criteria in terms of availability of dependable and qualified research co-ordinators.

Data gathering

The following data sources were used:

- Responses to open ended questionnaire items which were collected in stage one of this project.
- Focus group data which was collected in stage one of this project.
- Data from 14 focus groups conducted across the six sites incorporating the experiences of more than 60 respondents. Male and female focus groups were separately conducted. Selection of focus group respondents was based on the following criteria: member of the community being researched; under 25 years old; respondents should not know each other; and respondents should be from different sectors of the community including more at risk sectors.

  Amongst other issues structured focus groups covered the following: What is being done to assist youth to protect themselves from HIV/AIDS; communication about HIIV/AIDS; prevention responses of youth; specific topics relating to mediators of early sexual debut, abstinence, secondary abstinence, faithfulness, condom use, HIV testing, coercion and sexual negotiation, and age differentials in sexual relationships; experience of, and attitudes to people with HIV/AIDS; existence of resources within the community; and mobilisation of youth to action.

  Focus groups were conducted in home languages of the respondents, or where home language was not used, in mixed language focus groups, care was taken to ensure that all respondents were comfortable in the language of the focus group. Focus groups were tape recorded and translated by site co-ordinators and transcribed into text format.
- In addition to the above focus groups, material was analysed from six focus group studies conducted as part of the phase one study, incorporating more than 50 respondents. The content of these focus groups was an exploration of the way in which HIV/AIDS communication has penetrated participants' lives.
- To investigate issues around very early sexual debut in the rural Eastern Cape site twelve in-depth interviews and two focus groups were conducted on the topic of early sexual experience and childhood sexual communication. Respondents were asked about how they had learned about sex and about the cultural, familial, school and other processes whereby they had learned about sex. They were also required to discuss in detail their early sexual experimentation and first sexual relationships.

  Two males and two females from each of the following categories were interviewed about their childhood experiences of sexual communication and first sexual experiences: 55 years and older; 35-45 years; 18-25 years. These age

groups were selected to provide an historical perspective on the changing patterns of youth sexuality and an understanding of the impact of mass communication and the HIV/AIDS epidemic have impacted on youth sexuality.

In addition two focus groups for 10 to 14 year old's were conducted on the topic of sexual communication and AIDS. Caution was taken not to introduce new sexual content material to the respondents and to stay within the framework of what they know. Children were recruited with the consent of their parents who signed consent forms.

- To investigate the functioning of a successful youth group in one of the sites a focus group and three interviews were conducted, spanning the first and second stages of the research. The head of the clinic and another staff member of the clinic where the youth group is based were interviewed, as were members of the youth group. They were required to discuss the formation of the group, its activities, the difficulties it faces, its achievements and its successful ingredients.

All respondents were provided with modest incentives for participating.

DATA ANALYSIS

Interviews and focus groups were translated, transcribed and converted into appropriate format for analysis using Atlas.ti, a software package for qualitative data analysis.

Qualitative data presented in the stage one questionnaires was further interpreted in the light of the themes which have emerged as central to this study.

NOTE ON CONFIDENTIALITY

In order to safeguard the identities of participating individuals and institutions mentioned in this study, identifying features have in some instances either been omitted or changed. The key demographic features which define each of the communities in question have however been retained.

MEDIATORS OF AWARENESS

MASS MEDIA

Exposure to key messages

In understanding HIV/AIDS communication it is important to note that formal campaigns are quite often disparate and not always uniformly branded. In addition, television or radio programming with HIV/AIDS objectives is not necessarily presented to the public as such. Beyond the level of formal campaigns, there also exists a wide range of information emerging through news and feature stories, magazine programming and the like. It was not the objective of this research to understand the impacts of specific campaigns, but rather to understand the impact of the broader millieu of HIV/AIDS communication that emerges through mass media channels. The following discussion is based on youth perception of such communication.

Unquestionably, mass media communication has predominantly emphasised the prevention of HIV – particularly the use of male condoms as a primary means of HIV prevention. As a result youth are well aware of the value of condoms in preventing HIV infection. Youth are also well aware of where to obtain condoms and how to use them. There is an understanding that condoms are not 100% safe and that condoms can be incorrectly used. There is little evidence that condoms have been made appealing or erotic, although there is a perception that bought condoms are preferable to condoms available through national free distribution programmes.

The second most prominent message to which youth have been exposed relates to faithfulness to one partner. This message has been understood as synonymous with limiting the number of partners. Youth are well aware of the risk of having numerous partners, although the message has been received as it applies to having multiple concurrent partners, more than to the case of a rapid turnover of partners in the context of serial monogamous relationships.

The third most prominent message relates to abstinence. However, reception of this message tends to be eclipsed by the exhortation to use condoms, and it was commonly expressed that condom messages tend to endorse youth sexuality and may actually promote sexual behaviour amongst younger children, in the face of the fact that children are becoming sexually active younger and younger. (This issue is discussed in more depth later in the report.) There has been little development of understanding of what abstinence means, or how it relates to sexual debut, and also how the pressures to become sexually active might be counteracted.

There is little evidence amongst the youth who participated in the study that messages relating to gender dynamics have featured prominently in HIV/AIDS communication, although, as will be reported later, there are some indications of changing gender dynamics in sexual relationships.

Other specific issues which received very little mention in discussions about HIV/AIDS prevention messages are: the connection between STDs and HIV prevention; the promotion of voluntary counselling and testing; delaying sexual debut; and the problem of age differentials between sexual partners. The latter two are of particular concern, but all of the above messages are widely recognised as being integral to a comprehensive approach to prevention, and yet have received little attention.

The method of using youth opinion leaders and heroes to deliver messages, has not been widely used. More respondents mentioned Magic Johnson as an example of a youth hero who is associated with the fight against AIDS, than any South African sporting or other hero.

More generally, and not specifically related to prevention, there is widespread perception amongst youth in this study that AIDS poses a serious problem to society. This does not always translate into personal perception of risk, but it is nonetheless widely recognised that AIDS is a real problem that somehow needs to be addressed.

The connection between tuberculosis (TB) and AIDS appears to have been widely understood to the extent that in some contexts it is assumed that if one has TB one also has AIDS.

There appears to be no specific media item which stands out as influential above the others, suggesting that youth have been exposed to a wide array of stimuli, none of which has had a specific dramatic emphasis. The most predominant recalled messages relate to condom use, faithfulness to one partner, and care for affected people.

The red ribbon has been accepted as a universal symbol for HIV/AIDS and it is largely imbued with positive meanings around care, concern and support. It appears that the wearing of ribbons by prominent politicians and media personalities on television has had a significant impact in creating a way of being concerned about HIV/AIDS which does not have negative connotations attached. However, there are some who are reluctant to wear a red ribbon because it may connote being HIV-positive and may have negative consequences because of this. This attitude is exemplified in such statements as: “People will look at me badly” and “People will be afraid of me because I have AIDS”. Whilst such attitudes are not dominant, they are particularly present in the two rural areas where there has been relatively little mobilisation and response around HIV/AIDS issues. Here wearing of the red ribbon appears to establish a personal association with HIV/AIDS rather than the social concern of the wearer.

Messages relating to care and support have featured prominently in media coverage. It appears that the promotion of destigmatisation has, like prevention promotion, been conducted on a wide front. Messages promoting reaching out to people with HIV/AIDS also appear to have been widely disseminated and there is a widespread recognition of the need to support and accept affected people. There has been a significant impact of story based reporting (such as appear in magazines and newspapers) and many respondents reported having been specifically moved to action after reading stories about, for example, families of children living together after their parents died.

Youth experience themselves as being extensively exposed to HIV/AIDS media from a large range of different sources, even in areas which are relatively impoverished in terms of media exposure. Although there are areas of prevention media which have been emphasised less, it can confidently be said that to the extent that the response to HIV/AIDS has been inadequate it is not because of lack of media exposure, but arguably to do with media emphasis and prevention strategy.

INFORMATION DISSEMINATION

The quantitative study showed that youth have a fairly sound understanding of the causes of AIDS and its prevention. However, there are some areas where there is a fairly widespread interest in further information. Amongst these is the understanding of the symptoms of AIDS and the distinction between HIV and AIDS.

There are some misconceptions about this, as well as indications of inappropriate vigilance relating to some of the symptoms of AIDS. For example, the presence of fever blisters, a persistent cough and weight loss are widely suspected to be associated with people with HIV/AIDS.

There are some areas where there is little to no understanding of HIV/AIDS related issues. For example there is little knowledge of the law relating to the illegality of underage sex. There is also poor understanding of the processes involved in voluntary counselling and testing and about how to obtain an HIV test, although youth are generally aware that one can be tested for HIV.

There are some areas where understanding is poorly developed but where there has been sufficient media coverage to create an interest, leading to uncertainty and confusion. For example, there is poor understanding of whether or not breastfeeding is advisable for HIV positive mothers. There is also confusion about the relation between being circumcised and HIV infection risk.

Many youth believe that they have all the information they need about HIV/AIDS and its prevention, and they believe that if they need to find out more they have access to appropriate sources of information. This is not the case in the rural sentinel sites where there are few resources for having questions answered. Thus emphasis should be placed on servicing these neglected areas, rather than supplying well serviced areas with information that is already known.

Commonly reported unanswered questions about HIV/AIDS

In response to a request that respondents note down their unanswered questions about HIV/AIDS the questions below occurred most frequently. It must be noted that some of these questions cannot necessarily be easily addressed through public information campaigns, as the 'answers' are often complex and require more than the simple key message approach to which mass media lends itself. There is thus a place for local level infrastructures that promote dialogue, as well as initiatives such as the AIDS Action Office which provides detailed informational leaflets, and the AIDS Helpline which provides basic information, counselling and referral. Common questions included:

- *How safe are condoms?* There seems to be some confusion, fed by messages that condoms are not, after all, one hundred percent safe; and by stories of condoms tearing or having holes pricked in them.
- *What are the risks associated with kissing given the possibility of the other person having sores in the mouth?* There was a great interest amongst respondents about the safety of kissing.
- *What are the risks associated with oral sex?*
- *What are the risks associated with transmission through body fluids other than blood and saliva, including whether urine and perspiration might be modes of transmission?* This shows that the general message about transmission through body fluids has firmly taken hold.
- *What is the risk of transmission through insect bites (mosquitoes and bed bugs)*?
- *What is the risk of transmission through contact sports?*
- *When will a cure be found?* It appears that youth do not fully appreciate that a cure may not be readily available and there is a sense of incredulity and disbelief about this.
- *Can washing after sex help to prevent infection?*
- *How does one go about obtaining an HIV test?* (often referred to as 'AIDS test')

- *How does one detect the symptoms of HIV/AIDS?*
- *How long can one survive with HIV/AIDS?*
- *What is the difference between HIV and AIDS?* It was pointed out that in the Zulu language these two are often considered synonymous.
- There were numerous questions about the origins of HIV/AIDS.
- There were quite a number of questions about the safety of ear piercing.

There are a number of significant myths and misconceptions about the origins and causes of AIDS. Interestingly, the link between HIV and AIDS was not called into question, although a number of other causes of AIDS were raised as possibilities, including the possibility that the lubricant on condoms is one possible cause of AIDS.

Myths and misconceptions about HIV/AIDS

There were a number of questions both in the questionnaire and in the focus groups, about the truth of a few myths which appear to have spread through all sites. The most common myth which arose in the focus groups concerns fruit having been injected with HIV. Also common was the myth of people being injected with HIV in the cinema, and on public transport.

There were numerous myths about folk cures for HIV/AIDS, but there was little evidence that respondents really believed these. The dramatic nature of some of these 'remedies' lends them towards being spoken about: for example, 'cures' for AIDS which involve having sex with virgins and drinking water in which a frog's skin has been boiled. The way that such remedies were discussed however, was at the level of "Some people say that…", but from the way they are spoken about in a humorous, disbelieving way, we might assume that these do not transcend towards practice of them. This does not mean that respondents would not resort to such treatments were they to 'need' them.

A number of myths emerged about the origins of AIDS, mostly to do with genocide, and this seems to be linked to suspicion raised by the fact that there has been no cure for AIDS. At least ten respondents enquired "Why has there been no cure for AIDS?", implying that it is to be expected that a cure would be found. In some cases at least this reasoning was connected to the idea that AIDS has been designed to control the population. This is mentioned in this report not because it showed itself in a strong way, but more out of an interest in showing the fringes of opinion. On the whole the youth in this study were well-informed and quite rational about HIV/AIDS and the nature of their questions reflects this.

COMMUNICATION CONTEXTS

COMMUNITY-BASED SOURCES OF INFORMATION

Schools

The present study confirms the findings of the quantitative study that there has been little HIV/AIDS communication within schools in the selected sites. What there has been has mostly been delivered by outside agencies and particularly government health services. This has been the case even in the remote rural Eastern Cape sentinel site. Topics covered include puberty, STDs, HIV/AIDS and birth control. Specific HIV prevention programmes have also been conducted in schools within all of the sentinel sites apart from the rural Eastern Cape site, but these are for the most part once off events, with little evidence of ongoing health communication programmes or health development programmes.

There is little evidence of dialogue based health education, although the teaching delivered in schools allows opportunity for discussion. There is also little evidence of sexuality or HIV prevention work being situated in wider lifeskills curricula, although in the Gauteng school there is some integration of lifeskills development and HIV/AIDS education.

Clearly, the education department has not mobilised its resources to developing sustained programmes within schools, and lifeskills education programmes have yet to be delivered in the schools that form part of this study.

Peers

Teenage boys and girls report seldom talking about sex in connection with HIV/AIDS, although they frequently talk about the opposite sex and their interest in members of the opposite sex. When the topic of sex is discussed it is almost always with same sex friends and there is little evidence of boys and girls freely discussing sexual health matters together. The risk of contracting HIV is also not commonly discussed amongst peers. This creates a poor context for sexual negotiation. More is said about this issue later. Suffice it to say here, that there are firmly established cultures of male and female communication which adolescent youth appear to be strongly beholden to, and which are not likely to change without concerted input using structured programmes of intervention.

Parents

There is very little evidence of sex education or HIV/AIDS being discussed at home. The only evidence for this emerged from the Gauteng site where many of the parents are professional people. Here there appears to be a less traditional family structure in the sense of strict divisions between parents and children, and there is greater openness and communication between parents and children. In other sites, however, there is little communication between either sons or daughters and their fathers, and between mothers and sons. Mothers tend to communicate with their daughters about sexuality and especially the risk of pregnancy at the time of menarche, but this is more often than not the limit of their involvement in sex education. Mothers in rural areas sometimes take measures to protect their daughters from pregnancy at the first signs of sexual interest and even at menarche, whether they are sexually active or not. “What I did is to send them to the clinic for injection after noticing they have boyfriends.” This issue and its psychological implications are discussed later.

There is evidence of penetration of media encouraging parents to talk to their children about sex, even in remote rural areas. “People nowadays are talking about sitting down with your children and talking about these things, but I haven’t done it, because it was never done to me” (female, 58, Eastern Cape). The following extract from an interview with a 22-year-old female respondent also suggests penetration of media encouraging better parent-child communication about sex:

Interviewer: *Is it something that would make you feel funny and uncomfortable?*

Respondent: *No, I would like her (mother) to talk to me about such issues. I really would because I was listening to the radio yesterday, a programme on the radio, it was a phone-in programme. It was about parents and children, communication between them, things like that. And I kept saying to my mother, ‘Ma do you hear that, do you hear how other parents relate to their children?’. I mean I am interested in her talking to me and I was trying to communicate that to her yesterday.*

In the above excerpt the child shows an interest in more open communication, and suggests that the mother usually puts up barriers to communication in this relationship. But, the following suggests that reluctance to talk about sexual issues does not only come from the mother’s side and children are also sometimes uncomfortable with open communication.

Interviewer: *Does you sister discuss things with your mother?*

Respondent: *Yes, she has no problem, she speaks about everything with my mother, but I’m not comfortable doing the same thing… She’s older and she’s more comfortable talking to my mother about these matters, I don’t know why but I’m not… When she was my age she was not comfortable either.*

It would seem from the above that we should be conservative in expecting parents and children to begin communicating about sex, unless this starts very early in their relationship and is accompanied by an open relationship conducive to such dialogue. Unless parents are themselves comfortable about talking about sexuality, and knowledgeable about the same it is likely that they will not be able to usefully facilitate such communication. It seems that once communication patterns between parents and children are well established they are difficult to change. This points to the need to work with young parents and even with teenagers who will one day be parents in order to develop parent child relationships beyond the communication impasse which seems to prevail. Specifically also, it is necessary for communications campaigns to be informed by a clear understanding of the contexts in which such communication might realistically take place, and the obstacles to the same, before undertaking costly mass media activities.

Churches and community-based organisations

There is very little communication within churches covered by the scope of this study apart from sermonising about the ‘dangers of AIDS’ and the value of abstinence outside of marriage. The perception was expressed that when HIV/AIDS is preached about in church there is very seldom new or valuable material discussed, and that priests are not experts on AIDS, so there is not much interest in what they have to say on the matter.

The nature of church involvement and responsibility is contested within some congregations. “At the Methodist church it is not talked about. The elders are too primitive. The last time the subject was raised it led to an argument. The Reverend is busy burying people but the older people and parents do not want to talk about it” (Northern Cape). What we can extract from this and other such accounts is that attempts to address HIV/AIDS issues may easily be constrained by the existing communication dynamics and more abiding concerns of religious institutions.

Similar dynamics appear to hold with respect to other types of community-based organisations ranging from soccer clubs to ward meetings at local government level. It cannot be expected that community-based organisations could participate in HIV/AIDS development activities without straying from their main purposes as organisations. Not only do such organisations not have the necessary expertise, but they are not aligned to the kind of concerted efforts that are required. It is suggested that whereas piggy-backing AIDS on other community development concerns may seem to be a natural and easy route to follow, it is likely to be a limited route, compared to the possible advantages of promoting and developing community-based organisations dedicated to HIV/AIDS education, care and support. There are obviously exceptions to this where existing community-based organisations offer strong possibilities of mobilisation in managing HIV/AIDS at community level. In this connection, it seems that churches could be a tremendous resource in the field of care and support, but it would appear from the accounts of youth (which may be limited) that there has not been much development of this latent capacity, at least not in the sentinel sites studied.

Case study: The sex communication context

The Amatole basin is an isolated rural community. Households are clustered on hillsides in 13 villages in a valley. There are few men in the village and few working youth as there is almost no opportunity for employment in this community. Community members graze cattle and goats, and there is little other agricultural activity of any note.

Twelve male and female members of this community were interviewed about their sex communication practices with parents, peers, siblings, and within community institutions during their childhood and early years, spanning a period of 1950 to the present.

In this context the patterns of sex communication between parents and children have not changed very much over the past 40 years. There is little discussion of sexual matters in the home and cultural and community practices have for many years not included any significant form of sexual education. In the words of a 58-year-old female: “What I did with my granddaughter is to send her to the clinic for contraceptives because I want her to continue with her studies and not to be disrupted by pregnancy.” The abiding concern here is with pregnancy. It seems that historically in this community, parents have become involved in regulating the sexual affairs of their children primarily to avoid pregnancy. But the nature of this regulation changed with the introduction of injectable contraceptives.

Previously boys and girls had to be instructed ‘not to play inside’. Adolescent sexuality had to be regulated for prevention of pregnancy. Adolescents were instructed to avoid penetrative sex, and only to have ‘panty’ or ‘thigh’ sex.

With the introduction of injectable contraception, this pattern changed significantly. It became a fairly common practice for mothers to take their daughters to the clinic ‘for injection’ at the first sign of a boyfriend and sometimes at menarche. The widespread use of this form of contraception amongst sexually active young girls, did away almost entirely with the need for any form of instruction of young men or women. The outcome is that in this community there is almost no sexual instruction for boys and little other than a warning and a three monthly visit to the clinic for girls.

This has set a problematic context for sexual communication in the HIV context. Firstly, there is little history of male use of condoms for birth control purposes and little tradition of involvement of males in sexual health concerns. Secondly, parents are not comfortable with sex communication and do not have personal experience to work from. In the words of a mother expressing her difficulties in addressing the issue of HIV with a child: “Nothing has changed, even though there is a need now”.

Thus this is a highly sexually active community of youth (see 'Age at first intercourse' on p.29) without a tradition of sex communication to draw on in developing responses to the HIV epidemic.

Sex communication programmes are not delivered into a vacuum. Development of a model of response to the HIV/AIDS crisis in this community has to incorporate an understanding of the meaning and psycho-cultural consequences of the availabitility of contraception, and particularlry injectable contraception, which requires little dialogue or personal engagement with sexual and reproductive health decision making and responsibility.

PERSONAL EXPERIENCES OF HIV/AIDS

Personal experiences of HIV/AIDS appear to have a remarkable and lasting impact on youth, although they do not necessarily involve message based communication, nor lead to a better knowledge of HIV/AIDS. There is no transfer of knowledge in such experiences, yet much evidence emerged in the study of the transformative effects in terms of both prevention and care.

Respondents in focus groups were asked to talk about their experiences of meeting people who they knew to be HIV positive or who had AIDS and respondents in the questionnaire study were asked to describe any experiences they had had which changed their behaviour in relation to HIV/AIDS. The largest response category in relation to the latter question was those responses which reflected being exposed to stories of HIV infected people, or knowing family and friends who were directly affected.

Most accounts described an experience of empathy which brought respondents to realise the real human dimensions of HIV/AIDS which they could identify with in their own hearts and minds. In the words of one respondent "Talk only becomes serious when you know someone with it" and in the words of another knowing someone who died "made me see that AIDS really exists". It is relevant to ask what AIDS was to them prior to these watershed experiences.

Respondents tend to express incredulity at the magnitude of the AIDS problem expressed in statistical terms. This experience of disbelief is common, and is not based on challenging of facts so much as not being able to relate to a problem of that magnitude. Thus dramatic media reports, possibly intended to awaken people to reality, may have the opposite effect, by creating worlds which are difficult to relate to.

Exposure to the human experience of HIV/AIDS appears often to initiate prevention responses. If the experiences of participants in these studies is generalisable it would indicate the need for: support of disclosure projects; involving HIV positive people in AIDS education to a much larger extent; making voluntary counselling and testing much more widely available; and actively using the media to depict the triumphs and complexities of lives of individuals and families directly affected. This would serve the dual purpose of promoting support and care, and accenting the human realities of the epidemic may well prove to be an important prevention measure.

The above should not be too naively stated. For example, in the KwaZulu-Natal site there was the highest level of exposure to people who are sick with and dying of AIDS, yet these respondents responded poorly on prevention indicators. However, the experience of these respondents does show that the community response to illness and the secrecy around the illness has done little to allow identification with the human dimensions in the way that is intended. Exposure

to death and dying is not in itself a self-correcting measure. But it seems that those respondents who had the opportunity through circumstance to relate directly or indirectly to the suffering and tragedy of HIV and AIDS, and to develop an appreciation of its meaning, were transformed in their understanding of and in relation to its realities.

MEDIATORS OF RISK MANAGEMENT

PERCEPTION OF THE NEED FOR PERSONAL RISK AVOIDANCE

This section investigates further issues around perception of personal vulnerability and explores the issue of why youth perceive AIDS to be a general threat to society, without necessarily seeing themselves as being vulnerable. It is shown that this varies markedly across sites and some of the mediating factors are explored.

The survey showed that there is a generally high perception that HIV is a threat to our society, with the lowest site score being 67% who responded 'quite a lot/very much'. The survey also measured levels of perceived worry about being HIV infected, the perception that AIDS is scary/frightening, and estimation of the chances of becoming HIV infected. It was concluded that although youth are aware of the risks and worried about their own predicaments this does not necessarily lead to risk reduction measures. In the rural Eastern Cape site there was a high level of personal perception of risk and worry, but a low rate of adoption of risk reduction measures. The present study set out to explore some of the factors which might explain the incongruity between perception of risk and adoption of prevention measures.

The analysis considers two foci: 1) the need to understand the factors which work against perception of personal vulnerability even when there is a general perception of a high threat to the society as a whole; and 2) the need to understand the failure to act even when there is a high perception of personal vulnerability.

Factors working against perception of personal vulnerability as these emerged in the qualitative study include:

- *The perception that HIV occurs in 'other' communities.* "They regard it as far away from them" (KwaZulu-Natal respondent explaining perception of his peers of the threat of HIV/AIDS). Interestingly there is little perception in the KwaZulu-Natal sentinel site of the special severity of the epidemic in the province. Even in this context there is a perception that the crisis is somewhere else and a belief that if one travels outside of the community one is at risk. Thus reporting on what people had said at an AIDS-death funeral: "You could hear them say 'He has been to far away places like Cape Town, how could he not contract AIDS?'."
- *The lack of visibility of AIDS in communities, and public denial in some communities of the presence of HIV/AIDS.* Denial at this level is sometimes achieved by explanations relating to poisoning and witchcraft, in rural communities especially. It is also achieved by not showing the bodies of those who have died of AIDS so that families will not experience the shame of others realising the cause of death, when they see an emaciated body in the coffin. However, there are signs that some communities are increasingly being more open about the cause of death. Denial of the cause of death is mediated by a perception of AIDS deaths being shameful. Cause of death is therefore often not disclosed in public and seldom acknowledged, although there is sometimes reference to AIDS at funerals, even when there is not public acknowledgement. For example, a relative might say in a funeral speech that "Youth must be careful in what they do, because the world has changed", and thereby recognise indirectly that AIDS has a presence at the funeral.

- *Denial of the acknowledgement of one's own possible infection is mediated by the perception that AIDS is an untreatable and terminal disease.* This perception creates an untenable framework for acknowledging the disease, as it is perceived as a death sentence. For most respondents there was little realisation that AIDS is an increasingly manageable, albeit chronic condition.

- *Men's social psycho-cultural experience involves greater propensity for denial.* Women in general seem to be much more aware of the presence of AIDS and have a noticeably more sober evaluation of their own vulnerability. They are less susceptible to 'same sex group' forms of denial, which show strongly in male attitudes of feigned indifference. In males the lack of public acknowledgement of concern means that there is little social support or endorsement for changing behaviours. This is particularly strong in the two rural areas. In general this is less the case with women, where there is a decidedly stronger foundation on which to build social support for prevention and care.

Factors working against the failure to act include:

- *A sense of fatalism, and the sense that even if one does try to protect oneself, one is vulnerable.* This is sometimes accompanied by a sense of defiance of risk, expressed particularly strongly by men. Women in general were notably more thoughtful about risk, but showed a sense of fatalism about men's denial, as if men can't be changed and must be accepted. This trend is stronger in the two rural sites, and particularly so in the KwaZulu-Natal site.

- *The male value of risk taking.* The KwaZulu-Natal site shows highest levels of a culture of men colluding in defying the risks of infection, and men's 'esteem amongst men' is partly mediated by level of sexual activity and degree of expression of non-concern about HIV infection risk. For women, status and self esteem are not related to sexuality as such, but more to the association with a partner with material status, and there is little evidence of women achieving status through bravado at not taking risk aversion steps.

- *Poor self-efficacy*. There is a very widespread perception that HIV is a problem to the society, but not necessarily a sense that it is a problem that one might address oneself, or take responsibility for. This is exemplified by the following statement which was made in the context of discussing the unpleasant aspect of condoms: "The government should come out with something. We didn't know condoms and the government came along with them. We didn't know that there was a tube in order to have sex and it came along with the government. So the government should likewise come out with another method of protection" (male, KwaZulu-Natal site). There is a sense here that there must be another solution, that will be delivered from outside, and a correspondingly low sense of taking responsibility for addressing the problem either as an individual or as a community.

- *Goal directed lives and hope for the future*. Those with a sense of the future and who are actively planning their careers and educational futures tend to be less actively defiant and fatalistic, and more actively involved in avoiding risk. Those who are less future oriented, shown in their higher levels of concern for immediate peer group status and material concerns, are more prone to expose themselves to risk contexts and not to take risk prevention measures. They are more prone to opt for immediate gratification of sexual and status needs. This seems to apply to both men and women.

- *Susceptibility to manipulation*. Women are strongly susceptible to manipulation by men and tend to be vulnerable to male protestation and persuasion, thereby exposing themselves to risky sexual practices such as not using condoms against their own preference.

In the absence of the above factors, it might be assumed that people would be likely to acknowledge risk and to act in more risk averse ways. Therefore these factors need to be addressed in building risk aversive responses amongst youth.

A further dimension impacting on perception of vulnerability to risk concerns perceptions about who is likely or not likely to be HIV positive. Youth adopt their own schemata for evaluating infection risk and some of the problematic assumptions revealed in the study include:

- the assumption that if there is love in a relationship, the risk of infection is lessened;
- the failure to acknowledge the impact of previous sexual histories and networks in evaluating risk;
- the assumption that risk decreases during the course of a relationship, with youth beginning with practicing safe sex, then deciding to forgo safer sex practices when the relationship becomes longer term.

In the following sections more specific mediators of risk perception and management are explored, that are crucial to understanding response to HIV/AIDS.

THE RANGE OF RISK REDUCTION MEASURES

In this section the relative preference for different risk reduction measures is explored.

Participants were asked to list "…things which you have done to protect yourself from AIDS". The most common response was the use of condoms, followed by reduction in the number of partners (including faithfulness), followed by abstinence and more careful partner selection, and a number of other less frequently mentioned measures. Direct quotes from respondents give a good sense of how they understand their own change processes.

Measures adopted for reducing HIV risk

Condoms

- "I'm still a virgin but before I would consider losing my virginity without the use of a condom. Now I know that I will only sleep with a partner if he has an appropriate condom. Good expiry date." (Northern Province)
- "I use two condoms." (Gauteng)
- "I'm now very sensitive when it comes to sexual intercourse. I condomise." (Northern Province)
- "I use condoms and I don't risk. Whenever there is no condom I don't insist on sex." (Northern Province)
- "Since knowing about this I am using condoms even with my lover." (Northern Province)
- "Every time I have sex I use condoms." (Eastern Cape)

Number of partners

- "I started to accept one sexual partner and use condoms regularly." (Northern Cape)

- "I had to protect myself by having one boyfriend and by the time of sex I made sure that we have a condom." (Northern Cape)
- "I talked to my partner about the dangers of AIDS and made him aware that any other girl he might have in secret he must know that it's over between us." (Northern Cape)
- "I no longer sleep around." (Gauteng)
- "By using less ladies." (Western Cape)
- "I reduced the number of partners." (Eastern Cape)
- "I had four partners, now I have one." (Eastern Cape)

More careful partner selection

- "I'm more selective of my partners." (Gauteng)
- "I changed the partners I had." (Eastern Cape)
- "I reduced the number of girls and don't sleep with strangers." (Eastern Cape)

Abstinence

- "Not listening to my boyfriend when he tried to get me in bed; not having sex at all." (Northern Cape)
- "I haven't yet had sex and so because of AIDS I have to tell myself that I'll have sex when I get married." (Northern Province)
- "I controlled myself when we were just kissing mouth to mouth and not going further." (Gauteng)
- "I stayed a virgin." (Gauteng)
- "Abstained from sex." (Gauteng)

Secondary abstinence

- "I became sexually inactive." (Gauteng)
- "Yes, I'm scared of AIDS so I've decided to chill and not have sex for a while." (Gauteng)
- "I always use a condom, sometimes I'm reluctant to even have sex." (Gauteng)
- "I tried having sex once but later got scared to do it because of AIDS." (Gauteng)
- "I have changed because I have no sexual partner now." (Eastern Cape)

HIV testing

- "I first did a blood test and results were negative. After then I used condoms till now." (Eastern Cape)
- "I have made sure communication lines are open. Both me and my boyfriend have been tested, but I have not yet slept with my boyfriend." (Gauteng)

Communication

- "I have tried to talk about it with my partner." (Northern Cape)

- "I only sleep with people I know very well and only after much discussion." (Gauteng)

Alternatives to intercourse

- "Use oral sex as an alternative." (Gauteng)

Future intentions

- "Once I actually start, I will take precautions." (Gauteng)

Other responses included:

- "Wash regularly." (Northern Province)
- "I had my belly pierced. I checked the needle used and ring first, to ensure they had not been used before." (Gauteng)
- "I always look for sores on my private parts." (Northern Cape)
- "I stopped using the Afrikaans term: Saam drink, saam slaap (drink together, sleep together)." (Eastern Cape)

There is no doubt that certain youth are responding strongly to the need to avoid HIV exposure. However, it appears that they are often inconsistent in their adoption of these measures. The most significant vector for predicting level of sustained adoption of risk prevention measures is socio-economic background.

It is important to understand why poor socio-economic background has the negative effect that it does. The survey showed that socio-economically deprived respondents are less exposed to HIV prevention messages, but given the pervasiveness of HIV/AIDS knowledge this is probably not the defining feature of differential responses between wealthy and poor youth.

The resources offered by the environment are no doubt a significant factor to take into account. Economically advantaged communities provide youth with a greater range of options and resources for prevention and allow youth to access different kinds of prevention support services. Conversely, economically disadvantaged communities make for limited options. Respondents from the economically disadvantaged Northern Cape site remarked "It is difficult for young people to go for testing because there is a bad attitude at the clinic" and "I went for a test and there is no confidentiality anyway". The same would not be said of the well resourced and sensitively run health centre in the tertiary institution site, or of the high quality health resources available to the Gauteng respondents.

It is noteworthy that the mediating factor here is not necessarily a product of the direct effects of poverty on the minds of the youth, so much as the effects of an impoverished environment on the resources that are accessible to youth. Many prevention options however, do not require financial resources or even health facilities. Many only require the interpersonal capacity and self-confidence to make decisions relating to one's well being in the face of social pressure and immediate contextual demands. The sense of having choices and options and the sense that one has the freedom and capacity to act on them may be the central factor here. It needs to be understood how poorer and less educated communities come to be more lacking in such capacities. The concept of self-efficacy is perhaps the most useful explanatory tool to explain the phenomena of fatalism and denial discussed above. In the rural KwaZulu-Natal site 25% of respondents replied 'mostly not true/not true' to the statement "I have a feeling that my life is going to be successful", as compared to only 2% in the tertiary institution. It appears that

the sense of having a positive future and being able to take decisions that will affect one's life is a critical feature here. It should be noted that neither poverty nor a poor education background necessarily mean fatalism and an inability to act, and in all sites there are examples of individuals who are more risk and less risk averse in similar material and educational circumstances. It is at this level that we need to consider other mediators of risk aversion, of a more psychological and perhaps familial nature. It would be important to explore these aspects further, but this would require further study, using a multiple case study approach.

SEXUAL ACTIVITY

In this section the analysis is aimed at further understanding the need to take into account how sexual activity is mediated socio-culturally. It is shown that sexual practices cannot be thought about as simply driven by biological imperatives and there is a need to understand the marked differences that exist between sites in terms of levels of sexual activity and frequency. The following disaggregation of data gathered in the survey study provides a useful point of departure.

Financial status of household x Have had sex before
(15-19 year olds, all sites)

Not even enough money for basic things like food and clothes	74%
Money for food and clothes, but short on many other things	68%
Most of the important things, but few luxury goods	55%
Some money for extra things such as going away for holidays and luxury goods	38%

This table suggests that there is a link between socio-economic circumstances and levels of youth sexual activity. The data set was limited to 15-19 year olds to allow meaningful inter-site comparison, as one site was limited to this age group. The qualitative study identified three main explanations for the correspondence between poverty and high levels of sexual involvement.

Firstly, and most importantly, there is a very high level of association between sexual activity and material favours. There is a widespread exchange of sexual favours for all manner of material favours from sweets to cell-phones, and this is considerably less prevalent in more affluent communities. Often even when there is an emotional relationship between a boy and a girl, there is an expectation that sex will result from spending money on the girl, and that girls tend to succumb to this expectation. More is said of this aspect in the section on age differentials between partners.

Secondly, an often raised point in economically disadvantaged areas is that youth are highly sexually active at a young age as "they have nothing else to do other than have sex". This is no doubt a factor to be taken into account. In the two rural areas there is a marked absence of external activities for youth. There are almost no youth facilities, activities or clubs. Youth have much free time with little external stimulation. This kind of context lends itself to sexual distraction. By contrast, for example, the youth in the Gauteng site live in the suburbs and are taken up by a host of extra-mural activities and pastimes.

Thirdly, in the two rural areas with highest levels of sexual activity there has been a marked breakdown of parental authority. Whilst this may be a worldwide trend which does not necessarily lead to licentiousness on the part of youth, in the two rural sites in this study the trend is very strong. Migrant fathers have very little knowledge of their children's activities and mothers appear to avoid conflict with their children by ignoring their sexual activities. The need to take the situation in

hand leads mothers to take their daughters to the clinic for contraception – predominantly injectable contraception – when they suspect they are close to being sexually active, and this is seen as license to be sexually active, although daughters do continue to conduct their sexual activities furtively, at least until their late teens. Whatever regulatory effect parents may have had appears to have dissipated and the structure of families with one or both parents being migrant labourers, appears to be in disarray. In this context youth have little guidance or input from their parents and higher levels of sexual activity are one outcome.

Moving away from the poverty issue there is strong evidence of a rapidly changing sexual environment. There appear to be changes taking place in the society as a whole involving women taking sexual initiative to a greater extent, earlier sex debut, pressure on men to lose their virginities earlier, pressure on women to find a partner sooner, greater age differentials at sexual debut, less concern about age differentials in sexual relationships, greater levels of material exchange involved in sexual relationships, delay in the waiting period between starting a relationship and having sex, and higher levels of casual sex (variously referred to as 'take aways', 'never minds', 'one glass panty downs', 'same day deliveries').

There is a strong sense amongst participants in the study that popular media, and especially music videos on television and soap operas, have created a context for the acceptance of casual sexual relationships and licentiousness. However, this is speculation and it is important that we research and understand these trends further. We can only really understand the sexual responses of youth to HIV/AIDS by understanding the background factors out of which their responses emerge. It has already been suggested that youth are adapting their sexual behaviours in the interest of risk aversion. But at the same time they are subject to trends which may be more global in origin and which it appears are counteracting the adoption of risk aversion behaviour. These factors all have a bearing on prevention programming, and if distal or remote determinants of sexual behaviour can be shown to directly influence risk of youth exposure to HIV/AIDS these need to be addressed.

AGE AT FIRST SEXUAL INTERCOURSE

The following two tables present some of the data relating to the age of first sexual intercourse (sexual debut).

Age at first sexual intercourse

N = those who have had sex before, and were 11 or older on sexual debut

	Average		Median		Interquartile range	
	M	F	M	F	M	F
Rural site, KZN	15.8	15.9	16	16	15-17	15-17
Rural site, EC	14.8	15.9	15	16	14-17	14.5-17
Suburb, WC	15.6	17.8	15	18	15-18	16-20
Urban school, Gau	14.8	15.9	15	16	14-16	15-17
Township, NC	15.7	17.6	16	18	15-18	16-19
Tertiary Inst, NP	16.7	18	16	18	16-18.5	17-19
All	15.7	17	16	17	14-17	16-18

The data above becomes more meaningful if we break down the age of first intercourse as shown in the table on the following page.

Breakdown of age of first sexual intercourse

N = those who have had sexual intercourse before (71% of sample)

Cumulative %									
First sex at	KZN (M&F)	EC (M&F)	WC (M&F)	Gau (M&F)	NC (M&F)	NP (M&F)	M all sites	F all sites	M&F all sites
≤ 11 yrs	14	22	1	11	2	7	16	2	10
≤ 12 yrs	17	28	5	17	2	9	20	4	13
≤ 13 yrs	25	35	9	19	7	13	28	6	18
≤ 14 yrs	33	45	22	39	18	14	39	14	27
≤ 15 yrs	48	62	39	58	31	23	56	26	42
≤ 16 yrs	68	72	57	81	49	45	73	44	60
≤ 17 yrs	86	86	67	97	63	59	84	63	74
≤ 18yrs	97	94	82	100	80	77	93	79	87
≤ 19 yrs	98	96	86		93	86	96	88	92
≤20 yrs	100	99	89		99	93	98	94	96
≤ 21 yrs		99	95		100	97	98.6	98	98
≤ 22 yrs		100	97			98	99	99	99
≤ 23 yrs			97			98	99	99	99
≤ 24 yrs			97			98	99	99	99
≤ 25 yrs			99			98	99	99.5	99.3
≤ 26 yrs			100			98	99	100	99.5
≤ 27 yrs						99	99.5		99.8
≤ 28 yrs						100	100		100
	n=61	n=84	n=75	n=33	n=84	n=83	n=430	n=222	n=206
Cumulative %	0-20%		20-39%		40-59%			≥ 60%	

It can be seen that there is a substantial degree of sexual activity in the early adolescent years. In the last column it can be seen that 42% of those who have had sexual intercourse before, had their first experience at or below 15 years old.

The prevalence of early adolescent sexuality is dramatic enough to question whether the data may be unreliable or exaggerated. There has been a concern in the literature that males may over-report their levels of sexual activity and women under-report the same. There has also been much written about the reliability of self-reported survey data of this type and the recent trend has been to say that survey data on sensitive topics usually corroborates quite well with in-depth interview data, given confidentiality and well-regulated administrative processes. Suffice it to say that the above data was quite consistent with both focus group and in-depth interview data.

Other data presented in the survey study suggests there has been a marked decrease in age of first sexual experience over the last 15 years, averaging three

years across all sites. There is a world-wide trend in this direction that is attributed to decreasing age of biological maturity and sociological factors such as exposure to high sex-content media.

Some of the influences surrounding early sexual experiences are discussed below through an in-depth look at the Eastern Cape rural site where particularly low sexual debut ages were found. In this site the debut and early sexual experiences of 12 people ranging from 18 years old to over 60 were explored in an attempt to understand early debut. These are not necessarily the same factors operative in other sites, and it is likely that each site has its own unique dynamics reaffirming the need to understand sexual experience and risk prevention in context.

CASE STUDY: Factors mediating sexual debut

A focus study was conducted in the rural Eastern Cape site to develop an understanding of contextual mediators of the extraordinarily high levels of sexual activity amongst younger adolescents.

In the 1950s it was considered rare to have had sexual intercourse before the age of 16 years. In 1999, 72% of the of youth sampled (92%) had their first sexual intercourse experience at or below the age of 16 years. An astonishing 22% had their first sexual experience at or below the age of 11 years.

The following account attempts to understand the circumstances surrounding the drop in the age of sexual debut, and some of its mediating factors, in a community where the material circumstances have not altered significantly since the 1950s.

Early experimentation with sex is not new in this village, although only latterly has such experimentation increasingly involved intercourse. It is widely reported that now “They start having sex early, even before they reach teenagehood, at maybe 10” (female, age 42).

Sexual socialisation begins as early as eight years and early sexual experiences mostly take place in the context of games such as Undize which is a form of hide and seek.

Interviewer: *How old were you when you played this game?*

Respondent: *We were about 12 or 13 and then when we were about 15 we stopped playing Undize and had real boyfriends.*

Interviewer: *You said you would sleep with them, can you explain this to me?*

Respondent: *OK, well we would go hide with the boys in the bushes and that’s where we would start sleeping with them. We would take off our panties and they would take off their ‘undies’ as well and it’s then that we started having intercourse, but it was nothing serious at that stage.*

Interviewer: *When you slept with them was there penetration, or were you just playing ‘outside’, but just taking off your panties?*

Respondent: *Yes, there was penetration but as I said to you it was not really serious. There was penetration but there was no ejaculation. We were just doing it and we didn’t even experience any form of pleasure. Hence I say it was nothing serious.*

An interview with a 38-year-old male adds to this account:

Interviewer: Can you tell me about your first sexual experience. How old were you, and where did it happen?

Respondent: *I was 15 and this was nothing serious. We were just playing Undize.*

Interviewer: *Was it your girlfriend you slept with?*

Respondent: *No, it was just someone I happened to hide in the same spot with. There was nothing between us and maybe the next time we play Undize then we would be with another girl.*

Childhood sexual games have been played in this community since the 1950s at least, but previously it was played with 'dresses on' and some older members of the community did not think of Undize as being associated with sex. However, some older members (55 years plus) do recall that Undize involved some sexual exploration, but not to the same degree. Amongst youth it is universally known to involve sexual experimentation.

It should be noted that previously in this community there was no strong taboo on sexual experimentation but there used to be a strong distinction between sexual experimentation and sexual intercourse. This distinction appears to have blurred so that sexual experimentation much more rapidly translates into intercourse, to the extent that Undize now involves sexual penetration, albeit somewhere between experimentation and fully-fledged intercourse.

Historically, there were numerous regulatory mechanisms which stood between sexual experimentation and full sexual intercourse. Fear of pregnancy has historically been the most significant incentive for delaying sexual intercourse. In earlier times the avoidance of sexual intercourse in the context of relationships was delayed by a prolonged period of sexual experimentation, often lasting a few years and involving 'thigh' and 'panty' sex. In the words of a 62-year-old male, a girl's virginity was considered to be part of the family's property. He explains: "The knowledge that I got was that when you meet a girl you should not play inside, that is penetrate, because the mistake of playing inside is taking the girl's family wealth in the form of cattle. So I kept that knowledge and whenever I played with a girl, we played on the thighs and that was okay as it was stressed to me that you should never ever play inside because your family might be fined cattle for that." A female of 58 reports: "Even if you did sleep with your boyfriend you would make sure that you don't take off your panties."

The most significant factor to take into account in understanding this change is the introduction of contraception into this community. A community clinic administers injectable contraceptives and mothers, rather than face the possibility of pregnancy tend to take their daughters for 'injection' at the first sign of becoming involved with boys and often at menarche. "Well I'm very sharp actually, I know exactly what my children are doing. With my child the minute she went on her period I took her to the clinic for family planning and that helped in fact because she only got pregnant in her twenties," said one mother. The effect of this has been that young men no longer face the anxiety and consequent restraint that was historically associated with the possibility of sexual intercourse. The removal of this constraint appears to have led to much higher levels of sexual predation and sexual activity. It should also be said that the lack of need to take any precautions on the part of men has created a poor context for introduction of condoms, and condoms are a relatively new introduction into the community, whereas in sites where birth control was less 'taken care of' there has been a greater interest in males using condoms for birth control.

With the advent of contraception, cultural regulation of adolescent sexuality seems to have diminished considerably and youth have become sexually active much earlier. They tend now to bypass the intermediate stage of sexual experimentation without intercourse. Within relationships the transition from the stage of 'proposing love' to sexual intercourse has diminished dramatically, and there is also a much higher turnover of partners. This has been nothing short of a sexual revolution within this community, the cultural ramifications of which are significant.

Regulation of adolescent sexuality was historically achieved in a large range of ways including regulating the movements of young people and limiting their opportunities to have sex. Certain kinds of gatherings (Umtshotsho, Umgidi) and especially those surrounding male initiation were considered to be 'high risk' events as children would have to stay over in

other villages rather than walk back after dark and these gatherings involved free mixing of boys and girls. Another factor which traditionally regulated sexual activity was not allowing children to have their own outside rooms. Men traditionally have their own rooms after initiation and their levels of sexual involvement increase markedly after this. Having an outside room provides opportunities to entertain girlfriends and numerous stories are told of how young women are lured to their boyfriends rooms for sex, and how they conspire to sleep over at their boyfriend's under cover of being involved in other activities. It has increasingly become acceptable for young girls to have their own rooms (in one case as young as 15 years), whereas they were traditionally regulated by being required to sleep in the house. These changes at household level are consistent with many other changes which involve a diminishing degree of regulation of adolescent sexuality. For instance there is a taboo on boys and girls talking freely in groups in public, unless they are acknowledged as having a relationship. In the words of a 22-year-old: "In fact even now, as old as we are, when we see an older person approaching you can't just stand there with your boyfriend, you have to pretend to disperse until they pass, then you can resume your talk with your boyfriend." But there is evidence that there have been changes at this level and older people interviewed expressed a sense of indignation that young people have no shame about associating with each other in public.

Caution should be exercised in talking too generally about these issues. As with any community there are notable variations within the community. Family differences, for instance, are notable. Thus, "Oh, youth start (having sex) very early, as early as 12 years, more especially those whose parents are drinking". The absence of fathers in families also seems to hake a marked effect and the image of the father was often used, and still is, to warn children against becoming sexually involved. There is a high level of father absenteeism and the community is very noticeably devoid of working age men, other than over holiday periods. This has meant a lack of direct involvement of fathers in their children's lives. This has no doubt had a marked impact on sexual culture in this community, and on the socialisation of adolescents. However, this is not new and even in the early 1950s there were well established migrancy patterns in this community.

In conclusion, the introduction of injectable contraceptives into the lives of adolescents in this community, often with little real discussion with the girls involved, has had a marked effect on the sexual culture of this community. On the surface it appears to be an appropriate approach in the context of the risk of unwanted pregnancy. In cultural and socio-economic terms this also seems a well reasoned and practical solution. Yet it has born unpredicted fruit. It has led to the exploitation of young women who are subject to high levels of sexual predation. It has meant that men have little awareness of the need to take responsibility for reproductive health. It has created a poor context for the adoption of condoms as an STD measure. It has also led to changes in cultural and familial regulatory practices, the motivation for which has become redundant with the risk of pregnancy removed. The point is that the introduction of this particular reproductive health technology has had important deleterious ramifications. This should make us cautious about the introduction of health technologies in place of developing culturally supported responses to the health crisis. There is much more that could be said here, and certainly it raises questions about the ramifications of the widespread distribution of condoms through the society. Whilst this may indeed be a very viable solution in HIV prevention terms, as injectable contraception was to the problem of teenage pregnancy, it is an intervention which history may well show to have unexpected ramifications. These may of course prove to be of a positive nature, especially since condoms are a technology which (female condoms aside) are applied to the male anatomy, and which mostly alter the male experience of sexuality.

AGE DIFFERENTIALS BETWEEN SEX PARTNERS

The following table extracted from the survey study represents the alarming statistics relating to age differentials in the first sexual experience. A large proportion of first sexual experiences can be regarded as statutory rape.

Age difference between self and partner in first sexual experience

N: had sex before = 71%

	Partner 10 or more years older		Partner 5 or more years older		Partner 1 or more years older		Partner same age		Partner 1 or more years younger		Partner 2 or more years younger	
	male	female	Male	female	male	female	Male	female	male	female	male	female
KZN	3%	8%	6%	28%	24%	96%	12%	4%	64%	0%	39%	0%
E Cape	0%	2%	0%	17%	27%	100%	5%	0%	68%	0%	32%	0%
W Cape	0%	6%	2%	29%	49%	82%	24%	3%	27%	15%	15%	9%
Gauteng	5%	7%	5%	21%	43%	86%	33%	14%	24%	0%	5%	0%
N Cape	0%	0%	0%	23%	13%	92%	20%	8%	68%	0%	23%	0%
N Prov	0%	5%	5%	23%	17%	88%	19%	13%	64%	0%	26%	0%
ALL	1%	4%	3%	23%	28%	91%	18%	6%	54%	3%	24%	1%

Particularly notable in the above table are the following features:

- 23% of women who have had sex before had sex with someone five or more years older than themselves;
- this is particularly significant given that 44% of female respondents were 16 years or younger when they had first sexual experience.

These age differentials are particularly important in the case of younger people. A five year age difference at 20 does not have the same significance as a five year gap at the age of 12.

Examples of some of the differentials from the survey:

- 6 year girl – 24 year boy
- 9 year girl – 14 year boy
- 11 year girl – 19 year boy
- 12 year girl – 19 year boy
- 13 year girl – 18 year boy
- 14 year girl – 19 year boy.

In trying to make sense of this data in focus groups it emerged that there is widespread recognition that 'men don't respect age'. The taboos which exist against having sex with people much younger are largely disregarded and there is negligible awareness of the illegality of sex with minors. "Age does not come into it" (KwaZulu-Natal).

The tendency for young girls to partner with older men is not necessarily seen as manipulative or coercive. Examples of statements which suggest that these kinds of relationships are mutually attractive to younger girls and older men are: "Girls today do not want a scholar, they say, 'What can I do with a scholar because he has no money?' " (KwaZulu-Natal) and "You'll find her falling for an old person who'll take her to the shops and buy her beautiful things which you can't do" (KwaZulu-Natal). Relationships involving large age differentials between older men and younger girls are usually ascribed to material exchanges. There were numerous

stories told in interviews of younger girls being sexually pursued by older men who ply them with money and gifts in exchange for sex. However, these relationships are not only premised on money, but also on status – for example, the status of being associated with high profile individuals, including popular teachers.

There is evidence in the Eastern Cape site (the only site where elderly people were interviewed) that this trend is a recent development. In the words of a 40-year-old woman: "As children we were divided along different age groups. We knew things at the same time and everything we did we did in the age group". Now there is predation of younger girls by older men. A number of factors seem to contribute to this trend. Firstly, higher levels of unemployed out of school youth loitering in communities with nowhere else to go seek out opportunities for sexual pursuit of school girls. Secondly, mixing of age groups in schools seems to be a contributory factor. A third contributory factor seems to be the allure of material favours.

It was said in the relatively affluent high school: "The girls that sleep with older guys... it's a class distinction thing, the cheaper your school, the older the guys you sleep with." Another respondent from this school said: " I would never be comfortable with a guy with a 'Merc' that he paid for." They base these observations on their experience of the sexual activities of friends from less affluent backgrounds. By comparison girls from more affluent backgrounds tend to have relationships with people who are within their own peer group or only slightly older.

The view expressed by rural KwaZulu-Natal focus group respondents was that parents often turn a blind eye to these relationships. It was said that some parents are concerned that their daughters find a man and this explanation was given for why a young girls coming home with a large bag of 'unknown groceries' was not really questioned by her mother as to where she obtained them. The desire of mothers to pair off their daughters was also given as an explanation in the KwaZulu-Natal site as to why mothers are so accepting of courting behaviours which they don't otherwise approve of because they know that the the courtship involves sexual relationships.

It seems that women are particularly vulnerable to being manipulated by older and more experienced men at particular stages of their lives. Respondents report that in the first year of high school and the first year in tertiary education girls are particularly prone to being preyed upon by older boys and men.

There is also evidence particularly in the Western Cape and KwaZulu-Natal sites of older women initiating relationships with younger men. "Hier by ons gebeur dit baie, veral naweke... dit is ouer vroumense en jonger mans. Ek praat van persoonlike ondervinding" which translated means "With us there is a lot of that, especially at weekends... It's the older women and younger men. I'm talking from personal experience" (Western Cape). It appears that some such relationships are sustained and attractive for the material favours involved, but this trend is not nearly as prevalent as the trend between older men and younger women.

It appears unlikely that this trend would easily be reversed except through publicised implementation of the laws which exist relating to statutory rape. It may be that these laws need to be carefully shaped considering the normative nature of what is now legally considered to be rape. Age differentials of three years or more for under 16 year olds could arguably be deemed as opening the possibility of coercion and manipulation. This is an area where the law could exert an influence on limiting the spread of HIV. Considering that 23% of girls had their first sexual experience with someone five or more years older than themselves, this sets a damaging context for sexual socialisation. It is of great relevance that there

has been almost no attention paid to the matter of age differentials in South African HIV prevention campaigns and there has been little appreciation of the importance of age differential data in understanding epidemiology.

FACTORS AFFECTING SEXUAL NEGOTIATION AND DECISION MAKING

In this section an analysis of sexual negotiation and decision making is provided. It appears that sexual coercion most often takes subtle forms and the dynamics of this are explored across sites, as well as other social factors and processes affecting negotiation of sex and prevention practices. To set a context for this, it is worth considering responses to the question 'Do you like sex?'.

Do you like sex?

Site	Had sex before: Male			Had sex before: Female		
	Yes	Unsure	No	Yes	Unsure	No
Rural KZN	75	7	18	48	24	28
Rural EC	83	6	11	47	19	34
Suburb WC	93	5	3	81	16	3
School Gauteng	87	4	9	77	23	0
ALL	85	6	10	59	20	21

The above data represents only four sites, as the question was added only after the Northern Cape and Northern Province sites had been surveyed.

The relevance of the above table in this context is that it shows the degree of ambivalence that female respondents have about sex and throws into question the nature of their involvement in sex. Of particular note are the 41% of women who have had sex before, who respond either 'unsure' or 'no' to liking sex.

The following provides further insight into the thoughts and feelings of young women who have these negative sentiments to sex, yet feel obliged to engage in sexual activities.

Sexual expectations

What follows is a selection of quotations related to sexual expectations:

- *"Well for me personally, I don't find anything attractive about it (sex), I only do it because I love my boyfriend and I don't want to deny him when he wants to."*
- *"I'll do it even if I don't feel like it. I could just close my eyes and plait my hair till he is over with."*
- ***Respondent:*** *"Well I did find out (about sex) and I wasn't too impressed."*
  Interviewer: *"But you still went on doing it?"*
  Respondent: *"Ja, I mean I can't just say let's just stop doing it for no reason, I can't now can I? I never initiate it. I hardly ever want it, only sometimes."*
- *"You would trick her into coming to your home and then she would give in."*
- ***Interviewer:*** *"Does it ever happen that that you are the one who wants to sleep with him, wants to have sex with him? Do you ever go up to him and tell him let's go, let's go to your room, I want to have sex now?"*
  Respondent: *"No, definitely not, it never happens that way, he's always the one who wants to have sex and I'm used to it happening that way."*
- *"I asked for permission to attend Umtshotsho and I knew that there I would have a chance to meet him and he didn't come up front and say to me that okay I want us to*

have sex today. He tricked me. He asked me to accompany him somewhere and once we'd got there he said how about we go to my house, and I sort of didn't resist and on our way he sort of told me what was going to happen and I was so scared and I just like agreed to the whole thing."

Accounts like the above are particularly prevalent in the two rural sites where there appears to be a strong culture of men expecting and pressurising girlfriends to be sexually active. Numerous stories collected in this study demonstrate that the dominant form of coercion is a gradual wearing down of women to the point of relenting to sexual advances. There was also mention of women being beaten up by boyfriends for not being sexually co-operative after the expectation of sexual activities had been established through courtship. But for the most part coercion is a subtle manipulative process.

In the rural Eastern Cape site, men tend to construe this process as a game, and women see it as a necessary if unpleasant process for women wanting to secure relationships. The coercive process is not new and in the words of a 58-year-old woman: "When you went back to the spot where you had been the previous night you would find a trail from where you had been shifting and moving away from the boy and he would keep following you, so there was this trail as if bulls had been fighting."

Initiation of sexual relationships frequently involves men creating situations where it is assumed that the woman has already agreed to the sexual encounter, whereas this is not the case in her mind at least. Women appear to go along with this, half knowing that, for example, consenting to visit the boy in his room is likely to lead to sexual intimacies. The entrenchment of the relationship is contingent on such little progressive steps, none of which is consent to sexual relations, but which lead inexorably to that end. Women are often unable to resist because any step in the process is not in itself relenting to intercourse, although the end point in the succession of steps tends to end in this way.

These steps take place in a context of courting which is important if we are to understand women's role in sexual decision making. Accounts of the initiation of sexual relationships typically involve a period of courtship that may range from a period of a few days to a few months. It should be said that there is also good evidence that casual sexual relationships are increasingly a part of youth sexual culture, but these follow a different kind of process altogether.

Typically in the rural Eastern Cape site where most was discovered about courtship practices, the process leading to sexual intercourse begins with some form of declaration ('proposing', 'declaring love') and this is male initiated. However, there is evidence that women are increasingly taking an active role in 'declaring love'. It seems that relationships usually begin with this definitive step which, if accepted, binds a girl to a process which is expected to culminate in sexual relations unless deliberately withdrawn from, in which case the relationship is aborted.

The length of time between establishing a relationship and having sex appears to have shortened dramatically and respondents report that it is not uncommon for this to be less than a week, even in the case of girls in their teens. Experience in the rural Eastern Cape site shows that sexual intercourse in the past was not 'expected', although fondling and 'panty' and 'thigh' sex were often part of the process of courtship. It appears that the anxiety about pregnancy was previously a major disincentive for men to pursue sexual intercourse, and reports by older people show that relationships could previously endure for a few years without sexual intercourse.

It has been suggested that the subtle gender issues around courtship and sexual

decision making need to be carefully unpacked if we are to develop ways of intervening in contexts of sexual coercion. Further it has been suggested that in a changing 'sexual culture' environment, we need to understand the pressures on youth and especially women to engage in sex. There is a great deal more work that needs to be done in this area, around issues such as how people select partners, the workings of power in youth sexual relationships, the role of emotional intimacy in sexual relationships, the levels of discussion between partners and so on. These socio-cultural factors are an implicit part of the social epidemiology of HIV and in the nooks and crannies of how people manage communication within relationships we might expect to find decisive influences on the risk of HIV infection.

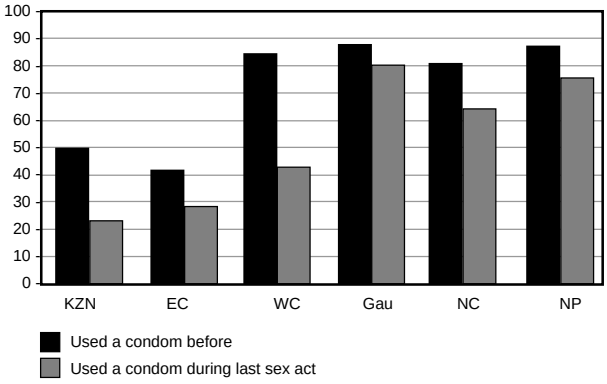
MEDIATORS OF CONDOM ACQUISITION AND USE

Data is provided in the survey study that condoms are widely available, but that there are significant differences between sites in terms of sexually active youth ever having used condoms, and also in terms of youth having used condoms in the last sexual act.

- There is widespread availability of condoms: 84% of respondents (sexually active or not) report that condoms are 'easy to get hold of'.
- The average 'ever used a condom' indicator across all six sites is 70% (range 40%-86%) of the 71% of respondents who have had sex before.
- The average reported condom use in last sexual intercourse across all sites is 52% (range 22%-79% amongst youth who have had sex before and who are not cohabiting with partners).

Of interest in the qualitative study is what factors mediate the difference between ever having used a condom and having used a condom in the last sexual act. The following two graphs illustrate this difference across the sites.

Used a condom before vs used a condom during last sex act



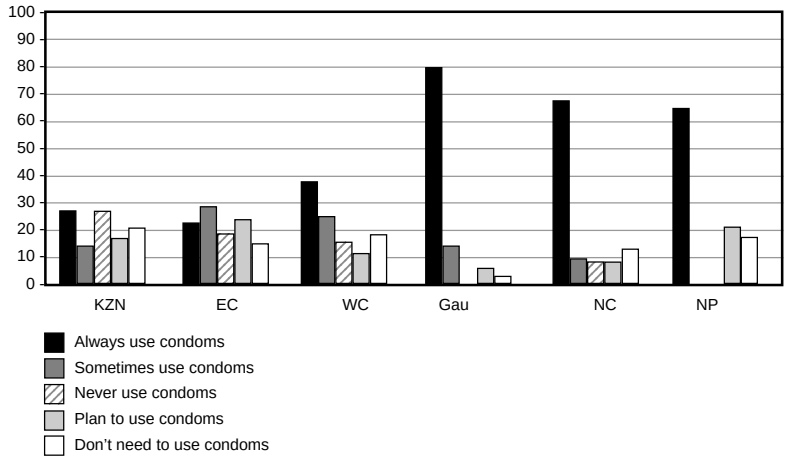
It can be seen that there is great variation between sites firstly in terms of having ever used a condom before, and also in terms of having used condoms last time. It might be assumed that campaigns aimed at condom promotion would need to increase the 'ever' used a condom levels and to decrease the gap between 'ever' and 'last time', such as can be seen in the Gauteng site.

We might interpret these profiles to understand patterns of condom access and use. Some sites have a low rate of 'ever used a condom' suggesting that there may be a lack of distribution or availability of condoms in a site. In the case of the Western Cape site there has clearly been a fairly high level of experimentation with condoms, but little sustained regular use. This may suggest a number of different factors including the possibility that condoms are irregularly distributed

or that there is high experimentation resulting in a preference not to use condoms. But this is speculation, leading to questions about what further we need to know to be able to interpret the meaning of these profiles.

The following graph takes us a little further. It breaks the features of condom use down showing that it is important to delve into the complexities of condom use rather than to look at only at 'ever having used condoms' or 'having used condoms in the last sexual act'.

Regularity of condom use



It would be inappropriate to suggest the ideal profile as being 'all people using condoms all of the time'. There are different needs with respect to risk aversion in different kinds of relationships. It would, for example, not be necessary to use condoms in a monogamous relationship where both partners are HIV negative and know their status, and we need rather to understand the sexual activity profiles of respondents to set a target. Consider the possibility that in the KwaZulu-Natal site above, 'always use' captures all those who are at risk due to not knowing the HIV status of their partners and who are not HIV positive themselves, 'sometimes use' refers to all those who use condoms only occasionally when they are unfaithful to their partners, 'never use' refers to all those who are in monogamous HIV negative relationships, 'plan to use' refers to all those who are not currently sexually active but plan to be, and 'don't need to use' refers to all those who are committed to abstinence. Were this to be the case the risk of HIV infection would be minimal, although only 25% always use a condom. Thus we should not be concerned so much to match the profile of the site with an hypothesised ideal, so much as to match it with the actual risk profile of the population. The point is that *until* we know the risk profiles of populations we have no real way of understanding what appropriate expectations are. Because we have so little data on the sexual practices of populations, we don't really have a way of knowing what risks they are exposed to. We need also to understand how risk exposure may change at different points in the person's life. For this it is important to have a much more thorough understanding of the context of youth sexuality than we presently do.

We also need to understand how youth interpret their own exposure, as this a co-determinant in the decision to use condoms. The study shows that the estimation of risk associated with particular partners plays an important role in determining condom use behaviour, although more strongly so where other determinants align to produce the profile of a risk aversive person. Whereas it might be said that it is advisable to use a condom whenever the HIV status of the partner is unknown, respondents in the study showed that they often use their own subjective measures for estimating risk based on, for example, understanding

of the sexual history of the other person; the apparent health of the other person often measured by specific indicators such as the thinness of the person and the absence of skin lesions; the character of the other person; how long one has known the person; the social group which the person belongs to; where the person comes from; the degree of casualness of the sexual encounter; the education level of the other person; the wealth of the other person; the age of the person; and so on. However naive, this is the reality of how people appraise risk.

It is obviously important in condom promotion to target those that need the service and to develop messages and programmes addressed to them. But sometimes people's understanding of their own risk exposure is at odds with the realities of HIV distribution within a population, and it is important therefore to attempt to understand people's subjective understanding of risk. In the Western Cape peri-urban site respondents do not use condoms regularly because of a low estimation of risk. In other sites respondents do not use condoms because they do not have access to good quality condoms. The numbers and graphs do not tell us this, and it is important therefore to understand the experiences of people in acquiring and using condoms, and to appreciate the contextual features which determine whether the match between the use of condoms and actual exposure to HIV infection risk is appropriate.

In exploring condom use amongst respondents it emerged that there is a considerable dislike of condoms. They are seen as 'unnatural', 'uncomfortable' and 'awkward'. Condoms are also widely believed to diminish sexual pleasure. This attitude is expressed by both women and men but is particularly strongly felt by men. It would seem important to acknowledge these realities of experience in condom promotion. As one respondent commented "I don't like it, but it is necessary so I use it". Endorsement of the pragmatic motive and acknowledgement of the disadvantages of condom use may go some way to create a context for acceptance of condom use.

The perceived purpose of condoms also varies across and within sites. Amongst younger respondents in early sexual relationships condoms serve a dual purpose, also acting as a needed contraceptive. This is not confined to early relationships. The following statements are relevant: "Teenagers use condoms for pregnancy not AIDS" (Northern Province); "Many guys are more scared of pregnancy than AIDS" (Northern Cape); "For me it wasn't AIDS that much, it was more against pregnancy. To stop pregnancy and in the process also lowering the risk of AIDS" (Western Cape). However, in sites where female birth control is practiced and especially where injectable contraception is used, contraceptive needs are taken care of and there is con sequently a lower motivation for condom use.

There is a problem with maintenance of condom behaviour in longer term relationships. The following statements express this reality: "The truth is like if you go out with somebody for let's say a year. After a year you stop using condom. That's the truth " (Northern Province). "Hier in die gemeenskap is baie mense wat kondome gebruik. En selfs ek doen dit ook. Maar as ek my 'partner' kan vertrou, dan sal ek dit nie gebruik nie" which translates to "Here in the community there are lots of people who use condoms. I also do it. But if I can trust my partner then I won't use condoms" (Western Cape). The obvious alternative to the long term use of condoms in established and trusting relationships is to undergo HIV testing. However, this is an option used by only a very small number of respondents in the questionnaire study. Voluntary counselling and testing is not widely promoted and often people feel insecure about the process and consequently avoid it. Others feel that the process of testing is problematic because of the way it is done: "It is difficult for young people to go because there is a bad attitude at the clinic" (Northern Province) and "I went for a test and there is no confidentiality anyway"

(Northern Province). Promotion and delivery of satisfactory HIV testing services is important as an alternative to the need for ongoing condom use in longer term relationships.

There was not much discussion about female condoms in focus groups, but those who were familiar with them expressed dissatisfaction, with the following statements: “they don’t stick”; “we are not all the same sizes”; “you cannot keep on holding it in position”; and “it can get pushed inside”.

An analysis of factors mediating condom acquisition was provided in the survey report. Problems experienced included unfriendliness of clinic staff, lack of confidential access and poor quality. Some evidence emerged in the present study that the “quality of condoms at the clinic has improved”. However, whilst access problems are an important mediating factor in some clinics and particularly in the rural areas, access is generally satisfactory and does not appear to be a major factor affecting condom use.

It must be noted however, that ondoms are not a technology that can be ‘thrown’ at people in the hope that they will be picked up and used, and appeals to use condoms may be lost in the complex dynamics of sexual relationships. “I had a condom but my boyfriend refused to use it and just because I love him, I just agreed, but initially I resisted… and so I was forward and said I think that we should use it and after that he didn’t have a problem… and so since then I’ve been using condoms regularly.” In this instance the girl was able to persuade her partner. Whilst it is more common for the male partner to have his way in contexts like this, there is evidence from all sites that women are becoming more assertive within relationships. HIV/AIDS prevention strongly demands this kind of response given men’s relative intransigence in adopting prevention measures.

Whereas quite a lot has been done to show people how to use condoms, not enough has been done to understand and address the psychological and sociological contexts which may stand in the way of establishing condom use in youth sexual culture. It is hopefully evident from the above that the successful promotion of condom use requires an understanding of a range of contextual factors which are at play in the perception of risk with a particular partner, the choice of condoms as a prevention method, and in the maintenance of condom usage.

SEX PARTNER TURNOVER

The survey showed that across all sites there was a 30% rate of respondents who had had sex in the past six months who reported having more than one sexual partner ‘at the present time’. This dis-aggregates to 42% for men and 18% for women. Considering inter-site variations, in the KwaZulu-Natal site the male prevalence of concurrent multiple partnering was highest at 72%, and lowest in the Western Cape site at 26%. In the Eastern Cape it was 41%.

Interestingly, whilst the KwaZulu-Natal site had by far the highest level of concurrent partners it was below average (1.9) on the total number of partners over the last six months. By contrast the Eastern Cape had amongst the highest scores for males with an average of 2.4 partners during the last six months.

What is most interesting about the above is that it seems to imply two different patterns of multiple partnering. In the KwaZulu-Natal site the tendency is towards multiple concurrent partners yet relatively less turnover of partners, yet in the Eastern Cape site there is a relatively high turnover of partners yet the relationships are largely monogamous. The latter might be termed rapid serial monogamy.

Qualitative data very much confirmed the existence of these trends. In the relatively closed rural Eastern Cape site there is high visibility of sexual relationships. Youth tend to know each other and sexually active youth all attend the same (and only) high school in the area. “When we were about 12 years old we started dating boys and in our practice of dating didn’t have that kind of mentality to have more than one boyfriend since we grew up in the village” (Eastern Cape). In the KwaZulu-Natal site there is much more movement in and out of the community, the community is much more scattered and less cohesive and there are much greater opportunities for having concurrent partners.

The important point of this is that it is necessary to take into account these distinctions between different kinds of relationships. Different prevention options are implied. The need to promote faithfulness in the Eastern Cape site is far less relevant than is the need to promote an understanding of how one becomes vulnerable in a faithful relationship in a serial monogamy context. In the KwaZulu-Natal site the promotion of fewer sexual partners is where the need lies, and where the largest impact is likely to be felt.

There are also other sexual relationship differences between sites which need to be taken into account. In urban areas and in the tertiary institution site there is more evidence of casual sexual relationships; i.e. outside of the context of an established relationship. This form of relationship has its own particular risk profile, especially since it seems to be less planned and generally involves alcohol consumption.

There are also lifestyle changes which impact on risk exposure with child-bearing bringing about a significant downturn in interest in sexual relationships and hence exposure to risk.

Unfortunately little data was collected relating to types of relationships and the risk factors associated with these. But it would be important to include an understanding of the relational context in any contextual risk analysis, and to address the relevant issues in prevention campaign planning. It would also be important to understand how different forms of relationship are subjectively rated for risk. For instance serial monogamy relationships tend to be rated as lower risk as compared to concurrent multiple partners and risk prevention decisions are made on the basis of such evaluations. These complexities of subjective experience need to be taken into account, and addressed in prevention campaigns, if a sustainable culture of HIV risk management is to develop.

ABSTINENCE

There has already been some discussion on the need to carefully examine the problem of increasingly early sexual debut and its impact on HIV infection risk. Besides promoting the delay of sexual onset, there is also a need to examine another and neglected prevention area, namely ‘secondary abstinence’ (the choice to forgo further sexual relations for a period of time).

Primary abstinence

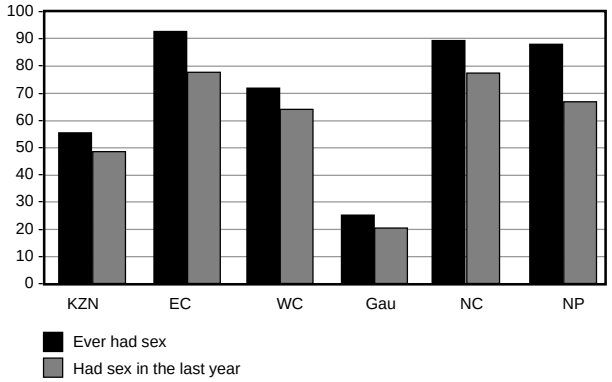
It is readily apparent from the qualitative data that there has been little promotion of the delay of sexual onset. It is particularly important to work at the primary abstinence level for the reason that once there has been sexual experience the likelihood of further sexual experience is considerably increased. In other words, the experiential step between never having had sex and having had sex for the first time is much larger than the step between the second and third time, the third and fourth time, and so on. Given the natural hesitation and deliberation involved in the first step, it would seem to be a more likely point to intervene. The factors which lie

behind the decrease in the age of sexual debut, discussed elsewhere in this report need to be further analysed and addressed if promotion of abstinence is to succeed.

Secondary abstinence

Given the above, the possibilities for promoting secondary abstinence would appear to be limited. Yet the following graph shows that having had sex before does not necessarily mean that the person is having regular sexual experiences or is committed to continuing with sexual relationships.

Secondary abstinence of females



Nineteen percent of tertiary institution women sampled have had sex before, but have not had sex in the last year. It might be argued that secondary abstinence measured in this way may reflect periods of sexual inactivity in the period between two sexual partners. This may well be the case in certain instances, and there is no way of knowing quantitatively whether this is indeed the case. However, there is good indication from the qualitative data that secondary abstinence is being initiated spontaneously as a response to the threat of HIV infection. Asked to comment on what behaviour changes they have had as a response to HIV/AIDS notably more respondents from this site responded that they have decided to abstain from sex. Some statements from this and other sites reflect this change: “I tried having sex once but later got scared to do it because of AIDS”; “Yes, I’m scared of AIDS so I’ve decided to chill and not have sex for a while”; and “I became sexually inactive (as a response to the threat of HIV/AIDS)”.

The second biggest gap (13%) between ‘sex ever’ and ‘sex in the last year’, is found in the Eastern Cape site. This is also the site where there is the lowest sexual debut age. Qualitative data from this site suggests that secondary abstinence is indeed an option which some young women feel empowered to exercise, but the 13% is also likely to reflect some non-AIDS related sexual abstinence. For instance having had early, unwanted or premature sexual experiences which were not followed by ongoing sexual activity. Again, this is an area of exploration which needs to be pursued. Understanding of the contextual complexities of a target behaviour is essential for success in promoting particular courses of action.

Secondary abstinence is an important target behaviour to understand and promote. It is interesting to note that this has been an overlooked intervention possibility, perhaps because of the belief that once one is sexually active one remains sexually active. This is not necessarily the case, and in particular given the ambivalence about sexual relationships that exists amongst many youth, and especially young women, this may be a much more viable prevention measure to promote than is generally realised.

CARE TRENDS

Care is a broad term which refers to a range of forms of relatedness of individuals and society to those directly affected by HIV/AIDS. Care involves direct health care (for example, counselling, treatment, care of the ill) as well as creation of a climate for psycho-social well-being (for example, through minimising discrimination and stigmatisation). Care also includes social mobilisation and advocacy around human rights and support for those who are infected or directly affected by HIV/AIDS. What follows is an examination of care as it manifests in attitudes to people with HIV/AIDS and community level responses.

Unfortunately a rather bleak picture has been painted of life with HIV and the belief in the inevitability of AIDS and death have mitigated against the idea of living positively with HIV. These images have been sustained by a paucity exposure to images of people living positively with AIDS. Having HIV is commonly seen as a 'death sentence' and respondents in the study have only poorly developed images of what it would mean to be positive in the face of HIV.

Some respondents had been exposed to people who are living positively with HIV and this has in all cases been an impressionable experience for them. But the predominant images to which they are exposed provide little reason for hope and a context for fatalism. In the words of one respondent "When I see him I have a vision of death as if he is already dead" (KwaZulu-Natal).

Youth show little recognition of the possibilities of treatment or management of AIDS, and the disease process has been represented as leading inexorably to death. In this context the psychology of denial of the possibility of infection hardly needs explanation.

Respondents mostly could see no point in being tested for HIV as no positive benefit can lead from this. The idea that there is no treatment and that one should anticipate death from HIV are well entrenched. In this context it could be said that attempts to alert youth attention to HIV/AIDS have been framed negatively and have not created a context for living with HIV/AIDS as a possibly manageable condition.

It is not surprising in this context that expressions like the following were not uncommon: "If I contract AIDS I'll spread it here there and everywhere. I don't want to die alone. I'll live for ten years and by then there'll be a lot whom I've infected" (KwaZulu-Natal). Stories of people who deliberately infect others "so as not to die alone" were recounted in all research sites. These stories are often not associated with a particular person, and in this sense can be understood largely as myths, with no-one personally knowing the individuals involved. The image of raging against the loneliness of a 'death sentence' by infecting others might be understood as an expression of agency and defiance against victimhood and isolation, but should be understood in the context of imagined response rather than actual response. Specifically, it is important to understand that myths and imagined (or anticipated) responses offer mechanisms for rationalising and responding to complex social phenomena.

This does not count out the possibility of some people who are HIV positive deliberately infecting others for perverse motives, or as part of an act of denial. How people respond to an HIV positive diagnosis would in all likelihood be different for each individual, and would be mitigated by the community context, support services and resources available in each site. Indications from this study are that common responses are denial, depression, withdrawal, and avoidance. However, this study did not really focus on this aspect but it is possible to draw

the inference that the context for living positively with HIV has not been well established amongst the youth in this study, with some exceptions.

The following section details the attitudes of youth to people with HIV/AIDS.

ATTITUDES AND CHANGES IN ATTITUDE

Mass media emphasis on prejudicial attitudes to people with HIV/AIDS appear to have led public opinion towards the view that the South African public is strongly prejudicial and negative towards HIV infected people and people with AIDS. High profile, but extremely isolated cases, such as the association of the stoning to death of Gugu Dlamini with her disclosure of her HIV status have provided 'evidence' for this general opinion. However, this survey has shown that youth are in general understanding of, and cautiously accepting of, people with HIV/AIDS. Although there are a few clear exceptions to this, the overwhelming impression is of youth becoming conscientised to the need not to stigmatise or show prejudice against people with HIV/AIDS. The Gugu Dlamini story was discussed in a number of focus groups and it appears that it did much to conscientise youth about prejudice against people with HIV/AIDS. The attitudes that must have been present in her stoning cannot be reconciled with the attitudes shown by youth in this study, as these tended largely towards concern and compassion.

The general question: "Has your attitude to people with AIDS changed over time?" received a wide range of responses. The response to the question should be treated cautiously, because whereas we may *show* attitudes in our behaviour and opinions, we are not always in a position to describe them accurately or to report them. Further, a problem with the question is that the response 'no' could mean, in the words of one respondent, "My attitude towards people with AIDS has not changed, because it doesn't need to change. It has always been good…", or it could mean, in the words of another respondent, "Het al gehoor maar ek het nie AIDS, so waaroor moet ek worry?" ("I have heard of AIDS, but I don't have AIDS, so why should I worry?") indicating no attitude change because of indifference and lack of empathic identification with people with HIV/AIDS.

The general finding is that people tend to feel initially cautious about people with AIDS, but that exposure leads them to feel safer. The following well describes initial first reactions to people with HIV/AIDS: "When I saw my brother's friend who was said to be having AIDS I was initially scared… You know I used to look at my brother and blame him for befriending such a person. I was worried he would get infected… I looked at my brother as a fool to befriend such a person." (KwaZulu-Natal).

However, respondents mostly went on to describe how they 'got used to it' and how they became sympathetic and compassionate in relation to those with AIDS. "At first I feel: 'If I touch this person' and try to keep a distance. But after time you get used to the idea and you can still hug but at the back of your mind you know it is still there. One opens up after a close experience" (Northern Cape). "You really don't have to discriminate. I also had a friend who had AIDS. She didn't tell anyone else but me. This meant I show her love at all times. I used to wake up in the morning and went to her so that we could talk and help her out with anything she wanted… I used to sit next to her on the bed and we chatted. I didn't just sit and be quiet because she would have assumed that she was approaching death" (KwaZulu-Natal).

There was a pervasive correct understanding of how HIV can and cannot be transmitted, yet respondents tended to say, for example, that even though they know that HIV cannot be transmitted through touch, they 'feel' that it can, at

least at first. But without exception exposure to people with AIDS led to increasing acceptance that one cannot be infected by touch or by being in the presence of someone with AIDS, leading to the conclusion that this is a self-correcting problem (and furthermore, a perfectly natural reaction).

Whilst there is good evidence of a predominantly compassionate approach to people with AIDS, stories about people sick with AIDS in communities suggest isolation. It seems that families may be as responsible for this as other members of the community. There is much evidence that families tend to feel ashamed about their AIDS ill, and in their attempts to avoid embarrassment, may avoid exposing them to the public. There is also evidence that families tend to avoid showing the bodies of their dead as is often the custom at funerals, because people would recognise from the thinness of the body that it was an AIDS death.

The section below reviews positive attitude statements, which can be seen as falling into two categories. The first relates to the question of blame and the second to acceptance.

Shift away from blame

KwaZulu-Natal respondents reported that the atmosphere at the funerals of people who die of AIDS differs as compared to the case of non-AIDS funerals, and a critical element is the extent to which the person was 'the actor of his own demise'. The question of blame is important in understanding response and plays an important role in crafting the initial response to people with HIV/AIDS. However, there are signs that this perception is not necessarily a persistent feature of response to HIV/AIDS. The following sample statements reflect this:

- "I used to think that they deserved it. Now I think it's not always their fault."
- "The more I learn the more I'm comfortable with them."
- "I don't blame them anymore."
- "I realise it could also happen to me. They are not to blame."

In the survey study only 13% of respondents in total said that people with AIDS were personally to blame, and deserved it. Moderation of blaming and unsympathetic attitudes seems to have been brought about by numerous stories in a range of media about people, and especially babies, having been infected with HIV without having been personally responsible. In the two most media exposed communities (urban Gauteng and suburban Western Cape) there was the lowest rate of 'they deserve it, they are to blame' responses. Numerous illustrations are provided by respondents from these communities in response to the question 'If something made you change your behaviour, even a little, what was it?' Respondents referred to magazine and newspaper stories and television programmes, for example: "I read a true story of someone with AIDS which really touched me in a lot of ways" (Western Cape), and "Reading about a person who was thrown out of the family because he had AIDS" (Gauteng). Many people, across all sites, responded that they had changed their attitude to "people with AIDS" because they realised "that anyone can get HIV/AIDS". It seems that the pervasiveness of the epidemic is eroding whatever belief there may have been on the part of youth that 'people deserve AIDS'.

It should be noted that rural KwaZulu-Natal had a notably higher rate of attribution of personal responsibility and blame. This site had by far the most negative attitudes towards people with AIDS, along with a generally fatalistic attitude towards the possibility of being infected, and greater expression of indifference to the possibility that they may infect others. The reasons for these

findings remain obscure, and are probably important to understand in developing response in that site.

Acceptance

Sample statements indicating attitudes of acceptance include:

- "Because they are people like other normal people." (Northern Province)
- "They are also humans." (KwaZulu-Natal)
- "People with AIDS are also human and need soulmates." (Northern Province)
- "They are ordinary people who also need our support and care and love." (Northern Province)
- "They are still the same person." (Northern Province)
- "I show them love by eating with them." (Northern Province)
- "I was afraid if I saw someone had AIDS but I've changed now, I fall in love with those people." (KwaZulu-Natal)
- "I think they too need love and support." (Western Cape)
- "Because they are still humans and deserve respect just like each of us." (Western Cape)

The Gauteng school responses showed a highly positive, tolerant and sympathetic response to people with AIDS, with a nuanced understanding of the difficulties faced by people with AIDS. These responses reflect an understanding of the need for care and support, and of the isolation and prejudice which people living with HIV/AIDS (PWAs) experience. The tertiary institution students in the Northern Province also showed an appreciation of human issues to do with the sensitivity of people to stigmatisation, the need to treat PWAs with dignity and 'humanity', the need to accept PWAs and to treat them as any other person, and the need to protect the rights of PWAs. There were only a few respondents in this site who showed any intolerance towards PWAs. The suburban Western Cape site and peri-urban Northern Cape site produced many statements which illustrate tolerance but a less well developed understanding of the plight of PWAs. The rural sites in Eastern Cape and KwaZulu-Natal showed many positive attitudinal responses but there was also a greater prevalence in these sites of prejudicial statements.

Negative attitudes

The following negative attitude statements were given in the response to the request to explain attitudes to people with HIV/AIDS:

- "I'm not free to eat with them or touch them." (Northern Province)
- "I'm afraid to eat with them." (KwaZulu-Natal)
- "(I feel negative attitudes) sometimes when I hear about deliberate infections." (Gauteng)
- "I changed because I don't like them, they have AIDS that kills." (KwaZulu-Natal)
- "I am afraid of people that have AIDS." (KwaZulu-Natal)
- "I withdrew myself from visiting them." (Eastern Cape)
- "I think they will infect me." (Eastern Cape)
- "I've stopped becoming of help to them." (Eastern Cape)

Anecdotal evidence shows that in the rural communities in particular there are still quite high levels of stigma attached to HIV/AIDS. In the words of a nursing sister working in one of the rural areas (details changed/withheld to maintain confidentiality): "We are responsible to a Sister 'X'. She is an instructor on AIDS. If we see signs and symptoms of AIDS we contact Sister 'X'. She goes to the person to deal with this. She has a blue car. People know what she is going to them for. It is a stigma. People isolate that person. People are suspicious."

Perhaps more disturbing are signs in at least one site that health care workers are not well informed and may be perpetuating prejudice. The following statement from an assistant health worker in one of the sites attests to this (site name witheld for reasons of confidentiality): "I visited the clinic when I saw a child whose mother had died of AIDS. And the child also had sores (on the body and on the mouth). I reported the case to the Sister. Tests were done. I also talked to the grandmother not to send the child to the creche, because she would scratch herself and pass it on to others. Children with AIDS should not go to school. We are scared of our children being infected."

An unexpected and perhaps important trend emerged in the rural Eastern Cape site concerning perceptions around the relation between HIV and TB. This was independently mentioned by a number of different respondents, including the local school principal, nurses and focus group respondents and relates to the notion that having TB appears to have become stigmatised because of its relation with HIV/AIDS. In the words of a school principal "Here, if you have TB, you have AIDS. In the township, if you have TB you don't hide it. Nurses come and visit, there is information on the television. Here people hide it… You are a black stain. You are treated differently. At traditional gatherings you cannot drink from the same jug." This trend is important as it must have a negative influence on TB help seeking and treatment compliance.

Finally, two anecdotes from one rural site are provided to reflect the range of attitudes that may coexist within a community, leading us to be cautious about drawing conclusions about communities in general:

- "Near my home there is a girl who died last week. She had AIDS. It was a problem because she had absconded from home. It has been eleven years that she was away. She just came back last month because she was sick. Her mother abused her and even chased her away from home. She died in some other home… she did not die even in her home. She came back home when dead. The mother did not even take her to the mortuary but buried her the following day wrapping her in a sleeping mat and said that she won't even mourn for her."
- "At home there was a sick person with AIDS but she was not treated so badly. They were washing for her. She died in hospital and was buried with dignity. There was no problem. They treated her well."

COMMUNITY LEVEL ADVOCACY, SOCIAL NETWORKS AND MOBILISATION

Youth oriented HIV/AIDS intervention activities

The survey study showed that over half the youth in the study had thought that they "should become involved in helping with the HIV/AIDS problem". Yet only 37% were aware of ways of becoming involved.

The qualitative study suggests that not only are youth not aware of ways of becoming involved, but that there are limited opportunities for involvement. In

the rural communities there are especially few opportunities and in the Eastern Cape site there are virtually no opportunities.

Whilst few of the youth respondents in the study reported being directly involved in youth AIDS activities, they were aware of some youth oriented AIDS activities in other communities, including, for example AA (AIDS Assocation) in schools, cultural groups which have adopted an AIDS focus for a period, sports clubs which have taken an 'anti-AIDS' stance, and youth volunteer community education programmes.

In the Gauteng site a school social projects programme has involved some of the pupils in visiting centres for children who are affected by HIV/AIDS. Although this initiative is not specifically or only about HIV/AIDS, it is worth commenting on as an instance of mobilisation, because of the effect it seems to have had on those involved. Asked to respond in the questionnaire to 'If something in the past really made you take the problem of AIDS more seriously what was it?' many commented on their visit to the centre for children affected by HIV/AIDS. It is an instance of advocacy which was developed as part of an ongoing and school initiated programme around social awareness and would seem to be a good example of how HIV/AIDS related advocacy does not have to stand alone as an activity. It can easily be developed as a 'piggy back' activity on other established and supported social concern initiatives – but these need to be present in the surrounding community.

A less successful initiative in the KwaZulu-Natal site was set up in 1993 following a successful intervention in the area by an AIDS organisation focusing on community theatre. The intervention had received a very positive response from the community and evaluations thereof showed evidence that it was remarkably effective in reducing STDs. Following this, a group was set up to pursue the initiative and to establish an AIDS Club in the area. For whatever reason there was no or little follow up, and although there was a meeting to try and put the initiative back on track, the initiative has stalled and now seems inoperative. There had been hope of starting a drama group oriented around HIV/AIDS but without the hoped for support the youth did not have the capacity, resources, or confidence to take the initiative further. It seems safe to conclude from this case that unless youth enthusiasm is actively supported it is bound not to bear fruit.

The context of the Eastern Cape rural site, which is ironically the site which is most coherent as a distinctive community, there is far less happening to move AIDS issues from the realm of the abstract and intangible into a set of practical initiatives. Yet youth in this site are very enthusiastic about the possibility of HIV/AIDS involvement and the widespread interest stirred by the presence of the researchers in the community strongly attests to the ease with which a community like this could be mobilised to address HIV/AIDS as an issue. This has not happened, and provision of resources for mobilisation of youth involvement in such contexts must be seen as a priority. In the context of the absence of any HIV/AIDS related community activity it is not surprising that youth are high on 'worry', and generally low on 'prevention' and 'care' indicators. There is little support for the positive intentions and this points to an urgent need for youth development support.

One of the main factors militating against youth activism is that activists put themselves at risk of being branded as having a 'suspicious' interest. Whether through wearing of a red ribbon or "talking about AIDS too much", a special interest in HIV/AIDS is sometimes seen to imply a personal connection with the disease, and this then also carries the meanings of being an HIV positive person.

Youth seem reluctant and negative about associating ongoing activities, for

example sporting activities, with AIDS awareness activities. This was especially strongly expressed in the KwaZulu-Natal site where, for example, the belief was expressed that 'AIDS talk' had no place in a soccer club. Thus, "We are here to play soccer, now go away!". The problem is that if this is the case, it is not clear how AIDS activism might be situated such that it has youth appeal? In the following case study youth appeal was successfully established.

CASE STUDY: An AIDS Awareness Club

At the tertiary institution site in the Northern Province there is a well-established AIDS Awareness Club. When the club was paid an unplanned visit in mid-1999 the researchers were highly impressed by the levels of enthusiasm apparent amongst the students, the level of group identity and cohesion, and the range of projects which were being undertaken. This was a picture of hope and optimism, a model of what can be achieved when the energy, time and enthusiasm of youth are harnessed. It was therefore surprising in a mid-2000 visit to find a dispirited and dissatisfied group of students with the club a shadow of its former self. What happened?

The activities of this club have included: running campus awareness campaigns amongst staff and students on the campus; counselling fellow students about sexual health matters and HIV/AIDS; directly distributing condoms to staff and students; assisting students to make decisions about HIV testing; HIV/AIDS education in local communities and schools; promotion of discussion about the introduction of rapid testing; running an abstinence week on campus; making an AIDS memorial quilt panel; activities around promoting the rights of HIV positive people; assistance in HIV/AIDS policy development; raising funds for education equipment and materials; support for, and sharing of materials and skills with community organisations trying to mobilise around HIV/AIDS; and many activities besides.

Every year more than 500 students apply to be members of this club when it is promoted in orientation week. A selection process involving individual interviews is conducted to make up a total of 50 students in any one year in the club. The students cover a range of faculties (for example, law, information technology and commerce) and years of study.

The programme is promoted as a work-study programme where students learn practical skills, including interpersonal and management skills in a working environment. The students earn a certificate for successfully participating in the activities of the club and are of the view that their involvement will enhance their employment prospects.

The staff at the health centre initiated the club and have put much effort into training and supporting activities. The club has its own office in the campus health centre which occupies a prominent position at the entrance of the campus.

The breakdown of the functioning of the club is fundamentally about funding and it seems that this is contingent on lack of recognition of the value of the club within the institutional environment. The institution funds the health centre which in turn funds the AIDS Club. There are also environmental and drug abuse clubs run from the centre and these have suffered the same fate of the AIDS Club with the common causal factor being the lack of funding.

The students hoped to raise funds themselves but were told that they had to do this through the institution's central fundraising channels. This involves a slow, bureaucratic process. The provincial Department of Health has invited the club to submit a funding proposal, and here too the process looks to take so long that the students were negative about the possibility of doing any meaningful work in 2000.

The AIDS Club members have no money for transport and can only visit schools within walking distance. As a result there had been very little activity in the club during 2000 in spite of there being operational plans and the necessary time and skills available. It looks unlikely that they will be able to earn certificates of performance and the whole project is lacking in

energy and dynamism because of this. Some private funding was raised for the purchase of education equipment and materials and there has been some interest by outside bodies in supporting what is obviously a very promising and cost-effective initiative. Also the Beyond Awareness Campaign supported activities of this club through a tertiary institutions mobilisation initiative. But there has been no consistent funding to cover basic running expenses, apart from that which can be drawn from the health centre budget supplied by the institution.

The factors which mediated the original success of this initiative are: integration of HIV/AIDS activism with learning of life skills; motivation for involvement because of enhancement of employability through having been involved; a youth friendly modus operandi; a creative approach; a committed mentor; assistance in defining objectives; clearly defined roles and objectives; a sense of being part of a broader, important social movement; a sense of being of assistance to the community; provision of a permanent venue; and a team approach.

The factors which are leading to the demise of the club are: lack of institutional prioritisation of HIV/AIDS; lack of recognition of the work being done within the club by institutional management; prevention of the independent fundraising of the club; funding bureaucracy; and lack of mechanisms in the society as a whole to identify success stories, support them and model other initiatives on them.

Conclusion

The students and health centre staff are way ahead of their institution in understanding the need to respond to the HIV/AIDS crisis and have pioneered effective models for doing this. In this case at least, all the successful ingredients are in place, but funding is necessary. The mobilisation in this instance needs to occur at the top and there needs to be recognition of the value of this kind of initiative. It is a tragedy that a society desparate for solutions cannot see such solutions and support them when it is confronted with them.

There is an urgent need to identify successful projects and to provide ongoing support for initiatives and for youth activities that are both personally enriching and socially valuable. It would seem important to identify successful projects and to focus on them as models of best practice which can be emulated elsewhere. Through analysis thereof one might develop an understanding of models of practice that are sustainable and yet which are fuelled by the energy, resourcefulness, and wish to contribute to society evident amongst youth.

COMMUNITY MOBILISATION

Sometimes we might express particular attitudes and yet our behaviour indirectly or implicitly shows different attitudes. For example, in one of the focus groups a respondent commented: “Take a seat next to me, its not like I’ve got AIDS!”. This was intended as a joke but it reveals a context of meaning where there is a shared recognition that if the person were to ‘have AIDS’ there would be some uncertainty about sitting next to her. As it happens the person who made this statement was quite aware that there would not be any risk of infection and would possibly not feel uncomfortable sitting next to someone with AIDS. This implies that the community and their shared meaning may have a somewhat different reality to the reality of any single individual. This leads us to the need to describe the reality of HIV/AIDS prejudice and discrimination not only by looking at what individual’s think, feel and do, but by studying the community as an entity in itself. It emerged in the study that in some sites more than others, and particularly in the rural Eastern Cape site, there is a strong shared response to HIV/AIDS, and this is more prejudicial and less touched by media than are the minds of the individuals that comprise that community.

This means that there is a need to work with groups and communities, as well as to target individual attitudes in overcoming underlying prejudice. Another way of saying this is that a community may be united in practices which are not 'owned' by any individual, and which might persist, at least for a time, until they are tackled at the level of community practice. The 'community of practice' needs to be tackled at the level of concerted community action and intervention.

Within the six sentinel site communities studied there is a marked lack of sustained HIV/AIDS mobilisation within community structures. There is ample evidence of non-governmental and community-based organisational involvement within urban communities, but the *agency* in all cases seems to reside in the outside group rather than within the community. Community-based organisations appear only to have been involved in an *ad hoc* way. "AIDS is discussed in groups for instance at ward meetings. But mostly it is joked about" (Northern Cape). Although youth are not necessarily in a position to know about ongoing involvement of community structures in AIDS issues, the evidence they do provide suggests that there is very little of substance going on. There do not seem to have emerged any influential community-based organisations, such as have been mobilised, for instance, in the fight against crime, or in relation to community agricultural and cultural issues.

There is especially little evidence of mobilisation of community care and support for individuals and families directly affected by HIV/AIDS. Whereas churches appear to play a role from the pulpit in promoting their own HIV/AIDS prevention solutions, they appear in the communities in question not to have played a significant role in organising care and support activities. To illustrate: "In my church we have never gone from house to house to help. It ends with the one who is preaching" (KwaZulu-Natal).

In general, women appear to be playing a more active role in initiating community-based activities and in the KwaZulu-Natal site there is evidence that some individual women have taken it on themselves to educate people about HIV/AIDS using groups of interested youth. There is also evidence of numerous once-off campaigns organised, for example, by gospel groups and theatre groups. It would seem important that such initiatives be harnessed and assisted in finding financial support. In rural areas there are no resource centres, advice centres, VCT facilities and counselling support facilities provided by non-governmental organisations and government, as there are in urban areas. Thus there are few opportunities for linking to resources which might form the foundation of more concerted efforts and community-based responses.

A CONTEXTUAL FRAMEWORK FOR APPROPRIATE HIV/AIDS COMMUNICATION

This study shows some encouraging signs that youth are responding positively to the HIV/AIDS epidemic, but also shows that youth response is not uniform. Youth response is contingent on many factors, some to do with resources and the support resources of the social environment, and others to do with more remote determinants in the form of entrenched social institutions and practices. The analysis in this study poses a challenge to the idea that behaviour change is something that can be achieved on the basis of having adequate information and understanding. To the extent that behaviour is contingent on social conventions, institutions, inadequate resources, and the like, sustained behaviour change is dependent on changes in these areas. In this closing section we consider, in broad terms, some of the implications for campaigns aimed at improving youth response to HIV/AIDS.

In South Africa there is a dearth of social research about HIV/AIDS, and core mechanisms for monitoring impact have yet to be developed at national level. To date, the social world of HIV/AIDS has been understood through largely dubious interpretations of the scant data that does exist – for example, extrapolations from annual antenatal HIV surveillance studies of pregnant women attending public sector clinics. One cannot draw inferences about the population as a whole from such sub-populations. Another source of understanding (and pessimism) about HIV/AIDS comes from media reports and qualitative research which draws attention to especially problematic contexts at the expense of understanding normative responses and more general responses as a whole. Instances of extreme prejudice against people with HIV/AIDS, for instance, often do not reflect predominant community positions, but reporting on one severe case may lead to assumptions that this reflects the norm. We were surprised in the present study, for example, to discover a much more sophisticated and tolerant understanding of the plight of PWAs than we expected. The point is that although the epidemic is regarded as 'advanced' our understanding of social aspects of an advanced epidemic are rudimentary at best.

In the present study we have identified some of the elements which we should be looking at in monitoring social response and in planning interventions. Attention has been drawn to a range of mediators of behavioural response including some which are important but are not usually thought about as determinants of response, for example: the widespread impact of female injectable contraception in rural areas and its impact on the psychology of sexual risk amongst young men. The present study has been exploratory rather than exhaustive and there is much to be known about the contextual mediators of youth response to HIV/AIDS. To begin with, studies in this area need to be conducted across a much broader range of 'communities of practice' in South Africa, so that we can appreciate the stratification of response across the full spectrum of society.

Pending further development of the science of behavioural response, behavioural education programme developers still need to continue to plan and deliver programmes. What follows are a series of planning steps that might inform and frame behavioural intervention in a way that is contextually sensitive.

1. Research target groups

Programmes which set out to 'change behaviour' need to be clear about existing levels of appropriate behaviours, and about what behaviours are realistic to try to change amongst what segments of the population. This report and the survey study have shown that even within the defined population of youth there is need to target specific categories of youth with specific behaviour change objectives, rather than to generalise levels of risk to the community as a whole. For example, cohabiting youth should be targeted with faithfulness messages rather than condom messages, and sexually inexperienced youth should be targeted with abstinence and delay of sexual onset messages, rather than condom use messages. This is a matter of aiming messages at the real issues and choices facing the lived realities of youth, rather than splashing the entire population with general exhortations which often do not fit their circumstances, and which may add further confusion to an already confusing environment.

If intervention programmes are based on research, the product is more likely to reach its target and to be effective. For example, we should not target or expect a change in the number of concurrent partners in a context where the problem is not multiple concurrent partners so much as high turnover in a serial monogamy context. This reflects two quite different strategies of multiple partnering. These patterns require different prevention strategies and it is all too easy to overlook such differences in planning campaigns around reduction in number of partners. So, interventions need to be more target-specific and more nuanced about the behavioural challenges which are faced.

2. Identify contextual mediators of behavioural response

In as much as we need to focus our intervention efforts more directly at the level of both behaviours and sub-populations targeted, we need to understand the contexts which are likely to mitigate against or give impetus to our efforts. This means understanding the contextual mediators, or contingencies, of behaviour change. Not only do we need to understand these, but addressing them should be central to our efforts. This means understanding changing societal and cultural trends and factoring these into our attempts at promoting behaviour change. For example, the increased sexual content in the mass media environment may lie behind the dramatic decrease in age of first sexual intercourse over the past 15 years. If this is the case, it is a factor which needs to be addressed as a possible area of intervention, along with factors that operate at a household level, a peer group level, and the individual psychological level.

3. Map contingencies of behavioural response

What we think and what we imagine ourselves to be capable of doing is a product of our experience, of the world we live in and the opportunities it offers, of the relationships we are involved in and the expectations associated with these, and of the possibilities and sense of a future that our circumstances promise. We act and change our behaviours in concert with all the surrounding events of our lives. It is important then, in planning behavioural interventions, to ask how the different contextual mediators relate to each other, and to know which offer opportunities for change.

It is obviously in the interest of programme developers to intervene at points in the network of mediators where the system is most susceptible to intervention. In particular we need to know, based on an understanding of context, whether to catalyse change through intervening at the macro-systemic (for example, socio-

economic or media environment), meso-systemic (for example, school system, health system and family) or micro-systemic (individual and interpersonal) levels. By mapping out all contingencies we are able to understand the best mode of engagement or point of entry into the system and the support mechanisms and complementary initiatives which need also to be addressed.

4. Identify emergent possibilities, capacities and norms

The belief that there has been little success in behavioural intervention has arguably led to the tendency to focus almost exclusively on 'changing current behaviours' rather than on exploring, promoting and endorsing existing and emergent low-risk practices. The solutions that spontaneously emerge in relationships and communities stand a much stronger chance of being sustained than those introduced from outside, and it is important in any intervention context to understand and harness such developments. When we are able to identify early trends we are able to endorse and support them. We know for instance, that secondary abstinence is appealing to many young women who find themselves trapped in sexual relationships. Their feelings of discomfort with such relationships might be picked up on, and it may be the germ for a new culture around sexual choices.

There is need for contextual support which would consolidate and develop the changes that many youth are experimenting with in prevention and care. Development of innovations within any community is likely to be led by a vanguard of often disparate individuals. In this study there were a number of examples of people who have stood out in youth communities as having a passionate concern about AIDS. In a community of youth such people are not necessarily the strong opinion leaders and their efforts are not necessarily admired or supported. Therefore, endorsement of, and support for emergent initiatives is important.

The challenge then is how to support positive innovations in such a way that they might lead to broader diffusion and ultimately the development of new norms amongst youth. A number of possibilities for this exist. These include dissemination of innovations using youth 'heroes' as examples. Creation of positive, appealing images around new behaviours is also likely to enhance possibility of broader uptake. But these solutions are limited, for reasons that are made apparent in this study.

Firstly, there is more to adoption of a new behaviour than finding it appealing. The behaviour of condom use, for example, is made up of many facets, and positive intentions will not necessarily motivate the person through obstacles that are introduced by the context. Furthermore, consistency of behaviour is far more complex than simply deciding to adopt a particular practice.

Normativity drives behaviour. The concept of 'normativity' concerns the use of common frameworks for doing things and understanding things. The point is that we should be endorsing new forms of positive response, in such a way that they might become normative. Interestingly in the survey study in the most socio-economically resourced site in Gauteng, where there was the highest rate of condom use, there was a relatively low prevalence of partners having discussed the risk of HIV infection. It appears that condom use in this site does not have to be discussed, but it is simply something that youth, for the most part, tend to do unquestioningly (i.e. normatively). The sooner we are able to understand that particular practices have become normative, the more able we are to move ahead to the next step. If youth are aware of key HIV/AIDS messages and issues, there is little point in expending large sums of money reiterating such information. Instead the challenge is to become more differentiated in our understanding of

issues, and to be open to developing and expanding new approaches to communication, which are linked to the day-to-day issues young people face in developing constructive responses to the epidemic.

5. Identify tools and human resources for supporting appropriate activities

Whatever is done by way of promoting behaviour change or endorsement of particular behaviours needs to be matched by response at the level of the constituent parts of a given behaviour. It needs to be asked of the context: What support for adoption of this set of behaviours can be mobilised at community level? Furthermore, what conceptual, linguistic, interpersonal, community, social and material resources are latent sources of support for the behaviour?

Considering promotion of secondary abstinence amongst sexually active early adolescents, for example, we might ask: How should secondary abstinence be conceptually framed in terms of motivation, feeling and thinking? What would secondary abstinence be called? How might it be supported as an interpersonal practice, and through what avenues of communication and support? What kind of support in the community would best be mobilised for this practice? What forms of social support in terms of services and involvement of agencies might be accessed? What kind of material and communications support would be appropriate to support the initiative?

There are significant human resources potentially available for HIV/AIDS activism that are not utilised. Youth have shown their interest in being involved, but it takes specific youth development inputs to mobilise youth energy and creativity. This study has shown that there has been very little mobilisation in rural communities, whereas in urban communities youth were able to speak about a large range of HIV/AIDS activities, organisations and groups. Even when these groups do exist, it seems that initiatives are commonly of a sporadic nature and not connected to a broader social programme. There is thus a need to take stock of the range of organisations, individuals, and skilled and unskilled human resources in any community, and to develop an understanding of how support might be garnered for changing behaviour and promoting care. Furthermore, this has to be done with contextual sensitivity.

The complexities of ‘participation’ come to the fore here, because not all forms of ‘support’ are necessarily welcomed and there is a need to closely understand the contextual dynamics of the way in which community support resources are perceived and what interests they serve.

Fostering participation of resources that do not usually work in concert within a particular context may be fraught with difficulties, especially where there are different forms of understanding at play, different capacities for self-expression and group mobilisation, and different capacities for working at the different levels of a system.

6. Indicators for monitoring and evaluation

In keeping with a contextually sensitive approach it is important to develop indicators for monitoring and evaluation which reflect this understanding. For instance, for purposes of evaluating condom promotion it is not all that useful to know the percentage of the generalised target population who have ever used a condom. We need to be more specific in defining the denominator, or population, which we are trying to measure with respect to condom use. We would accordingly need to exclude, for instance, those who are not sexually active, and those who are in monogamous, faithful relationships, because they are not targets

for the promotion of condom use.

As this study has shown, sexual activity cannot simply be generalised across teenage and adult age groups. Amongst those whom we might expect to be sexually active there are significant proportions of individuals who are not sexually active, or who have never been sexually active. And there is a large range of prevention measures adopted with varying degrees of consistency, according to circumstances. This is where inferences drawn from antenatal data fall down – for they tend to be generalised to the geographic localities and age ranges from which the samples are drawn, with little understanding of sexual activities and practice within these confines. This study has shown marked differences across sites and also within sites, and our attempts to understand sexual behaviour should be crafted in such a way as to pick these up and thereby identify vulnerable communities, areas of vulnerability to risk, as well as sectors within communities and sub-communities that can confidently be emphasised or de-emphasised in prevention efforts. A similar argument might be applied to care efforts.

Identification of mediators of vulnerability and risk-aversion requires that appropriate biographical and demographic information be collected, as well as that questions based on an understanding of the constituents and mediators of behaviour are used. These should then also be included in the measures used for monitoring and evaluation of interventions.

INTERVENTION

1. Move beyond message based, individual oriented interventions

Behaviour change models which try to persuade people to use condoms or not to discriminate against people with HIV/AIDS need to be complemented by initiatives aimed at creating 'contexts' of change, and communities of practice which are conducive to desired behavioural outcomes.

It is necessary to see HIV/AIDS work as an integral part of broader social programmes aimed at developing communities – that is, to move towards a more comprehensive framework for adoption of practices that involve lower risk of HIV infection and higher levels of care provision.

This study identified a youth activity that showed strong promise and looked to be a model, yet its value was not recognised or given the necessary support and it faced possible disbandment because of this. The challenge of sustaining responses rather than merely initiating them, begins where the message ends. It begins with an appreciation of the need to develop the social capital of communities, so that they might respond more effectively to the AIDS crisis. This includes the harnessing of human and other resources (for example, the time, energy, enthusiasm and creativity of youth) within communities, as well as the deployment of resources in the form of strategies, skills, services, and other forms of externally generated support.

2. Deploy or promote appropriate resources (and appropriate delivery)

'Behaviours' are contingent on the availability of resources for action. Condoms, for example, may not be widely available, may be of poor quality, may not be available consistently, or potential users may be subject to judgemental attitudes of distributors. Such factors undermine the success of condom promotional activities. Consequently, any condom promotion campaign should operate in tandem with resource delivery and site-level promotion activities, and should

understand, support and if necessary, improve the quality of condom delivery systems.

All HIV preventive behaviour is contingent on the availability of support resources. For example, youth friendly condom distribution, youth friendly sexual and reproductive health services, peer support groups, parent support, school-based lifeskills education that is tuned to tackling the realities and challenges of changing gender relations, male involvement in HIV/AIDS campaigns, counselling services, testing services, care and support resources for those struggling to deal with HIV/AIDS related problems, and community-level organisational activities. In the absence of such support services there is need to be cautious about over-investing in communication campaigns. Campaigns which locate themselves specifically within the domain of communication are unlikely to succeed in the HIV/AIDS field unless they clearly understand the contexts within which they operate, and are committed to developing networks and partnerships with organisations working in areas of service delivery. Communication campaigns need to be accompanied by investment in resources, both at a formal institutional level – for example, resource provision through clinics and hospitals – and at secondary level where support and resources are devoted to emerging non-governmental and community-based organisations, or instititutional initiatives such as those in the workplace.

In this regard careful consideration must be given to communications campaigns that are not grounded in an understanding of the need for such support. Our mass media channels are filled with costly products that continue to appeal to youth at the level of basic awareness. Strategists need to carefully analyse the cost-benefit of multimillion rand communications campaigns that target contexts that do not have the basic pre-requisite resources to engender a sustained and appropriate response.

This study has shown that even when it appears that a willed activity directly produced an intended outcome it is usually the case that important foundations upon which the activity is contingent, have already been set in place. In intervention programmes it is necessary to lay the foundations for a desired outcome which makes this outcome likely to come about, as opposed to aiming messages directly at resolving problems in the hope that the capacity already exists for initiating and supporting action.

Given that individual behaviours always depend upon practical and material conditions, behaviour change models need to be supported and sustained by changes at a structural level where such conditions are determined. For example, it has been shown that condom promotion should proceed through the channelling of appropriate resources in the health system, and training of condom distributors, which in turn depends upon organisational factors far removed from the minds of potential condom users. It also involves promoting the use of facilities or resources (for example, sexual health clinics or lifeskills education) which are seemingly remote from the behaviour of the actual sexual encounter. Again, whilst behaviour change models aim to directly achieve desired outcomes, they fail to theorise apparently remote determinants of desired outcomes, which are the important building blocks of new behaviour.

3. Develop and promote opportunities for involvement in sustainable HIV/AIDS related social action

In the gay community in America during the 1980s there rapidly arose a vociferous and highly active group who rallied the community to effectively adopt new codes of practice in the face of HIV/AIDS. Here there was a distinct sense of community and mobilisation was rapid and largely successful. Systems for

information dissemination, condom distribution, and counselling and support were quickly set in place, and existing social networks were redirected for HIV/AIDS advocacy. This contrasts sharply with South African communities where there has been little opportunity or framework for social coherence and cohesion around these issues.

In broad terms the solution to the need to develop more active and sustainable responses to the epidemic lies in the creation of contexts for change. This involves engaging people in HIV/AIDS related activities through which community response frameworks might develop. 'Activities' could refer to a range of different ways of being involved at different levels, from practical activities such as distributing leaflets and posters, painting a mural, working in a group on an AIDS memorial quilt, to community organisation level including addressing the AIDS crisis in community meetings and planning mobilisation and advocacy campaigns. Being a part of such activities may do more to develop a culture of concern and even HIV risk avoidance, than would communication campaigns which appeal to people to change their attitudes or sexual practices. The present study has found ample evidence that when HIV/AIDS enters peoples' lives or imaginations through practical involvement, they are most likely to develop an appreciation of HIV/AIDS as a practical reality, and a more considered response to the epidemic.

4. Engage with supportive national efforts

The society as a whole needs also to be mobilised to a much greater degree to develop responses to HIV/AIDS. Apart from context specific issues and mobilisation, there is a need to mobilise a supportive national context. There are issues which cut across all contexts and which require support at the level of inter-sectoral collaboration. But integrated approaches do not fit easily into existing governance frameworks and as Marais (2000) points out, intersectoral collaboration is hard won. This takes political will, which then also needs to be built into our understanding of how behaviour change occurs.

Related to this is a need to support community efforts at the level of advocacy and policy development. For example, there is a need in addressing high levels of early sexual activity, high age differentials between sexual partners, and sexual coercion, to work in concert with those involved in drafting legislation relating to statutory rape. Communication about these issues can be significantly promoted and supported by development of appropriate legislation.

Gender issues are perhaps the most powerful example of the need to intervene at a macro-social level. This study has shown that gender issues are fundamental to youth decision making. Yet we do not choose our sex and for the most part we do not choose the behaviours that are expected of us, and which we are enculturated to adopt when we are a member of a particular gender group. Whereas individuals may under certain circumstances be empowered to make choices which go against prevailing gender norms, we are overly optimistic to hope that campaigns of behaviour change will successfully bring about this possibility. Gender practices and stereotypes need to be dismantled at a societal level, through promotion of gender rights and through understanding and unpicking the fabric of patriarchy through which the cords of individual lives are woven. This is a social programme, and not simply an AIDS programme, and ongoing work in such areas as gender and socio-economic empowerment are in a very real sense coterminous with management of the AIDS crisis.

If there is a silver lining to the AIDS epidemic, it is the possibility that the AIDS crisis provides a pressing context for fast-tracking social development across traditional sectoral divides. For example, the urgent need for response in the area

of HIV/AIDS calls for more responsive health services, urgent development around gender issues, introduction of life-skills into the education system and delivery of a broad range of community development resources. This requires a national co-operative effort.

CONCLUSION

We urgently need to move beyond direct and 'common sense' exhortations to change behaviour. In aiming for a systemic and contextually sensitive model for developing behavioural and community response, there is a need to actively adopt integrated models which combine education, service delivery and social development. Whilst there is a huge range of HIV/AIDS initiatives in the country, there is little co-ordination of efforts, and little understanding of the contributions of specific programmes to the broader intervention effort.

Throughout history communities have responded to environmental exigencies such as floods, earthquakes and famine by rapidly organising interventions, systems and practices to deal with these problems. Such response is also occurring in relation to the complex exigencies of HIV/AIDS, but the gradual, insidious and complex nature of the epidemic has meant that responses have emerged slowly. Some communities have experienced the spontaneous development of youth groups that address peers on HIV/AIDS issues, or care groups that provide support to families and individuals affected by HIV/AIDS. Similarly, this research has identified novel individual level responses. On the other hand there are communities which show a relative paucity of response. It is important to understand the different social responses tath do exist, with a view to supporting them and to providing the models and tools which are necessary for managing the crisis in the different contexts where its presence is likely to be felt.

We need to understand that sexual behaviour change is but a narrow segment of the necessities of broader social change in relation to HIV/AIDS. Other segments include promotion and intervention in the areas of gender, rights and issues of care and support. The more we imagine sexual behaviour change to be an overarching goal, the more we limit understanding of the need for parallel areas of focus. It is only when we understand interventions to be located in the social realm rather than purely the realm of the 'individual', that we can truly move forward.

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APPENDIX: DEMOGRAPHIC FEATURES OF SENTINEL SITES

Age and gender

	Average age	Median age	Min-max age	Interquartile age range	Male	Female
Rural site, KZN	19	18	15-30	16-20	46	54
Rural site, EC	20.5	20	15-30	17-24	42	58
Suburb, WC	22	22	16-30	19-25	48	52
Urban school, Gau	17	17	15-19	16-17	50	50
Township, NC	22	22	15-30	18-26	49	51
Tertiary Inst., NP	23	23	17-30	21-25	52	48
ALL	20.4	20	15-30	17-24	48	52

Self-rating of financial status of home

	Rural site KZN	Rural site EC	Suburb WC	Urban school Gau	Township NC	Tert.inst. NP
Not even enough money for basic things like food and clothes	23	25	16	1	47	12
Money for food and clothes, but short on many other things	33	62	23	2	36	43
Most of the important things, but few luxury goods	26	9	44	31	12	40
Some money for extra things such as going away for holidays and luxury goods	18	4	16	66	5	4

Media resources in the home

	Rural site KZN	Rural site EC	Suburb WC	Urban sch. Gau	Township NC	Tert. inst. NP	ALL
Television	70	45	97	98	77	89	81
Radio	96	86	96	99	80	94	92
Daily newspaper	41	10	49	79	33	25	42
Sunday newspaper	15	2	34	86	23	42	36
Magazines	49	11	71	90	37	57	54
Telephone in home	28	2	77	92	16	41	45
M-net or Satellite tv	11	4	46	65	10	10	26
Internet	1	2	1	49	0	2	11
Ave. sum of media resources in home	3.1	1.6	4.7	6.6	2.8	3.6	3.9
(rank)	(4)	(6)	(2)	(1)	(5)	(3)	
Range of number of media resources in home	1-6	1-6	1-7	1-8	1-6	1-8	1-8
Standard deviation of media resources in home	1.6	1	1.6	1.4	1.5	1.6	2.2

Studying and income (categories not mutually exclusive)

	Studying %	Not studying %	Earning (full time or part-time)	Not earning and not studying
Rural site, KZN	77	23	15	9
Rural site, EC	70	30	8	26
Suburb, WC	14	86	62	23
Urban school, Gau	100	0	12	0
Township, NC	41	59	7	46
Tertiary Inst. NP	100	0	13	0

Highest education level completed

	Gr. 7 or less	Gr. 8	Gr. 9	Gr. 10 (matric)	Gr. 11	Gr. 12	Incom-plete tert. educ.	Tertiary dipl. or degree	P-grad. study
Rural site, KZN	2	15	24	17	26	13	3	0	0
Rural site, EC	3	16	19	27	21	12	1	1	0
Suburb, WC	1	8	13	17	8	38	11	3	1
Urban school, Gau	0	0	0	100	0	0	0	0	0
Township, NC	8	8	18	14	19	24	4	4	0
Tertiary Inst. NP	0	0	0	0	0	31	51	12	6

Cohabitation status: Living together with a partner

	Yes	No
Rural site, KZN	24	76
Rural site, EC	8	92
Suburb, WC	17	83
Urban school, Gau	0	100
Township, NC	29	71
Tertiary Inst. NP	9	91