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**HIV/AIDS AND BEHAVIOUR CHANGE:
FROM AWARENESS TO ACTION - A STUDY OF STUDENTS AT THE
PRETORIA TECHNIKON**

By

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DECLARATION

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I declare that **HIV/AIDS AND BEHAVIOUR CHANGE: FROM AWARENESS TO ACTION-A STUDY OF STUDENTS AT THE PRETORIA TECHNIKON** is my own work and that all sources I have used or quoted from have been indicated and acknowledged by means of complete references.

Signature
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Date

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SUMMARY

FROM AWARENESS TO ACTION - A STUDY OF STUDENTS AT THE PRETORIA TECHNIKON

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HIV/Aids has become a household term in South Africa. Most people are aware of the existence of the disease and how it is transmitted. Several people have used this information as the impetus for behaviour change but there are many individuals who have not heeded this call and have not made any significant changes to their lifestyles. This is reflected in South Africa's high infection rate. It would seem as if, for various reasons, people know how to protect themselves but have not used this knowledge to guard against possible infection.

The purpose of this study is to explore the reasons why people have not changed their behaviour and to identify possible techniques that can be used to amend this situation. This will take the form of an intensive three-day prevention workshop where participants will be asked to think critically about their own behaviour. The aim of the programme will be to discuss, demystify and debate ideas.

How will this programme be designed? The researcher will make use of focus groups consisting of Technikon students who will offer their thoughts and opinions. Once these focus groups have been conducted the researcher will

undertake an intensive analysis of the data and identify certain key issues. A literature review will then follow. Therefore, the foundation of this programme will be based on the ideas of the participants, the researcher's ideas and some points from formal behaviour change theories.

The goal of this study is to add to the already growing body of HIV/Aids prevention literature and to design a programme that is useful and relevant.

OPSOMMING

MIV/VIGS EN GEDRAGSVERANDERING: VAN BEWUSTHEID TOT AKSIE - 'N STUDIE VAN STUDENTE AAN DIE PRETORIA TEGNIKON

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MIV en Vigs is reeds lankal huishoudelike terme in Suid Afrika. Die meeste mense weet van die siekte en hoe dit oorgedra word en het gevolglik hulle gedrag dienooreenkomstig verander. Tog is daar mense wat dit nie gedoen het nie. Hulle maak hulself steeds kwesbaar vir infeksie. Hierdie tendens word beaam deur die hoeveelheid mense wat MIV positief is. Die implikasie is dat mense van MIV en Vigs weet maar dat hierdie kennis nie 'n gedragsverandering tot gevolg het nie.

Die doel van hierdie studie is, eerstens, om te bepaal waarom mense nie hul gedrag verander het nie en tweedens, om maniere en tegnieke te identifiseer wat gebruik kan word om hierdie situasie te verander. Die navorser gaan 'n voorkomings-werkswinkel ontwikkel. Die doel van hierdie werkswinkel is om mense te kry om krities na die wêreld te kyk en vrae te vra. Deelnemers sal hulle eie gedrag moet bestudeer en daarna evalueer of hulle hulself kwesbaar maak deur hierdie gedrag.

Die werkswinkel sal in hierdie studie ontwikkel word en op 'n latere tydstip getoets word. Die navorser gaan fokus groepe gebruik om idees oor voorkoming direk vanaf jongmense te kry. Die navorser gaan ook na formele gedrags-veranderingsteorieë kyk. Die werkswinkel gaan op beide die terugvoer en teorie gebaseer word.

Die primêre doel van hierdie studie is om met nuwe idees en konsepte vorendag te kom wat waardevol sal wees in die daarstel van 'n doeltreffende en relevante werkswinkel in die veldtog teen MIV/Vigs.

Keywords

Human Immunodeficiency Virus (HIV)
Acquired Immunodeficiency Syndrome (Aids)
Prevention programme
Behaviour Change
Focus groups
Grounded theory
Pretoria Technikon
Tertiary student
Risky behaviour
Safe sex

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CHAPTER 1

AWARENESS, EXPLORATION AND STATEMENT OF PROBLEM: HIV/AIDS

AIDS makes me feel alive. Every day I am thankful and grateful for being alive. I breathe and enjoy the fresh air; notice the blue skies and the colourful flowers; I feel the warmth of the sun; I am living with AIDS. (A person with advanced HIV/AIDS 1990) (Evian, 2000, p. #)

1.1 INTRODUCTION

HIV/Aids has landed a devastating blow on the world and left society reeling in its wake (Van Dyk, 2001). The once mysterious and misunderstood virus has now grown into a pandemic of major proportions with sub-Saharan Africa being one of the hardest hit regions (Van Dyk, 2001). Today HIV/Aids has become one of the most destructive plagues in the history of the human race (Van Dyk, 2001). According to Van Dyk (2001) it can be seen as a monster, which threatens to devastate society as we know it because it has changed all the rules by which we live. Never before has one disease presented so many problems and challenges for society and very few illnesses are quite as capable of producing such an emotional response. The virus arouses feelings of panic, anxiety, fear, hopelessness and provokes a great deal of guesswork. The origins and transmission of the disease have always provided food for speculation and accusing fingers have been pointed in several directions.

With the rate of infections soaring in sub-Saharan Africa we are all living with HIV/Aids, either directly or indirectly. Many of us know people who are HIV positive or who have lost a friend or relative to the disease. The researcher believes that HIV/Aids has made its mark on the South African psyche. We discuss the disease and its origins. We make projections about its devastating consequences and we talk about possible cures and misconceptions. We wonder about neighbours or friends and we talk about people whom we think have HIV/Aids.

In response to the threat of HIV/Aids there has been a global movement and many governments around the world have sprung into action, including ours. The government has launched a programme designed to prevent the spread of HIV/Aids in South Africa that covers nearly all aspects of the media including radio, television and the print media. We are encouraged to protect ourselves and avoid risky sexual behaviour yet misconceptions still exist. Individuals living with HIV/Aids are encouraged to speak out and become role models. Information regarding the disease abounds. Despite all of this our infection rate is skyrocketing. Why are people not heeding the message in the media and changing their risky behaviour?

1.2 AWARENESS OF THE PROBLEM

The researcher's first real introduction to HIV/Aids occurred during her undergraduate studies when she worked at a centre for abandoned babies, many of them HIV positive. Here, she was confronted with her own misconceptions and biases. Since then, she has maintained an active interest in the topic. By listening to debates and to ordinary people's opinions on HIV/Aids she has realized that gross misconceptions and stereotypes still exist. She has also had the opportunity to talk to medical doctors about their experiences and learn their thoughts on HIV/Aids.

An experience that played a very important role in her decision to do this study occurred at a basic HIV/Aids education and awareness workshop. At one point in the workshop the facilitator mentioned some statistics. The data was shocking and a few of the participants had trouble accepting this information. The question is why was it so difficult for them to accept what is truly happening and the fact that the statistics are an accurate reflection of what was happening in the country? The dominant response was disbelief. Some of the participants simply refused to accept the data while others questioned its scientific validity. The researcher began to wonder whether there are still individuals who deny the existence of the disease, or whether these individuals simply do not believe that the disease can affect their lives.

In her counselling sessions the researcher has also been exposed to several young clients who are pregnant. This, and the high rate of teenage pregnancies in South Africa, led her to conclude that sexual risk taking behaviour has not been curbed and that young people do not make use of safe sexual practices. These young women were students at a tertiary institution and they had easy access to information regarding HIV/Aids. This poses the question - why did they still partake in unsafe sex? It leads to further questions about whether or not the message is getting through to young people and whether or not the information is making any difference?

Recently, in South Africa, there has been a spate of baby rapes and several people have linked these occurrences to the myth that having sex with a virgin is a cure for HIV/Aids. This is not the only misconception about the disease and this prompted the researcher to start wondering why do these misconceptions exist?

In the recent past, various statements have been made by important persons in the South African government that HIV does not cause Aids and that the statistics about HIV/Aids in Africa are grossly overestimated. This caused the researcher to wonder about the impact that these contradictory statements have on society. Did they, or did they not, serve to undermine existing prevention programmes by causing more confusion about HIV/Aids? The statement that HIV does not cause Aids is in direct conflict with the generally held beliefs about the virus and with most of the prevention programmes in South Africa. Who is one supposed to believe?

All of these experiences added to the researcher's desire to do this study and to investigate the impact that HIV/Aids prevention programmes have (or have not had) on the lives of people, especially young adults.

1.3 ANALYSIS OF THE PROBLEM

When looking at the problem of HIV/Aids it is impossible to ignore the impact that the disease has on society. These devastating consequences act as a motivation to investigate the impact that HIV/Aids prevention programmes are having. It is important to investigate why people are not curtailing their risky behaviours or changing their dangerous lifestyles.

What makes HIV/Aids different from many other diseases is the fact that it has brought so many unanticipated changes to the way in which we live our lives and it has had a tremendous impact on nearly all aspects of society (Van Dyk, 2001). The disease has had a major impact on the psychological, medical, social, spiritual, educational and economic aspects of society (Van Dyk, 2001).

The impact of HIV on South Africa is only just being felt. There are several scenarios on the effect that HIV is going to have. None of them present a very pretty picture but as yet many of these scenarios are still hypotheses. On the household level the impact of HIV has been immediate but the effect on the economy may not be felt immediately. Ultimately, the economic impact of the disease will depend on how many individuals become infected (Whiteside & Sunter, 2000). Even though there may still be some uncertainty as to the real economic implications of HIV, we know that the impact will be long-term, complex and surprising (Whiteside & Sunter, 2000).

For family life HIV/Aids can be devastating and it can result in the collapse of the family. One very potent example is the number of children left without their primary care givers. In South Africa the number of HIV/Aids orphans is growing daily. Increasingly, grandparents are coming under pressure and taking on the role of primary care givers. Some children end up living on the streets because either the extended family has broken down, or there have been problems at home. Many mothers abandon their babies. The lucky children end up in homes and centres for abandoned children. The

psychological toll of parents losing their children to the disease is also immeasurable. The disease is merciless in its dismantling of the family.

Financially, the disease also takes its toll. If a family member has full-blown Aids and is too ill to work he or she places overwhelming pressure on the family. Looking after an ill family member for a long period of time is very expensive. It can foster feelings of resentment. The fear of HIV/Aids can also cause families to ostracize members who have the disease. In South Africa there is a terrible stigma attached to the disease and to avoid this stigma a family may hide the status of one of its members from the community. Another problem with regard to the disease is that a family member such as a wife or husband may not disclose their status to their spouse and therefore place this person in major jeopardy.

HIV will affect the individual in some manner. An individual is a family member who is an income earner, caregiver and educator. The individual is a consumer who purchases goods and services and is a user of health and welfare services (Whiteside & Sunter, 2000). The individual is a community member who serves in the community, shows leadership and is a support. The individual is also a producer whose labour can be lost through illness or death and whose savings and investments can also be lost. Therefore, even if a person is not infected with the disease, the illness and death of other individuals could have a very distinct impact on his life (Whiteside & Sunter, 2000).

How will HIV affect the country's economic growth? There are several models but many of them suggest the same things. The illness and death of productive people may lead to the consequent fall in productivity. There will be a diversion of resources from savings to care (Whiteside & Sunter, 2000). Money will be spent on medication and health care. Financial resources will get used up and people will begin to cash in on insurance policies, selling capital items like homes and, in the rural areas, things like cattle (Whiteside & Sunter, 2000). The loss of the economically active population will mean that

there will be more orphaned children and families headed by children. The government will need to allocate resources to these families.

Even though nobody truly knows what effect the epidemic will have on the South African economy there is talk that it will lower the country's gross domestic productivity over the next 15 years. Other key areas identified include (Whiteside & Sunter, 2000):

- Skills shortage. South Africa is already battling with a skills shortage. HIV will exacerbate this and raise remuneration and replacement cost for companies. This refers to the loss of human capital (Whiteside & Sunter, 2000).
- Lower tax revenues. There will be a smaller labour force with lower productivity and income at the same time as the demand for services like health care and welfare increase. This will place pressure on the government because of lower tax revenues and higher health care spending.
- Decreased savings. A rise in the inflation rate together with a smaller savings pool could well put pressure on interest rates.
- Lack of foreign investment. Domestic savings may be squeezed to a point where foreign investments are vital to plug the gap. However, the incidence of HIV may deter such foreign investment.

Poverty may also help to drive the epidemic. HIV/Aids can further decrease the income of poor people and increase the demand for scarce resources. Once infected, poor individuals may also not have the money to care for themselves properly. They may not be able to afford medication or food to keep themselves healthy. Many individuals may turn to risky behaviour like prostitution to generate income. Here they either place themselves in danger of becoming infected or they may infect someone else.

HIV/Aids may also lend to the increasing inequality between the "haves" and "have-nots" (Whiteside & Sunter, 2000). Workers who are too ill to work are

either retrenched or medically boarded and they lose most of their benefits. Ultimately they rely on the state, or their family. Often these individuals get sent home, either they cannot afford hospital treatment, or the hospitals do not have the resources to care for HIV positive patients. This places an increased burden on the already limited resources of the family. Infected individuals often return home to the rural areas but they no longer have any access to health care.

Not only does the community lose its economically active members but community leaders also succumb to the disease. In communities rumours and stigma can lead to aggressive acts motivated by fears and misconceptions. Communities can ostracize and loathe people who are HIV positive. In South Africa, regardless of the high infection rate, there is still a negative stigma attached to the disease. An individual may either find themselves in a community that is supportive and unbiased, or in a community that is biased and aggressive. The HIV/Aids prevention message is very dependent on the community, not only in the sense that the community needs to support the programme and change its attitudes and behaviour, but also in the sense that people need to inform and talk to each other. The onus is on those who know about the disease to challenge misconceptions.

1.4 FORMULATION OF THE PROBLEM

It has been indicated that although there is an abundance of information regarding safe sexual practices and how to protect yourself from HIV/Aids, South Africa's rate of infection is still one of the highest in the world. Prevention programmes seem to focus more on awareness than anything else. The idea behind this is that awareness will lead to behaviour change. One has to ask why countries, like Uganda, that are less developed than South Africa have managed to lower their infection rates while this is not the case in South Africa. Clearly, if the present infection rate in South Africa is not reduced, the country will not be free of HIV and so faces a very bleak future. Possibly, with a better understanding of why risky behaviour is not being curbed, the problem could be approached in a different manner. One of the

important aspects of this study is to question why young adults who know about HIV still behave in a risky manner. Seemingly, the available prevention information makes no difference to their lives.

1.5 STATEMENT OF THE PROBLEM

Question 1

- Why are people not changing or adapting their risky behaviour in order to protect themselves from HIV/Aids?

Question 2

- What will motivate behaviour change?

1.6 AIM OF THE RESEARCH

A distinction is made between the specific and general aims of this research.

1.6.1 Specific aim

The specific aim of this study is to investigate why risk-taking behaviour has not been curbed and why the infection rate continues to increase. Other aims are to identify the reasons for lack of behaviour change and the obstacles that may make behaviour change difficult. This information will then be studied and used as the foundation for the development of a future prevention programme. To gather the necessary information the researcher will make use of focus group discussions.

1.6.2 General aims

The ultimate aim of this study is to contribute knowledge to the fight against HIV/Aids. One of the aims of this study is to create a clear image of how

South Africans deal with HIV/Aids and what affect it has had on their lives. Ultimately the aim is the development of a new HIV/Aids prevention programme. A preliminary outline of the programme will be drawn up in this study but will only be tested at a later stage.

1.7 DEFINITION OF THE CONCEPTS

1.7.1 HIV (Human immunodeficiency virus)

Individuals become infected with the HIV virus. At first the infected person may not become ill but can pass on the virus to other people. The HIV virus invades the immune system and begins to destroy it by killing the white blood cells that protect the body against illness (Visagie, 1999). As this occurs the body can no longer fight off life threatening illnesses like pneumonia and tuberculosis (Visagie, 1999). When the number of white blood cells drops below a certain level, the individual has full-blown Aids.

1.7.2 AIDS (Acquired immunodeficiency syndrome)

Immune deficiency means that the immune system is incapable of functioning as a defensive barrier against disease (Visagie, 1999). A syndrome is a group of illnesses originating from one cause. Aids is therefore a collection of diseases resulting from the breakdown of the immune system after it has been invaded and undermined by HIV (Visagie, 1999).

1.7.3 Prevention programme

For the purpose of this study a prevention programme can be defined as a programme that is aimed at the prevention of the spread of HIV/Aids. This does not include only government programmes. There are many different forms of prevention programmes but the common goal of many of the programmes is to prevent HIV/Aids transmission and to empower people. There will be a more detailed discussion on prevention programmes in chapter 2.

1.7.4 Tertiary student

For the purpose of this study a tertiary student will be defined as any student who has either a Grade 12 or equivalent qualification and therefore meets all the criteria to study at a tertiary institution e.g. a University, University of Technology or private college.

1.7.5 Pretoria Technikon

The Pretoria Technikon is a tertiary institution situated in Pretoria. The focus of the Pretoria Technikon is on both traditional classroom education and on experiential learning.

1.7.6 Risky behaviour

For the purpose of this study risky behaviour will be defined as any behaviour that makes the individual vulnerable to the transmission of HIV. This would include unsafe sexual practices, multiple partners and intravenous drug usage.

1.7.7 Safe sex

For the purpose of this study safe sex will be defined as using a condom at each and every sexual encounter.

1.8 RESEARCH METHOD

1.8.1 Literature study

A literature study will be done in order to:

- highlight the current situation with regard to HIV/Aids in South Africa.
- describe existing prevention programmes.

- establish the impact of HIV/Aids.
- define the concept of behaviour change.
- compare theories of behaviour change.
- state what is necessary for behaviour change to occur.
- identify obstacles to behaviour change.

The literature study will be completed after data collection has occurred.

1.8.2 Empirical study

The researcher will make use of a focus group discussion to gather information. From this procedure and from the literature study a prevention programme will be designed.

1.9 RESEARCH PROGRAMME

The research is planned as follows:

- Chapter One is an introduction to the research and it includes a discussion of how the researcher became aware of the problem. In the chapter the researcher formulates and explores the research problem. Concepts relevant to the investigation are defined and the aims of the research are also discussed. Chapter One is entitled “**Awareness, Exploration and Statement of Problem: HIV/Aids**”.
- The focus of chapter two is on the principles of prevention programmes and on various prevention programmes in South Africa. The researcher identifies the important characteristics of a prevention programme and gives a history of prevention in South Africa. Chapter Two is entitled “**South Africa and Aids**”.

- Chapter Three explores the methods that will be used to collect and analyze the focus group data. Chapter Three is entitled “**The Research Design**”.
- Chapter Four contains a discussion and analysis of the focus group data. This chapter includes a discussion on the themes that surround HIV/Aids and behaviour change. Chapter Four is entitled “**The Empirical Research**”.
- Chapter Five gives a brief overview of some behaviour change theories and techniques. The chapter ends with a short discussion linking the focus group data with formal behaviour change theory. Chapter Five is entitled “**Theories regarding Behaviour Change**”.
- Chapter Six includes a preliminary discussion and outline of a prevention programme. This programme is based on information acquired from the focus group discussions and the literature review. Chapter Six is entitled “**The Prevention Programme**”.
- Chapter Seven entitled “**Conclusions, Recommendations and Implications of this study**” is the last chapter of this study. It entails a discussion of the recommendations and implications that can be drawn from the findings of the investigation. The data gathered is used to answer the research questions.

CHAPTER 2

SOUTH AFRICA AND AIDS

The fresh mounds of earth stretch as far as the eye can see. Each grave in Zambia's Chunga cemetery is topped with a withered floral tribute and a makeshift cross. During the weekend, a new funeral procession arrives every 15 or 20 minutes. On one day, 52 people were buried; 43 of them between the ages of 19 and 50. Most are Africa's latest victims of Aids (Whitelaw, 2000, p. 1).

2.1 INTRODUCTION

Whitelaw (2000) states that the deaths of skilled workers will wipe \$22 billion off South Africa's economy by 2010. In more than 8 African countries more than 15% of the adult population is HIV positive. The United Nations estimates that one third of the 15 year olds in these countries will die from Aids (Whitelaw, 2000).

2.2 WHAT ARE PREVENTION PROGRAMMES?

Whiteside and Sunter (2000) divide intervention programmes into roughly two sets of interventions.

First, there are the biomedical interventions. These are medical interventions that focus on reducing the risk of transmission and good sexual health. The biomedical focus includes aspects like the treatment of Sexually Transmitted Infections (STI), the maintenance of the good health of individuals who are HIV positive, the discouragement of dangerous sexual practices and condom usage (Whiteside & Sunter, 2000).

Second, are those interventions that focus on changing behaviour. Whiteside and Sunter (2000) refer to the “KAB” interventions. “KAB” stands for **knowledge**, **attitude** and **behaviour**. These interventions are based on the belief that to prevent people from becoming exposed to HIV their sexual behaviour has to be altered. This is based on the belief that once people have **knowledge** they can then change their **attitudes**. Once this has occurred **behaviour** change happens (Whiteside & Sunter, 2000). Behaviour change then follows the classic “ABC” message. This refers to **abstaining, being faithful** and using **condoms**. (Whiteside & Sunter, 2000).

The origin of the “ABC” message can be linked to Uganda. In the early days of the fight against HIV/Aids President Yoweri Museveni decided to include the clergy in the fight against HIV/Aids. He invited both Christian and Muslim clerics to be part of his prevention programme (Dreher, 2003). Through a massive public awareness programme people were warned to walk the “sexual straight and narrow” because it was a matter of life and death (Dreher, 2003). The clergy were asked to preach more candidly to Ugandans about the need to abstain from premarital sex and be faithful to their partners (Dreher, 2003). Uganda’s HIV/Aids rate peaked in 1991 and has steadily slid ever since.

According to Whiteside and Sunter (2000), prevention in South Africa should actually address the socio-economic situation in the country and therefore make it easier for people to change their behaviour. If prevention is to move beyond knowledge into action, interventions also need to improve the socio-economic situation in the country (Whiteside & Sunter, 2000).

UNAIDS developed a Global Strategy Framework on HIV/Aids. This strategy is based on the following points (Piot & Seck, 2001).

- Leadership is required at all levels to combat HIV.
- Responses to the epidemic must not only come from the health sector.
- There has to be some sort of national co-ordination.

- Responses are successful when people living with HIV are centrally involved in the programme.
- Successful responses have their roots in communities. Local inhabitants can determine the most effective priorities for action and what resources are available within the community.

Most prevention programmes also target young people. Not only do young men and women need to be warned about the epidemic but they also need to make it their responsibility to educate other young people about the disease. They can change the course of the disease if they are equipped with the right knowledge and support (Piot & Seck, 2001). In every country where HIV transmission has been diminished it has been among the youth where the greatest reductions have occurred (Piot & Seck, 2001).

2.3 CURRENT PREVENTION PROGRAMMES IN SOUTH AFRICA

Before we can begin with the study it is important to investigate current prevention programmes in South Africa and to examine the guidelines that they follow.

2.3.1 The South African Government

The first two cases of Aids were identified in South Africa in 1982 and for the next eight years the epidemic was primarily located among white homosexuals (Whiteside & Sunter, 2000). By July 1991 the number of heterosexual cases equaled the number of homosexual cases and since then the homosexual epidemic has been overshadowed by the heterosexual epidemic (Whiteside & Sunter 2000). Since 1990, antenatal surveys have been carried out annually and have taken place every October/November (Whiteside & Sunter, 2000). After the installation of the new government in 1994, the entire country was covered (Whiteside & Sunter, 2000). These surveys provide the baseline on which calculations of overall HIV prevalence and number of cases and deaths are based (Whiteside & Sunter, 2000).

According to these surveys the HIV prevalence rate was 0.8 % in 1990 and in 1999 it had risen to 22.4 % (Whiteside & Sunter, 2000). Overall, the 1999 data indicated an increase of HIV prevalence in six provinces, a decrease in two and the status quo in one (Whiteside & Sunter, 2000).

Some of the earliest responses of the South African government included (Simelela, 2002):

- The creation of the inter-ministerial committee (IMC) on HIV/Aids in 1997. It was chaired by Thabo Mbeki, then deputy president.
- The launch of the “Partnership against Aids” in 1998.
- The launch of the South African National Aids Council in January 2000. It replaced the IMC.

In 1997 a national review of South Africa’s response to the Aids epidemic was published. The review findings highlighted the need for (Whiteside & Sunter, 2000):

- political leadership and public commitment.
- meaningful involvement of people living with HIV/Aids.
- responses that were interdepartmental.
- close collaboration with the TB programme.
- an urgent address of human rights abuses and the reduction of stigmatization.

One of the most important responses was the launch of the “HIV/AIDS/STI Strategic Plan for South Africa, 2000-2005”. This plan included policies concerning four major areas namely (Simelela, 2002):

- Prevention
- Treatment, support and care
- Human rights and legal issues
- Research and surveillance of the HIV epidemic.

With regard to prevention it was decided in the strategic plan that the government would focus on (Simelela, 2002):

- The procurement of high quality male and female condoms
- STI management
- TB control and the integration of this with HIV/Aids prevention
- Life skills and HIV/Aids education
- Prevention of mother-to-child transmission
- Vaccine development
- Blood safety.

Various forums have also been established to facilitate the formation and operation of partnerships, notably the National AIDS Council (Whiteside & Sunter, 2000). The council was launched early in 2000 with the aim of bringing together sectoral representatives (Whiteside & Sunter, 2000). The South African Business Council on HIV/Aids was also re-launched with the intention that companies form a united front to fight HIV/Aids in the workplace (Whiteside & Sunter, 2000). This was done to facilitate the exchange of ideas and resources (Whiteside & Sunter, 2000).

There has also been the rise of “Aids politics” and this has not always been a positive occurrence. In 1995 the *Sarafina 2* scandal erupted when irregularities in the tender process were highlighted (Whiteside & Sunter, 2000). *Sarafina 2* was meant to be a lavish stage production aimed at mobilizing young people in the fight against HIV/Aids but soon financial irregularities came to light. There was a public outcry and many people viewed the money set aside for the production as wasted (Whiteside & Sunter, 2000). Barely a year later the Virodene debacle hit the front pages. Toted as a treatment for HIV/Aids it was later revealed that Virodene contained a dangerous industrial solvent known to cause liver damage in people (Whiteside & Sunter, 2000).

In 2000 the Department of Health distributed about 250 million free male condoms in the public sector and the distribution of female condoms was increased from 27 sites to 114 sites (Simelela, 2002). In the plan it was decided to make use of life skills education for the purpose of HIV/Aids prevention. These life skills programmes were then taken to the various communities and continue to run in schools and tertiary institutions. The Department of Education now manages them. The aim of these workshops and educational programmes is to enable the youth of South Africa to make informed choices regarding their decisions.

The treatment, support and care of individuals who are HIV positive is largely dependent on making sure that sufficient information is available for healthcare workers (Simelela, 2002). Healthcare workers need to be able to address HIV/Aids, STI's and opportunistic infections effectively. This will go a long way to ensuring that there is adequate treatment, support and care for everybody. To this end the launch of the following HIV/Aids related guidelines in October 2000 are significant (Simelela, 2002). Healthcare workers were and still are being trained in the following nine areas (Simelela, 2002):

- Rapid HIV tests and testing
- Recommendations for managing HIV infections in children
- Management of occupational exposure to HIV
- Prevention of mother to child transmissions and the management of HIV positive pregnant women
- National policy on testing for HIV
- Policy and guidelines for the feeding of infants of HIV positive mothers
- Ethical considerations with regard to HIV research
- Tuberculosis and HIV/Aids
- Recommendations for the prevention and treatment of opportunistic and HIV related diseases in adults.

Emphasis has also been placed on voluntary HIV counselling and testing. There is compulsory pre and post-test counselling for individuals who are

tested for HIV. The aim of this programme is to improve public awareness, to plan for the care for HIV positive individuals and to reduce the number of new infections. Another aim is to lessen the negative stigma that surrounds HIV. The fact that HIV is not a death sentence is also emphasized.

Much importance has also been placed on home/community-based care in South Africa. Families and individuals are taught to care for individuals who are ill. The main challenge has been to make sure that the quality of care is up to standard and that the public health system can act as a support (Whiteside & Sunter, 2000).

The government has also tried to deal with the stigma that surrounds HIV/Aids through voluntary counselling and testing. The Chris Hani-Baragwanath Hospital is pioneering a community outreach programme that promotes testing and counseling (Piot & Seck, 2001). The government also put in place provisions in the Employment Equity Act that makes it impossible and illegal to carry out pre-employment testing (Piot & Seck, 2001).

HIV/Aids is no longer only addressed by the Department of Health. With the launch of the “Partnership against Aids” several governmental departments became involved (Simelela, 2002). The Department of Education became involved through the life skills programmes while the Department of Transport initiated the “Trucking against Aids” drive (Simelela, 2002). The Department of Correctional Services has made HIV/Aids drugs and education available to its populations.

In general the South African government is trying to spread certain core statements about HIV and Aids. Some of the important core statements are (Van Dyk, 2001):

- HIV is not spread through ordinary contact or the sharing of utensils.
- It is not an airborne virus and sneezing or coughing, kissing, hugging, touching and handshaking cannot spread it.

- Sharing utensils, linen or cups and saucers does not spread HIV.
- Mosquitoes do not spread HIV.
- You cannot get HIV from toilets.
- It is not spread through food preparation (Exposure to heat, salad dressings, air and gastro-intestinal juices destroy the virus).
- It is not spread by swimming with someone who is HIV positive.
- It is not spread through social contact between children on a school ground.

HIV is transmitted through (Van Dyk, 2001):

- Unprotected sexual intercourse
- Transmission through contaminated blood
- Intravenous drug users who share needles
- Mother-to-child transmissions.

Society is continually being reminded that the virus can only be transmitted when bodily fluids are exchanged in sexual intercourse, through mother-to-child transmissions or when a person is exposed to contact with HIV-contaminated blood (Van Dyk, 2001).

2.3.2 Other prevention programmes in South Africa

In South Africa all aspects of the media have been vital in addressing HIV/Aids prevention. An abundance of information has appeared in the print media. There are often supplements devoted to HIV/Aids in newspapers. There have also been several articles in magazines featuring people who live with the disease. Organizations and various non-governmental organizations regularly distribute pamphlets and booklets

Radio is also used and there have been several radio campaigns advocating abstinence and safe sexual practices. The rights of the individual to say “No” or to demand safe sex have been greatly emphasized.

Television has also been a very powerful medium. There have been several programmes devoted to the disease, in which topical issues related to HIV are discussed. Popular local series like *Generations*, *Soul City* and *Isidingo* have featured characters that are HIV positive. Even the local version of *Sesame Street* has introduced a new character that is HIV positive. Programmes like *Isidingo* use this opportunity to dispel and challenge the myths and stereotypes around HIV/Aids. The characters in these programmes are loved by the viewers and even after the disclosure of their status they remain so. These programmes are not only used to challenge discrimination but they are also used as an educational tool, informing people about the disease, e.g. how HIV is transmitted. Recently, on television, there has been a series of inserts on people who are HIV positive. These individuals look healthy and lead an active lifestyle. They point out tips for general healthy living and give individuals living with HIV/Aids ideas on how to stay healthy. These inserts also stress the idea that HIV/Aids need not be a death sentence because the individuals that they feature have been living with the disease for several years. These local series and inserts all feature South Africans. They are tailor-made for the South African environment and tackle issues and stereotypes that are unique to South Africa. The principle that people living with HIV/Aids are deserving of care and no more dangerous than anybody else is heavily emphasized.

The “Love Life” initiative is an active campaigner in the fight against HIV/Aids. They make use of television, the printed media and radio. In conjunction with this they have erected billboards on main roads and highways. “Love Life” has a very high profile in South Africa. The emphasis of their message is very much one of personal rights and the right to say no. “Love Life” focuses very much on teenagers.

Local personalities and celebrities have also been involved in the fight against HIV/Aids. They have organized several charity events to raise funds and awareness. These individuals spread information regarding the disease and act as role models for the youth by advocating responsible behaviour. They range from high-powered government officials and church ministers to sports

stars. Both Nelson Mandela and Bishop Desmond Tutu have been on television imploring parents to teach their children about sexual intercourse and how they can protect themselves. It is assumed that these people will serve as positive role models for healthy living and help to reduce the stigma that surrounds HIV/Aids.

Another important aspect in HIV/Aids prevention is the work of individuals who are HIV positive. Individuals like young Nkosi Johnson made it their life's work to raise consciousness about HIV. Nkosi Johnson gave HIV/Aids a face and he also highlighted the plight of Aids orphans and HIV positive children. He has left a lasting legacy and will forever be associated with the fight against HIV/Aids.

Nurses and doctors in both urban and rural areas also spread the prevention message. Prevention programmes are part of the government's emphasis on primary health care but it is not only the government that is trying to raise HIV/Aids awareness. There are several non-governmental agencies and international organizations in the country that have their own programmes running. Large companies are now focusing on HIV/Aids in the workplace and how to deal with the disease in that context. Several companies have also begun to make Aids drugs and condoms available to their workers. Many South African mining companies have also begun peer-counseling programmes where enthusiastic workers are identified and trained to work as volunteers. "Life Line" also has a telephone number that people can call if they are in need of information and support. In several secondary schools and tertiary institutions peer-counseling programmes have also be instituted

2.3.3 The Pretoria Technikon Aids Clinic

The Aids Clinic on the Technikonrand campus in Pretoria offers students several services free of charge. The prevention message is based on the "KAB" proposition, namely knowledge, attitude and behaviour (Whiteside & Sunter, 2000). Knowledge is used to fight further infections. The services that the clinic offers includes:

- HIV/Aids awareness campaigns
- Hosting information sessions on HIV/Aids and other health related issues
- Basic education and awareness training
- Distribution of HIV/Aids and STI pamphlets and posters
- Distribution of condoms
- Care and support for people living with HIV/Aids
- HIV/Aids project facilitation
- Networking with Technikon Pretoria structures as well as other HIV/Aids structures.

The clinic also offers HIV testing and compulsory pre and post-test counselling. Students who are HIV positive receive counselling in healthy and positive living. Emphasis is placed on the fact that their diagnosis is not a death sentence.

The clinic also makes use of peer supporters. These students are trained volunteers who spread the message of HIV prevention. They offer support to those who are already HIV positive and they also work in the clinic and receive and deal with any queries. The peer supporters are involved in campaigns, outreach programs and HIV education. They try to combat the stigma of HIV and the belief that it is a death sentence.

2.4 CONCLUSION

The researcher has highlighted the current situation in South Africa with regard to prevention. The focus will now fall on the research design, data collection and analysis.

CHAPTER 3

THE RESEARCH DESIGN

3.1 INTRODUCTION

After the discussion of the impact of HIV/Aids and the current situation in South Africa the focus will now fall on research design.

3.2 RESEARCH PROBLEM

The research problem is defined as:

Question 1

- Why are people not changing or adapting their risky behaviour in order to protect themselves from HIV/Aids?

Question 2

- What will motivate behaviour change?

3.3 AIM OF THE RESEARCH

3.3.1 Specific aim

The specific aim of this study is to investigate why risk-taking behaviour has not been curbed and why the infection rate continues to increase. Other aims are to identify the reasons for lack of behaviour change and the obstacles that may make behaviour change difficult. This information will then be studied and used as the foundation for the development of a future prevention programme. To gather the necessary information the researcher will make use of focus group discussions.

3.3.2 General aims

The ultimate aim of this study is to contribute knowledge to the fight against HIV/Aids. One of the aims of this study is to create a clear image of how South Africans deal with HIV/Aids and what affect it has had on their lives. Ultimately the aim is the development of a new HIV/Aids prevention programme. A preliminary outline of the programme will be drawn up in this study but will only be tested at a later stage.

3.4 QUALITATIVE VERSUS QUANTITATIVE RESEARCH

A qualitative research design will be used because the research will be exploratory and interpretative (Struwig & Stead, 2001). Behaviour change is a complex notion and many variables may affect it, therefore the researcher decided to do an in-depth study using qualitative techniques. This will be done to try and gain a deeper understanding of behaviour. The researcher does not expect that the participants' answers will be simple one-word responses as the questions asked will be about the context of their lives. The qualitative researcher tries to discover and capture meaning and qualitative analysis proceeds by extracting themes from evidence and organizing data into an understandable and consistent picture (Neuman, 1997). A qualitative research design should give a deeper understanding of behaviour.

The qualitative researcher focuses on aspects like subjective meanings, definitions, metaphors, symbols and descriptions and tries to capture meaning by becoming immersed in the data (Neuman, 1997). Concepts are formed by looking at themes, motives and generalizations (Neuman, 1997). Data can be words, phrases and transcripts (Neuman, 1997).

This study is also a pilot study because the aim is to collect data for future research projects. Some of the major purposes of this study are the development and clarification of ideas and the formulation of hypotheses and questions for more precise investigation at a later stage (Struwig & Stead, 2001). A large amount of information will be gathered from a small sample

(Struwig & Stead, 2001). The researcher will make a detailed observation of the world and then move towards refining concepts, relationships and a theory. In this way the theory will be built from the “ground up” (Neuman, 1997).

Although the researcher is going to develop her own prevention programme, she will be making use of grounded theory as a method of doing research. The results of the data collection and analysis will be used to develop a prevention programme. The ideas of the focus group participants will be incorporated into the programme.

3.5 RESEARCH DESIGN

According to Murray and Chamberlain (1999) the essential features of grounded theory are that it is grounded and theoretical. By theoretical it is meant that a theory should be developed about the phenomena in question and that this has to be more than descriptive (Murray & Chamberlain, 1999). The researcher will begin with a broad research question and once the data collection is commenced a theory will begin to develop (Neuman, 1997). Therefore, the theory is built around or grounded in the data collected (Neuman, 1997). Strauss and Corbin (in Neuman, 1997) state that grounded theory is a qualitative research method that uses a methodical set of procedures to develop a theory about phenomena. It is also primarily a method of data analysis rather than a technique for data collection (McLeod, 2001). The richness and relevancy of findings may be more dependent on the quality of the relationship between researcher and informant than on the rigour of the analysis of the data (McLeod, 2001).

Grounded theory can then be seen as a robust method for the generation of a practical form of knowledge that is well suited to contributing to social welfare (McLeod, 2001). It calls for the researcher to become immersed in the data and be aware of his or her own biases and assumptions.

Grounded theory also makes use of exchanges where interviewees can talk back, clarify, and explain their points (Rubin & Rubin, 1995). This will occur in the focus group discussions. These explanations are not only of academic value as they have a practical application as well (Rubin & Rubin, 1995).

There are three main principles of grounded theory. First, the aim is to discover new ways of making sense of the world. Second, the goal of analysis is to develop a new theory or framework. Third, this new theory or framework should be grounded in the data that has been collected (McLeod, 2001).

The researcher plans to use the following steps in her own research based on the manner in which Strauss and Corbin (in McLeod, 2001) operationalize grounded theory. First, the researcher will identify a broad and open-ended research question e.g. why are people not changing their behaviour in the face of possible HIV infection? This question implies that people are purposeful agents that engage in behaviour and respond to change (McLeod, 2001). Therefore the aim of grounded theory is to uncover basic social processes that underlie behaviour (McLeod, 2001).

Second, collect data from the focus group participants. The individuals chosen for data collection will embody several facets of the research question (McLeod, 2001). The researcher has chosen to collect data from young adults at the Pretoria Technikon and this will be done through the use of focus groups. The selection of informants, or cases, is made on the basis of availability sampling rather than on the basis of random or stratified sampling (Bless & Higson-Smith, 1995). This means that the sample will be chosen purely on the basis of accessibility. The respondents will be selected in such a manner because of the difficulty in acquiring volunteers. To make a selection, the researcher will explain the purpose of the research to potential participants and use those individuals who volunteer in a focus group discussion. This also means that the researcher will only make use of participants who are willing to take part. The size of the focus group will depend on the number of volunteers.

The researcher will conduct semi-structured focus groups with the students. These focus groups will be recorded and then transcribed. The data collected from these focus groups will be analysed and coded.

Third, the researcher will not review the literature in advance of collecting the data. The aim is to approach the phenomena with an open mind so that themes and categories materialize from the data rather than being imposed on it (McLeod, 2001). Therefore, the programme will contain ideas and concepts highlighted by the participants and not only those of the researcher. The researcher will undertake a literature study once the focus group data has been collected and analysed. This will be done to keep with the procedures of grounded theory set out by Strauss and Corbin (in McLeod, 2001). Also, the researcher would like to keep an open mind and not analyse the data according to any specific behaviour change theory, as the literature review will focus on formal behaviour change theories. Both sets of data will be combined and the information used to develop a prevention programme.

Fourth, data collection and analysis will be synchronized. The theoretical framework that emerges will be used to sensitise the researcher to the types of concerns that should be covered in the next interview (McLeod, 2001). This simply means that if a focus group highlights a new or interesting idea the researcher will discuss the topic or idea with the next focus group. It calls for flexibility and allows the researcher the opportunity to explore many ideas.

Fifth, data collection will end after the focus groups have been conducted. Once the data has been collected, the researcher will begin the data analysis.

3.6 THE SELECTION OF CASES

The single criterion for the selection of cases for the focus group is that participants need to be students at the Pretoria Technikon. This was decided on because HIV/Aids affects everybody, regardless of gender, age or educational level and the researcher did not want to minimise the amount of stories that could be uncovered in the focus groups. Another cogent reason

for choosing students is that they are an important group of people to begin with in the attempt to decrease the current infection rate. Currently, many prevention programmes target teenagers and young adults and they have first hand experience of them. In addition, young people have the ability to verbalise their own thoughts and opinions and may have ideas that they would like to share.

Accidental or availability sampling will be used (Bless & Higson-Smith, 1995). It is recognised that this may create a bias, but it is felt that due to the nature of student life finding volunteers may be very difficult. Because of this no volunteers will be turned away. Initially, the researcher did test to see whether or not posters advertising the focus groups would work but after two weeks there was still no response. It could be that the students did not see the posters or that they simply were not interested in the study. Many students could have felt that they did not have the time to attend focus group discussions.

Accidental or availability sampling can introduce serious biases as certain groups can be under or over-represented in a sample (Bless & Higson-Smith, 1995). This could mean that the focus groups will not be representative of the general population with regard to aspects like gender and race. Despite the fact that the sample will not be representative, the researcher sees all stories and ideas as useful no matter where they come from or how they are sampled. Each participant may have informative and useful ideas.

3.6.1 Process of selection

At the Pretoria Technikon students in certain courses are obliged to attend life skills classes. The counsellors at the Technikon present these classes. The life skills classes will be used to conduct the focus groups sessions. Two focus groups will be conducted with first year Engineering students. The researcher has decided to make use of the Engineering students because she has noted that they are a vocal and lively group of students who are not afraid to air their opinions.

The third focus group will be conducted with Journalism students who are not life skills students but instead volunteers. The researcher will make use of Journalism students because they represent a group of students who should have a good general knowledge and understanding of the role that the media plays in society.

None of the participants will take part in more than one focus group because the researcher would like to uncover as many themes or ideas as possible. The size of the focus group will also depend on the amount of students who volunteer for the research but will not consist of more than thirty students. The researcher is able to accommodate thirty students as she is accustomed to working with large groups and wants to collect as many ideas as possible. The venues to be used are suitable for large groups.

3.6.2 Definition of focus groups

Focus groups usually consist of participants who discuss one or more issues in an hour or two (Neuman, 1997). The facilitator introduces issues and ensures that nobody dominates the discussion (Neuman, 1997). Focus groups are useful in research to generate new ideas for questionnaire items and for the interpretation of results (Neuman, 1997). The advantages of focus group discussions are that they provide a secure setting and an in-depth discussion of a topic can occur (Struwig & Stead, 2001). The disadvantages are that the facilitator may be partial in directing the discussion topics or participants may be unwilling to disclose all their thoughts (Struwig & Stead, 2001).

3.6.3 The focus group process

The researcher will do the following when conducting the focus groups:

- Introduce herself and the research project.
- Hand out the information leaflets and explain them (see Appendix 1).

- Hand out the consent forms (see Appendix 2).
- Invite interested participants to stay and sign the consent form. (Students who are not interested will be asked to leave).
- Begin with the focus group once everything is signed.
- End the focus group with a short summary of the main ideas. The researcher will make sure that the participants know how she can be contacted.

Throughout the whole process participants can ask questions and nobody will be forced to participate if they do not wish to do so. The researcher will make use of a tape recorder and take notes to record what is happening in the session. The participants' permission will be requested to tape the sessions. The researcher will inform the participants that the information will be used for research purposes only. The aim of the focus group will be to study what is necessary for behaviour to change, barriers to behaviour change and whether or not the participants have any of their own ideas regarding HIV/Aids prevention.

Questions that can be asked during the focus groups have been designed to stimulate debate and discussion. Therefore, the focus group can be seen as semi-structured. All the questions, except three that pertain to the knowledge participants have about HIV, have been designed as open-ended. These three questions are:

- What is the definition of HIV?
- What is the definition of Aids?
- How is HIV transmitted?

The following questions will be used in the focus group discussions:

1. What is the definition of HIV?
2. What is the definition of Aids?
3. How is HIV transmitted?
4. Do you believe that there is enough information available on HIV/Aids?

5. Do you believe that prevention programmes like “Love Life” are successful?
6. Do you believe that people are changing their behaviour so that they can protect themselves from HIV/Aids?
7. What do you believe are the greatest obstacles in HIV/Aids prevention?
8. Do you have any comments or suggestions on how to prevent the spread of HIV/Aids?

Questions on the definition of HIV and Aids will be asked to verify the hypothesis that people do have the necessary knowledge to protect themselves. The final question has been included because the researcher wants to develop her own prevention programme and in addition to her own ideas about HIV/Aids needs the stories and thoughts of others to develop a comprehensive programme.

To develop the questions the researcher started with her research questions and identified all the important ideas and topics linked to it. She then refined these ideas and transformed them into questions. These questions were tested on volunteers and feedback was given. The volunteers included students and colleagues. Once feedback had been given the questions were again improved and changed accordingly. The above-mentioned questions are the final product.

3.6.4 The focus group conducted with the Journalism students

As previously mentioned, the journalism students are not life skills students and the group will be organized on a volunteer basis only. A colleague will share the information with a few Journalism students and the researcher will use any volunteers who are interested. The number of participants will depend on the number of volunteers. The same process will be followed as with the other focus groups.

3.7 DATA ANALYSIS

An interpretative analysis of the data will be used. The reason for this is to foster an understanding of aspects such as specific social contexts and the views and reasoning of others. Data analysis will be done as follows (Strauss & Corbin in McLeod, 2001):

First, the researcher will read the material and engage in a process of open coding or concept formation (McLeod, 2001). This can be described as breaking down, comparing, conceptualising and categorising data (McLeod, 2001). The aim is to generate many alternative categories so that as many options as possible can be explored. Not only will this conceptualisation help to reduce the amount of data, it will also help to highlight relevant ideas (Neuman, 1997).

Categories used in grounded theory can be based on three possible sources. These are the analyst's own common-sense constructs, technical terms drawn from theoretical literature, or the language used by the participants (McLeod, 2001). The categories that will be identified in this study will be based on the language and ideas of the participants. Ultimately, what really matters is that these categories can be made to fit together in a coherent manner and that they are congruent with the data (McLeod, 2001). It is important to note that in this study the researcher will refer to "themes" and not to "categories".

Once the researcher has identified these themes she will analyse each one and look at the main idea that emanates from it. The researcher will then identify whether or not this theme is repeated in the other focus groups. This will help to identify the ideas and notions that seem to be more important to the participants. It will also help to identify what significant ideas should be included in the prevention programme. Throughout the whole process the various themes and the data generated by the different focus groups will be compared. The researcher will look for links between the various themes. This is known as axial coding (McLeod, 2001).

The researcher will try to connect the themes highlighted in the focus group discussions with ideas highlighted in the literature review. This combined information will be used to develop a prevention programme. The results of the focus groups will also be used to answer the two research questions namely:

Question 1

- Why are people not changing or adapting their risky behaviour in order to protect themselves from HIV/Aids?

Question 2

- What will motivate behaviour change?

Once the main themes have been identified the researcher will write up the analysis (McLeod, 2001).

3.8 RELIABILITY AND VALIDITY

Because the researcher will be making use of a qualitative method of study rather than a quantitative method the notion of reliability and validity comes into question. According to the quantitative paradigm, reliability can be defined as the extent to which test scores are consistent and stable (Struwig & Stead, 2001). Validity can be divided into two categories namely, external validity and internal validity. External validity refers to the extent to which the results of a study can be generalized to the wider population while internal validity measures the extent to which the test actually measures the correct variables (Struwig & Stead, 2001). Both the concepts of reliability and validity are linked to the more modernist and quantitative methods of research. Quantitative research rests on the foundations of reliability and validity. In the quantitative paradigm the aim is to prove something by using statistics while in the qualitative paradigm the aim is to understand the individual and the context that surrounds them.

In the qualitative paradigm emphasis falls on the concepts of transferability and credibility. Transferability refers to the extent to which the research findings can be applied to other contexts (Byrne, 2001). Terms like applicability and fittingness have also been used in conjunction with this idea (Byrne, 2001). When it comes to transferring data to another context descriptions that provide information on the themes, labels and constructs of a study can provide the researcher and the reader with enough information to judge the appropriateness of applying the information to other settings (Byrne, 2001).

The qualitative paradigm aims to find and understand meaning. People are treated as unique therefore reliability takes on a different meaning. In qualitative research it is not expected that data will be consistent and stable. The researcher does not expect that one situation will yield the same results as another. Instead, the qualitative researcher should take note of these differences and how they influence people and behaviour. Therefore, in qualitative research, the repetition of research results is given less priority.

In qualitative research the term “reliability” can also be replaced with the word “trustworthiness”. The researcher aims to make sure that her research has meaning and that the interpretations make sense with regard to the context of the participants.

To maintain the trustworthiness certain checks will be put into place. First, the researcher needs to be aware of her own personal story and how it will affect the interpretation of the data. The qualitative researcher is also aware of the fact that it is impossible to remain so objective that one is not influenced by ones own experiences. Our personal stories will have an effect on what we observe and record. These stories will also influence the aspects that are discarded. A qualitative researcher takes advantage of personal insight to understand the social life under study but is aware of their own ethics and assumptions (Neuman, 1997). This researcher will be active in her interpretation of the data and constantly ask herself questions about why she is including or discarding certain inputs. This process is known as maintaining

credibility. This means that in qualitative research the researcher's own perspectives need to be articulated because qualitative research is an inherently interpretive process (Byrne, 2001).

Second, the researcher will confirm information and check stories with colleagues. Credibility does not only refer to the researcher but also to the research method and the subsequent findings (Byrne, 2001). To maintain credibility the researcher will check her interpretations by asking colleagues to read through the information to see whether or not they reach the same or different interpretations. This could lead to the generation of new ideas or the highlighting of important concepts that have not been explored (Struwig & Stead, 2001). The researcher will be open to other ideas or notions.

The researcher will also check interpretations and information with participants, if necessary. Individuals are viewed as the experts in their own lives and therefore it is vital to check and clarify interpretations with the participants. Taking data back to the participants and checking the use of terminology is very important (Struwig & Stead, 2001).

Third, the researcher is also aware that to a large extent the trustworthiness of the data depends on her. She will take the responsibility for accurate and honest interpretation of the data. She will submerge herself in the data and not make interpretations quickly or lightly. She will spend adequate time on the analysis of the data and not make hurried interpretations. Again, these checks have been put into place to maintain the credibility of the research.

With regard to ethics the researcher will adhere to the following (Struwig & Stead, 2001):

- The researcher will be honest, fair and respectful towards others. No attempt will be made to mislead others or the research participants.
- The researcher will accept the dignity and rights of others. This entails respecting the privacy and autonomy of the research participants.

- The welfare of others will be of major importance to the researcher. The researcher will seek to eliminate or minimise any harm to the participants.
- The researcher will take full responsibility for her research.

The researcher will need to obtain the informed consent of the participants in the study. It will be explained to the participants that they may opt out from the research at any point and that there will be no negative consequences if they do (Struwig & Stead, 2001).

The researcher will ensure the confidentiality of the information gained in the research project. If confidentiality cannot be guaranteed the participants will be informed. Participants' names will not appear in the research. Participants will also be informed that some of the information that they share will be discussed and read by colleagues of the researcher (Struwig & Stead, 2001).

The researcher will not deceive the participants. The researcher will explain clearly the nature of the research and how the information gathered will be used. The researcher will also make herself available if debriefing is required (Struwig & Stead, 2001).

Because of the personal nature of HIV/Aids the researcher is aware that a discussion may be very difficult and traumatic. She will be available to the participants after the study if personal counselling is required. Although the researcher is a facilitator during the focus group if severe conflict occurs she will step in. She will also be honest with regards to any questions that may be asked by the participants.

The researcher will also make the final research product available to the participants if they ask to see it. This is vital because their thoughts and ideas are an important part of this research. The researcher feels that this is necessary to facilitate accountability and transparency.

3.9 LIMITATIONS

Because the researcher is carrying out a qualitative study, the aim is not to generalize the results to the entire population. Rather, when doing qualitative research the aim is transferability. The researcher will be developing a programme that will be used in different contexts but she is aware that the programme may need to be altered and refined. Once the programme has been implemented the researcher can judge the appropriateness of the programme and future participants can also contribute to the transferability of the programme by giving feedback on the programme.

Also, the nature of behaviour change is very complex therefore it may be impossible to identify certain guidelines regarding HIV/Aids prevention that may work for everybody.

3.10 CONCLUSION

The research design having been highlighted the next few chapters will focus on the reporting and analysis of the data.

CHAPTER 4

THE EMPIRICAL RESEARCH

Now that I have HIV, it makes me feel that I am living outside of the world. Every day and every hour and every minute I am aware that I am infected with HIV. (A well patient trying to cope with HIV/AIDS 1998) (Evian, 2000, p. #)

4.1 DISCUSSION AND INITIAL CODING OF THE FOCUS GROUPS

The initial coding of the data entails the researcher reading through the data and identifying any themes that emerge from the individual focus group discussions. The researcher will read through the data several times so that immersion is facilitated. These themes will then be compared and linked to other concepts at a later stage.

4.1.1 Focus group one

The first focus group consisted of three individuals. All three of the participants were Journalism students and their ages ranged from 18 to 21. Although the focus group consisted only of three participants the researcher nevertheless felt that their opinions were valuable and informative and did not diminish with the size of the group. The researcher acted as facilitator and although certain questions were asked the participants were able to relate their own stories and ideas.

The questions used to elicit the participants' stories were:

1. What is the definition of HIV?
2. What is the definition of AIDS?
3. How is HIV transmitted?
4. Do you believe that there is enough information available on HIV/Aids?

5. Do you believe that prevention programmes like “Love Life” are successful?
6. Do you believe that people are changing their behaviour so that they can protect themselves from HIV/Aids?
7. What do you believe are the greatest obstacles in HIV/Aids prevention?
8. Do you have any comments or suggestions on how to prevent the spread of HIV/Aids?

The respondents gave very detailed answers that reflected their personal stories regarding HIV/Aids. The following is a summarised account of the respondents’ answers.

All three participants responded adequately to questions one and two. There were no major misunderstandings. Participants used words like “virus”, “immune system” and “acquired”. The participants seemed to have a basic knowledge of HIV and Aids.

In response to question three the participants stated that HIV is transmitted through “contaminated blood, sexual intercourse, needles, using the same razors and making contact with open sores and wounds”. They stated that HIV is not spread through “kissing, kitchen utensils, hugging, shaking hands, talking or being near an infected person”. There were no gross misinterpretations of the nature and transmission of the virus.

In response to question four the participants replied that they believed that there is enough information available on HIV/Aids. They mentioned that they acquired this information through “leaflets, billboards, television programmes, soap operas, and magazines” and the media in general. The participants highlighted the effectiveness of soap operas like *Soul City*.

The participants stated that although there is information available there is still ignorance. The participants linked this to the attitude of teenagers and to the fact that teenagers tend to focus more on pregnancy because “it affects you

the rest of your life”. When asked about the reasons for this, the participants replied that teenagers would rather use contraception, i.e. the pill, than condoms. Contraceptives may be effective in preventing pregnancy but they are not an effective means of prevention when it comes to HIV/Aids or Sexually Transmitted Infections (STI). The participants felt that teenagers pay more attention to pregnancy because it has an immediate effect on lifestyle. HIV/Aids does not have an immediate effect as it may take years for symptoms to develop therefore the consequences of infection are not as immediate as a pregnancy.

Participants stated that many girls feel that they need to please men and not use condoms. The issues of trust and love were brought up. The respondents stated that “many girls want to please guys therefore they will be brave”. This is referring to unprotected sexual intercourse. Also, the idea of whose role it is to introduce condom usage was brought up, with one or two participants stating that girls need to be more proactive in this regard.

The focus group also introduced a very interesting point relating to the frequency of HIV/Aids messages. They postulated that many people might actually be ignoring the message either because they are simply tired of hearing about it or because “they think they know enough”. An answer as to how this can be combated is unclear.

In response to question five the participants stated that they feel that the “Love Life” campaign specifically is successful. When asked for their reasons the participants stated that the programme targets the correct audience, they are active in rural areas and they cater for different languages and illiterate people by way of radio messages. The programme also involves individuals who would be of interest to the youth e.g., celebrities.

The participants also chatted about the role of parents in prevention and could not really reach consensus on this issue. One respondent stated that older parents may find it very difficult to talk to their children about sexual matters and many young people may blame their parents if they get pregnant. For

some, friends have become the only source of information. Another participant mentioned that she may not really want to talk to her parents about sexual matters and she would therefore prefer to talk to her friends. Another participant mentioned that talking to both parents and a counsellor might be helpful. Therefore, the role of parents in prevention in general and in prevention programmes may still be unclear.

In response to question six the participants stated that because they have several friends who are pregnant they feel that people are not making use of safe sexual practices. It was also stated that many people only rethink their behaviour once they have come into contact with HIV/Aids e.g., “only when it comes close to you”. The respondents felt that the reason behind this is personal choice. They felt that prevention is all about the individual and how people choose to live their lives. So, even though there is a lot of peer pressure to have sex it still comes down to personal choice. They made statements like, “all about the person”, “taking precautions” and “you choose your life”.

The discussion also included references to culture and the effect that culture has on prevention. The conversation was specifically centred on the Swazi king who has several wives and whether or not he is leading through example. The respondents asked whether or not polygamy undermines the idea of monogamy. This occurrence seemed to cause much confusion in the participants. The conversation also turned to religion and the use of religion as a prevention tool but the respondents felt that clergymen who rape and molest people have undermined religion and the church. They feel that religion therefore cannot be used on its own as a prevention tool. The topic of abstinence was also brought up but the respondents were very uncertain about whether this is really possible.

In response to question seven the respondents stated that poverty and ignorance play a large role. With regard to poverty, the respondents stated that people cannot afford to keep themselves healthy and that very often young girls fall into prostitution to survive and make money for the family.

Ignorance also plays a very large role according to the participants. They stated that there are still individuals who “simply don’t care” about becoming infected. The participants also talked about HIV positive individuals who are “angry inside” and because of this they infect others knowingly. The respondents also made mention of individuals who do not believe in the existence of HIV/Aids.

When asked about the myths that have an effect on prevention the respondents highlighted a few, namely:

- “Sleeping with a virgin is a cure”
- “Sleeping with an old women is a cure”
- “Sleeping with a baby is a cure”
- “The African potato cures HIV/Aids”

The conversation also included the role of stereotyping, i.e. that HIV/Aids is a black disease. The participants felt that when people talk about Africa all they think about is “poverty, war and Aids”. Regarding prevention, this may make certain population groups feel safer than others. The participants also discussed the role of Sangomas and how this influences prevention. They highlighted the fact that on nearly every street corner there is someone professing to have found a cure for Aids. This is simply a tool to make money and it may serve to confuse and deceive people. It may also undermine the prevention message and the way in which people perceive the severity of contracting HIV e.g., it is curable therefore I do not have to worry.

In response to question eight the respondents answered that they believe that prevention should be taken out into the rural areas where more information and counselling is needed. The respondents feel that this is necessary because in these areas women are still seen as inferior and this makes them vulnerable to infection. Very often the men contract HIV while they are working in the cities and then infect their wives who cannot insist on condom

usage. If the wife does insist, the man becomes suspicious of her and blames her for the infection e.g., it may imply that she is being unfaithful.

The participants also mentioned the media. They spoke of a lack of good and consistent role models. They identified several individuals in South Africa who stood as role models but who then either contracted HIV or who fell pregnant e.g., Khabzela, a popular DJ who died recently. This lack in congruency is seen in a very negative light. A very strong “practice what you preach” message came through. The participants also felt that role models who reveal their status should have sincere motives and not do it to increase their prominence or wealth. Participants stated that disclosure “should not be a stunt”.

In response to the questions several other topics were highlighted. The following is a summary of these ideas.

The attitude of nurses in the clinics is a great barrier to any form of prevention. The respondents said that nurses are rude and that they have an “attitude”. The respondents stated that there is a great lack of “people skills” among the nurses. One of the biggest problems is the fact that nurses may berate individuals who come into the clinics to get contraceptives and condoms. They may call the individual names or question him or her about why they require condoms. Many may threaten to tell parents. At the same time, the nurses criticize individuals who test positive and question them about why they did not make use of condoms in the first place.

The idea that one can “just say no” to sex was also discussed. Peer pressure was cited as the biggest culprit with regards to sexual intercourse. Sex is seen as something “cool” and you have to do it to belong. Sex is seen as an integral part of a relationship. The respondents stated that “sex is everywhere” and that sex gets glorified in the media e.g., music videos. Therefore, this may undermine the abstinence message.

The respondents also mentioned that there are individuals who are scared of sex and that many girls are afraid that they will be dumped afterwards. Also there are also individuals who “simply do not care”. This was used to highlight the fact that the respondents feel that in the end it all comes down to a personal choice.

After reading this extract there are several themes that emerge from this focus group. What follows is a discussion of these themes.

First, the researcher feels that the importance of role models for the participants has been highlighted very strongly in this conversation. For the participants it is very important that there is congruency between words and actions. The idea being that better role models may facilitate behaviour change and help to lower the infection rate.

Second, the researcher feels that it is important to take note of the impact that myths and misconceptions have on people and on prevention e.g., sleeping with an old woman is a cure. The participants were also very concerned with the fact that people are making money through selling “cures” for HIV/Aids.

Third, the role of peer pressure was highlighted. According to the participants, peer pressure is a very powerful thing and in their view it can be a very negative because it can encourage people to do things that they may not normally do. When looking at an aspect like peer pressure it may be important to explore the reasons why peer pressure is so pervasive and what makes it difficult for young people to stand up to their peers. In addition, one may need to explore the idea that peer pressure can also lead to positive behaviour change.

The participants also linked sexual behaviour to the role of the media. They stated that the media promotes sexual behaviour and that to be seen as “cool” one needs to be sexually active. Therefore, the influence of the media may even be more powerful than peer pressure. Related to both these ideas is abstinence. The focus group acknowledged the importance of abstinence but

they were not sure that it is actually possible. They stated that the “just say no” model is not working. The participants also introduced the role that culture plays in promoting and undermining the prevention messages. It would seem that the media, culture and peer pressure make it difficult for young people to remain abstinent.

Fourth, it would seem to be very important to discuss the gender roles regarding the spread of HIV/Aids, i.e. what are the roles of men and women in relation to condom usage and sexual practises. The participants mentioned that “many girls want to please guys therefore they will be brave”. The respondents also mentioned that in the rural areas many women are still seen as inferior and therefore they struggle to insist on condom usage. If the wife does insist, the man becomes suspicious of her and blames her for any possible infection. Many of these beliefs seem to make it very difficult for women to take control of their own lives and protect themselves.

Fifth, the participants highlighted the problems around condom usage. How people view condoms seems to be inextricably linked to prevention. It would seem as if the stories around condoms may prevent people from using them e.g., “my husband will think that I am cheating on him or that I don’t trust him if I insist on a condom”. In general, the person making the request to use condoms may suffer very negative consequences. Condoms also seem to be linked to the concept of trust, i.e. “if you insist on using a condom it must mean that you do not trust me”.

Sixth, the idea that in the end everything rests on a personal choice was also emphasised. It is very interesting to note that although peer pressure, culture and the media play a very powerful role in the lives of young people many of the participants felt that it is possible for people still to make independent decisions, which implies taking responsibility for your actions.

Seventh, the theme of ignorance was also emphasised. The participants seem to have highlighted two types of ignorance. First, they talked about people who simply do not worry about becoming HIV positive and second,

about teenagers who worry more about pregnancy than HIV. Neither seems to be related to a lack of knowledge. These attitudes almost seem to reflect an idea of “HIV will never happen to me”.

Eighth, the theme of suspiciousness and threat was introduced. The participants talked about “angry” individuals who are HIV positive and as a result they infect others knowingly. The researcher wonders if this a generally held belief? Is this not an integral part of the stigma that HIV positive people have to live with daily? If this were the case it would make their integration into society after disclosure very difficult.

Ninth, there seems to be a paradox developing in connection with the frequency of the use of current prevention messages. The aim of the message is to spread as much information as possible and to keep it fresh in the minds of people. This does not seem to be working as some people are actually getting bored with the message. They feel that they know enough because the same message is being repeated over and over again.

Tenth, the role of parents in prevention is also still unclear. Should they take part in prevention or should it be left to outsiders? The focus group was divided on this issue.

Finally, the researcher feels that it is important to note that any programme devised should also be taken to the rural areas.

4.1.2 Focus group two

The second focus group consisted of 19 first-year Engineering students, the average age of the participants being between 18 and 22. The researcher acted as the facilitator and although questions were directed at the participants they were able to relate their own stories and ideas.

Initially the participants seemed very hesitant to air their opinions but as the session progressed many of the participants started to become more vocal and towards the end of the session there were some heated debates.

The questions used to elicit the participant's stories were:

1. What is the definition of HIV?
2. What is the definition of AIDS?
3. How is HIV transmitted?
4. Do you believe that there is enough information available on HIV/Aids?
5. Do you believe that prevention programmes like "Love Life" are successful?
6. Do you believe that people are changing their behaviour so that they can protect themselves from HIV/Aids?
7. What do you believe are the greatest obstacles in HIV/Aids prevention?
8. Do you have any comments or suggestions on how to prevent the spread of HIV/Aids?

The respondents gave very detailed answers that reflected their personal stories regarding HIV/Aids. The following is a summarised account of the respondents' answers.

With regard to questions one and two a few of the participants were not sure of the exact definition of HIV and of Aids. In general, it seemed as if most of the participants were aware of the definitions. Most of the respondents seemed to have a basic idea of what the concepts mean. They used words like "virus", "acquired" and "immune".

In response to question three there were no gross misinterpretations of how HIV is transmitted. The respondents stated that HIV is spread through "having unprotected sex with an infected person, sharing needles, blood transfusions and from mother to baby". HIV is not transmitted through "safe sex, mosquitoes, abstinence, kissing, shaking hands" and simply sleeping in the same bed.

The answer to question four was “yes” and “no”. Many participants even stated, “yes, too much!” This is because every time they turn on the television or look at a magazine there is something to remind them of the epidemic. Respondents believe that this may result in people becoming bored and not paying enough attention to the prevention message.

Individuals who felt that there is not enough information available specifically highlighted the rural areas saying that there seems to be not only a lack of information but also a lack of access to services.

Many participants also felt that there is a lack of scientific information available on the effectiveness and usefulness of condoms. Also, the recent statements made by the President of this country that HIV does not cause Aids have caused much confusion. This kind of message may serve to undermine prevention programmes.

While discussing the effectiveness of condoms one participant brought up the point that individuals have to take care of themselves. This also means taking responsibility for your actions.

When asked how they acquired their knowledge about HIV/Aids most of the participants stated that they attained their information from school and television. A few participants also stated that they learned about the disease by coming into contact with people who were already HIV positive.

With regard to question five participants were divided. Some of the participants felt that prevention programmes “accommodate all opinions” and people. There were one or two participants who felt that “Love Life” is successful, saying that the programme advocates abstinence and should that not be possible, safe sex with a single partner.

Other participants disagreed stating that prevention programmes only advocate the use of condoms and not abstinence, although abstinence is the only reliable method of protection. This sparked off another debate on the effectiveness of condoms with one participant asking what is the use of using

condoms are if “they are not totally safe anyway?” This reflected a very strong “why bother” attitude. Participants then discussed stories about government officials punching holes into condoms. This attitude towards condoms can be characterised by feelings of intense pessimism and negativity.

Abstinence was also a hotly debated issue with a few of the participants saying that they felt that abstinence is not really a viable option. When asked about this the participants stated that during adolescence a person feels certain urges and one wants to experiment sexually, i.e. it is really difficult to resist sexual impulses. Again, this ignited a very heated debate. At the conclusion of the debate one participant stated very emphatically that we should all remember that abstinence is not forever and that all you need to do is wait for the right person. The group laughed at this notion with some participants asking, “how do you know when it is the right person?” Here the topic of trust was discussed and it almost immediately became linked with gender when one participant stated that you can “trust a man but not a women”.

With regards to question six many of the participants felt that things were actually worse. One participant mentioned that an infected person might knowingly transmit the disease to other people as a form of “revenge”.

The conversation then turned to the statistics that are released regarding future estimates of the HIV infection rate. Responding to how this makes them feel the participants used the words “uncaring”, “scared” and “give up”.

The group’s attention was then focussed on the role of the media and one participant specifically used the word “pornographic”. The word was used in conjunction with the idea that the media promotes sexual promiscuity. Participants responded and said that the media encourages the idea that sex makes you look “cool”. Again, this matter sparked much debate. Some participants stated that you can be exposed to these aspects but still react as an individual and decide for yourself on how you want to behave. Other participants stated that pornography promotes promiscuity, especially in the

case of young people who still need guidance. Their view is that young children are given too much information and this then encourages them to experiment.

Certain participants linked this idea to the role of parents. Some participants stated that “parents need to guide” and help their children. Some participants disagreed saying that it is not always easy or possible for parents to control what children see and experience.

In the end the group was split. Several participants felt that although the media is a powerful force you can still make your own decisions while other members of the focus group felt that the media promotes sexual behaviour and that parents cannot always control what their children experience. This began a very heated debate about the role of parents in sex education. As with the previous focus group, there was much disagreement about whether or not parents should talk to their children about sexual matters.

On the one hand, there was a group of participants who felt that talking to their parents about sex would be too embarrassing. They also felt that young people might not necessarily believe their parents and that parents may be too over-protective, therefore advising their children to be abstinent. Parents’ advice is definitely not seen in a very positive light in this argument.

There were other participants who felt that parents should be involved. Their arguments were that parents are more experienced in life and therefore if you do not talk to your parent you may be tempted to experiment on your own. You may also turn to your friends who may not have the correct information. One participant stated that “if you cannot trust your parents with this information who can you trust then?” Another said, “If you can’t make up your own mind how can you expect another eighteen year old to have the answer?”

No compromise could be reached. One participant stated that he felt that it was the parent’s responsibility to talk to their children. He said that parents

should be more proactive and “learn more about HIV/Aids”. They should not be afraid to approach their children.

The response to question seven was that a lack of money is a very large barrier. Other participants stated that ignorance with regard to aspects like susceptibility to the disease is also an important roadblock. The fact that very often the Aids message is “not taken seriously” is also a problem. Some participants described individuals who simply believe that they are HIV negative and that they will remain so. This then gives them the freedom to be promiscuous. Therefore, ignorance equals freedom.

With regard to question eight the participants stated that more information on the effectiveness and quality of condoms is required. This includes the female condom. It was suggested that the prevention programme should make use of Christianity and religion. One participant actually stated, “we need to pray hard!” There was a feeling of cynicism and desperation linked to this statement. According to the participants there also needs to be more discussion on abstinence. It was also suggested that young people should work in hospices with infected individuals so that they can make contact with the disease.

After reading this extract there are several themes that emerge from this focus group. The following is a discussion of these themes. One can see some similarities with the previous group emerging.

First, one distinct theme regarding HIV/Aids that emerged from the discussion is that of powerlessness. The researcher has chosen this term because it encompasses the following feelings: pessimism, frustration, cynicism, aggression, suspicion, sadness, fear and hopelessness. This attitude can also be seen in a statement made by one of the participants, “we are all going to die anyway.” This feeling permeated the entire session.

Condoms also featured in this debate and, as with the previous group, nothing positive was said about condom usage. Instead, the discussion was

dominated by questions about safety and reliability and the fact that there is a lack of scientific knowledge available on condoms. This may cause feeling of powerlessness because although the participants know they need to use condoms they feel that condoms are not one hundred percent effective. Then why use them anyway?

As with condoms, abstinence was also a fiercely debated issue. Whether or not it is possible being the core consideration. This issue is also further highlighted by the fact that many participants feel that it is the only reliable method of protection.

It seems as though participants know how to protect themselves. The problem lies with the fact that many of the participants view these methods of protection as irrelevant and useless. This could possibly lead to feelings of powerlessness and fatalism e.g., “I cannot do anything to protect myself!”

Second, there is also a very powerful story of mistrust. This mistrust is directed at individuals who are already HIV positive. They seem to have been demonised to a large extent and during the focus group they were characterised as people who may want to infect others with the virus because of a need to get revenge. This theme was also present in the first focus group.

Third, the power of speculation was also highlighted. Participants asked the facilitator questions about aspects like how long can one live with HIV and why should two people who are already HIV positive have protected sex? Questions were also asked about transmission in the rest of the world. While answering these questions the researcher was considering that these are hotly debated topics. These are not simple questions about transmission but rather they are topics that are open to conjecture and debate and there are several theories that surround these issues. The President of the country, himself, is responsible for a certain amount of speculation and debate. The theories will possibly have an effect on the actions that we take. The mere fact that there are so many differing theories about HIV/Aids can also be very perplexing.

Fourth, discourses surrounding trust, specifically when does one trust enough to have unprotected sex were also highlighted. The feeling that one gets from this question is that it is difficult and dangerous to trust other people. One participant said in a focus group that one can “trust a man but not a women”. In this way discourse on gender is introduced. The same focus group also mentioned “you don’t know how many men she has slept with!” Once more, the women’s sexual history is up for speculation and one can imagine that the women would then carry the blame for possible infection.

Fifth, the researcher also feels that the stories of adolescence and what occurs during adolescence should be questioned. According to the participants it is very difficult to resist the sexual impulses that are a feature of adolescence. This also links with the theme of powerlessness because this idea implies that one does not have the power to deny sexual impulses.

Sixth, in this focus group participants stated that the media promotes sexual activity, the idea that one has to be sexually active to look “cool” and to fit in. The result? A generation of young people that know too much and therefore experimentation occurs.

Seventh, there also seems to be a lot of pressure on parents. On the one hand there are people who believe that parents may be too over-protective and that it is too embarrassing to discuss sexual matters with parents, while on the other hand there are individuals who believe that parents are not proactive enough and that they should not be afraid of talking to their children.

Eighth, ignorance was mentioned again. This focus group stated that there are people who simply believe that they will not become HIV positive therefore they can do what they want. It is not a denial of the existence of HIV, rather it reflects a specific type of thinking, i.e. “Aids will not happen to me!”

Ninth, personal choice was debated. The group was split as to whether or not this is possible. They mentioned several factors that may make this very

difficult. Finally, the issue of the repetition of the HIV/Aids prevention message was highlighted, with the participants stating that people may become “bored”.

4.1.3 Focus group three

The third focus group consisted of 27 first-year engineering students. The average age of the students being between 18 and 22. The researcher acted as the facilitator and although questions were directed at the participants they were able to relate their own stories and ideas.

The participants were quite keen to share their stories with one or two individuals playing a relatively dominant role in the group. There was less disagreement in this group than in the previous focus group.

The questions used to elicit the participant’s stories were:

1. What is the definition of HIV?
2. What is the definition of AIDS?
3. How is HIV transmitted?
4. Do you believe that there is enough information available on HIV/Aids?
5. Do you believe that prevention programmes like “Love Life” are successful?
6. Do you believe that people are changing their behaviour so that they can protect themselves from HIV/Aids?
7. What do you believe are the greatest obstacles in HIV/Aids prevention?
8. Do you have any comments or suggestions on how to prevent the spread of HIV/Aids?

The respondents gave very detailed answers that reflected their personal stories regarding HIV/Aids. The following is a summarised account of the respondents’ answers.

As with the previous groups, there were a few individuals who were unable to give definitions that were one hundred percent correct but most seemed to

have a basic understanding of the two terms. There were no major misunderstandings.

In response to question three the respondents stated that HIV is transmitted “sexually, in the bloodstream, through intercourse, open wounds, injections, needles and drug usage”. HIV is not transmitted through “kissing, touching, sleeping in the same bed, mosquitoes and using the same cutlery”. During the session it was re-iterated by a participant that the HIV virus is fragile and may not be able to survive outside the human body and as far as cutlery is concerned the virus cannot be spread if there is “no contact with bodily fluids”. Another participant stated that one has to “swallow seven litres of saliva” before there is a chance of infection. The group seemed to be very well informed.

About question four there was division among the participants. Certain participants stated that information on HIV/Aids is all over the place namely on television, billboards and in magazines. A few participants also mentioned that the lecturers talk about HIV/Aids. Others disagreed, saying that there is a major lack of scientific information available on HIV, on the safety of condoms and in the rural areas, an idea echoed in all the focus groups. The participants backed up this statement by saying that in the rural areas few people have televisions and radios. Other participants disagreed, saying that many people in the rural areas do have access to some form of technology, if not a television then a radio. One participant stated that people in the rural areas “know the word HIV but they think that it is an animal or a person”.

In response to question five the participants stated that the billboards used specifically by “Love Life” are vague and that very often the meaning and language used on the billboards is hard to understand. It was also stated that many prevention programmes do not target enough people and that the message does not reach certain communities. Some participants also mentioned that because they have heard the prevention message so many times, it has become boring and cliched. Again, this is a repeated message.

Another point that was raised is the fact that many of the prevention programmes rely on newspapers and radios and that many people cannot afford these things. A few participants also stated that “Love Life” markets sex and may actually promote sex rather than emphasising abstinence e.g., be faithful to your current partner and always use a condom.

Participants who felt that prevention programmes are successful stated that at least “people are using and buying condoms now”. It was also mentioned that a few years ago people were being encouraged to use condoms but now the emphasis is much more on abstinence therefore the prevention message has evolved.

This served to spark off a debate on abstinence with some participants saying that abstinence is possible and other saying that either it is not possible or at least very difficult. The participants who stated that abstinence is possible said it is simply a matter of attitude and self-control. It is your personal decision. Participants who disagreed with this notion said that the media promotes sexual behaviour and that at times it may be very difficult to ignore this. They backed this statement up by saying that even very young children know about sex. One participant stated that humans are fallible and this mixed with aspects like peer pressure make it very difficult to abstain. A few participants also questioned whether or not people ever know if they have found the right person. This is a repeated theme.

As with the previous groups the idea of personal choice was introduced with many participants saying that you still have the power to control your own actions. Others disagreed and one participant even stated that only “one person out of every ten” thinks like this, meaning that most people are influenced by the media and cannot make their own independent decisions.

It was during this conversation that participants also stated that we need to look at other aspects like drugs and alcohol abuse and their contribution to the spread of HIV/Aids. This may be a very important avenue to explore, as these aspects are not usually included in most prevention programmes.

In response to the sixth question there was dissent yet again. Many of the respondents stated that behaviour change is not occurring because there are still many men who refuse to wear condoms for a variety of reasons. Many respondents also stated that condoms are seen as a form of contraception and not as a method of protection. One participant stated that people might have become less careful and vigilant because of condom usage. In other words, people may have become a little complacent with regards to safety and the choosing of sexual partners. Another point that was raised is that very often people only change their behaviour when they come into contact with HIV/Aids. The idea behind this is that people may not feel a need to change because they have no contact with the disease. One participant stated that people say things like, “if only I had known... then...”

The discussion then turned to the fact that there is currently no cure for HIV/Aids and the researcher asked the participants about how this makes them feel and many stated that it scares them. Participants also remarked that many people feel that they are going to die anyway so why bother with protection. The issue of people professing to have a cure for Aids was also raised and this was linked to the fact that there are people who are making money from the epidemic.

In response to question seven the participants listed “a lack of money, a lack of knowledge on condoms and bad media”. The comment on “bad media” caused a stir, several students re-iterated the important role that personal choice plays.

The participants had several recommendations for the new prevention programme. What was highlighted strongly is the fact that abstinence rather than sex should be marketed. Another aspect that the participants felt strongly about is the need to bring people closer to the reality of HIV/Aids. How can this be done? It may be very useful to include HIV positive people in a prevention programme. The aim would not be to “scare people” but rather to “show them reality”. Many of the participants also requested that the programme should contain more scientific information on the virus including

its origins. Some participants felt that it was important to look at other methods of transmission such as drug and alcohol abuse. The need for more information on condoms was introduced.

The importance of knowing your own personal status was also touched on, as was the role of voluntary testing. It may also be beneficial to discuss these aspects in a prevention programme. This can be linked to relationships and how one approaches a partner about their HIV status.

The participants also came up with several catchy phrases that could possibly be used in a prevention programme e.g. “every time you have unprotected sex you reduce the number of years you are on this planet”, “Aids is not the problem, people are” and “no sex is safe sex”.

Many theories regarding HIV/Aids were discussed. They were introduced haphazardly during the conversation and discussed. Some of the theories highlighted are:

- “HIV is a man-made disease designed to reduce the number of people in third-world countries”.
- “Certain people are immune to HIV/Aids e.g., a specific group of prostitutes in Uganda”.
- “Monkey’s transmitted the disease to humans”.
- “Government condoms are different to the one’s sold in shops”.
- “Government officials have stapled holes into condoms before”.

After reading this extract there are several themes that emerge from this focus group. The following is a discussion of these themes. Many of the sentiments aired by this focus group were also evident in the previous focus groups.

First, although a story of powerlessness e.g., “if there is no such thing as safe sex, then what?” was evident in this conversation another very important aspect was highlighted and this is the amount of speculation that surrounds

HIV/Aids. This is backed up by the fact that during the conversation many theories regarding HIV/Aids were aired. This further emphasises that fact that there are so many stories about HIV/Aids that it is hard to discern fact from fiction.

When asked about the origins of these stories the participants were unable to give an answer. They were also unable to identify whether or not speculation influences their behaviour. The researcher feels that this aspect is important because it highlights the power that speculation has over our behaviour and also the fact that very often we do not question these ideas or theories. We never seem to ask about the origins of the stories and how they affect our behaviour.

Second, this group highlighted something that the other focus groups did not, namely the role that drugs and alcohol play in the transmission of HIV/Aids. It may be an important aspect to include in a prevention programme. HIV/Aids is not only spread via sexual contact but it is also spread through aspects like intravenous drug use. Also, when people are drunk they may engage in dangerous sexual behaviour. Excessive alcohol or drug usage seems to be linked to sexual behaviour in the minds of many people.

Third, the group highlighted the fact that some prevention programmes may not work because outsiders design them. This can be illustrated by the fact that a few of the participants stated that they do not always understand the language used in certain prevention slogans. This only serves to further highlight the importance of making sure that programmes are useful, understandable and relevant.

Fourth, the focus group also highlighted the importance of voluntary testing and knowing your own status. Important aspects of voluntary testing include disclosure of your own personal status and approaching someone else for their status. From the responses gathered from the focus groups it seems as if this is a very difficult task indeed. It may also be valuable to spend some time on what it means to test negative and what it means to test positive. The

focus group also questioned whether or not you can really be sure that this is the “right person”? When does one really know that you can trust someone else?

Fifth, the focus group highlighted the fact that people may not take the prevention message very seriously because they have not had any direct contact with HIV/Aids. Therefore, the group recommended that the new programme include people who are HIV positive. It is assumed that by doing this one would be giving a face to HIV/Aids thereby making the dangers of infection more tangible.

Sixth, the issue of condoms was again brought up. Many participants stated that there is a lack of information available on condoms, that people have become less careful because of condoms and that they are viewed as a method of contraception rather than as a protection against HIV. Nothing positive was said about condom usage.

Seventh, most participants felt that there is a lack of information on HIV/Aids in the rural areas. One participant indicated that although people know the term HIV they do not know the necessary details.

Eighth, abstinence was a hotly debated issue with some participants saying that it is simply a matter of attitude and self-control while other participants opposed this statement saying that the media promotes sexual behaviour and that it is very difficult to remain abstinent. These participants stated that sex is “marketed”.

Ninth, the role of the media was a fiercely debated subject with some participants saying that it promotes promiscuous behaviour and this, combined with peer pressure can be a lethal combination. Other participants felt that personal choice still regulates behaviour. Making your own decisions about your life and whether or not this is possible was again up for debate with one participant proposing that it is something out of the ordinary in today’s world, i.e. only one out of every ten people thinks like this!

Tenth, the effect of the repetition of the prevention message was raised. There were no positive comments linked to this occurrence and according to the participants it may have a very negative effect on people. Participants highlighted the importance of bringing people into contact with HIV/Aids. This should not be done to scare people but rather to educate.

Finally, what this focus group highlighted that none of the other groups really emphasised is that some change may have already occurred. The focus group stated that at least people are now buying and using condoms and that current prevention programmes have shifted their emphasis a little. More attention is being paid to abstinence than before.

4.2 AXIAL CODING OF THE INDIVIDUAL FOCUS GROUPS

When looking at the results from participants one can see that there are many stories about HIV/Aids. However, it is possible to highlight the common threads that run through all three of the focus groups. What follows is a short summary of these themes.

Theme 1: The Rural Question

The idea is that people in the rural areas lack the necessary knowledge and skills to fight the virus. One has to ask whether or not this is true or simply a popular discourse held by people who live in cities about people who live in rural areas. Rural people are seen as backward, traditional and illiterate. We naturally assume that there is a lack of access to resources in the rural areas. In the researcher's prevention programme this discourse can be discussed. If the situation in the rural areas is in fact so dire it may be useful to have a conversation with the participants about any possible suggestions they have on how to improve the current situation. Therefore, a possible lack of knowledge in the rural areas can be seen as a barrier to behaviour change.

Theme 2: The Condom Question

There seems to be a very strong discourse surrounding the effectiveness of condoms. The general argument being that condoms are not an effective method of protection. Various reasons are given for this e.g., there are holes in condoms, the quality of different types of condoms varies and the virus is so small that it passes through the latex. Condoms are viewed with much suspicion and some individuals see them as promoting risky behaviour e.g., people now have more sexual partners and are less careful. Condom usage and the issue of trust seem to go hand-in-hand. For some people condoms are an indication of a lack of trust between sexual partners. This may then prompt people not to make use of them.

Kelly (1995) actually identifies some of the more negative connotations attached to condom usage, namely:

- Using condoms interrupts sex and is awkward.
- Condoms reduce pleasure and decrease sensitivity.
- Condoms are too expensive.
- Condoms imply that you are dirty.

Despite all the negativity a participant in one focus group did mention that at least more and more people are making use of condoms. For a prevention programme it may be very beneficial to include scientific information on the effectiveness of condoms. It may also be useful to spend some time on the origins of the speculation surrounding condoms. Therefore, negative stories around condom usage can be seen as one of the aspects that make behaviour change difficult.

The theme of condoms is a very complex one and very often gender enters the debate. The theme of condoms can also be linked to gender e.g., whose role is it to demand the use of a condom? During one focus group a female participant specifically mentioned that there are many men who refuse to use

condoms and in another focus group participants talked about young girls “being brave” and having unprotected sex to please their partners.

Theme 3: The Gender Question

It may also be very important to discuss how gender influences the spread of HIV. The researcher has included this topic because in one focus group a participant stated that men do not want to use condoms and in another focus group a participant stated that women cannot be trusted.

The role of women with regard to condom usage, sexual intercourse, male superiority and gender roles seem to make them more vulnerable to infection. Focus group participants mentioned something similar when they talked about the fact that many girls may take part in certain activities to please their boyfriends. From this viewpoint gender seems to be a roadblock. This statement can also be linked to research done by Chitamun and Fichilescu (2003) that found that young South African women still tend to define themselves in terms of a relationship with a man. It would seem that with some women finding and keeping a partner is more important than health concerns (Chitamun & Fichilescu, 2003). This has serious implications for HIV/Aids prevention. The same researchers also found that when it comes to pre-marital sex young South African women tend to consider the emotional implications of a sexual relationship before they think about HIV or sexually transmitted infections (Chitamun & Fichilescu, 2003). Young women tend to consider things like how they will feel if the relationship ends or how would they feel if they think that they have made an unwise decision. Aspects like pregnancy and HIV seem to come second or even third (Chitamun & Fichilescu, 2003).

According to Van Dyk (2001) women are both biologically and socially more vulnerable to the disease. Women are more liable than men to become infected through unprotected sex and because of their traditionally low status in many societies they may find it very difficult to demand that their partner use protection (Van Dyk, 2001). Socially, this makes women vulnerable to

dangerous sexual practices and it takes the control of their own sexuality out of their hands. They may suffer abuse and physical violence if they do stand up to their partners (Van Dyk, 2001). Many women are emotionally and financially dependent on their partners or husbands and without these men they would not be able to survive, therefore they meet all the demands that their partners or husbands make. Many men also have casual sexual relationships with other women, frequent prostitutes or have multiple partners, thus placing both parties in danger.

Women may also be more socially susceptible because of pregnancy. A woman may become pregnant and be left on her own to care for the child, a task that is further complicated if both are HIV positive. There is also the emotional trauma that a mother may go through when she realizes that her child is HIV positive.

Many women who live in dire poverty have to turn to prostitution in order to survive and naturally this increases their chances of becoming infected (Van Dyk, 2001). The increasing occurrence of rape also makes women more vulnerable to HIV/Aids. Young girls are at an even greater risk of being raped. In a report done by the Medical Research Council of South Africa the majority of women in their study had been raped between the ages of 10 and 14 (Van Dyk, 2001).

It is also important to explore the discourses that surround male sexuality. One should also asks questions about what society expects from men and whether or not these expectations also put them at risk of infection. Therefore, gender roles and expectations can be seen as a possible barrier to behaviour change with regard to HIV/Aids.

Theme 4: The Personal Choice Question

In all three focus groups there were participants who raised the issue of personal choice. These participants stated that whatever the effects of the media or peer pressure people still decide for themselves. This also implies

that people take responsibility for their actions. However, it is also important to remember that there are many people who are not free to make their own choice. The reasons for this can be very varied and can be as a result of aspects like a desire to fit in, a lack of self-confidence or as a result of outside forces coercing people to act in certain ways.

Therefore, the researcher feels that it may be worthwhile to discuss this aspect in a prevention programme. Possible questions that could be discussed include:

- Where does personal choice come from?
- What does one need to make an independent decision?
- How do aspects like poverty and power influence personal choice?
- How does culture affect personal choice and the ability to make an independent decision?
- When do we have the ability to make a personal decision?

The aim of this activity would be to increase feelings of personal power and self-confidence. The goal would be empowerment. An inability to make your own choices and control your own behaviours can be a roadblock in prevention.

With personal choice one can also include the theme of powerlessness. The researcher has chosen to do this because there seems to be individuals who know that they need to protect themselves but they do not know how to do so. The options given to them are not seen as very viable. Either they may feel that they do not have the capacity or ability to change or, they do not see any viable solutions. This could possibly lead to feeling of powerlessness, frustration and fatalism. “We are all going to die anyway...” would be a good way of describing this sentiment. The focus groups seemed to feel this way about condoms and abstinence.

This thinking style can possibly be linked to the idea of learned helplessness. (Carson, Butcher & Mineka, 1996). Learned helplessness occurs when an organism learns that it has no control over aversive events (Carson et al., 1996). This learned helplessness can lead to three kinds of deficits namely motivational, cognitive and emotional. Motivational deficits include thinking that can be characterised by the words “why bother?” while the cognitive deficit interferes with the ability to learn new ways of doing things (Carson et al., 1996). Finally, the emotional deficit may lead to feelings of depression and passivity (Carson et al., 1996).

Learned helplessness and the accompanying feelings can act as a barrier to change. These feelings may remove any desire or motivation for behaviour change. But at the same time personal choice can also motivate behaviour change. If you feel that you have the ability to make your own decisions freely then this may motivate behaviour change.

The aim of a prevention programme would be to increase feelings of personal agency. Various prevention strategies can be discussed and practised. Participants could be asked to develop strategies for themselves, making use of relevant and effective behaviours.

According to many of the participants there are several themes that have a very strong impact on personal choice. These include:

- The media
- Speculation
- Adolescence
- Parents

Theme 5: The Media Question

Although all the focus groups were not unanimous about the effect that the media has on the spread of HIV, there was a strong emphasis on the fact that

the media markets sex and that this may make it very difficult to practice something like abstinence. Many participants stated that the media makes sex look “cool” and that too much information is available to young children.

The new prevention programme can highlight the impact of the media by focussing on certain questions:

- How much of an effect does the media have on people’s behaviour?
- Why can certain people stand up to the discourses portrayed in the media?
- Why do we perceive the media to have so much power over our personal thoughts and behaviour?
- Who controls the media?
- Why is it so difficult to ignore the messages that we get from the media?
- Does the media shape society, or does society shape the media?

It is also interesting to note that the media has actually played a pivotal role in many prevention programmes and that most of the participants acquired their knowledge through the media. Therefore, it would seem as if the media plays a dual role when it comes to HIV/Aids. It can facilitate change through the promotion of safe sexual practices or act as a barrier to change by promoting promiscuous sexual behaviour.

Related to this theme is the idea that people may be tired of the HIV/Aids message. All three focus groups mentioned this. This is a double bind situation. The aim is constantly to remind people but at the same time the message may bore people. It might be a good idea to brainstorm tactics during the prevention workshop on how to prevent this from happening. The focus would be on aspects like how to communicate the needed information in a different and innovative manner. Kellogg (2002) refers to this pattern as “safe sex fatigue”.

Theme 6: The Peer Pressure Question

Many of the participants in the focus group felt very negative about the idea of peer pressure. Nothing positive was said about this. Peer pressure is seen as a large contributing factor in the spread of HIV because peer pressure seems to promote promiscuous sexual behaviour and also experimentation. Many of the participants did not think that their peers would have the “correct” solutions or advise.

Nothing was said about the positive aspects of peer pressure and that peers can help to spread the prevention message and that they can help to support and encourage each other. Young people can talk and debate ideas and it is possible for them to learn from each other. Young people can also encourage other young people to engage in safer sexual practises. Therefore, if seen in a negative light, peer pressure can be a barrier to behaviour change.

Theme 7: The Speculation Question

The researcher also feels that it will be important to take note of the impact that speculation has on people and on prevention e.g., Aids can be cured by sleeping with a virgin. The researcher feels that it will be important to spend some time on these ideas and discuss their origins and meanings. These speculative theories seem to have the power to confuse people, to reduce feelings of susceptibility and threat e.g., HIV does not cause Aids. They also have the capacity to exploit people and give them false hope. Where this message originates from may also have a strong impact. A message originating from a person of high regard may carry more weight than a message from an “ordinary” person. It could be important to note why these stories still exist even though they seem to be in direct contradiction with the dominant stories regarding HIV/Aids e.g., Aids is incurable. Probably it would be beneficial to discuss the reasons why people are so desperate to believe this speculation. The researcher has included this theme because many of the participants felt very strongly about people exploiting the situation and making money from selling “cures”.

When looking at the speculation theme one can also include the impact that stereotypes may have on behaviour e.g., Aids is a black person's disease. With HIV/Aids this may be a very dangerous tactic because nobody is safe from the disease. Deconstructing the origins of these stereotypes and their validity may be important. Stereotypes can foster a false sense of safety and a false sense of reduced susceptibility and in this way they can act as a barrier to behaviour change. Stereotypes can also facilitate the development of stigma and discrimination.

Theme 8: The Adolescence Question

Although this theme was only mentioned in one focus group it seems to have a strong impact on behaviour. The researcher also feels that the stories of adolescence and what occurs during adolescence should be discussed, especially the idea that teenagers have to be sexually active and inquisitive during this stage. This includes the idea that it is impossible to resist sexual urges when you are a teenager. The discourse maintains that sexual activity and adolescence go hand-in-hand and therefore abstinence is impossible because of the need to experiment. It may be beneficial to deconstruct these ideas and introduce some adolescents who differ from this discourse. The consequences of such thinking should also be examined.

Erikson (in Milne, 2003) describes adolescence as a time when the adolescent is busy establishing an identity or a reliable self-concept (Milne, 2003). The developing youth's major concern is how they appear to others in relation to their own self-concept (Milne, 2003). Adolescents have many challenges. They are learning how to assert themselves in the peer group and how to deal with their developing sexual identity (Milne, 2003). The youth experiments in different ways in a quest for self-understanding (Milne, 2003).

This is the general viewpoint that people have of adolescence but one has to ask whether or not this is how all young people experience adolescence and whether or not there are other stories about adolescence. Adolescence and the stories that surround adolescence could act as a barrier to behaviour

change especially if the stories of sexual experimentation are seen as the norm.

For the purpose of this study and the prevention programme, the term adolescent will be used to describe young people between the ages of 13 and 21/22.

Theme 9: The Parent Question

The role of parents was heavily debated in the focus groups, with no resolution. It is clear that many parents seem to be uninvolved in their children's lives but parents also seem to be left out of the prevention message. When did this happen? Would it not be useful to include parents in prevention programmes so that they can play a more meaningful role in their children's lives? When listening and reading the responses one also gets the impression that parents and their contribution are not seen in a very positive light e.g., they may be too over-protective. The researcher wonders whether or not it may be a good idea to invite some parents to the discussion to garner their ideas. Most of the participants of the focus groups could be classified as adolescents and one wonders whether or not these negative ideas about the involvement of parents can be linked to the age of the participants. It is a generally held belief that teenagers have difficult relationships with their parents. Very often, parents are seen as old-fashioned, judgmental, not very open-minded, strict and out of touch with the modern lifestyle.

Dupree and Beck (1991) are of the opinion that recruiting family members and friends of HIV positive people to discuss how the disease has affected them and their loved one is very important as these individuals can be very moving advocates of safe sexual practices. They can also share valuable information on prevention with others (Dupree & Beck, 1991).

Parents can act as barriers to change if they are inflexible, over-protective, lacking in knowledge and unwilling to discuss certain matters with their children but at the same time the refusal of young people to talk to their

parents and inform them of what is going on in their lives can also be a barrier to change. According to certain authors, parents and other adults can be used effectively to motivate behaviour change.

Theme 10: The Suspicion/Stigma Question

In the focus groups participants mentioned the fact that many HIV positive individuals may knowingly transmit the virus to others because they do not care, because they are angry at the world or because they want revenge. It may be interesting to deconstruct the origin of this story and also to investigate whether or not this adds to the stigmatising of a specific group of people. In South Africa there is already a very strong stigma attached to people living with HIV/Aids. The following statement comes from a South African text (Evian, 2000, p.#):

It is not the HIV virus which is killing me or making my life not worth living, but the bad attitudes of people towards me and their rejection of me (A person with HIV infection, December 1992).

Stigma also plays a very large role in the failure of HIV prevention. Although human rights and legal interdictions can protect people against discrimination in aspects like housing and employment they cannot protect people from stigma, which is social rather than structural. Paradoxically, treating HIV/Aids is different from other diseases in that treatment itself probably enhances the stigma rather than reducing it (De Cock, Mbori-Ngacha & Marum, 2002). Emphasis has been placed on the anonymity of HIV positive people but this may have been counter productive because the secrecy promotes rather than breaks down the destructive silence and stigma that surrounds HIV (De Cock et al., 2002). Stigma can be a barrier to behaviour change. People may be afraid of disclosing their status and asking for help because they are afraid of how other people will react. Suspicion and stigma may stop people from trying out new behaviours, talking and asking questions.

Theme 11: The Abstinence Question

All three groups seemed to share a discourse that abstinence is almost impossible. Very few individuals in this study felt that it is a viable option although many stated that it was the only sure way of protecting yourself. This can be linked to the issue of powerlessness. One gets the impression that the participants feel that it is an old fashioned idea.

Various reasons are given for this but the role of the media is especially highlighted. According to the focus group participants, the media promotes promiscuous and dangerous behaviour and this makes abstinence very difficult e.g., sex is everywhere. The researcher feels that it would be worthwhile to include a discussion on this discourse in the prevention programme. It may be useful to look at aspects like the benefits and disadvantages of abstaining and whether or not it is really impossible to do so. One can also look at the discourse that sexual intercourse is an integral part of life and that is “not normal” to abstain.

According to Kellogg (2002) the “just say no” models are losing their effectiveness because the choices portrayed are so extreme e.g., “abstain or die”. The old scare tactics of the past no longer seem to apply. Kelly (1995) suggests that it may be useful to invite participants into a discussion where the following topics can be discussed:

- Relationship goals
- Identifying how sexual activity early in the relationship may contribute to positive or negative outcomes
- Weighing up the positive and negative outcomes of having sex at various points in the relationship.

According to Kelly (1995) this may help individuals to identify times when sexually assertive resistance responses will help them to achieve outcomes

that are consistent with their own values. The negative stigma that surrounds abstinence may act as a barrier to change.

Theme 12: The Role Model Question

The researcher feels that the importance of role models to the participants was highlighted very strongly in the first focus group. For the participants it is very important that there is a congruency between words and actions. This may reflect the importance that society in general gives to the influence of “role models”.

It would seem that a role-model who is not congruent and whose actions are in stark contrast with their words may be more destructive than a role model who models dangerous actions. These role models may de-motivate people.

When we think of role models we often talk about individuals who are in the public eye and are known to many. In the prevention programme one could identify such role models and discuss with participants why these individuals hold so much sway over people. The programme could also encourage participants to find their own personal role models. These could be people that are not necessarily known in the public eye e.g., a friend or family member. The facilitator of the prevention programme could then ask about these personal role models.

The programme could also focus on the qualities of role models, either in public or private life. Participants could be asked to identify the qualities of these people and then be asked whether or not they see themselves as having the same qualities.

Questions like these can be asked:

- Are role models really so important?
- Do they have the ability to change behaviour?

- Should people not be able to motivate themselves and maintain this motivation?
- Do we rely too heavily on role models?

According to the participants, “good” role models can act as a motivation for behaviour change.

The next theme is very closely linked to the current theme. The researcher will make use of this aspect in her prevention programme in conjunction with role models.

Theme 13: First-hand knowledge

A few participants stated that many people do not change their behaviour until either they themselves are infected, or somebody close to them is. In the case of prevention, one could say that by exposing people to the consequences of the disease we are giving HIV a face. Direct experience has many facets. It includes role-playing, lectures, making use of television and outings such as going to a hospice. Therefore, in a prevention programme it may be very useful to introduce the participants to a wide variety of people who all have differing stories regarding HIV/Aids. This might give the participants a chance to ask the questions they never have been able to, or to check the stories that they have about HIV/Aids.

In a study done in the United States among gay college students it was found that there has been a significant decline in safe sexual practices. Kellogg (2002) links this occurrence to the fact that young gay people have very little contact with the disease today and have not witnessed the devastating effects of HIV/Aids. The fact that many of the students believe that Aids is a chronic and manageable disease and not a death sentence also influences behaviour (Kellogg, 2002). Many young college students believe that they are invincible and because of more effective medication the fear of Aids has receded (Kellogg, 2002).

Included under this heading is the idea of voluntary testing. Many prevention programmes emphasise this aspect but people seem to be very hesitant to get tested. Fear could play a very large role here. A discussion may help to debunk any myths about the testing process and help people to learn coping strategies if they do test positive.

Van Dyk and Van Dyk (2003) did research into the state of voluntary testing in South Africa and one of the findings was that 86% of the participants felt that it was not advisable for people to find out their status if no treatment options were available for these people. These individuals felt that to know one's status without the option of treatment, follow-up care and support would only cause despair, depression and anxiety (Van Dyk & Van Dyk, 2003). Therefore, the issue of voluntary testing is far from resolved.

First-hand knowledge and experience can act as a motivation for behaviour change according to the participants.

Theme 14: The Ignorance Question

According to the participants, ignorance about HIV/Aids seems to be widespread. First, there is ignorance regarding personal susceptibility e.g., "I will always remain negative". This gives people the freedom to do what they want to do. Second, there are people who simply do not care about becoming infected. This attitude does not seem to be a denial of the existence of the disease. Third, there may be people who do not believe in the existence of the disease. Fourth, there are individuals who have other worries and see possible HIV/Aids infection as a lesser worry e.g., teenagers who worry more about pregnancy than HIV. Fifth, there are people who subscribe to certain stereotypes that may exempt them from worry e.g., Aids is a gay disease. This kind of ignorance could be a barrier to behaviour change.

According to Kelly (1995) sensitising people to their susceptibility is a tricky matter. Excessive levels of fear can lead to aspects like denial or a refusal to seek out more information on the disease (Kelly, 1995). It can also induce a

sense of hysteria that would be counterproductive (Kelly, 1995). It is very important that people have a clear idea of their levels of risk.

Techniques that are suggested to achieve this include making use of the relevant statistics, emphasizing the background similarity between the participants and people with Aids, and associating risk with personal behaviour (Kelly, 1995) e.g., what have I done in the last few years that may have made me vulnerable to HIV infection?

Theme 15: The Relationship Question

Under this theme one can mention many aspects because HIV/Aids can be devastating for any kind of relationship. HIV influences aspects such as trust, personal expectations and others' expectations. Trust and HIV seem to go hand-in-hand. Important questions of trust that are raised include the following:

- What does trust entail?
- Can you trust somebody else completely?
- When can you trust somebody else?

Other aspects that can be covered include the following:

- How does one approach a partner for their status?
- When do you know this is the right person?
- How do you disclose your own status to another person?

There are no easy answers when it comes to this theme, therefore it may be beneficial to get the views and ideas of others. By means of discussion the participants can be introduced to new ways of thinking and different kinds of strategies to deal with various problems. Included under this theme is asking about and knowing the status of your partner. Asking this question may be very difficult and detrimental to relationships. Therefore, a discussion may

help equip people with enough confidence and interpersonal skills to ask the needed questions.

When discussing relationships one can also focus on personal stories of HIV and how these stories affect people's behaviour. Participants can also be asked how they would support someone who is HIV positive.

The effect that HIV/Aids has on a relationship can act as a barrier to change especially if it means that the other person in the relationship may not like or understand these changes.

Theme 16: Other methods of transmission

A few participants mentioned that it is also important to focus on other methods of transmission e.g., intravenous drug usage. It would be interesting to note whether or not other people agree with this viewpoint.

According to Kelly (1995) it is very important for people to dissociate alcohol and recreational drug use from sex. Avoiding high-risk sexual behaviour at times of alcohol or drug abuse is the key idea, not the total curtailment of excessive use (Kelly, 1995). Therefore, it may be very beneficial to discuss this statement with the participants to garner their ideas. Alcohol and drug abuse could become barriers to change and actually facilitate the spread of HIV/Aids.

4.3 CONCLUSION

Having looked at the themes that emerged from the focus groups we can turn our attention to the literature review. In keeping with the tenets of grounded theory, the literature review was done after the data collection stage. Both of these sets of data will be combined to create a prevention programme.

CHAPTER 5

THEORIES REGARDING BEHAVIOUR CHANGE

I am a young man and I need and want a close and intimate relationship with a woman, yet whenever I tell her that we must use a condom, because I have HIV, she is no longer interested in a sexual relationship. It is very difficult with HIV. (A man with early HIV infection) (Evian, 2000)

5.1 INTRODUCTION

In keeping with the tenets of grounded theory, a literature review was done after the collection and analysis of data. The literature review will not be used to overrule the focus group data but rather it will augment the already acquired data. The researcher will combine these two sets of data to create a user-friendly and relevant prevention programme.

From the literature review one can get important hints on what to include and what not to include in a prevention programme. The literature review is also a good source of ideas and strategies. It could be that the focus groups identified a certain idea or topic and the literature review can be used to shed some more light on the related topic. The value of combining the two sets of data is that it allows for elaboration.

Therefore, this chapter will focus on:

- Social Cognitive Learning Theory
- The Stages of Change Approach
- The Theory of Reasoned Action
- Extended Parallel Process Model
- Health Belief Model
- Differential Association Theory

- Narrative Psychology
- Social Inoculation Theory
- Cognitive-Behavioural Approach.

The researcher has decided to make use of these theories because she would like to give the reader an indication of the sheer volume of literature devoted to behaviour change. She hopes that with this choice the reader will gain a basic idea of what behaviour change is and how the different schools of thought define behaviour change. Each school of thought has some very interesting propositions and many ideas overlap. The researcher also realises that not all schools of thought are represented in this chapter.

5.2 SOCIAL COGNITIVE LEARNING THEORY

This approach adopts an interactional view that states that human behaviour is constantly influenced by three principles that are in perpetual interaction. These principles are person, situation and behaviour (Meyer, Moore & Viljoen, 1993). Behaviour then occurs as a result of the interplay between cognitive and environmental factors, a concept known as reciprocal determinism (Kaplan, Sadock & Grebb, 1994).

According to this approach people are not passive robots but rather they can be seen as active and self-evaluating beings that respond to stimuli, evaluate events, judge, compare, believe and reason (Meyer et al., 1993). This means that people do have a degree of freedom when it comes to making decisions, but that this freedom is limited by the person's abilities, his experiences and the choices offered by the environment (Meyer et al., 1993). Social learning theorists believe that a person determines his own life and chooses what is valuable and rewarding. The basic motive of a human being is to search for meaning (Meyer et al., 1993).

Albert Bandura is one of the most important representatives of the social learning approach. Bandura acknowledged that an individual's values and

interests play an important part in the learning process. He stated that each individual has a “response repertoire”. This refers to the various behaviours that the individual has at his disposal (Meyer et al., 1993). What behaviour is chosen from the “response repertoire” depends on the nature of the situation, previous learning, objectives, future plans and also the behaviour that is eventually produced (Meyer et al., 1993).

5.2.1 The learning process

The main tenet of the social cognitive learning theory is the view that behaviour is acquired through learning. Bandura identified how learning and behaviour acquisition occurs and also several aspects that have an influence on both. In order to explain the various types of learning, Bandura identified three categories of reinforcement namely (Meyer et al., 1993):

- Direct reinforcement and direct punishment
- Vicarious reinforcement and vicarious punishment
- Self-reinforcement and self-punishment.

Direct reinforcement occurs when an external agent rewards an individual for behaviour or something unpleasant is taken away once an action is completed (Meyer et al., 1993). Direct punishment refers to the punishment of an action by an external agent or to the removal or withholding of something pleasant. Vicarious reinforcement or punishment refers to the observance of somebody else getting punished or rewarded for his or her behaviour (Meyer et al., 1993).

Another aspect that influences behaviour is self-reinforcement and self-punishment. While an individual is capable of rewarding himself through praise an individual can easily blame himself or herself and feel ashamed about their behaviour (Meyer et al., 1993). This is a form of self-punishment. Therefore, these two aspects can have either a negative or positive influence on behaviour.

All three of these aspects play an important role in the learning and behaviour change process. Bandura recognized three types of learning namely (Meyer et al., 1993):

- Learning through direct experience
- Observational learning
- Self-regulation.

Learning through direct experience occurs when the individual experiences various situations himself. According to Bandura man does not just reproduce behaviour but rather he consciously perceives, evaluates and reproduces behaviour (Meyer et al., 1993). An individual does not only react to stimuli, he also thinks about what is happening to him. He interprets events and makes hypotheses. Thinking plays a very important role in direct experience because people give meaning to the things that happen to them. Repetition of behaviour is never guaranteed.

Bandura also stated that observational learning was a very important way of acquiring behaviour. He was quick to add that observational learning is not always uncomplicated and that it is not simply something that always occurs automatically and consistently (Meyer et al., 1993).

There are three aspects of observational learning. The observer needs to **pay attention** to a model and to **reproduce the behaviour** and one needs to **remember the actions**. Whether or not behaviour is seen, remembered and reproduced is dependent on aspects like the nature of the behaviour being modelled, the distinctiveness of the model, the characteristics of the observer and the results of the behaviour (Meyer et al., 1993). According to research, unfamiliar and striking behaviour is more easily acquired than familiar and known behaviour (Meyer et al., 1993). This is perhaps why belligerent behaviour is more readily imitated than any other behaviour (Meyer et al., 1993). A model with a high status or who has similar characteristics to those of the observers is usually more readily imitated than an unfamiliar model with

a lower status (Meyer et al., 1993). The results of the model's behaviour are also important. Vicarious rewards usually leads to imitation while vicarious punishment leads to an avoidance of that behaviour (Meyer et al., 1993). Motivation is also influenced by a positive outcome. A positive resolution encourages repetition of the behaviour because it increases the motivation to repeat the observed behaviour.

Bandura also felt that norms and values are learned like any other behaviour. Bandura does acknowledge that these values can be taught through direct instruction but he also stated that they could be learned through observation. Usually, a significant other models these aspects and the observations are stored as mental images and symbolic representations in the mind and thus enable children to imitate the behaviour at a later stage (Louw, Van Ede & Louw, 1998).

Self-regulation refers to the individual's ability to regulate his own behaviour particularly his learning processes (Meyer et al., 1993). It therefore includes self-reinforcement and self-punishment. Bandura believes that an individual is continually regulating his behaviour. There are two basic types of self-regulation. Both can operate either positively or negatively either as self-reinforcement and self-punishment (Meyer et al., 1993).

Internal self-regulation refers to the individual's subjective evaluation of his own behaviour (Meyer et al., 1993). This evaluation is based on previous incidents, self-efficacy, future expectations and ideals. External self-regulation refers to arranging the situation so that rewards or punishment are concrete e.g., a person may reward himself with a movie after the successful completion of a test (Meyer et al., 1993). It is also important to remember that even though the individual may have been rewarded by an external agent the effect of this reward can be increased or lessened by the individual's interpretation and acceptance of it. Learning requires the integration of experiences and judgments of what might happen to the individual, therefore cognitive processes mediate our behaviour (Durand & Barlow, 1997).

Another aspect that may have an effect on whether or not behaviour is reproduced is self-efficacy. Self-efficacy theory proposes that an important predictor of whether someone will enact a desired behaviour is their belief that they can successfully complete the action (Slater, 1999). Social cognitive therapy provides many avenues for increasing this confidence (Slater, 1999). Self-efficacy can be increased by using models that are attractive or similar to the audience members, by using behaviours that are positively reinforced and by using actions that are clearly and intelligently modelled (Slater, 1999).

Behaviour can then be seen as the result of a very complex process of reciprocal determinism. Environment, rewards, punishment and observance all play a very important role in behaviour acquisition and change. It is also important to take note of the fact that people evaluate and give meaning to the experiences that shape their lives.

5.3 THE STAGES OF CHANGE APPROACH

The stages of change approach evolved primarily to better understand the process of behaviour change and it proposes five stages in the change process (Slater, 1999). The first stage is pre-contemplation. During this stage people have no intention of changing their behaviour and see no reason for it. The second stage is contemplation. In this stage people have recognized that there is a problem and they are considering behaviour change in the not too distant future (Slater, 1999). Stage three is preparation and in this stage people begin to experiment with new behaviours. During this stage there is experimentation but there is no successful behaviour change yet (Slater, 1999). The fourth stage is action. It is during this stage that behaviour change takes place and new behaviours are maintained for some time. The fifth stage is called maintenance and it occurs when new behaviour is sustained over a very long period of time.

The process very seldom runs so smoothly because the progression is spiral rather than linear (Slater, 1999). Behaviour like condom usage, improving

diets or changing sexual behaviour is difficult because it requires the changing of personal and social habits and convictions (Slater, 1999).

5.4 THE THEORY OF REASONED ACTION

The theory of reasoned action posits that people's beliefs about the outcome of their behaviour combined with their perceptions about the expectations of others will predict behavioural intentions (Slater, 1999). Therefore intended condom usage could be affected by the individual's views on aspects like decreased sexual pleasure or the perceived reactions or expectations of a partner. Culture and preconceived notions would also play a role in influencing behaviour. The theory of reasoned change can also be used to identify specific beliefs that need to be countered or reinforced (Slater, 1999).

5.5 THE EXTENDED PARALLEL PROCESS MODEL

This health behaviour change theory focuses on fear and the channelling of this fear into a positive protective direction rather than a negative and maladaptive one (Witte, Cameron, Lapinski & Nzyuko, 1998). This model is called the Extended Parallel Process Model (EPPM) (Witte et al., 1998). The development of this theory was based on research done in Kenya using HIV/Aids prevention posters.

According to EPPM, prevention messages should contain a threat component as well an efficacy component. The one aspect of the message wants to make the audience feel threatened and susceptible while the other half of the message wants to make people aware of the fact that they have the personal power to avert the threat (Witte et al., 1998).

This paradigm is based on the belief that when it comes to prevention messages there are two aspects that are appraised, namely (Witte et al., 1998):

- First, people evaluate whether or not they are susceptible to the threat and whether or not the threat is serious. If the threat is not seen as serious then the message goes not further. If the threat is seen as serious the individual feels fear.
- Second, the efficacy appraisals begin. People begin to judge whether or not they can actually protect themselves from the threat and then they evaluate whether or not the recommended action is actually useful.

If people feel that they can make use of the recommended behaviour and that they can avert the threat they change their behaviour but when people either feel unable to perform self-protective behaviour or they believe the response is ineffective, they give up and there is no behaviour change (Witte et al., 1998). Instead people try to control the fear by denying the threat e.g., only homosexuals get HIV or, HIV is a government conspiracy.

According to this theory a preventative campaign should promote high levels of susceptibility and severity but also of self-efficacy and response efficacy (Witte et al., 1998). High perceived severity and susceptibility to the threat motivates people to act and high perceived response and self-efficacy directs appropriate acting (Witte et al., 1998).

In research done in Kenya, it was found that posters that only depicted the threat of HIV without telling people how to protect themselves motivated people to control the fear through defensive avoidance and resistance (Witte et al., 1998). Posters that gave people explicit information on how to protect themselves served to increase self-efficacy. The research also highlighted various levels of susceptibility. It was found that if global susceptibility was emphasized (we are all vulnerable) it was likely to produce low levels of perceived susceptibility (Witte et al., 1998). The severity of the threat was also increased if the physical consequences of HIV were highlighted (Witte et al., 1998).

In terms of self-efficacy the Kenyan participants wanted more information on aspects like how to approach or initiate condom usage, how to use condoms and where to get them. It was also found that more information on the effectiveness of condoms was required. It was also found that role modelling and pamphlets were very useful for audiences with already existing high levels of threat (Witte et al., 1998).

5.6 HEALTH BELIEF MODEL

This model is similar to the EPPM model except for one important variable. The HBM model identifies various barriers that have an important influence on health behaviours. These barriers may be psychological, structural or financial and they may impede one's perceived ability to perform a given action. A psychological barrier could be fear, a structural barrier could be an inability to get to a clinic for medication and a financial barrier could be a lack of money. Therefore, there is no behaviour change.

DiClemente and Peterson (1994) identified five major components of the HBM model, namely:

- Perceived susceptibility refers to one's perception of the risk of contracting a serious health problem.
- Perceived severity refers to the feelings concerning the seriousness of contracting an illness. This also includes beliefs about leaving the affliction untreated or of the social consequences that may be linked to treatment of the disease.
- Perceived benefits refer to the perceived benefits of taking action. Individuals weigh up both the pros and cons of taking part in certain actions.
- Perceived barriers will act as impediments to undertaking a specific behaviour. Barriers could be aspects like finances, time required or whether or not the necessary actions are seen as painful or upsetting.
- Self-efficacy.

5.7 DIFFERENTIAL ASSOCIATION THEORY

Linked to the social learning approach is the differential association theory. This theory states that people teach each other certain behaviours e.g. crime is learned in social situations by associating with people who are already involved in this behaviour (Deutsch & Swartz, 2003). The idea behind this is that people can also easily learn positive behaviour from other people. This theory states that the mere association with others provides a learning opportunity (Deutsch & Swartz, 2003).

5.8 NARRATIVE PSYCHOLOGY

The narrative school of psychology adopts the postmodern view of reality. There are four basic tenets to the postmodern view, namely (Freedman & Combs, 1996):

- Realities are socially constructed.
- Realities are constituted through language.
- Realities are organized and maintained through narrative.
- There are no essential truths.

Narrative psychology embraces all of the above. The aim of narrative psychology is to highlight to the individual that there are in fact a multitude of possible realities and the impact that discourse has on individuals. Discourse refers to generally held beliefs or practices. It could also be something that we call common sense. Discourse can be defined as a set of meanings, metaphors, representations, images and stories that in some way produces a particular version of events (Burr, 1995). There are many discourses in our reality but certain discourses claim to be the truth e.g., HIV is a gay disease. These discourses have a powerful influence on people. Language and culture are tools that keep these discourses alive. Very often people have experiences that are in conflict with these dominant discourses and this may

cause anger and confusion. Very often people come for therapy because their personal experiences no longer match or fit with the dominant discourses.

After a while these discourses become so entrenched in society that nobody questions them anymore and they simply become the way things are done. These discourses greatly influence how we think and act because they can become ingrained in us e.g., adolescence goes hand-in-hand with sexual activity. With regard to HIV/Aids, many women still labour under the discourse that they are subordinate to men and that they have no say in sexual matters. Other discourses could be that HIV/Aids is a disease of the poor, a specific race or homosexuals.

The aim of the narrative psychologist is to highlight these ignored experiences and to flesh them out with the client. Current discourses in the client's life are also examined and deconstructed. The experiences that are contrary to the dominant discourse are called "unique outcomes". Very often these unique outcomes can also be used to highlight to people that they are capable of overcoming a problem and they themselves are not the problem, rather they have a relationship with the problem. In narrative therapy people are never viewed as the problem but rather that people are in a relationship with the problem. These unique outcomes can be used to foster behaviour change or at least to open up the possibility of alternative narratives, stories or discourses.

When it comes to behaviour change, unique outcomes are very important but it is still up to the client to decide whether or not they want to follow an alternative discourse. A client may decide to choose an old dominant narrative over a new and possibly less oppressive narrative for various reasons.

Narrative psychology may be very useful for deconstructing the dominant narratives in a person's life. This is important because these dominant stories may be acting as a barrier to change.

5.9 SOCIAL INOCULATION THEORY

Social inoculation theory states that young people lack the negotiating skills to resist unhealthy behaviour arising from peer pressure and other negative influences. Therefore, the theory proposes that through the use of a range of techniques and skills one can inoculate young people against these influences (Deutsch & Swartz, 2003). There is a flaw in this theory because one can then also become immune to any positive help because of factors like common unspoken social pressures and the desire to conform and fit in with everybody else (Deutsch & Swartz, 2003).

5.10 THE COGNITIVE-BEHAVIOURAL APPROACH

The cognitive-behavioural paradigm can be traced back to the philosopher Epictetus, who observed, “people are disturbed not so much by events as by the views which they take of them” (Woolfe & Dryden, 1996, p. 156). This means that people give meaning to what happens to them and that these explanations need not necessarily be accurate or positive. The implication of this is that situations are better viewed from some angles than they are from others and that in principle people choose their own orientation (Woolfe & Dryden, 1996). However, a person’s orientation is itself influenced by a person’s beliefs about himself and the world. One can also refer to a “cognitive strategy”. A cognitive strategy is a mental plan used by the person to understand self and environment (Kaplan et al., 1994). An individual who is struggling with depression may be using a cognitive strategy that includes a negative view of self, negative interpretations of experiences and negative expectations of the future (Kaplan et al., 1994). Therefore, the aim of cognitive-behavioural therapy (CBT) is to relieve emotional disturbance by helping people change their maladaptive beliefs and behaviours (Woolfe & Dryden, 1996).

From this viewpoint human experience is viewed as a product of four interacting elements namely physiology, cognition, behaviour and emotion. Thus, if I have to write an essay I am tense (physiology) and this may lead me

to think that I am not going to write a good essay (cognition) which in turn may lead me to feeling anxious (emotion) and that may lead to me putting my pen down and going for a walk (behaviour). The effect of the walk may be to reduce my tension (physiology) and then I may be more inclined to think that I can do well (cognition) (Woolfe & Dryden, 1996). In this instance the behaviour broke the chain of events and the negative reaction. The primary emphasis is on breaking out of the negative chain via the cognitive and behavioural ports of entry (Woolfe & Dryden, 1996). There has also been a move toward using emotions in behaviour change because emotions play a powerful role in people's performance. A person who feels that they are stupid may struggle to complete the task well.

There are two main premises that characterize the cognitive-behavioural approach (Carson et al., 1996). The first premise is the conviction that cognitive processes influence behaviour and motivation (Carson et al., 1996). The second entails the use of cognitive and behaviour change techniques in a pragmatic manner (Carson et al., 1996).

There are several notions that fall under the cognitive-behavioural approach that illustrate the notion that cognitive processes influence behaviour. The researcher will discuss a few.

Within the cognitive-behavioural paradigm there is much emphasis on self-defeating thoughts and how they influence behaviour. These thoughts can negatively influence aspects like motivation and self-efficacy. Beck introduced the cognitive distortion model and in this model he proposed that people make use of three types of cognitive distortions namely (Milne, 2003):

- Over-generalization - the tendency towards sweeping generalizations from limited evidence
- Personalization - the tendency of distorted thinking which involves the individual imagining that events are the result of their faulty actions

- Dichotomous thinking - the tendency to see situations as either all good or all bad, polarized view of reality.

Other types of distorted thinking patterns include (Woolfe & Dryden, 1996):

- Automatic discounting which refers to absorbing the negative and discounting positive information.
- Emotional reasoning, which refers to using feelings as evidence of the truth of a situation.

Change is often synonymous with symptom reduction and behaviour change. When looking at behaviour change, it is also important to identify the obstacles that stand in the way of behaviour change. Behaviour change can be brought about by the use of various techniques where the individual can learn through listening to or reading instructions (Kaplan et al., 1994). These therapeutic instructions are used to modify both the outcome and efficacy expectations of clients (Kaplan et al., 1994). Clients are encouraged to monitor themselves so that new behaviour strategies are learned. The therapist also needs to help the client define and set realistic goals because this increases the likelihood of success (Kaplan et al., 1994). Goal-attainment will increase self-efficacy, which in turn positively affects future performances (Kaplan et al., 1994).

5.11 LINKING THE FOCUS GROUP DATA TO FORMAL THEORY

From the various focus group discussions held several important themes have been highlighted. It is also possible to link several of these themes with certain behaviour change theories. These combined ideas will be incorporated in the newly designed prevention programme.

First, the results of the focus groups highlighted several important tenets of the social cognitive learning theory namely self-regulation, especially internal self-regulation, reinforcement, self-efficacy, modelling and direct experience.

Internal self-regulation plays a very important role in prevention. Many of the respondents stated that personal choice is very important and this links with the idea that people regulate and evaluate their own behaviour. Therefore, if an individual does not accept the results of a new behaviour, even if it leads to good results, the behaviour will not be repeated. The individual's own evaluation of the situation is very important. How the individual evaluates his or her experiences would depend largely on aspects like previous experiences, expectations and goals.

The focus groups also highlighted a very important point namely self-efficacy. If you don't believe that you can bring about a change you will not make any attempt to do so. It would then be important for any prevention programme to highlight not only susceptibility but also focus on how people can protect themselves from HIV/Aids. It would also seem that self-efficacy is something that can be developed and fostered through practice.

This also links very strongly to the Extended Parallel Process Model discussed earlier in this chapter. If people feel that they can protect themselves they may make a change to their behaviour but if you bombard people with statistics and pictures of dying people you may undermine any feelings of personal agency. This could lead to situations where people deny the existence of HIV/Aids, i.e. it is a myth made up by the government to stop us from having children! Some people may simply deny their susceptibility to the disease by taking on the attitude that Aids will not happen to them or they firmly believe that they are HIV negative and will stay negative.

Self-defeating thoughts also play a very important role in behaviour acquisition in that they can reduce feelings of self-efficacy. If an individual is constantly telling himself or herself that they will fail, then this self-talk will seriously damage performance. It could actually lead to failure. It is possible to change negative self-statements into more positive ones through practice.

With regards to reinforcement it is also important to keep in mind that, especially with HIV/Aids, the changing of behaviour does not necessarily lead

to direct or vicarious reinforcement. There is also no direct punishment or reward for abstaining from or continuing with dangerous behaviour. In fact, abstaining from dangerous behaviour may actually lead to things like interpersonal difficulties and anger, i.e. a relationship could end. This could then be seen as direct or vicarious punishment. This situation is also compounded by the fact that the symptoms of HIV/Aids are not immediately visible and often neither is the result of behaviour change.

The influence of modelling was also been highlighted in the focus groups, specifically the fact that models should be sincere, trustworthy and relevant. Modelling does not only entail the use of live models but also making use of individuals, who appear on television, work on radio or who appear in the print media. These models may not be physically present but people are aware of them and their behaviour. Movies stars model lifestyles and ideas. They influence people even though there is no actual contact. Therefore, the researcher believes that they can be referred to as models. Modelling also includes activities like role-playing that can used as an effective tool to pass on helpful interpersonal skills.

Panford, Nyaney, Amoah and Aidoo (2001) have also stated that folk media can be used in the fight against HIV/Aids. They have linked this aspect with Bandura's social learning theory, which states that most behaviour is learned through modelling (Panford et al., 2001). Folk media performers can be seen as role models from whom people can learn. In rural Ghana local concert groups perform dramas designed to focus attention on various social issues. These dramas then stimulate discussion (Panford et al, 2001). The African musical heritage is rich with songs that serve the dual purpose of entertaining and educating. Traditional funeral songs are now being changed and several with messages about various health issues have been created (Panford et al, 2001). These songs get played on national radio and television stations (Panford et al, 2001). This method entails making use of traditional songs, proverbs, storytelling, drumming, dancing and drama in the fight against HIV/Aids (Panford et al, 2001). These methods may also be very effective because they are recognized by the community (Panford et al, 2001).

Closely linked to the idea of modelling is direct experience. Bandura stated that people are not inert beings and that we give meaning to our experiences; therefore direct learning may be very important when it comes to prevention. According to Dupree and Beck (1991) it is very important to humanize the Aids epidemic by arranging meetings between people who are positive and those who are not. They also encourage individuals who work with HIV infected people to share their personal experiences (Dupree & Beck, 1991).

When looking at the Stages of Change Theory the researcher will take with her the idea that not all people are at the point where they want to change their behaviour or where they even see a need to change. Also, it is important to remember that once change has occurred it needs to be maintained and this may be very difficult. There may still be periodic lapses at times as self-protective behaviour may clash with the demands of society (DiClemente & Peterson, 1994).

The Theory of Reasoned Action states that people's beliefs about the outcome of their behaviour combined with their perceptions about the expectations of others will predict behavioural intentions (Slater, 1999). Therefore, the mere fact that a woman wonders about what her husband will think if she insists on condom use may affect her behaviour. The fact that many of the participants do not see condoms as safe may also have an effect on their behaviour. Also, the fact that many people may not raise important issues like HIV status because of the perceived negative response of others must also be taken into account.

The Health Belief Model reminds us that although there are external barriers many of the barriers to change reside within ourselves. These psychological barriers can be a lack of self-efficacy or a lack of personal susceptibility. It may also be the case that we see more problems with behaviour change than perceived benefits e.g., more relationship difficulties may be created if one partner demands safe sex.

The clinic sisters, as mentioned by the first focus group, also serve as a physical barrier according to the health belief model. They serve to make the access to the necessary information very difficult. One only needs to hear about the stories of clinic sisters to discourage you from making use of the clinics. The lack of funds in South Africa can also be seen as a physical barrier while the lack of long-standing and sincere role models can be seen as a psychological barrier.

From the Differential Association Model the researcher would like to incorporate the idea that we learn from other people, therefore talk and debate may open up new pathways for learning. It may also be even more beneficial to involve people who are already living in a certain manner e.g., people who are abstinent or people who are already HIV positive but living in a healthy manner.

Social Inoculation Theory states that young people lack the negotiating skills to resist unhealthy behaviour arising from peer pressure and other negative influences (Deutsch & Swartz, 2003). This can be linked to the participants' statements about the influence of the media and peer pressure. It must also be noted that aspects like peer pressure and the media may make self-protective activities very difficult (DiClemente & Peterson, 1994). But what the researcher would like to emphasize is that this theory states that it is possible to teach people or help people come up with ways in which they can minimize the impact of peer pressure. The aim of the new prevention programme is to identify and practice new types of interpersonal skills. The aim of the programme is to empower people in this regard.

From the Cognitive-Behavioural Approach the researcher would like to link the information collected from the focus groups with the idea that self-defeating thought can minimize self-efficacy.

When looking at the data collected one can see evidence of several types of self-defeating thought patterns. When it comes to something like personal choice the participants seem to make use of dichotomous thinking. Either you

make your own decision or the media influences you. It may be a gross oversimplification of the situation especially since there are several factors that can influence a person's ability to make an independent decision. Evidence of emotional reasoning can also be found. Many participants talked about HIV positive individuals who are angry at the world. This may be how the participants would feel if they themselves were infected but because they may feel this emotional does not necessarily mean that it is the truth. Just because the feeling exists for the participants does not mean that other people would experience this emotion.

There also seems to be a large amount of automatic discounting when it comes to aspects like condom usage. The benefits of making use of protection seem to be discounted while a large amount of time is spent on aspects like the lack of perceived effectiveness of condoms.

There is also evidence of some over-generalization e.g., because once holes were stapled into condoms, it does not mean that this has happened again and that all condoms are now ineffective.

5.12 CONCLUSION

Having combined the two sets of data the researcher will now turn her attention to developing a prevention programme. The researcher has decided to take into consideration the various themes that emerged from the focus group data and from the literature review when developing her prevention programme.

The prevention programme will focus on increasing feelings of self-efficacy, making use of modelling, role-playing, debate, practising new skills, reflection, questioning, developing strategies, checking reality, looking at barriers and developing negotiating skills.

CHAPTER 6

THE PREVENTION PROGRAMME

Struggle: To make a vigorous effort, in unfavourable circumstances, to overcome difficulties and problems (Evian, 2000, p #).

6.1 INTRODUCTION

The prevention programme is based on the ideas of post-modernism and the focus is on the sharing of information and thoughts rather than on imposing ideas. As Bullock and Trombley (1999) state, post-modernism is “a fading of progressive modernity, marked by distinctive ideological, philosophical, cultural, social and technological circumstances, and the end of totalistic explanations or ‘grand narratives’” (p. 673). One of the aims of the programme is to give the participants something to think about, pass on new interpersonal skills, and increase feelings of self-efficacy and not just to try and change behaviour patterns. Also, the prevention programme will encourage participants to look critically at the world around them and ask questions.

This programme embraces the idea that people are not passive entities and that they give meaning to events. The programme will call for the participants to appraise their own actions and the reasons behind these actions by making use of self-reflection. The onus will rest squarely on the participants to plan for the future and think about the consequences of their actions. Whether or not behaviour change occurs will still be in the hands of the participants. The aim of the programme is also not to label certain behaviours right or wrong but rather to explore the various behavioural alternatives that may arise.

The researcher will act as a facilitator and should be willing to learn from the participants and share knowledge with them. The facilitator will pose questions and highlight certain ideas but will by no means impose knowledge on the participants.

As said earlier the programme will take on a post-modern guise. The programme is based on four principles (Freedman & Combs, 1996):

- Realities are socially constructed.
- Realities are constituted through language.
- Realities are organized and maintained through narrative.
- There are no essential truths.

Participants of this programme will be asked to examine the contexts within which they live and to identify the dominant discourses in society. They will be invited to question “general knowledge” or any of the knowledges that we take for granted as “the truth”. Participants will also be asked to look critically at these discourses and how they influence personal behaviour. This may include a discussion on the times when the participants have acted against the requirements of the dominant discourses. It will also be important to explore the origins of these discourses and why these discourses are kept alive. The discourses and stories of different societies can also be compared.

Because the programme is based on post-modern ideas it will entail much discussion and self-reflection. Participants will be asked to comment on how they have experienced the programme and whether or not the programme has been meaningful for them.

A schedule for the prevention programme has been drawn up but it must be kept in mind that the programme is very flexible; therefore there will not be any time allocations for the various sections of the programme. These sections can also be swapped around or even left out if necessary.

The researcher aims to have between 15 and 20 participants in the programme. It has been decided to limit the numbers of participants to facilitate learning and interaction. The participants will often be asked to work in small groups and in pairs. The researcher will ask the participants to refrain from working in the same small groups over and over again. It is important

that participants mix with each other so that they can be exposed to new ideas and opinions. The researcher may also involve more facilitators in the programme.

The programme has been designed with adolescents and young people in mind. The researcher sees adolescence as falling between the ages of 13 and 21/22 and would like to make use of participants between the ages of 16 and 22. This closely parallels the ages of the participants in the focus group discussions. This age spread would make it possible to present the programme to schools as well as tertiary institutions. If older participants are uncomfortable with the term “adolescence” it can be replaced with another phrase or idea. The facilitator and participants can also discuss at what stage of development the participants see themselves in and whether or not these stages are necessarily linked to age.

6.2 PRELIMINARY BREAKDOWN OF THE PREVENTION PROGRAMME

6.2.1 The programme for day one

The first day of the workshop entails both discussion sessions and group and individual activities. The aims of the day include:

- Getting to know each other
- Highlighting personal stories that surround HIV/Aids
- Discussing stigmatisation
- Discussing the effect of the media on HIV transmission
- Discussing the role of personal choice.

Participants will be given the opportunity to debate ideas and to ask questions. The participants will have to bring their own stories and experiences into the session. There should be a communal building and sharing of knowledge.

1. Welcome and introduction:

The facilitator introduces herself so that transparency is maintained and so that the participants are aware of the facilitator's own expectations. The participants then get a chance to introduce themselves and to discuss their expectations of the programme. Notes are taken and at the conclusion of the programme the facilitator will refer back to these notes to ascertain whether or not all the goals and expectations of the participants have been met. If any expectations were not met, the facilitator will have to establish the reasons for this.

2. Ice breaker:

The facilitator asks the participants to break into dyads, hoping that this will make it easier for the participants to get to know one another. The facilitator also participates. Each participant is asked to interview the other person. Once this is done they will have to report back to the main group and share the information that they have learned. The participants are asked to concentrate on the more unusual characteristics of the individual being interviewed e.g., hobbies, dislikes or nicknames rather than on the usual questions like how old are you or what are you studying?

3. Discussion:

(Personal stories about HIV/Aids and stigmatisation)

The session begins with an informal discussion on HIV/Aids that allows participants to share their views regarding HIV/Aids. Participants are allowed to ask each other questions about aspects like transmission, economical consequences and ethical issues. Any clarification of medical concepts can take place if necessary. The facilitator makes sure that detailed notes are taken.

The participants are then asked to identify their own personal relationship with HIV/Aids based on the previous discussions e.g., what are your personal

views and how does this influence your behaviour? Participants can share this information with the group if they wish to do so. This feedback can be in any format e.g., a speech, collage or poem. This personal relationship is also used to discuss the stigmatisation of HIV positive people in South Africa e.g., does your personal story about HIV/Aids influence your views on HIV positive people?

Participants are then asked whether or not they have any specific image of a HIV positive individual or an Aids sufferer in mind. To do this participants are asked to break up into small groups and draw up a picture of the “typical HIV positive person”. The various viewpoints are then compared and discussed in the large group. The aim of this exercise is to identify common stories and ideas about HIV positive people and also to highlight the differences.

Various questions can be asked:

- What are the origins of these ideas?
- How are they kept alive?
- What influence does this have on your own behaviour?

The researcher can then introduce the idea of stigma or suspicion e.g., that some HIV positive people may knowingly infect other people. If the participants are willing to test their stereotypes, various questions like the following can be asked:

- What is the origin of this story?
- Is it necessarily true of all HIV positive people?

4. Break

5. Discussion:

(Speculation and its effect on behaviour)

The facilitator starts this session with a question:

“Shall we discuss stories/theories/notions/truths/myths regarding HIV/Aids?”

The facilitator gives her own examples to illustrate the meaning of the question e.g., “Aids is a black/homosexual disease” or “Aids is a death sentence”. This should then open the way for a discussion on the speculation that surrounds HIV/Aids.

This discussion should also involve the deconstruction of the myths and misconceptions that surround HIV/Aids. Participants can also be asked to speculate about the origins of these stories. If possible, participants are asked to identify specific stories that they have heard about HIV/Aids e.g., it is a disease that originated in monkeys. Participants can be asked why they think these stories exist.

The effect that these ideas have on people’s behaviour should also be emphasised. Does it hinder or facilitate the prevention message? The facilitator can use the following case study to illustrate the point that she is trying to make:

Jenny is working with a group of young people. Somebody asks about the origins of HIV/Aids and the group quickly lapses into conjecture and media inspired stories. In a short while, they are looking for scapegoats and blaming others. They all feel better now that they do not have to take any personal responsibility. Why is that? (Dixon & Springham, 1991)

The facilitator can then use this case study as the stimulus for a discussion on how myths and speculation can influence behaviour.

6. Break

*7. Discussion and activity
(Media and personal choice)*

Questions are then asked about the role that the media plays in the story of HIV/Aids. Participants are asked to go through magazines and identify the meanings and messages behind the advertisements in the magazines. The aim of this activity is to highlight to the participants that these messages are created by people to achieve a specific goal. It is possible to identify the ideas or messages behind what is being sold or promoted. Hopefully, this will serve to undermine somewhat the perceived power of the media and to illustrate that certain messages can be ignored. Participants will also be asked to reflect on whether or not these advertisements influence their behaviour. The facilitator can also tape some advertisements, music videos and television programmes and ask the participants to watch these. They can be studied in the same manner as the magazines are. Who created this message, why was it done in this fashion and what is the message behind it?

If participants say that either the magazine or television advertisements have an influence on their behaviour the facilitator can ask them to explain why this is so. The same could be done with a negative answer. Participants can also be asked if there have been times when they have not followed the suggestions of the media.

The facilitator can also focus on questions such as:

- When did the media gain so much power?
- Has the media always been so powerful?
- Who created the media?
- Can the media be used as a prevention tool?
- What are the positive aspects of the media?
- What positive impact can the media have on prevention?

Once again, the participants are asked to break up into small groups and discuss the impact of the repetition of the prevention message, i.e. repetition leads to boredom. If groups feel that it has a negative effect they are asked to come up with some ideas on how this can be combated.

This discussion can then be linked to the idea of personal choice, which most of the focus groups felt very strongly about.

Part one: A discussion will be held with the entire group on what exactly personal choice means and whether or not they believe that it is possible.

The facilitator can ask questions like:

- How does one go about making a decision?
- When is it easy to make a decision and when is it not?
- What takes away the power to make a personal choice?
- What gives people power to make personal decisions independent of something like the media?
- How does personal choice influence the transmission of HIV/Aids?

If participants have not already mentioned the role of peer pressure, the facilitator can introduce the topic now. Participants can remain within the large group and discuss aspects pertaining to peer pressure. They can also share ideas and strategies about reducing the power of peer pressure. Participants can also be asked to highlight the positive aspects and functions of peer pressure.

Part two: Once the group discussion is over the participants work on their own. They are asked to think about these questions and what the group said and then to draw a picture of their relationship with personal choice. Participants are asked to think about the reasons why they are capable or incapable of making their own decisions. They should not only focus on the media. Feedback is optional. In this picture the participants should include the external aspects that facilitate and make personal choice difficult. Once they have completed this drawing, they need to think of a few strategies that may help them overcome any obstacles to personal choice.

7. Break

8. Closing

Participants are asked to give the group some feedback regarding the effect that personal choice, the media, speculation and stigmatisation have on the transmission and spread of HIV/Aids.

Once the discussions have ended participants are asked to evaluate whether or not the day has been a meaningful experience. Participants are requested to come up with a metaphor to describe their experiences of the day, which will be shared with the class the next day.

6.2.2 The programme for day two

Day two consists of much discussion but there is also a large amount of role-play. The aims of the day include:

- A discussion regarding the personal metaphors
- A discussion surrounding the possible relationship between gender and HIV
- A discussion on the stories surrounding condoms, abstinence and adolescence and the effect that this has on HIV transmission
- A discussion on the effect of feelings of powerlessness and how feelings of personal power could be restored.

Participants will be given the opportunity to debate ideas and to ask questions and they will have to bring their own stories and experiences into the session. There should be a communal building and sharing of knowledge.

1. Discussion

(Metaphor)

Day two will begin with a discussion of the previous day's task. The participants are asked to discuss their experiences by using the metaphor that they have created.

2. Discussion and activity

(Gender and the spread of HIV/Aids)

The facilitator introduces the idea of gender into the conversation and the possible role that it plays in HIV transmission by saying something like

“It seems as if women are more vulnerable to HIV infection because of gender“. The facilitator lets the participants respond to this.

The aim is to get the respondents talking about aspects such as gender roles, expectations and the beliefs that surround sexual practices. This will entail a short discussion. Once this is complete the participants will be asked to break up into small groups and design posters that depict both gender roles, i.e. “what is a man” and “what is a woman”. The groups then compare and discuss the various posters.

Once this discussion is complete the facilitator introduces role-play. Two participants are asked to “change gender for a few minutes” and experience what it feels like. The facilitator can either create a specific situation e.g., your girlfriend has just told you that she is pregnant or HIV positive, or just let the participants dictate the course of the role-play. The role-play will be very interactive as participants are free to ask questions and make suggestions. The role-play is followed by a discussion. In the discussion role-play participants can be asked to explain what it feels like to be a man or a woman. The facilitator can also ask the participants if there are any alternative options for the role-players to follow. The role-play can then be redone using different tactics.

The session ends of with the participants working on their own and using the time to reflect on their own beliefs about gender and how this affects their behaviour. Participants can use any format that they like. Feedback to the whole group is optional.

3. Break

4. Discussion and activity

(Condoms, abstinence and adolescence)

The facilitator then introduces condoms into the discussion, as they also seem to be linked to the gender question.

In this discussion it may be important to talk about condom usage and discuss the stories that surround condoms. The participants can ask each other questions and explore the various ideas that are raised. Although the facilitator is not an expert, it may be important to have some scientific knowledge available on the effectiveness of condoms. The facilitator asks the participants to break up into small groups and to brainstorm some questions regarding condoms:

- What aspects influence whether or not you use condoms?
- How do you feel about the effectiveness of condoms?
- What are the difficulties regarding condom usage?
- What are the benefits of using a condom?

The aim of this activity is the sharing of knowledge. Once the groups have come up with some answers feedback is given to the whole group.

Because there may be very negative connotations attached to condom usage Kelly (1995) has developed an activity that the facilitator can make use of. Participants stay in their groups and then list all the negative ideas linked to condom usage. They are then asked to re-label the statements in a more positive or countering manner e.g., “condoms imply a lack of trust” can be positively redefined as “using condoms is the best way to show someone that you care about them” (Kelly, 1995). The aim of this activity is to consider the benefits of condom usage that may not be perceived by the participants, i.e. they may currently only see the problems with regards to using condoms and therefore not the benefits of using them. The aim is to help the participants

develop a “pro” and “con” list. Also, it may help to put certain worries about the safety and effectiveness of condoms into context.

Once this is complete role-play is introduced. Two participants are asked to role-play a situation where a condom is introduced. Again, participants can choose their own context or the facilitator can give a few options. The role-play is done in front of the entire group. Examples that the facilitator can give include:

- Negotiating condom usage on a first-date.
- Negotiating condom usage in a long-term relationship.
- Persuading a partner to use a condom.
- Negotiating condom usage with a partner who has a negative attitude towards condoms.

The aim of this activity is to practice interpersonal skills and negotiating strategies. The role-play is subject to discussion where all the participants can make suggestions. The role-play can be re-done if the participants wish to do so, applying new strategies.

The facilitator then introduces the story of abstinence by asking a question and allowing the participants to answer.

“Are condoms the only way to protect yourself from HIV/Aids?”

Again, the entire group breaks up into smaller groups to discuss abstinence. The groups are asked to brainstorm the benefits and disadvantages of abstinence. The small groups give feedback and ideas can be compared and discussed. It may be beneficial to introduce the stories of outsiders who have abstained and those who have not, in the conversation. These individuals can share their stories with the group and should be willing to answer questions. With this step the facilitator is making use of modelling as well as direct experience.

Participants return to their small groups to discuss the next topic. The facilitator then introduces the concept of adolescence. The facilitator should explain the meaning behind the idea and if all the participants are in agreement the session can continue. If some of the participants do not like the term then there should be further discussions to find an agreed upon idea.

The small groups can be asked the following questions about adolescence:

- Does adolescence have any kind of influence on abstinence?
- What is adolescence?
- What are you allowed to do in adolescence?
- What are the difficulties of adolescence?
- Is there are relationship between HIV transmission and adolescence?

The small groups can then debate and compare their ideas with the other groups.

At the end of the discussion the facilitator asks the participants to find out where condoms are available in their community and what types are obtainable. They will have to report back the next day.

4. Break

5. Discussion and activity

(Powerlessness and self-efficacy)

Participants now have to work on their own. They are not to collaborate with anybody else.

One of the themes that was highlighted in the focus group is the notion of powerlessness e.g., there is nothing I can do to protect myself from infection. The aim of this session is to try and instill a sense of power, i.e. I am in control of my life and there is something that I can do to protect myself.

Participants are asked to think about the ways in which they can protect themselves from infection. The facilitator asks the participants to take the day's discussion into account and then develop their own personal prevention programmes, tailor made by themselves for themselves. They should do this on their own. This will ensure that prevention is relevant to the participants. The facilitator also mentions that if participants struggle to do this they must try to identify the reasons for this. Participants are also asked to reflect on whether or not feelings of powerlessness influenced the development of their personal prevention programmes.

6. Closure

Participants are also asked to review their metaphors and see if they are still relevant to the process.

6.2.3 The programme for day three

Day three is the final day and consists of discussions, activities and role-playing. The aims of the day include:

- A discussion of personal metaphors
- A discussion about the personal prevention programmes
- A discussion about other methods of transmission
- Direct experience
- Role-playing
- A discussion around voluntary testing
- A question and answer session.

Participants will be given the opportunity to debate ideas and to ask questions. The participants will have to bring their own stories and experiences into the session. There should be a communal building and sharing of knowledge.

1. Discussion

The day starts with a discussion based on the previous day's experiences. Participants are asked about their metaphors and if any changes have been made to them. Participants are asked for feedback concerning where condoms are available in their communities.

2. Discussion

(Personal prevention programmes)

The discussion then turns to the personal prevention programmes. Each participant is asked to share their programmes if they would like to. The facilitator and other participants are allowed to ask questions. The facilitator feels that it may be useful to ask questions such as

- What will have to happen so that you stick to this programme?
- Do you foresee any difficulties to sticking to this plan?
- How will the outside world respond to this plan?
- Why did you choose to include these aspects in your plan?

The aim is not to criticize plans but rather to place them in the context in which they will be occurring. It may be important to emphasise to the participants that not everybody may react favourably to these changes. Participants are then requested to identify a few statements that they can say to themselves when they feel vulnerable to risky behaviour (Kelly, 1995). These statements can act as a motivation to the participants. These statements can be written down and shared with the group if the participants are willing to share.

The participants are then asked to turn their attention to the rural areas. The participants break up into small groups and are asked to discuss the situation in the rural areas. They are also asked to give feedback on possible ideas that

can be used in the rural areas. Participants are also asked to keep in mind what they can do personally.

3. Discussion and activity

(Other methods of transmission)

Participants are asked to divide into small groups and brainstorm together about any other factors that may influence the spread of HIV/Aids. Together the group can design a poster, slogan, collage or story to illustrate the relationship between this aspect and HIV/Aids. The results are shared with the other participants and ideas and themes are debated.

Once this is complete the participants are asked to work on their own and make use of some self-reflection. Participants are asked to think about times when they have placed themselves in vulnerable positions and what caused them to do this. There can be various reasons for this including aspects like alcohol or drug abuse or even feelings of depression and loneliness (Kelly, 1995).

Once participants have identified these times they should then see whether or not their personal prevention programmes have included these aspects. They can be given some time to revise their own programmes if necessary.

Participants can also be asked to identify what behaviours they would not want to repeat again in future (Kelly, 1995). They can also identify ways in which they are going to make this happen.

4. Break

5. Discussion and activity

(Modelling/direct experience)

A speaker who is HIV positive is introduced to the group. The speaker will have to be very carefully chosen so that the group can relate to this person.

The group has the opportunity to listen to the speaker's story and also to ask questions. To encourage interaction, the facilitator also asks the speaker questions.

An individual who is HIV negative is also present. The reason a HIV negative person has been introduced is so that participants have the opportunity to ask this individual about the steps that he or she has taken to remain so. The aim of this exercise is to make behaviour change seem less impossible and daunting. This individual should be someone who has made drastic changes to their life e.g., an ex drug addict or someone who changed their sexual habits or lifestyle in order to protect themselves. This will give the participants the option to ask about why this individual made these changes and whether or not they have managed to sustain the new behaviour.

The facilitator can stimulate the conversation by asking questions like:

- Was it difficult to change your behaviour?
- How did other people react to your behaviour change?
- What do you miss most about your previous lifestyle and how do you deal with this?
- Did you have to change all aspects of your life?
- Do you feel that the change has been worthwhile?

In this session the facilitator also includes a parent of a HIV positive child in the discussion. This parent can explain how HIV/Aids affects their relationship with their child. The parent would need to be very comfortable in answering these questions and would need to respond to questions in a calm and non-judgmental manner.

To stimulate the conversation the facilitator could ask questions like:

- Did you discuss HIV/Aids before your child was infected?
- Do you feel that it is beneficial to discuss HIV/Aids with your children?

- How do you feel about HIV/Aids?
- What is your relationship like with your child like?
- How did you respond when you found out that your child was HIV positive?
- What advice would you give to young people when it comes to HIV/Aids?

At the end of the session there is a group reflection on the discussions. Participants discuss the aspects of the conversations that they found to be insightful and meaningful.

6. Break

7. Activity

(Role-playing)

Part one: This session begins with a role-play. The facilitator asks the participants to choose any topic linked to HIV that they feel may be important to role-play. The facilitator takes a back seat in this discussion and allows the participants to direct this session. If participants struggle to identify certain issues that they want to role-play the facilitator can suggest the following topics (Kelly, 1995):

- If dating, or in a relationship where sex is expected to occur on the first date, raise the topic of HIV/Aids and safe sex.
- Have a conversation with a partner about intended condom usage or refuse to have unprotected sex.
- If confronted with unwanted sexual advances, decline the offer.

Part two: The facilitator then introduces a topic. The group is asked to discuss the effect that HIV/Aids has on relationships. Once this is done they can decide on a topic or scene that they want to role-play. Options include:

- Asking a partner about their HIV status.
- Disclosing their status to somebody else.

8. *Voluntary testing*

The facilitator will undertake a discussion with the entire group of participants concerning voluntary testing and the effects of knowing your own personal status. The facilitator can ask questions like:

- Is it important to know your personal status?
- Why do you think people are afraid to find out about their own status?
- What do you want your life to be like in 5 years? What are your personal, relationship, work and family goals? What will your life and plans be like if you find out that you are HIV positive? (Kelly, 1995)
- What does it mean to test positive?
- What does it mean to test negative?

9. *Break*

10. *Discussion*

(Questions and answers)

This is followed by a question and answer session. Here the participants can ask each other or the facilitator questions. They can also highlight any topics that they feel still need to be covered or they can refer back to previous discussions.

11. *Closing*

The last session involves a final discussion of the metaphors and any parting thoughts that the participants may have. These parting thoughts may include any comments or suggestions. The facilitator also refers back to the notes taken on the first day to make sure that all expectations have been met.

Participants are given some time to design their own participation certificates. Feedback to the group is optional. This is done further to strengthen feelings of self-efficacy and personal agency.

Once this discussion is complete it is time for reflection. The facilitator asks each participant to write a letter discussing his or her experiences regarding the programme. These thoughts can be shared with the group if the participant wants to share. Letters can be written anonymously and will be given to the facilitator at the end of the session.

The facilitator will make sure that all the participants have her details and that they know that they can contact her at a later stage if necessary.

6.3 CONCLUSION

When looking at the programme the researcher hopes that it covers all the ideas and themes highlighted in the focus groups and in the literature review. The researcher also realises that the programme is very long and time-consuming. Much is expected of the participants but the researcher is of the opinion that people need to begin with themselves if prevention is to get anywhere.

CHAPTER 7

CONCLUSIONS, RECOMMENDATIONS AND IMPLICATIONS OF THE STUDY

7.1 INTRODUCTION

In this final chapter the researcher will look back at her research and highlight some important thoughts. This will begin with a recapping of the aims of the study followed by a highlighting of key issues emanating from the focus groups and from the literature study. Even though the prevention programme has not yet been implemented, the researcher would like to compare the prevention programme to important prevention principles highlighted by certain authors. Once this has been completed she will turn her attention to the flaws of this study as well as the implications. The chapter will be concluded with some recommendations.

7.2 AIMS OF THE STUDY

7.2.1 Specific aim

The specific aim of this study was to investigate why risk-taking behaviour had not been curbed and why the HIV infection rate is still increasing. Other aims were to identify the reasons for lack of behaviour change and the obstacles that make behaviour change difficult. This information was studied and used as the foundation for the development of a future prevention programme.

7.2.2 General aims

The ultimate aim of this study was to contribute knowledge to the fight against HIV/Aids. One of the aims of this study was to create a clear image of how South African's deal with HIV/Aids and what affect it has on their lives. Ultimately the aim was the development of a new HIV/Aids prevention

programme. A preliminary outline of the programme was drawn up in this study but it will only be tested at a later stage.

7.3 FINDINGS FROM THE EMPIRICAL RESEARCH: THE FOCUS GROUP DATA

The researcher would like to highlight some significant themes that stood out.

7.3.1 Personal Choice

This point was raised very vocally in all three focus groups. The implications of this for any prevention programme are serious. It means that no prevention programme could really claim to be one hundred percent successful because behaviour change can never be guaranteed. People are not inactive beings and they can choose to disregard any new information no matter how comprehensive or well developed. Therefore, as stated earlier the aim of this programme is not top change behaviour but rather to widen the participant's horizons. Also, not everybody may feel that they have the freedom to make personal decisions and one of the aims of the programme is to help such individuals.

Context may also influence personal choice. In certain contexts some participants may feel more empowered than in others, therefore they would not follow through on the ideals of the prevention programme. In some contexts they may be forced to act in certain ways even though they do not want to do so.

7.3.2 Angry people

Another idea that stands out for the researcher is the notion of "angry" HIV positive individuals who maliciously spread the virus. This notion goes to the heart of everyone, the fear that somebody out there wants to harm us. Why should HIV positive people want to hurt anybody else, why should they be angry? This belief may play a very large role in the stigma that surrounds HIV.

Even though this data was collected from a very small amount of people it still raises a very interesting point that could be investigated further. If this idea prevails in a much larger section of South Africa's population then it is better for people not to disclose their status because if they do they are immediately labelled "dangerous and angry". This idea is linked to the notion that HIV/Aids is a death sentence. Yes, the disease does kill but there are also documented cases of individuals who have lived with the disease for years. It may also be related to the idea that as soon as you are infected you cannot carry on with your life as you normally would. You cease to be a person and you become an "infected" person who is waiting to die.

7.3.3 Condoms

From the focus groups, it seems as though there is a very negative stigma attached to condoms and their effectiveness. Using condoms is advertised as the principle way of protecting yourself from HIV, therefore it is worrying that people have such a pessimistic outlook on using condoms. Nothing really positive was said about using condoms and the fact that many people are embarrassed to talk about or buy condoms may also make the situation more difficult.

7.3.4 Powerlessness

The researcher also feels that this feeling came through in the focus group discussions. The researcher is referring to the idea that people know how they should protect themselves but at the same time they see the proposed methods as unrealistic, irrelevant and ineffective. This could possibly lead to feelings of frustration and fatalism. This can be linked to aspects like condom usage, trusting people and abstinence.

Also, the comments on adolescence and the irresistibility of sexual experimentation during this stage has also struck a cord with the researcher because it repeats the theme of powerlessness, i.e. people are unable to control their sexual urges. If this were the case then it would make prevention

among young people very difficult because it would be a case of “the prevention message versus unstoppable biological and cultural urges”.

7.3.5 Peer pressure

Peer pressure can be positive but overwhelmingly the majority of participants viewed it as a negative occurrence. It is not a new occurrence but one has to wonder if it has become harder to resist, especially with the rise of the information age. Included in this theme is the need to “fit in”. Peer pressure and this desire to be “in” or “cool” can, according to the participants, lead to sexual experimentation.

7.3.6 The media

The media was another important aspect highlighted quite emphatically by the focus groups. Does the media really have such a powerful effect on human behaviour? Or is this something that we are taught to believe? According to the focus groups the media has a very damaging effect on people, especially on young people as it may encourage them to experiment sexually. Everyday we are bombarded with information in books, magazines, on the radio and television and the Internet. So, does it mean that it has become more difficult to resist adopting the messages of the media? Has it become more difficult to an individual to make up his or her own mind? The researcher also wonders whether the perceived power of the media is something that lessens, as people get older.

7.4 FINDINGS OF THE LITERATURE REVIEW

Although the findings from the literature review were combined with the findings of the empirical research, there are several important points that the researcher would like to highlight. While writing the chapter it occurred to the researcher that many of these theories seem to be interlinked and many ideas appear in more than one theory, very often with a different name.

For the researcher the literature review identified a few key ideas that may be crucial in behaviour change. It is these key elements that she has tried to include in the prevention programme. What follows is a short discussion on these important ideas.

7.4.1 Observance

From the moment we are born we are observers. We take note of what is happening around us and very often we learn through watching others rather than through direct instruction. We can watch the results of behaviour and then come to our own conclusions. The Social Cognitive Learning Theory places much emphasis on modelling and the use of relevant models. Modelling implies learning from others and the Differential Association Theory echoes this sentiment. The possibility of learning from others seems to be infinite. This theory states that mere association with other people can be a learning opportunity. It is also important to take note of the fact that observance can act as a counter to behaviour change. According to the Social Inoculation Theory, factors like social pressures or the desire to fit in can make people immune to behaviour change.

The Social Cognitive Learning Theory also describes a “learning process” and that implies that learning does not always occur overnight and that behaviour change may take some time.

7.4.2 Direct Experience

Being in a situation where one can directly see the need for change may also be very beneficial to behaviour change e.g., by going to a hospice, working with Aids orphans or speaking with someone who is HIV positive. This direct experience could be achieved through modelling, role-playing, and actual experience. The Social Cognitive Learning theory states that we learn through direct experience and Narrative Psychology states that we give meaning to our experiences and that together these experiences serve to create a coherent and consistent story of our lives.

7.4.3 Self-efficacy

This is probably one of the most important aspects in behaviour change and links with the theme of powerlessness. Self-efficacy could probably also be referred to as personal agency, a term used by Narrative Psychology. It refers to whether or not an individual feels capable of performing a specific action. Without this belief in yourself, you may not feel motivated to change your behaviour or even perform a specific action. The Social Cognitive Learning Theory relies very heavily on the idea of self-efficacy stating that it can be increased through modelling. The Extended Parallel Process Model also states that if people feel that they do not have the capabilities to perform an action they may give up and no behaviour change will occur. It could lead to aspects like denial of susceptibility. People need to be told how they can protect themselves and these methods also need to be realistic and achievable. In Narrative Psychology the aim is to highlight to people that they are capable of overcoming a problem and that they themselves are not the problem. Rather, they can see themselves as having a relationship with the difficulty. In the Cognitive-Behavioural Paradigm the focus is on the removal of self-defeating thoughts that may have a negative effect on self-efficacy. Together the client and the therapist define a set of realistic goals and achievement of these goals may have a positive effect on feelings of self-efficacy. It is almost as if the client proves to himself that he is capable of doing things.

Self-efficacy also implies that people are willing to take on responsibility for their behaviour and are prepared to make the effort to change. People need to be able to motivate themselves and be ready to take the first step.

7.4.4 Man is an active being

Most of the behaviour change theories discussed view man as an active being who gives meaning to what he experiences. Most of the theories view man as an energetic being who questions, evaluates, compares, ignores, listens and remembers. People are unique and have their own set of expectations.

People are also influenced by the outside world, expectations and occurrences like peer pressure. When it comes to behaviour change it should be kept in mind that in the end the individual still has the power to accept or reject any new information or prevention programme.

7.4.5 Barriers

The Health Belief Model states that when it comes to behaviour change we need to take a look at possible barriers to change. For the researcher it is important to remember that although many barriers may be external, a lot of the barriers reside within ourselves. These psychological barriers can refer to feelings about personal susceptibility, the severity of a problem and even the perceived benefits of a new action. Psychological barriers could also include feelings like fear and uncertainty. Perceptions on how other people are going to react to the changes may also play a crucial role, as mentioned in the Theory of Reasoned Action. The researcher is reminded that these barriers may not be easy to overcome and people may need some time to work through them. Ineffective cognitive strategies according to the Cognitive-Behavioural Approach can also be considered psychological barriers.

Other barriers that reside in the external world, according to Narrative Psychology, are discourses. These discourses can have a strong impact on people especially if they have become internalised. Discourses have the capacity to change the course of people's lives and the meaning that they give to their experiences. So, if the prevailing discourse on condom usage is very negative, then it may dissuade people from using condoms. How does one overcome these discourses? Probably by critically looking at the world and asking questions.

7.4.6 The outside world

The reaction of others to behaviour change also seems to play a vital role. The Social Cognitive Learning Theory talks of direct and vicarious punishment. This may make behaviour change very difficult to sustain or even

attempt. The Health Belief Theory identifies physical barriers that may make it very difficult to sustain behaviour change. Associating with people who question or challenge the new behaviours may also make things very difficult for the individual. The desire to conform, or at least fit in with the external world may also make behaviour change complicated. Peer pressure may have a very powerful effect in this regard. The Social Inoculation Theory states that very often people who do not have the skills to resist unhealthy behaviour fall prey to peer pressure.

7.4.7 Change is possible

Change is possible, according to most of the learning theories discussed in chapter five. It may take time and it may not be easy but most view change as achievable. Change comes in various forms and may be different for each individual but if the person chooses to do so, it could very well be possible.

7.5 THE RESEARCH QUESTIONS

The researcher will now combine both sets of data and use the information to answer the research questions.

Question one: Why are people not changing or adapting their risky behaviour in order to protect themselves from HIV/Aids?

- A lack of feelings of self-efficacy, a belief that one cannot protect oneself.
- Feelings of powerlessness and fatalism, i.e. we are all going to die anyway, so why bother? This can also be linked to self-defeating thoughts.
- A lack of positive role models who “practice what they preach”.
- Negative responses to behaviour change.
- A feeling that personal choice is being undermined or influenced negatively by the media or peer pressure.

- Not perceiving a need for change.
- Negative expectations
- Negative connotations regarding condom safety and effectiveness
- Negative connotations attached to the advice and help that parents may offer.
- Parents who may be unwilling to talk about certain matters or who are too overprotective or judgmental.
- The perception that behaviour change may lead to relationship difficulties.
- Denial or scapegoating others.
- Speculation and accepting various theories regarding HIV/Aids that may minimise feelings of personal susceptibility.
- Stigma
- The gender roles and expectations attached to these discourses.
- Adolescence - referring to the belief that young people cannot resist sexual urges.
- The negative discourse that surrounds abstinence.
- The media that promotes sexual behaviour inferring that to be cool and to fit in one has to be sexually active.
- An inability to resist peer pressure.
- A lack of information in the rural areas.
- Excessive alcohol and drug usage.

Question two: What will motivate behaviour change?

- Positive and reliable role models
- Direct contact with people (first-hand knowledge) who are already HIV positive or who have AIDS
- Feelings of self-efficacy, i.e. I am capable of changing my behaviour.
- A desire to change behaviour
- A willingness to take responsibility for actions
- More discussion and focus on abstinence

- Parents who are willing to share information and ideas with their children
- Personal choice - when a decision is made free from the influence of peers and the media
- Practising new skills and strategies
- Speaking to and learning from others
- A willingness to test and challenge stereotypes.

7.6 DISCUSSION OF THE PREVENTION PROGRAMME

The researcher would like to compare the newly developed prevention programme to the criteria of DiClemente and Peterson (1994). According to DiClemente and Peterson (1994), HIV/Aids prevention programmes should have three major components. These components are:

- Information: People's knowledge and awareness of health risks need to be improved. People need to know about aspects like the transmission of HIV.
- People need to be given the opportunity to develop self-protective skills and strategies on how to control and improve self-efficacy. People need to develop effective prevention actions of their own.
- A programme should help to develop social support for personal change. Programmes should take note of socio-cultural realities and the restraints that this poses on self-protective behaviour. Deconstruction and discussion may be useful here.

Van Dyk (2001) also has several criteria for a prevention programme. According to Van Dyk (2001) prevention programmes should not only be aimed at the prevention of HIV/Aids but should also equip people with the necessary life skills that will change attitudes. Programmes should empower people to protect themselves and to care for those who are already infected. Looking at the newly developed prevention programme, the following can be highlighted. The researcher's programme does not aim to pass on scientific

knowledge. It is the assumption of the researcher, backed up by the answers of the focus group participants, that people are aware of how HIV is transmitted and how to protect themselves from the disease. Most of the focus group participants knew how HIV is transmitted and how it is not. The researcher will try to answer any questions that are asked about this topic in the session but this is not the main aim of the programme. The information that the programme hopes to impart is more focussed on interpersonal and negotiating skills.

The newly developed programme is aimed at giving participants the opportunity to develop self-protective skills. How can this be done? Discussion, debate, deconstruction and modelling can be used as tools for this purpose. By watching somebody else handling a tricky situation a participant may learn a new strategy, or by deconstructing a certain way of doing things participants can be introduced to alternative ways of behaving. The researcher feels that this is very important because it is of no use to pass on information if people feel that they cannot use or apply this new knowledge.

By practising and developing strategies and skills one would strengthen feelings of self-efficacy. Modelling and role-playing can be very effective with regard to corrective feedback and guided practice (DiClemente & Peterson, 1994). It can be used to teach people about how to deal with aspects like resisting unwanted sexual advances, or how to talk about sexual matters and contraceptives.

The researcher has also taken socio-cultural realities into account when developing the programme. During development this was accomplished by using the ideas of the focus group participants. Also, the participants who take in the new prevention programme will be asked for feedback. Therefore, the programme may undergo some changes. Several of the activities like the role-plays will be generated by the participants themselves therefore they should reflect the world of the participants.

When looking at social support for personal change it is hoped that participants will leave the programme with a changed attitude or new ways in which to interact with the world. This means that they themselves may change the way in which they support others. They may be willing to contemplate new ways of behaving. Therefore, in this way the programme could facilitate the development of support for social change.

The researcher's prevention programme is not only aimed at equipping people with skills but it requires much self-reflection. The participants are asked to think about their own behaviour, values and attitudes. They are also asked to consider how these aspects influence their own behaviour e.g., do my beliefs about HIV/Aids influence how I respond to HIV positive people?

Van Dyk (2001) lists two further criteria that prevention programmes need to fulfil:

- People living with HIV/Aids are often the best advocates for behaviour change. The newly designed prevention programme does include the stories and ideas HIV positive individuals.
- Prevention programmes must be conceptualised so that they are sensitive to local customs and cultural practices. Traditional African beliefs and customs should be taken into account when developing prevention programmes. The new prevention programme is based on the ideas of the focus group. Because the facilitator does not take on the role of sole expert the programme is very flexible and can be changed to include any aspect, behaviour or custom that the participants would like to include.

When looking at Whiteside and Sunter's (2000) classification of prevention programmes we can see that the newly designed programme falls within the "KAB" interventions, i.e. knowledge, attitude and behaviour.

The aim of the programme is to get people involved in challenging existing beliefs and to encourage people to ask questions. In the prevention programme opinions, are highlighted and shared in an attempt to uncover new stories and ideas. The aim of the programme is for people to leave with some new ideas or thoughts but if a participant chooses to leave without any new ideas then that is their choice. One cannot force people to think in the same way or adopt new ideas if they are not willing to. “Deconstruct, debunk and demystify” would be the three main aspects that characterize this programme

7.7 FLAWS AND DEFICIENCIES IN THE STUDY

There are several limitations to this study. First, the type of sample used may limit this study's transferability. All the participant's used were students at the Pretoria Technikon and similar in age. Therefore, the results may not be applicable to all contexts. Transferability will also be improved once the programme has been implemented and evaluated by future participants. The researcher has attempted a comprehensive description of the research results by looking at as many themes and constructs as possible but she feels that only once the programme has been implemented can transferability really be assessed. The fact that many of the suggestions made are based on the personal experiences of the participants may also make transferability more difficult.

Second, even though the students are all studying at the Pretoria Technikon they do come from varying backgrounds and this may have influenced their viewpoints regarding HIV/Aids. It was not possible for the researcher to examine and explore all of these stories.

Third, there may have been some students who, for various reasons, did not feel that they could speak up in the focus group discussions. Therefore, their contributions would not have been included in this study. Participants may have felt that they did not know or trust the researcher enough to disclose their ideas.

Fourth, the large size of the focus groups may also have made it difficult for the researcher to collect everybody's stories and to explore all the participants' ideas fully. Some stories may have got lost in the process. Also, because the researcher only conducted a single session with each group she did not get the opportunity to go back to the students and collect and research more stories. The fact that the researcher conducted only one session with each focus group could have had a negative impact on the credibility of the study. The researcher did, however, clarify and test interpretations with the participants during the focus group sessions and make use of multiple readings.

Fifth, behaviour change is a very complex process. Many differing variables can play a role in this process. Although, the researcher does offer some explanation as to why behaviour change may not occur, this is by no means a final answer to the question.

7.8 THE RESEARCHER'S PERSPECTIVE

At this stage the researcher feels that it is important to state her opinion regarding the spread of HIV/Aids. She feels very strongly that the spread of the disease needs to be curtailed as soon as possible. In fact she often refers to the "war/fight" against HIV/Aids. Although, this is probably a good summary of the researcher's own personal feelings towards HIV/Aids she is aware that for many people HIV/Aids is not an important issue. Knowing and understanding her own motives has helped the researcher avoid judgmental and categorical thinking. It reminded her of the fact that there is no single truth and that people give different meanings to the things that they experience. Thus, no story should simply be discarded or ignored instead, people should be given the opportunity to discuss, debate and disagree. Trying to impose your ideas on others may be futile or even very damaging.

To ensure the credibility of her research the researcher tried to submerge herself in the data and look for links and themes. No interpretation was made lightly and the researcher tried not to stray from the ideas and thoughts of the

focus group participants. This was done to ensure that the prevention programme is as relevant and useful as possible. The researcher queried and checked ideas with colleagues and was flexible and open to suggestions. She was careful to note the differences between the three focus groups and did not expect that the responses would be similar. The researcher did not impose any of her ideas on the focus groups nor did she label any thoughts as correct or incorrect.

While doing this study the researcher also experienced personal growth as she was exposed to new ideas and new ways of thinking. Through the research she could get a glimpse of the participant's experiences. This gave her food for thought and raised several questions. Listening to the stories of others was very enlightening.

7.9 IMPLICATIONS

For the researcher one of the biggest implications of this study is the fact that anybody interested in developing prevention programmes needs to make sure that the programme is relevant and usable. The programme needs to be understandable and its messages should be direct and unambiguous. Making use of credible role models or people who have come into contact with the disease is one way of trying to keep programmes relevant. These programmes also need to be available in all areas of South Africa.

The role of condoms needs to be discussed because there seems to be a hesitancy to use them. Speculation about condoms abounds. It is possibly a good idea to spend some time focussing on condoms in a prevention programme, answering questions and explaining certain concepts. It may be that condoms need to be marketed more aggressively, i.e. people need to be more comfortable with the idea of talking about and using condoms. Debating and talking about condoms in a prevention programme may be helpful in this regard. In a prevention programme it is also important to identify where participants can get condoms. The benefits of condom usage also need to be advertised rather than just instructing people that they need to use condoms.

This study also highlights the importance of discussing the role that parents need to play in HIV/Aids prevention. All three the focus groups struggled with the idea, but parents cannot be left out of the equation as they are also affected by the epidemic. Often, parents of HIV positive children make very good advocates for motivating behaviour change.

Although only mentioned by one participant in one focus group, the role that alcohol and drug abuse play in the spread of HIV also needs to be examined and discussed. Not only is HIV spread through intravenous drug usage but very often alcohol and drug abuse leads to dangerous sexual behaviour e.g., being drunk can lead to a loss of inhibitions. More emphasis needs to be placed on breaking the link between these two aspects and individuals need to recognize the behaviours that make them vulnerable to infection and identify ways in which they can protect themselves at these times.

The role of the media was hotly debated. Yes, maybe the media does use the idea of sex to market products but when did we loose the ability to stand up to the media and make up our own minds? Many behaviour change theories would have us believe that we are not passive beings but rather that we are beings who give meaning to experiences and that we react to change. So, should we not have the capacity to make independent decisions?

Another implication of this study is the fact that HIV needs to get a face. By this the researcher means that people need to be introduced to HIV positive people. There needs to be an opportunity for face-to-face interaction be it through a public speaker or at a hospice. By doing this, a programme creator will also lend some credibility to his or her programme because these individuals can work as health advocates.

An essential fact highlighted by this study is that people need to begin with themselves and their own behaviours. To make effective decisions and to change behaviour people need to be aware of their own feelings, attitudes and thoughts regarding HIV/Aids and how these aspects affect their own

behaviours. People need to understand what their motives are and whether or not they actually want to change their lifestyles.

Further implications are that to improve the effectiveness of HIV/Aids prevention it is important to enhance interpersonal efficacy rather than simply rejecting a specific behaviour (DiClemente & Peterson, 1994). The major difficulty is not teaching people safe sex behaviours but rather it is equipping them with the necessary skills and self-confidence that will enable them to put the guidelines into action even in the face of counteracting influences (DiClemente & Peterson, 1994). Difficulties arise because self-protection often conflicts with interpersonal pressures and sentiments (DiClemente & Peterson, 1994).

When discussing prevention it is also important to take note of how many of the participants really see HIV/Aids as a serious problem, how many feel that they need to change their behaviour and also how many people feel that by changing their behaviour they can decrease their susceptibility (DiClemente & Peterson, 1994). Furthermore, it is important to assess the extent to which the participants possess the necessary self-efficacy to carry out the prescribed actions (DiClemente & Peterson, 1994). Changes in beliefs and knowledge will continue to be a requirement in any effort to change people's behaviour. Therefore, it may be very useful to make a concerted effort to spend some time on empowerment, not for those who are relatively free to make decisions but rather for those individuals who cannot, or who feel that they have no control over their own lives.

At the end of this study the researcher is left with some questions. One of the questions being whether or not you can really convince someone who believes that they will never contract HIV that in fact they are also vulnerable. We, as human beings, have our stereotypes and if we are not willing to challenge these stereotypes then no amount of persuasion and information may make a difference.

7.10 RECOMMENDATIONS

It is recommended that the prevention programme developed in this study be implemented. This would mean that the programme can be refined if necessary and topics can be added or scrapped. If possible, original focus group members can be part of the programme. Their feedback would be very valuable. This programme should also be implemented early enough in an academic year so that follow-up sessions are possible.

It is also recommended that this programme be used on adolescents or young people between the ages of 16-22. The size of the group should also be limited to no more than 20 individuals. It may also be useful to have more than one facilitator. Periodic reviewing of the programme will also be necessary.

The researcher feels that in the future, to aid with the development of this programme, she would like to undertake more research in some areas namely, the role of parents not only in HIV/Aids education but in sexual education and the role and power of peer pressure. The researcher would also like to spend some time in the future researching the role that ignorance, specifically the denial of personal susceptibility, plays in the spread of HIV.

7.11 CONCLUSION

In the age of HIV/Aids people's lives have been drastically affected, very often negatively, but sometimes also positively. Many people have seen the need to change their behaviours in order to protect themselves and in this way they have empowered themselves. But at the same time there are many individuals who have not chosen this route and the reasons for not doing so may be very varied. Aspects like lack of knowledge, suspicion, fear, stigma, gender and lack of direct experience may all have an influence. It is for these individuals that the prevention programme has been developed. Hopefully, because this programme is based on the ideas of young people it may be seen as relevant and useful. It is hoped that this programme, when

implemented, will make a difference in the lives of the participants and they will give meaning to this experience.

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APPENDIX 1

RESPONDENT INFORMATION LEAFLET AND INFORMED CONSENT

Each respondent must receive, read and understand this document before the start of the study

TITLE OF PROJECT

HIV/AIDS AND BEHAVIOUR CHANGE: FROM AWARENESS TO ACTION -
A STUDY OF STUDENTS AT THE PRETORIA TECHNIKON

INTRODUCTION

You are invited to volunteer for a research project. This information leaflet is to help you decide whether you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions that are not fully explained in this leaflet do not hesitate to ask the researcher. You should not agree to take part unless you are completely happy about all the procedures involved.

WHAT IS THE PURPOSE OF THIS RESEARCH?

The purpose of the research is to study the effect that HIV/Aids is having on the lives of South Africans. The researcher would like to investigate your thoughts on HIV/Aids prevention in South Africa. Is it working? What do you think could be changed to make it more effective? Do you think that people are protecting themselves against HIV/Aids?

The researcher will invite you to take part in a group discussion on HIV/Aids prevention. In this discussion several questions will be posed about HIV/Aids and whether or not you think that people have changed their behaviour.

The researcher is interested in developing her own HIV/Aids prevention programme in the future and your ideas and stories will be incorporated in this programme.

WHAT IS EXPECTED OF YOU DURING THIS RESEARCH?

The project entails the following:

The researcher will convene one meeting with the participants and the duration of this meeting should be about one hour. The meeting will simply be a discussion. The researcher will record the meeting but no names will be used in the research to ensure that anonymity is maintained. The researcher will act as a facilitator but participants will be free to air their opinions. The participants will not be forced to answer any questions or be asked to reveal their HIV status.

Once the focus group is completed the researcher will not expect the participants to complete any further documentation or questionnaires.

At the end of the meeting the researcher will negotiate a voluntary follow-up session with the participants if required. This session will be used to give feedback to the participants about the researcher's progress and also to answer any questions that the participants may have. The date for this will be organized on the day of the meeting.

WHAT ARE MY RIGHTS AS A PARTICIPANT IN THIS PROJECT?

Your participation in this project is entirely voluntary and you can refuse to participate or stop at any time without stating any reason. The investigator retains the right to withdraw you from the study if it is considered to be in your best interest.

WILL THE RESEARCH RESULT IN DISCOMFORT OR INCONVENIENCE?

The researcher does not foresee any discomfort caused by the research. The researcher will make notes during the meeting. If this causes discomfort the participants can read the notes. The researcher will also be available to answer any questions that the participants may have.

WHAT ARE THE RISKS INVOLVED IN THIS RESEARCH?

There will be minimal risks attached to the research. The researcher realizes that HIV/Aids is a sensitive issue and she will make herself available if any of the participants need debriefing or need to continue the discussion with her for personal reasons. The participants will be told how they can contact the researcher.

DISCONTINUATION OF FOCUS GROUP

Your participation in his project is entirely voluntary and you can refuse to participate or stop at any time without stating any reason and without prejudice.

SOURCE OF ADDITIONAL INFORMATION

If at any stage you feel that you need more information regarding the project and its purpose, please do not hesitate to contact the researcher, Lynne Gradwell or her supervisor, Prof Louis Jacobs.

CONFIDENTIALITY

All information obtained during the course of this investigation is strictly confidential. Data that may be reported in psychological journals will not include any information that identifies you in this investigation. No names or identifying data will appear in the research

Researcher: Lynne Gradwell (012) 318 5010 or 073 137 1581 Supervisor: Prof
Louis Jacobs (012) 420 3147

APPENDIX 2

RESPONDENT INFORMED CONSENT

I hereby confirm that I have been informed by the researcher, **Lynne Gradwell**, about the nature, conduct, benefits and risks of the project: **HIV/Aids and Behaviour Change: From awareness to action**. I have also received, read and understood the written information in the Information Leaflet regarding the project and its purpose.

I am aware that the results of the project, including personal details regarding my sex, age, date of birth and initials will be anonymously processed into a final report for a Master's dissertation as undertaken by **Lynne Gradwell** for the MA Psychology.

I may, at any stage, without prejudice, withdraw my consent and participation in the project. I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the project.

Participant's name _____ (Please print)

Participant's signature _____ Date _____

The following is only necessary if working with participants who cannot read the information leaflet for themselves, and has to be done in the presence of a witness.

I, **Lynne Gradwell**, herewith confirm that the above client has been informed fully about the nature, conduct and risks of the above study.

Researcher's name _____ (Please print)

Researcher's signature _____ Date _____

Witness's name* _____ (Please print)

*Consent procedure should be witnessed whenever possible.

Witness's signature _____ Date _____