University of Cape

CENTRE FOR SOCIAL SCIENCE RESEARCH

HOW DO THE YOUTH IN TWO COMMUNITIES MAKE DECISIONS ABOUT USING CONDOMS?

Donald Skinner

2

Abstract

From the behavioural perspective, there is a key problem that needs to be overcome to enable effective action against the HIV epidemic. Why do people who are aware of and understand the nature of the HIV epidemic and how to protect themselves, choose to behave in a manner that puts them at risk? Historically, the social sciences have proposed multiple theories that attempt to explain how people make decisions, about the nature and structure of conscious thought, and how information is processed. There are acknowledged gaps in these theories, but what will be argued here is that an improved application of this theory may give us better direction.

This paper will examine how the youth in two communities near Cape Town make decisions about condom usage. Three theories will be employed to attempt to understand the data collected - namely Lay Theory, Theory of Reasoned Action and Theory of Planned Behaviour. During the research, information was obtained from 43 depth interviews, two focus groups and a survey of 406 respondents. The theories are able to examine, from different perspectives, problems behind the behaviour choice. Using the data from the depth interviews and the focus groups, Lay Theory offered the following explanations: culture was influential in supporting gender dominance and multi-partner sexuality; and in social situations, both men and women felt a pressure to conform to pre-set roles, to undermine condom usage and to emphasize sexual pleasure. The Theories of Reasoned Action and Planned Behaviour offer more insight into individual decision processes by examining the roles of attitudes, the influence of those close to the person, and perceived controls of behaviour. Factors that were important included sexual desire, love, fear of partner's anger and whether there was knowledge of where to get condoms and how to use them. The data generally showed a lack of belief on the part of the respondents that

AIDS really would affect them. These theories do not provide all the answers, but taken together they could provide some useful insights into the contribution of psychology theory and on how to design and implement intervention campaigns.

How Do the Youth in Two Communities Make Decisions About Using Condoms?

Introduction

One of the principle methods that help to limit the spread of HIV is the use of condoms. It is also one of the best-known pieces of information in relation HIV and AIDS. So the question of lack of knowledge of the importance of condoms cannot be a problem in the implementation of this safer sexual practice, although knowledge on how to use them may not be as generalised. The problem is that many people are still not using condoms in potentially risky situations. In trying to change this behaviour, it is necessary to develop a deeper understanding of how people make such decisions.

This approach draws on material covered in many old discussions, such as why people do not stop smoking, or why racist patterns of behaviour are difficult to change. Theories developed in these and other contexts can be useful in understanding the hidden processes and blocks affecting condom usage. This paper will draw on those theoretical approaches which have relevance to the subject from the discipline of psychology. Two sets of theories are identified for discussion. The first is broadly termed "Lay Theory" and examines how lay people develop theories for themselves about the world, and how these theories assist them to make sense of the world around them (Furnham, 1988). The second theory is Planned Behaviour (Ajzen, 1988), a development on the Theory of Reasoned Action (Fishbein and Ajzen, 1975). These fall more into a cognitive behavioural framework and are centrally based on the construct

of individual attitudes. The key objective is to outline the importance of the application of theory to a context.

Data Sources

The research on which this paper is based was conducted in two poor semi-rural African townships attached to small towns near Cape Town. Prior to entering the field, access to both communities was carefully negotiated with the civic and other important leadership. A total of 43 depth interviews with individuals, and two group interviews, were done by myself and a trained female Xhosa-speaking fieldworker from one of the communities. The emphasis here was on the youth, although some respondents who were important in the community, or who had special knowledge of youth, were also interviewed. Diary notes were also used as a data source and a validity check. A survey of 406 respondents was also completed. The survey methodology was constructed predominantly in terms of the Theory of Planned Behaviour (Ajzen, 1988). It is important to note that most of this research was done in 1991, so the actual information on the communities is dated. It is being presented here to provide insight into how ideas and behaviour are structured. Many of the responses do remain consistent with more recent findings (Campbell, 1997; Swart-Kruger and Richter, 1997; Gilgen, Campbell, Williams, Taljaard and MacPhail, 2000).

Lay Theory Results

Lay Theory is the study of the layperson's implicit, informal, "non-scientific" explanations of events or processes in the world (Furnham, 1988). Lay theories play the role in society of making the world understandable to those interacting within it,

by making sense of the relationships between events or objects. Lay Theory can be seen to represent knowledge and beliefs that people use to construct their own thinking about a subject and which is used by a society to construct and develop its ideas. As such, these ideas become the factors that facilitate communication between the members of that society, and become the basis on which new ideas may become part of that society. Key to this is the concept that knowledge is socially constructed and does not exist just in an individual, but is shared by the community from which the person comes (Moscovici, 1984; Sherr, 1989; Sherr, Strong and Goldmeier, 1990).

In the experience of the individual person, lay theories interact with the established scientific theories, but will often differ from or reinterpret these theories. Furnham (1988) has attempted to put some structure into the concept of Lay Theory, comparing lay theories to the formal scientific theories. For this comparison Furnham uses a set of criteria normally associated with scientific theories. He makes the point that these criteria should not be seen as rigid and that there is considerable overlap between lay and scientific theories. This paper uses some of Furnham's theoretical principles as a basis, drawing on those parts that are more relevant to explaining the material provided by respondents.

1. Lay theories are often more implicit than explicit, with tacit, non-specified assumptions or axioms. In contrast, scientific theories are

generally formal, in the sense that they are set in a logical, internally consistent manner.

2. As lay theories are seldom formally presented, they are frequently ambiguous, incoherent and inconsistent. Two mutually incompatible or contradictory ideas or beliefs can be held at the same time without the person being troubled by the inconsistency. Scientific theories should be, and usually are, both coherent and consistent.

3. Lay theories are often supported using the approach of verification rather than Popper's principle of falsification, which is more commonly accepted in scientific circles. In this sense, lay theories are based on the principles of induction rather than deduction, the latter more usual with scientific theories.

4. Lay theories often confuse cause and effect and so infer cause where it may not necessarily exist. There is a reliance on correlational evidence, which is insufficient to infer causation. These "causes" are also often unidirectional, based on what makes intuitive sense to the lay theorist.

5. There is a tendency for lay theories to be more orientated towards content than process, as in the case of scientific theories.

6. Lay theories more often see factors that are internal to the person as being causative, as opposed to external events.

7. Lay theories tend to be more general in their application, with one theory serving a multitude of functions, whereas scientific theories are far more specific in their application, with more tightly controlled specifications.

8. In terms of a set of definable criteria for measuring the strength of a theory, lay theories are generally weaker. (Furnham, 1988)

Many of the factors mentioned above have been drawn from a range of pre-existing theories and findings; for example, point six is drawn from the Fundamental Attribution Error Theory.

Selected results from the depth interviews are now presented below. General responses to AIDS and sexuality are covered first, as these are central to informing the discussion around condom usage, which then follows. This discussion goes beyond the narrow definition of Lay Theory as defined by Furnham, and draws in contributions from the theory of Social Representations (Moscovici, 1984), Urban Legend (Goldstuck, 1990) and Attribution Theory (Antaki, 1988).

Does AIDS exist and am I vulnerable?

One key area in which Lay Theory comes into its own in the explanation of condom behaviour is in the use of knowledge. It notes how the lay theories people use can contradict one another, and how theories are developed and created out of situations that do not scientifically support the original lay theory. Almost all the respondents knew that AIDS was sexually transmitted and that there was no medical cure. They knew that the main methods of protection involve sticking to one partner, abstinence and the use of condoms. Unfortunately this was confused with a number of misunderstandings, which contradicted the knowledge. Many people took what appeared to be an active decision - to deny that AIDS actually exists. A young, well-educated and informed woman spoke of her interactions with her colleagues and friends.

'I became furious and said, "Hey, you guys, have you heard that you can get AIDS?" and then all of them, they started swearing at me, said, "Ah! Get lost. No we have not got it, we are not dying."'

People wanted to see a disease before they altered their behaviour. A woman, admittedly poorly informed about AIDS, said directly what many felt:

> 'No I do not believe… because I have not seen a person with AIDS.'

However, even in the case of those who had seen a person in a community recently die of AIDS, the event was quickly forgotten, and the old patterns emerged.

A second level of denial involved the belief that AIDS did not exist in their communities. Instead it was seen as a problem in America, the rest of Africa, Johannesburg, KwaZulu Natal, among whites or another nearby community. Significantly, some residents of Kayamandi thought AIDS was in Mbekweni, but not Kayamandi, and vice versa. Even within communities, a similar distancing occurs. For example, this is directed primarily at hostel dwellers by those living in the permanent housing.

A different form of misunderstanding related to other real or supposed forms of transmission. There was an excessive concern over contracting AIDS via needles, operations in health institutions or a blood transfusion. One respondent presented the following story which, although it did bear some of the marks of an urban legend, was still going to impact on those who heard it.

> 'Last week I was talking to my friend, who said he had a sister-in-law, went for an eye operation and then she got AIDS. I don't know how she contracted AIDS, but it was through the operation, she was sure because she was having only one partner.'

The role of casual transmission also became a major area of concern for the respondents. Even the many people who stated that AIDS could be passed only via sexual or blood contact later became uncertain about casual transmission. For example, earlier on in the interview the person would state that HIV can be spread only by sexual or at times blood contact, but later suddenly indicated that casual contact could be a means of transmission. Those mentioned included kissing, teacups, toilet seats, physical contact and toothbrushes. Even education linking HIV and TB had led to some confusion about the means of transmission.

> 'Yes, AIDS is contagious like TB for example. If you have TB and I am sitting next to you then I will also get TB. AIDS too is like that, if we are staying under the same roof with an AIDS sufferer then you will all get it.'

In Kayamandi, the fears of casual transmission were reinforced by a story told by a leading political figure, that the health authorities had not allowed the body of a person who had died of AIDS to be returned to his home prior to his burial. A causative relation immediately made was that AIDS could be contracted from the corpse. This fear of casual transmission also increased discrimination against people with HIV.

Competing knowledge systems relating to means of protection were also found. A number of respondents indicated that trust in their partners was a defence against contracting HIV. This concept is difficult to interpret, given most of the respondents had more than one partner. Another response mirrored this when it was stated that you got AIDS by sleeping with strangers, also a popular notion in both communities. The perceived threat of dying of AIDS was also reduced amongst about a third of the youth, who

claimed that the sangomas or traditional healers could cure the disease, a piece of information that many of the sangomas were ready to support.

It is important to note here how small stories or events get reinterpreted to support a theory, e.g. casual transmission. These took the status of lay theories and would have influenced the way in which the respondents constructed their thinking. It is clear that when a person wishes to find an explanation for a chosen behaviour, factors from the environment can be chosen and combined in such a way as to support that "theory". The role of Lay Theory can already be clearly seen here. Contradictory pieces of information are accepted as part of one knowledge system and exist side by side, while processes of causation are accepted without proof. One of the implications of these lay theories is that of allowing a person not to have to change their behaviour, as modifications of sexual practice would not increase risk of infection if causal transmission were possible.

AIDS factors that complicate education and change

Scientific explanations of HIV have two major weaknesses that undermine the credibility of the information: namely, uncertainty about the origin of the disease, and lack of clearly identifiable symptoms. Most respondents found it difficult to believe that a disease as devastating as AIDS could have no history and no visible symptoms for most of its life cycle. The key argument, "How come it did not affect my fore-fathers who had many sexual partners?" was felt to be unanswered. The question of the symptoms of AIDS involved two problems firstly, the lack of a clear understanding of the asymptomatic period, and secondly the fact that AIDS has no symptoms of its own. All the symptoms are in reality symptoms of other diseases. An overall picture of the syndrome has begun to appear, consisting largely of a combination of all the possible opportunistic infections together. The powerful image of decay and disease as decribed by Sontag (1988).

Many of the educators were seen as being out of touch with the youth, so there was little point of identification. This would popular idea of a rash or sore is to some extent synonymous with the have exacerbated the extent to which the respondents looked for alternative sources of knowledge. These sources presented concepts which allowed the respondents to change the information that they had heard about AIDS and to discredit their previous knowledge. Clearly, the respondents were seeking to align this new knowledge about AIDS Many of the educators were seen as being out of touch with the youth, so there was little point of identification. This would have exacerbated the extent to which the respondents looked for alternative sources of knowledge. These sources presented concepts which allowed the respondents to change the with their existing conceptualisations of the world.

The problem of providing education about AIDS is compounded by the difficulty that most respondents reported in talking about sex generally, and especially to any person from a different generation. Sex predominated by issues of shame, together with the obvious associations of sex with power and status. It is only amongst peers that sex is spoken about, and even here there appears to be a restricted dialogue. Conversations about sex and HIV amongst youth tend to happen within a framework of machismo, or when discussing some speculative or different idea about AIDS that someone had heard from a source different from the norm. Rumour and existing belief systems tended to get confused.

Monogamy

The option of monogamy is essentially a separate behaviour from that of condom usage, but considerable insight into the latter is provided by the understanding of sexuality regarding this option. Lifetime monogamy was

not considered as a possible choice by any of the youth interviewed. Even the option of serial monogamy was responded to with doubt, especially by the males. This appeared to arise mainly out of a culture of male dominated sexuality, where promiscuity is a point of pride and status. The more partners a man has the more he is respected and considered to have power in the community.

> 'Hey man there is this thing called AIDS, we should try to avoid this thing."But others will say "No man, if AIDS means to stop having many partners then I will just contract it, you see.'

Among the major reasons given for the perceived necessity of having multiple partners included the following:

- Male sexual needs. A man cannot survive physically or psychologically for an extended period without sex.
- Availability of partners. A person needed a back up if their regular partner was not available
- Social conditions in the townships, referring especially to the single sex hostels
- Cultural arguments, for example that it is culturally correct for Black men to have many partners, drawing partly on the history of polygamy
- Some men blamed women for entrapping and seducing them
- Alcohol and drug abuse played a large role in many "one night stands", especially amongst those attending the shebeens.

Arguments in favour of serial monogamy were generally more faltering, and related primarily to protection from disease and love for their partner. However, these discourses held less power than those against serial monogamy.

The power differential between the genders was clear, as was the double standard in relation to sexual norms. This allowed the men to continue with the practice of having many sexual partners, which was often accepted by the women. Women did have power to the extent of their capacity to attract men, but this remained defined within the male terms of reference.

Condoms

Most respondents claimed knowledge of condoms. However in some cases later on in the interview, the respondents acknowledged that they did not know how to use them. The basic knowledge that was available was that condoms can be used to prevent pregnancy and AIDS, that it is used as a sheath over the penis and that it is made of rubber. For most respondents this information remained at an abstract level. It appears that some of them had never come into contact with a condom, and more had never used one. One young women exemplified the lower levels of knowledge with this quote.

> 'I have never seen a condom, but they say it is like a balloon,
> but I do not know its usage.'

There were several incorrect notions about condoms. One fear was that the condom could slip off the man's penis during sex and get stuck inside the woman.

Access to condoms

For condoms to be used they must be available, but access must be possible, affordable and comfortable. The question of access immediately

ran up against the problem of the secrecy associated with sexuality, and difficulty that the youth have in talking openly to older people about sex, as well as being identified by elders as sexual. Most respondents knew that condoms could be obtained from the clinic, but virtually all felt that there was a barrier in this regard. People objected to collecting condoms there because of the high visibility of the building. Many of the youth also stated that it was difficult to go to the clinic, as they were scared the nurses would ask them questions and mock them. One student stated that the nurses would not give him condoms when he had been to the clinic before.

'The problem is that the nurses at the clinic are very unkind. Sometimes they even refuse to supply us with condoms….they say we are troublesome. They think that we are not serious if we want condoms.'

This appeared to part of a general conflict with the nursing staff, by whom it was, however, denied. It is therefore difficult to know whether it is simply as excuse not to use condoms or a valid complaint. The result remains that this is a further block to access.

Evaluation of condoms

The almost universal perception was that condoms were not acceptable, both at a cultural and a personal level. This derived from a number of factors, but the central ones encompassed the experience of sex and the impact of condoms on the sexual relationship. The nurses from the clinics in Kayamandi said that most of the youth that came into the clinic did not want to take condoms.

'They know about AIDS, but they don't want to use the condom. To use the example of those that come to visit, I say "Take some, they are free". They don't pay anything, they don't want to take them…I say to them, "Are you not afraid, not scared of AIDS?" They say, yes, they are, but they don't want to use the condom.'

This quote was typical of the response of the youth and draws on some of the lessons outlined above. The youth know about AIDS, how it is transmitted, and how to protect themselves, but there are too many pressures in terms of the prevailing sexual norms for condoms to be widely used. Some respondents did however try to present themselves as being responsible about the dangers of AIDS, and people from both sexes claimed that they would like to use condoms, but that the other gender that did not want to use them. This implies a superficial acceptance of the scientific theory, but that at a deeper level, alternative theories focussing on sexual relations have more influence.

Even when further pressures are introduced it is difficult to persuade respondents to change. One woman with a breastfeeding child could not get her partner to use condoms, even when she introduced motivations concerning her child.

'No, I once brought condoms to him, the present boyfriend, because I was still breastfeeding and I was thinking that I will get diseases from him that affect my baby…he totally refused to use condoms. He said he does not like them.'

Even where some youth did move towards using condoms, there were often messages of condemnation from authority rather than support. One of the

school principals interviewed reported that a Grade 6 boy was brought to him by a teacher for having a pocketful of condoms. The boy claimed he had them so he could protect himself from AIDS. However, the punishment of being brought to the principal may have reduced the likelihood of his using condoms again. A clear message was given here that sex has to remain hidden, and tell-tale signs like having condoms are not allowed.

Sexual Pleasure

Both sexes stated virtually uniformly that condoms limit the sexual pleasure, feeling and sensation of the sexual act. The argument, as many respondents expressed it, was that they wanted flesh to flesh and this applied to both men and women. Some of the female respondents stated they wanted to feel the man's sperm inside them, and that the condom robbed them of that sensation.

> 'They say you don't fully enjoy sex. People want to feel the sperms when a man is ejaculating.'

Respondents also spoke of condoms being unnatural.

> 'They didn't really like the idea of using condoms because they said it's not natural you know and things like that, but for their safety they understand that they should. They don't agree with the idea of using condoms.'

There is a perception about what is 'natural' or 'unnatural'. Sex is perceived as a natural, enjoyable experience, into which 'unnatural' phenomena should not be introduced. Students generally complained that

condoms 'disturbed' sex. The important point is that the experience of sex as an immediate reality was considered far more important than the future threat of AIDS. Going back to some of the points raised earlier, it was argued that AIDS does not really exist (at least not in their communities), that AIDS could be contracted in other ways, so condoms were not a protection, that sangomas can cure AIDS, and that contracting AIDS was an matter of fate rather than behaviour. All these factors would help to diminish thoughts of AIDS during a sexual encounter.

Some of the respondents became quite eloquent in their refusal and disgust. Humour was used in explanation:

'…they tell you won't feel anything of what you are doing, if you are using plastic. People just tell you, "You cannot wear a raincoat when there is sun."'

It is generally more difficult to argue against humour, so the position remains safer. The analogies used do not make any real sense, but via a lay theory, conceptualisation acquires a quasi-scientific legitimacy. A clear cause and effect are shown and a connection established, as if to say the processes are the same, so condoms should be rejected.

Image

A distinct problem involving condom usage was that it had implications for the youth in relation to their perceived sexual image. Wanting to use a condom reduced a person's status and raised fears of rejection. Condoms were associated with STDs and AIDS, or with people who sleep around and so are at risk. To get that label or even to be associated with it is very detrimental and would certainly reduce a person's sexual and social status in the community. Perceptions of people with AIDS were that they were

dirty, but more important, that they were people to be avoided. A few respondents went so far as to state that if they had AIDS, that would be an especially good reason not to use a condom, as it would identify them too easily.

> 'It is difficult, I think the reason why it is difficult (to suggest condom usage) they are afraid of ending relationships (rejection), that's the main reason. The second one is that if I talk about condoms she will think that I only want to use her.'

The information that you wanted to use a condom could also spread, and such a person would be undermined in other circles as well.

> 'If you use it with one woman and she should tell others so you will find that they will be talking about you and gossiping.'

Furthermore, wanting to use a condom could imply that you do not trust your partner or you think that they have an STD or AIDS.

> 'The main reason is that of trust. Sometimes they think you want to use a condom because you do not trust them. To them using a condom is an insult.'

The issue of trust was advanced as an argument against using condoms. This was then extended to the discourse on love: if you loved and trusted someone you didn't have to use a condom. It was interesting that one of the major arguments for serial monogamy, i.e. love and trust, was now being

given as an argument against another safer sex behaviour, namely condom usage. This means that some of the additional discourses which are brought to bear in the context of AIDS have to be used with caution.

Additional motivations against condoms

One of the students in the focus group, felt that condoms were not very secure, were too big or too small, and did not fully protect you from diseases. This was supported by some of the group. Others argued that for political reasons faulty condoms were sent to Africa or to their communities. When boys in the group raised these arguments it was interesting to note that the response from at least one girl was that they were trying to find excuses. However, although these alternative theorisations were present, they carried less power.

Motivation for using condoms

There were very few positive notions about condoms, only that they prevented AIDS and STDs. This message was very clearly known in the community. As in the case of serial monogamy, the concept of HIV prevention carried very little weight and did not compete with the need for sex, or the desire for sexual pleasure, which was seen to be threatened by condom use. Physical needs rapidly overpowered their knowledge of protection, and excuses were made for not using condoms, although, from the interviews it appeared that those who had direct contact with PWAs were more likely to use them. In these cases, the reality of AIDS had become more powerful, so protection was seen to be justified.

Summary

A clear system of ideas begins to emerge in relation to sexuality and in turn to HIV and AIDS. HIV arrived in the social spectrum in the early 1980s with no real warning or background. It needed to be explained in some way and the most apparent form of explanation is via the discourse it is mostly closely related to, namely sex. Other explanatory connections such as disease, death, love and morality also had to be drawn into the examination. Many of these factors present confusing messages in relation to each other. Knowledge about HIV and safer sexual practice therefore faces real, and at times almost insurmountable, challenges when coming into direct confrontation with an individual or a community construction of the nature of HIV, not to mention other pressures of the social context. A particular difficulty concerning sexuality is the confusion over both its obvious and its hidden status. Condoms and their relationship to HIV and sex now also have to find a place in this secretive meaning system. This does not happen instantaneously. Currently, a system of rejection is developing, which has to be acknowledged and worked with. What then becomes crucial is to explain how and why these lay theories influencing condom usage appear, and how to make adjustments to them.

Notice needs to be taken of the role of chance commentary, news items about AIDS, and the misinterpretation of policy, as these may provide different messages from the core ones that need to be put out. An examples of this is the statement of President Mbeki which questions the link between HIV and AIDS. President Mbeki's comments could be seen effectively to state that it is acceptable to ignore the safer sex messages, since HIV does not cause AIDS. Although I know of no formal study into the impact of his statements, anecdotal comments are indicating that a

number of people are now refusing to take condoms from clinics or pursue safer sexual practices, as this is not considered necessary.

One of the complicating factors raised by this research is the centrality of sexuality to identity. It became clear in many of the interviews that the respondent's sexual success was integral to their self-perception. This applied both to their social status in the community, and to the way they saw themselves. This creates complexity in terms of intervention, as by advocating changes in sexual practice, the core identity of a person is being impacted upon, or even threatened.

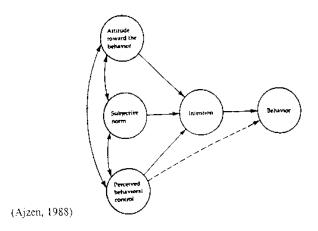## Results for the Theory of Planned Behaviour

The Theory of Planned Behaviour draws on a cognitive behavioural theoretical base, thereby implying a more individualistic base of behavioural decision-making. The theory builds more directly on a long history of research on the influence of attitudes on behaviour. It develops more specifically on the Theory of Reasoned Action (Fishbein and Ajzen, 1975), which itself constituted a large advance in this work. This advance centered around the theory tying behaviours more tightly to attitudes about the behaviour, rather than the objects of the behaviour. For example, the person would be asked about their attitudes to using condoms themselves when having sex, rather than their attitude towards condoms in general. This allowed for greater precision to be obtained in the research. Strong supporting evidence has been found in research for these theories for a range of behaviours, including compliance behaviour of hypertensive patients (Miller, Wikoff and Hiatt, 1992), children's decisions about substance use (Morrison, Simpson, Gillmore et al, 1996) and exercise

behaviour (Godin, Valois and Lapage, 1993; Hausenblas, Carron and Mack, 1997). General reviews of studies applying the theories to a broad range of behaviours can be found in (Fishbein and Ajzen, 1975; Ajzen and Fishbein, 1977; Ajzen and Fishbein, 1980; Ajzen, 1988). Studies using the theory of Reasoned Action concerning condom usage have been done, which also gives support to the theory (Middlestadt and Fishbein, 1990; Fishbein, 1990; Reinecke, Schmidt and Ajzen, 1997; Albarracin, Fishbein and Middlestadt, 1998; Godin, Maticka-Tyndale, Adrien et al, 1996), as well as a study done in Malawi (Bandawe and Foster, 1996). A meta-analysis of research examining condom usage across a number of sites was done using studies that applied the theories of Reasoned Action and Planned Behaviour (Albarracin, Johnson, Fishbein and Muellerleile, 2001). This paper reviewed 96 data sets, covering a total sample of 22 594 respondents, during which the behaviour of condom use was examined. Generally the results found that the model was a powerful predictor of intentions regarding condom use.

Planned Behaviour begins by clearly defining the behaviour of interest: making sure the behaviour is clear in terms of action to be performed, and identifying the timing of the behaviour, its target, and its context. The theory then follows a very obvious logical approach, by drawing a progression of links from the behaviour backwards over three stages to a set of beliefs. (See the figure below for a visual depiction of the theory) At the first level is behaviour which is seen as being determined primarily by behavioural intention (BI), which, simply put, is the stated intention on the part of a person to perform or not to perform a particular behaviour. Behavioural intention in turn is seen as being determined by a combination of attitudes (A), subjective norms (SN) and perceived behavioural controls (PBC). The relative contribution of each is defined by a regression analysis using the data obtained from a highly specified

research methodology. Attitude is defined as the relative positive or negative feelings that the person has towards the behaviour, and is generally considered to be most central of the three variables. Subjective norms are the attitudes a person feels that those who are important to them have towards them, completing this behaviour. The perceived behavioural controls are those influences that the person feels will assist or limit the behaviour. These controls can arise from the context or from the person themselves (Ajzen 1988).

Model for the theory of Planned Behaviour

(Ajzen, 1988)

Each of the variables pertaining to attitudes, subjective norms and perceived behavioral controls, are in turn determined by a set of beliefs relating to the variable in terms of the behaviour. The beliefs are linked to the factors by a mathematical equation termed the Expectancy Value Equation. The beliefs are normally limited to about seven, as the theorists believed that this is the most that a person can consider at one time when deciding on whether to behave in a certain way. All the factors considered under Lay Theory and its associated theories are seen as being incorporated via these beliefs, i.e. the issues of culture, class, knowledge, religion and

belief system. Previous experience is also seen as being sifted out and incorporated into these beliefs on the basis of their relative importance. In the research process the relevant beliefs to be used in the model development are obtained from an earlier research process (Ajzen, 1988).

A multi-phase methodology is used to collect the information for the development of the theoretical models used. First a clearly defined behavior has to be arrived at, in terms of action, context, time and target. All other variables in the model then have to conform to this definition. In the first phase of the research, an open-ended questionnaire is used to obtain lists of the major beliefs that the group being investigated associates with the behaviour. As in the model, these beliefs are divided according to attitudinal beliefs, normative beliefs and control beliefs. Those which are most common are incorporated into the survey together with the questions looking at intentional behaviour, attitudes, subjective norms and perceived behavioural controls. The survey questionnaire used to collect the data also follows a clear structure in terms of the ordering of the questions. The individual questions follow a Likert scale or semantic differential structure (Fishbein and Ajzen, 1975; Ajzen, 1988).
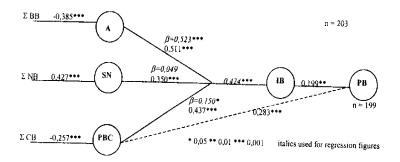
For the purposes of this research, the behaviour pertaining to condom usage was separated into male and female categories, as the behaviour relating to condom usage is different for the two sexes. By its nature, condom usage is male-dominated. Because women have to ask their male partners to use a condom, they do not have direct control, especially in a highly patriarchal context. Only the results for the male respondents will be presented here. The full model for the behaviour is presented first. This will be followed by a table giving the primary beliefs relating to the behaviour of using condoms and their correlations to the next stage variables. One of the problems with the methodology in this case was that it produced results that probably over-emphasised safer sexual practice in

comparison with the data obtained in the qualitative research, as well as what is reported in the South African literature on AIDS research (Abdool Karim, Mathews, Gutmacher, et al, 1997; Nicholas, 1999; Shefer, 1999). The problem with the results appears to be related to a problem with fieldwork. Due to the relative isolation of the communities and the hours over which the research had to be done, fieldworkers from the communities themselves were used. This appears to have created problems due to the sensitive nature of the research. Communities were also eager to co-operate in the research, so did not wish to refuse to be interviewed, and wanted to assist as much as possible, so many may have given information that they thought the researcher wanted to hear. Secondly, the survey was constructed around the issue of AIDS, so this construct may have predominated in their minds over the issue of sexual pleasure, meaning that the responses fell into line with what was expected in the context of AIDS. In a different scenario their responses may also have been very different.

Results for men using condoms

The results obtained for the behaviour of men using condoms using the Theory of Planned Behaviour are presented in the figure below. PB is past behaviour. This was used instead of current behaviour due to the sensitivity of the subject of the research. All the numbers show correlation scores between the variables, unless otherwise indicated.

Planned behaviour model for men to use condoms

All three of attitudes, subjective norms and perceived behavioural controls achieved a significant correlation with intentional behaviour, and the overall regression score for the model was high. The correlations of A, SN and PBC back to the summed beliefs scores, using the expectancy value equation, were also reasonably high, although higher scores would have been expected. The negative correlation between Σ BB and A was expected, given the negative correlations between many of the individual beliefs and A, but it does mean that most of the beliefs that encourage the behaviour still have to be found. Most of the beliefs shown on the table below concerned sexual pleasure or partner's reaction to the use of condoms. However the respondents still reported a positive attitude to using condoms. It appears from the β weights that A was very influential and overshadowed the remainder. The behaviour appeared to be predominantly under attitudinal influence. There were in fact high levels of multi-colinearity between A, SN and PBC, with the correlations between them being between 0,369 and 0,497. They all seem to be picking up on a similar

construct. This may to some extent be expected, as many of the key beliefs for A, SN and PBC all deal with the influence of partners, and ultimately all deal with the same behaviour.

In the survey, 149 (73.4%) of the 203 men who responded to the survey stated that they did intend to use condoms when they had sex in the future. The attitude score obtained, using a semantic differential scale, was mildly positive towards condom usage. 145 (71.4%) men felt that the normative influence on them was to use condoms. In assessing the perceived behavioural controls, 138 (68%) felt it was easy to use condoms, and 176 (86.7%) felt it was possible. The correlations of the individual beliefs with the next stage variables are shown in the table below.

From the beliefs listed below it is apparent that in this sample, condom usage was not associated with HIV or disease. In the first phase of the research, in which the more common beliefs influencing behaviour were obtained, the issue of HIV was not raised often enough to enter the questionnaire independently and in the survey, prevention of disease was not significantly associated with attitudes to condom usage. As expected, the beliefs relating to sexual pleasure correlated negatively with attitudes and were the most significant. The impact of condoms in people's relationships was also significant and negatively correlated with attitudes.

Partners, friends and families were all considered important normative influences. The presence of families as a normative influence is confusing, as from the qualitative data the youth do not inform their families about their sexual practices. The normative influence must therefore operate in another manner. This may be some sense of caring from the family, which suggests to the respondent that they should protect themselves from harm. For the control beliefs, issues of access in which respondents felt embarrassed about obtaining condoms, and knowledge about condoms, attained the higher correlation.

30

Correlations of beliefs with attitudes, subjective norms and behavioural controls

	Attitudes n = 203
Using a condom everytime I have sex:	
will prevent pregnancy	0,251***
will protect me from diseases	0,085
will reduce my sexual pleasure	-0,313***
will mean that I do not feel my partner's body	-0,467***
will mean that I do not trust my partner	-0,246***
means that my partner will not be satisfied sexually	-0,369***
will make my partner angry	-0,296***
	Subjective Norms
Girlfriend	0,324***
Friends	0,300***
Members of family	0,390***
Nurses and doctors	0,151*
	Perceived Behavioural Controls
My partner will not like me to use condoms	-0,167*
Condoms cost too much money	-0,073
It is embarrassing to get condoms from the clinic	-0,249***
I do not know how to use condoms	-0,245***

Summary

The results shown on the figure and the table provide guidance for the person designing the intervention. A few clear foci emerge from the data. In order to encourage condom usage, some of the key lessons include the need to educate those who do not know about how to use one, as well as facilitating access to condoms. These are comparatively easy interventions to develop. There is also a need to make the link between condoms and the prevention of STDs and HIV. As with the Lay Theory findings, there may

be a need to create an individual sense of vulnerability in relation to HIV. Negative correlations were consistently made between sexual pleasure and partners' responses to the use of condoms. While there are enormous difficulties in making condoms sexually exciting, some interventions are required in order to overcome these barriers to condom use. The major normative influences were family, friends and partners. The actual role and method of influence of the family needs further investigation, as given the silence on issues of sexuality, ways of showing concern and of allowing normative influences to have an effect need to be found.

Directions provided

Both sets of results and theories provide directions about possible interventions. While at first impression these are contrasting, they actually give complementary inputs as to how to structure intervention campaigns. There is both overlap and separation in terms of what can be provided and done. For example, the normative influences are important, but require an openness for discussion of sexuality. This openness would also reduce the barriers which inhibit access to condoms. Both theories emphasise certain core motivations as to why people in these communities did not want to use condoms: the desire for sexual pleasure, relationship issues, knowledge about the use of condoms, and problems of access to them. Both also saw HIV as having a relatively small role in most people's consciousness when making decisions about using condoms.

From the Lay Theory approach, it is clear that interventions are needed into the entire way in which attitudes both to condoms and HIV have been constructed in these communities. These constructions centered

on sexuality, but death, illness and disease, "culture", gender power relations, power of influence, political philosophies and communities' dynamics, amongst others, are all important as well. While this variety of factors apparently complicates the process, if understood, it suddenly makes sense as to why sexual behaviour has been so difficult to change in relation to the HIV epidemic. Other aspects of sexuality, such as what is considered cool and sexy to wear, change almost organically on a continual basis. These feed into people's lifestyles and their personal realities, so are easier to adjust to. Acknowledging this reality means that change is a long-term process, but some sort of map, or at least a direction-finder, does start to emerge. Some immediate pointers about where to start are also indicated. These include the opening up of discussion on sexuality, the breaking down of barriers to the access and use of condoms and the empowering of women so as to equalise power relations between the genders. A constant monitoring and research process is required, as none of these structures is fixed. As was shown in the results above, beliefs and theories of the world are constantly malleable.

On the other side, the Theory of Planned Behaviour offers some initial points of intervention and focus. It highlights the immediate, "top of mind" factors that are influencing behaviour. As expected, many do overlap with the results of the analysis of the Lay Theory. Each of the beliefs or factors identified can become a focal point, e.g. the requirement for improved private access to condoms and information on how to use them - including information on how to use condoms in such a way as to minimise the reduction in sexual pleasure such incorporating them into sexual foreplay; and the emphasis of the importance of condoms in HIV prevention, amongst others. Some of these ideas have already been incorporated into campaigns with varying levels of success. Results such as the influence of normative factors require further research.

Any education or intervention is going to interact with the broader systems of meaning in our society, so the immediate programmes suggested by the theory of Planned Behaviour need to be monitored at the level of systems of meaning in the society as well. This implies an ongoing connection between the two theories in follow-up research as well. At a more general level, there has to be some encouragement towards a greater openness about sexuality if interventions at any level are to work. This will generally open up the space for the interventions suggested by the theory of Planned Behaviour to be introduced.

Conclusions

A lot of factors in our society need to change if safer sex is to become part of life or even acceptable to the mass of people. This approach has to be consistent if the required change is going to take place and all the tools available are to be used. In this paper, just two of the potential theoretical tools available from psychology have been presented, and these are only two contributions from one discipline. While the overlap from these to others is high, it remains a just a small part of the process of understanding - an understanding which can only improve with further contributions. Within this area of work, further research questions are opening up as well. Processes of education for attitude and behaviour change require theoretical input looking at pedagogic theory. Social change theory needs to be incorporated, including use of the notions of early or late adapters to change. Knowing your target group is absolutely vital to this process and an essential first step - implying that research needs to be done prior to any intervention. Further research is obviously also required to make full sense of these interpretations and to evaluate the resultant interventions.

References

Abdool Karim, Q., Mathews, C., Gutmacher,S., Wilkinson D., & Abdool Karim, S. 1997. HIV/AIDS and STDs in South Africa. Unpublished report, Medical Research Council, Pretoria.

Ajzen, I. 1988. *Attitudes, Personality and Behavior.* Milton Keynes: Open University Press.

Ajzen, I., & Fishbein, M. 1977. Attitude - Behavior Relations: A Theoretical Analysis and Review of Empirical Research. *Psychological Bulletin, 84(5),* 888-918.

Ajzen, I. & Fishbein, M. 1980. *Understanding Attitudes and Predicting Social Behaviour.* Englewood Cliffs: Prentice-Hall.

Albarracin, D., Fishbein, M., & Middlestadt, S. 1998. Generalizing behavioral findings across times, samples and measures: A study of condom use. *Journal of Applied Social Psychology, 28(8),* 657-674.

Albarracin, D., Johnson, B., Fishein M., & Muellerleile, P. 2001. Theories of Reasoned Action and Planned Behaviour as models of condom use: A meta-analysis. *Psychological Bulletin, 127(1),* 142-161.

Antaki, C. 1988. Explanations, communications and social cognition. In Antaki, C. (ed) *Analysing Everyday Explanations: A Casebook of Methods.* London: Sage.

Bandawe, C., & Foster, D. 1996. AIDS-related beliefs, attitudes and intentions among Malawian students in three secondary schools. *AIDS Care, 8(2),* 223-232.

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

Fishbein, M. 1990. AIDS and behaviour change: An analysis based on the theory of reasoned action. *Interamerican Journal of Psychology, 24(1),* 37-56.

Fishbein, M., & Ajzen, I. 1975. *Belief, Attitudes, Intention and Behaviour: An Introduction to Theory and Research.* Reading: Addison-Wesley.

Gilgen, D., Campbell, C., Williams, B., Taljaard, D., & MacPhail, C. 2000. The Natural History of HIV/AIDS in South Africa: A Biomedical and Social Survey in Carltonville. Johannesburg, CSIR.

Godin, G., Maticka-Tyndale, E., Adrien, A., Manson-Singer, S., Willms, D., & Cappon, P. 1996. Cross-cultural testing of three social cognitive theories: An application to condom use. *Journal of Applied Social Psychology, 26(17),* 1556-1586.

Godin, G., Valois, P., & Lapage, L. 1993. The pattern of influence perceived behavioural control upon exercising behaviour: An application of Ajzen's Theory of Planned Behaviour. *Journal of Behavioural Medicine, 16(1),* 81-102.

Goldstuck, A. 1990. *The Rabbit In The Thorn Tree: Modern Myths and Urban Legends of South Africa*. London: Penguin.

Hausenblas, H., Carron, A., & Mack, D. 1997. Application of the Theories of Reasoned Action and Planned Behaviour to exercise behaviour: A meta-analysis. *Journal of Sport and Exercise Psychology, 19,* 36-51.

Middlestadt, S.E., & Fishbein, M. 1990. Factors Influencing Experienced and Inexperienced College Women's Intentions to Tell Their Partners to use Condoms. Poster presented at the Sixth International Conference on AIDS in San Francisco, USA.

Miller, P., Wikoff, R., & Hiatt, A. 1992. Fishbein's model of reasoned action and compliance behaviour of hypertensive patients. *Nursing Research, 41(2),* 104-109.

Morrison, D., Simpson, E., Gillmore, M., Wells, E. and Hoppe, M. (1996) Children's decisions about substance use: An application and extension of the Theory of Reasoned Action. *Journal of Applied Social Psychology, 26(18),* 1658-1679.

Moscovici, S. (1984) The phenomenon of social representations. In Farr, R.M. & Moscovici, S. (eds) *Social Representations.* Cambridge: Cambridge University Press.

Nicholas, L. (1999) Black South African students' beliefs and attitudes about condoms. *Psychological Reports, 83(3,pt 1)*, 891-894.

Reinecke, J., Schmidt, P. and Ajzen, I. (1997) Birth control versus AIDS prevention. A hierarchical model of condom use among young people. *Journal of Applied Social Psychology, 27(9),* 743-759.

Shefer, T. (1999) Discourses of heterosexual subjectivity and negotiation. Unpublished PhD thesis, University of the Western Cape.

Sherr, L. (1989) Health education. *AIDS Care, 1(2),* 188-192.

Sherr, L., Strong, C. and Goldmeier, D. (1990) Sexual behaviour, condom use and prediction in attenders at sexually transmitted disease clinics - implications for counselling. *Counselling Psychology Quarterly, 3(4),* 343-352.

Sontag, S. (1988) *AIDS and its Metaphors*. London, Penguin.

Swart-Kruger, J. and Richter, L. (1997) AIDS related knowledge, attitudes and beliefs among South African street youth: Reflections on power, sexuality and the autonomous self. *Social Science and Medicine, 45(6)*, 957-966.