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A Participatory Audience Analysis Approach in the Design Process of an HIV/Aids Prevention Document targeted at young Africans in South Africa.

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July 2006
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This thesis has been written within the framework of the EPIDASA-project (www.epidasa.org) and submitted July 2006 in partial fulfilment of the requirements for the degree of Master of Arts in International Business Communication.
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Note: the illustration on the cover of this thesis also served as the cover illustration for the HIV/Aids prevention document that was designed in conjunction with this research project (see chapter 8, p. 183 for the final document).

Abstract

This thesis consists of a case study that demonstrates how *participatory audience analysis* has made a fundamental contribution to the design process when seeking to determine a more user-centered content and form for an HIV/Aids prevention document targeted at young African South Africans. Up until now, remarkably little research has been carried out concerning the extent to how the target audience's input in the design process might improve HIV/Aids prevention documents in South Africa. Whereas numerous efforts in the past failed to motivate the audience to change their risky sexual practices, due partially to the fact that the top-down approach used resulted in communicating an irrelevant, unappealing, and sometimes even incomprehensible message. In this study, participatory audience analysis was employed as a qualitative research method in order to obtain an in-depth understanding of the audience's perspective. By means of a participatory audience analysis, the factors that exert an influence on the audience's contraceptive usage and the audience's communication preferences were investigated in order to determine the audience's information needs and interests. Equipped with this insight, an HIV/Aids prevention intervention could be designed in which the content and form was geared to the audience's needs. This could be instrumental in increasing the intervention's effect on the audience.

Keywords: *Designing user-centred texts, audience analysis, feedback-driven audience analysis, improving HIV/Aids documents, participatory design.*

Preface

When I first heard about the EPIDASA-project in 2003 I was instantly struck with enthusiasm about participating in this project. Conducting research in South Africa on how to improve HIV/Aids prevention documents seemed the most challenging and socially relevant topic I could imagine to write my Master thesis about. Particularly the humane aspect of this research highly appealed to me as it allowed me to elaborate on the knowledge I had obtained in the courses I took on Social Psychology. Since I had acquired quite a fair share of quantitative research skills during my study in International Business Communication, I was eager to take on a new challenge and do something I had not yet done before. Therefore, in researching this thesis, I wanted to gain more experience in using qualitative research methods and in the practicalities of designing an actual HIV/Aids prevention document.

When I finally arrived in South Africa, I felt extremely privileged to be able to fulfil my dream of studying and conducting research at the beautiful and well-known Stellenbosch University. However, after some time I realized that this utopian, predominantly white Stellenbosch was keeping me from learning more about 'the real' South Africa. That is why I decided to target my research at an audience that differed greatly from my own European cultural background: young Africans living in townships. This proved to be an invaluable decision. Especially the intense contact and collaboration with my four fifteen-year-old 'experts', Bathabille, Xollile, Amanda and Shanda, made my South African semester an incredibly enriching experience!

This thesis could never have been completed without the kindness and help of many people, thank you all! In particular I would like to thank my two supervisors, Professor Jansen and Professor de Stadler. Thank you for the freedom you gave me to pursue my interests and ambitions in this research project. Although these ambitions certainly did not make my life easier and resulted in this lengthy Master thesis, I cannot express how appreciative I am for this experience! I am truly grateful to you both for your patience, academic support and critical feedback on the drafts of my thesis! A special thank you goes to Karen Schriver. You inspire me and I feel very fortunate to have met you! No words match my gratitude for the true friendship and support from my South African friends (Daniel, Vuh & Phumlani) and my friends at home (Ferhat, Deborah, Martine, Wim, Meryem & Wietske). I owe many thanks to Mama and Hans for being there for me when I needed you the most. Not to mention offering me a home upon my return! Dad, thank you for your unconditional interest in me and my research, and thank you Siobhan, for being the best sister I could have ever wished for!

Sarah van der Land
Mook, July 2006

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In this online version of the thesis we prefer not to disclose the data in the appendices, for the privacy's sake of the participants. These data are in the possession of professor Jansen at the department of Business Communication at the Radboud University Nijmegen: c.jansen@let.ru.nl. For additional information the author of this thesis can be contacted at: sarah.vdland@gmail.com

Chapter 1. Introduction

> *"The billboards are bizarrely incomprehensible, [they] say only youth can understand them, but none of my younger siblings can either…"*
> (as cited in Halperin, 2002)

Recent epidemiological studies in South Africa estimate that over 60% of all new cases of HIV/Aids currently occur among youth aged 15-24 (Abt Inc, 2001). Therefore, prompt efforts have been made to target this group with HIV prevention from age 12 and older, in order to reduce their risk of becoming HIV infected (Pettifor et al., 2004). Although pharmaceutical research has advanced and introduced antiretroviral medicines (ARTs) which increase the quality of life of a person who has HIV/Aids, these ARTs are not available for everyone in South Africa. Therefore, in this context, prevention of HIV infections is 'today's medicine'.

One of the major challenges South African health organisations face is how to effectively reach this target audience that is at risk of contracting the virus. The comment quoted above refers to the billboards that *loveLife,* one of South Africa's major Aids prevention organisations that focuses on young South Africans aged 12-17, launched in their initial phase in 1999 (Halperin, 2002). At the time, *loveLife's* campaigns reflected contemporary marketing methods which worked well for youth in the United States, but their one-liners such as 'Drop Dead Gorgeous' did not hit home with young South Africans, who were unfamiliar with the references to American popular culture. Other unsuccessful efforts include the South African government's "ABC" campaign (Abstain, Be faithful, Condomize) during the early 1990s. Promoting abstinence to youth is unrealistic, since 'the vows of abstinence break more easily than latex condoms' (as quoted by Elders, 2002). Simply telling a fifteen-year-old girl to "abstain" does little to protect her, whereas providing her with strategies to negotiate safe sex and correctly use condoms may save her life.

The two above-mentioned flaws illustrate the necessity of understanding the audience's perspective. These messages failed to change unsafe practices in part because the audience and sender differed in age and cultural background. Consciously or unconsciously, writers write from their own perspective and base their design decisions on a (stereotyped) imagined audience (Longo, 1995; Schriver, 1997). To tailor the message to the audience's needs, several studies stress "getting to know" the intended audience, the flesh and blood recipients of the health intervention (see Schriver, 1997; Moody, 1991; Bartholomew et al.,

2001). Most importantly, it is crucial to pre-test messages on the audience before disseminating them. Pre-testing increases the likelihood that the message will be *comprehended*, will be *appealing*, and most of all will *motivate* the intended audience to change unsafe practices (Moody, 1991; Bartholomew et al., 2001). Little is known about how document designers in South Africa collect audience data and pre-test draft materials on their intended audiences (Kramer, 2004).

But why do planners of health interventions neglect to carry out thorough audience research? In the words of an employee at a South African Aids prevention organisation: 'We are an NGO, we don't have time and money to conduct an extensive audience analysis' (personal communication, March 15, 2005)[1]. Schriver (1997) points out that if pre-testing is used, it is often used as a 'crash test', a final test on the target audience to evaluate the material *after* the intervention has been produced. Not surprisingly, many creative staff members in the field of advertising are sceptical towards pre-testing and perceive pre-testing as 'enemy number one', since their egos might suffer from the judgement (Grondel, 2005).

Effective messages cannot be developed in a vacuum, neither can they be developed from a single, authoritarian position of 'expertise' (Wallerstein, 1992, as cited in Bartholomew et al., 2001, p. 7). Several studies emphasize that decision-making in the planning of an intervention can effectively be guided by the systematic participation of the audience (Schriver, 1997; Moody, 1991; Bartholomew et al., 2001). As in the words of a frequently cited passage from the Alma-Ata Declaration: "People have the right and duty to *participate* individually and collectively in the planning and implementing of their health" (WHO, 1978, as cited in Bartholomew et al., 2001, p. 19). The fact is, that up until now, remarkably little research has been carried out on participation of the target audience in health campaigns in South Africa.

Therefore, the purpose of this research is to investigate to what extent participatory audience analysis can contribute to the design process regarding the content and form of an HIV/Aids prevention document targeted at young African South Africans. We[2] propose that frequent contact and collaboration with the intended audience (the use of the qualitative data collection method *participatory audience analysis*) may help establish a more user-centred

[1] We prefer not to disclose this person's identity for his/her privacy's sake.

[2] The use of the words 'we' and 'our' refers to the viewpoints expressed by the author of this thesis, Sarah van der Land, who conducted this research project. The plural has been used in reporting this study's research since it is more objective and neutral than the use of 'I' and 'my', and more engaging and personal to read for readers than the use of the passive voice (see Jansen, 2004, p. 313). The exceptions are the sections of this thesis in which we explain that the author of this thesis performed a certain role. For instance, when we describe how the author of this thesis performed the role of moderator or document designer, the words 'I', and 'my' are used.

HIV/Aids intervention of which the content is geared to the audience's needs and presented in a clear and appealing way.

To meet this purpose, this thesis has been divided into two parts that chronologically reflect the design process leading up to the HIV/Aids intervention that we intend to design. In contrast to practice, in which document designers rarely document the process of decision-making underlying the design of their interventions (Schaalma et al., 2000), we will carefully report to what extent participatory audience analysis contributed to adapting the content and form of our intervention to the audience's needs. In order to do so, part I of our thesis focuses on pre-production decisions such as determining a meaningful and relevant *content* for our intervention. In part I participatory audience analysis is employed as a research method to gain insight into the factors that influence the audience's contraceptive usage in order to be able to adapt the content of our intervention to the audience's information needs. Then, in part II, we enter the actual design process of our intervention. In part II participatory audience analysis is used as a research method to analyse the audience's communication preferences in order to determine the appropriate *form* for communicating our content.

This first chapter provides a general introduction to this thesis. Firstly, we will justify why we decided to target our document at this specific audience (section 1.2). Then, in section 1.3, we will review research in the field of Document Design and Health Education in order to gain an understanding of how 'participatory audience analysis' fits within the design process of an HIV/Aids prevention campaign. This will result in a more precise definition of the concept 'participatory audience analysis'. In section 1.4, we will present our aims and research questions. Finally, in section 1.5 an outline of this thesis is provided.

1.2 The Audience: Young African South Africans

To increase the message's effect, Social Marketing principles stress the segmentation of a 'high risk' target audience which is as homogenous as possible among a general population (Smith Romocki, Gilbert, & Flanagan, 2004). One message rarely moves all, and segmentation allows one to design messages that are better tailored to the specific *audience's needs* (Smith Romocki et al., 2004). In this research, an audience of black South Africans aged 12-19 who are enrolled in high schools located in townships (ghettos) in Western Cape, who speak Xhosa as a mother tongue, and English as a second language was targeted for the following reasons:

Black African South Africans account for the largest population (80%) of South Africa (Nelson Mandela/HSRC study, 2002). The first nationally representative survey of HIV

prevalence of South Africa conducted by the Nelson Mandela Foundation (2002) found that the highest prevalence of HIV (12.9%) was among Africans aged two years and older, with peak-incidence (27%) of Africans in the age group 25-29. The prevalence among the White population was 6.2%, Coloureds 6.1% and for Indians the prevalence was 1.6% (Nelson Mandela/HSRC study, 2002). Of youth aged 15-24, youth in informal settlements (townships) showed a significantly higher rate of sexual experience (78%) than their peers in rural areas (58.3%) and urban formal areas (53.2%) (The Nelson Mandela/HSRC study, 2002). The focus of HIV/Aids interventions should therefore be on preventing new cases of HIV. In the words of UNAids advisor Richard Delate: "Those who have not been infected, and they are by far the majority, should be kept that way" (Cape Times, 2005a).

The lowest prevalence of HIV was found in the age group 15-19 (4.8%) in a recent national survey among youth (aged 15-24) conducted by Pettifor et al. (2004). As can be seen in table 1 below, females aged 15-19 displayed a higher HIV prevalence (7.3%) than their male counterparts (2.5%). In general, females are being infected at an earlier age than men, because they tend to seek older (already infected) boyfriends (Abt, Inc 2001). Biological factors also account for females' greater susceptibility to HIV/Aids since their immature vaginal tracts tear easily during intercourse. The mean age of the reported sexual debut of the total sample was 16.7 years. Fear of being perceived as promiscuous for females might explain why they were significantly less likely to report a sexual debut at age 14 or younger (7%), than sexually experienced males (13%). Although this study focuses mainly on improving interventions for reducing HIV prevalence, the high pregnancy rate (33%) and the average age of 18.5 for females to conceive their first child, is an indicator that young people are having unprotected sex.

Table 1. *HIV Prevalence and Sexual Behavior young African South Africans aged 15-19 (Pettifor et al., 2004)*

HIV positive	**Sexual Debut**	**First Child birth**	**Pregnancy Rate**
Males: 2.5% Females: 7.3% Total: 4.8%	Males: 13% less than or equal to 14 Mean age sexual debut: 16.4 Females: 7% less than or equal to 14 Mean age sexual debut: 17 Total: 10% less than or equal to 14 Mean age sexual debut: 16.7	Mean age of first child birth 18.5 years.	33% of sexually experienced women (aged 15-19) reported ever having been pregnant.

One of the reasons why African youth fail to protect themselves against HIV transmission, is because they have inadequate knowledge and skills about contraceptive usage. Most Africans

are part of the lower socio-economic classes of South Africa's society, an economic status that often indicates a poor level of education (Perloff, 2001). Consequently, many Africans face difficulties in overcoming communicative barriers such as illiteracy and understanding the English language (their second language) which is used most frequently in current prevention efforts. Perloff (2001) argues that the risk of youth is also fuelled by young people's tendency to believe in an 'illusion of invulnerability'. Youth rarely believe that a catastrophe such as HIV infection could possibly happen to them and they fail to internalize their personal risks.

By targeting (potentially) sexually active African youth to use contraceptives consistently and correctly, considerable opportunity exists to prevent new cases of HIV transmission. Young people are in the process of learning sexual behavior, and are more receptive to adopting safer practices than older people who are habituated to established (most unsafe) sexual practices (Abt Inc, 2001). Traditional African culture's view of dealing with sexual matters has rapidly evolved after the ending of apartheid legislation in 1994 (Varga, 1997). These cultural shifts present the possibility of influencing cultural values through sexual health education among the new, post-apartheid generation. And most importantly, effective interventions during adolescence have the potential to influence sexual behavior over a long term (Schaalma et al., 2002), shaping the future of the epidemic.

Therefore, it makes sense to focus on improving an HIV/Aids intervention targeted at an audience of young African South Africans aged 12-19 (the age range of their high school), who live in townships in Western Cape, speak Xhosa as a mother tongue and English as a second language. For practical reasons, this research was conducted at two high schools located in the townships of Kraaifontein and Kayamandi in Western Cape. In turn, this segmentation had a positive effect on the sample's homogeneity.

1.3 Bridging the Gap: Participatory Audience Analysis

Too often campaigns fail because the message conveyed was not meaningful and relevant to their intended audience. On a very elementary level, after segmenting a high-risk target audience, a document designer has to make two decisions: 1) What will be the content of the HIV/Aids intervention? (pre-production; Part I of this thesis) 2) How will the content of the HIV/Aids intervention be presented? (Part II of this thesis) (see Smith Romocki et al. 2004; Bartholomew et al., 2001). Participatory audience analysis is a research method that helps answer these two questions by bridging the social gap between the audience and the designer of Aids prevention messages. This section elaborates on the concept of audience analysis and

provides a context in which 'participatory audience analysis' fits within the design process of an HIV/Aids prevention campaign. At the end of this section a definition of the concept 'participatory audience analysis' is given.

In order to increase the user-centeredness of the intervention, and hence its impact, Schriver (1997) suggests three audience analysis strategies: 1) intuitive audience analysis 2) classifying audience analysis, and 3) feed-back driven audience analysis. Schriver (1997) stresses that although there is no blueprint, the best results are often obtained when these audience analysis strategies are used interchangeably during various phases of the writing process. Most document designers try to imagine themselves as a member of their audience, relying heavily on their emphatic skills, and use Schriver's (1997) first strategy: *intuitive audience analysis*. An intuitive approach can only be successful when the document designer him/herself is a representative member of the target audience (a rather unrealistic, but ideal form of participatory audience analysis). This intuitive strategy evidently leads to complications when the document designer and the target audience differ in culture, race, age and information needs, and most important: the document designer neglects to evaluate drafts on the intended audience. For instance, Schriver, Hayes & Cronin (1996) asked the target audience of American teenagers to evaluate drug education brochures in the US. Their study made clear that there was a significant gap between the middle-aged document designers 'imagined' audience of youth, and the real audience. Reportedly the teenagers pointed out that the author's tone of voice ("Was this written by someone's grandma?"), and the outdated graphics which were chosen ("Is this picture a seventies kind of guy?") did not work very well with them (as cited in Schriver, 1997). This example illustrates the importance of audience feedback in order to address the document's content and form to the audience's needs.

Document designers who go beyond this approach use a conventional *classifying audience analysis* (as suggested in most studies e.g. Bartholomew, 2001; Smith Romocki et al., 2004; Maibach et al., 1993, as cited in Perloff, 2001). This method often serves as a point of departure for developing a health campaign. Document designers who use this method, for instance, conduct literature research and gather demographic information, examine anthropological studies, investigate the audience's media consumption and literacy levels to determine which medium is most appropriate to convey the message. Difficulties arise when the documentation is not accurate and up-to-date, or does not provide insight into the particular audience (e.g adolescents from Kayamandi) and/or behavior of interest (e.g. condom usage). Moreover, Schaalma et al. (2000) point out that parameters of successful

communication strategies among a particular audience are rarely documented. These are very plausible constraints when designing messages for so-called development countries. A pitfall of solely focussing on a classifying audience analysis strategy is that most document designers still use an *intuitive audience analysis* strategy when translating their interpretations of the literature study into design decision in the actual material. In turn, as previously illustrated in Schriver's et al. study, considerable opportunity exists that the message will fail to interest the audience, and hence will be rejected by the audience. In our case of HIV/Aids interventions, which involves matters of life and death, it seems evident to challenge personal assumptions, and research if the intervention "works with the audience".

Very few document designers use Schriver's (1997) third method, the *feedback-driven audience analysis,* to collect new audience data among the intended audience. This method derives from a trend in technical communication in the 1980s and 1990s to increase the user-centeredness of a text called *participatory design*. Whereas the former two audience analysis strategies suggest a top-down approach, this third method focuses on a *bottom up* approach. According to Bartholomew et al. (2001), a participatory approach is crucial in order for planners to fully understand and convey "the real world" of the intervention's context. Hence, the audience determines *what* is being said (e.g. content), and *how* it is being said in the intervention (e.g. form). This method proposes that by collaborating and evaluating draft materials with the target audience as early and as often as possible in the design process helps ensure that the text is tailored to the target audience's needs. Moody (1991) also perceives that the audience should be the ground line for all campaign decisions, and provides practical insight into how to obtain this audience data in development countries. In the context of South Africa, little is known about how (and if) health organizations evaluate their materials with their intended audiences before disseminating them (Kramer, 2004).

A general shortcoming of the above-mentioned conventional audience analysis and participatory audience analysis is that few approaches are driven by Social Science theory in the collection of their audience data. While recent research has shown that interventions that are based upon articulated theories about what leads to behavioral change, are more likely to be effective (Bartholomew et al., 2001). Moreover, these two audience analysis approaches rarely acquire their audience data in an academic way. Hence, we may question the reliability and validity of the translation of their findings into the established intervention.

But why do planners fail to incorporate theory and to scientifically conduct audience research? Kok et al. (2004) point out that translating findings based on theory into interventions is a core intellectual and academic process. This might explain why planners

experience difficulties in this process and find it time consuming. To guide planners in this process, Bartholomew et al. (2001) established the Intervention Map. This Intervention Map provides guidelines for theory-driven, effective decision making in each step of the design of an intervention. In the Intervention Map, three complementary processes are suggested when collecting data concerning the determinants of the audience's risky behavior: 1) examining theory, 2) reviewing empirical evidence and 3) collecting new data. According to Bartholomew et al. (2001), applying these three processes will give more "explanatory power" of why the audience of interest performs the behavior. As we can see, there is a great resemblance between Bartholomew's et al. (2001) review of empirical evidence and Schriver's (1997) classifying audience analysis and Bartholomew's et al. (2001) collection of new data and Schriver's feedback-driven audience analysis. We regard the latter processes of Bartholomew et al. (2001) and Schriver (1997) as *participatory audience analysis*. On the basis of this review, participatory audience analysis is defined in this thesis as:

> '*Systematic, frequent contact and collaboration with representative members of the audience, carried out scientifically and driven by theory in order to determine the appropriate content and form of the message.*'

1. 4 Aims and Central Research questions

The main aim of this research is '*to investigate to what extent participatory audience analysis can contribute to the design process regarding the content and form of an HIV/Aids prevention document targeted at young African South Africans in South Africa'*. This research is divided into two parts.

The aim of part I is *' to investigate how participatory audience analysis can contribute to the design process regarding the content of an HIV/Aids prevention document targeted at young African South Africans in South Africa.'* In order to investigate the audience, the following research questions can be identified:

Part I: 1. What might be according to a preliminary investigation of theory, exploratory interviews and empirical evidence, relevant determinants of contraceptive usage of young African South Africans, and to what extent do these determinants influence their contraceptive usage?

2. What data gaps can be identified in the preliminary investigation, and what

audience analysis questions can be posed in order to guide the data collection of the focus group interviews?

3. To what extent do the findings in the focus group interviews support the preliminary research on the audience's determinants of contraceptive usage?
4. How can the findings of part I be translated into communication strategies for the *content* of an Aids prevention text targeted at young African South Africans?

The aim of part II is *' to investigate how participatory audience analysis can determine how the content should appear in an HIV/Aids prevention document targeted at young African South Africans in South Africa'.* The following research questions can be identified:

Part II: 5. What can we learn about the audience's communication preferences by evaluating an existing Aids prevention text aimed at young South Africans of *loveLife* through participatory audience analysis (focus group interviews intended audience)?

6. How can participatory audience analysis (collaboration four representative audience members) contribute to *presenting* the content of the Aids prevention text in an appealing way (e.g. language, tone of voice, and form)?

1.5 Outline of this thesis

In part I, qualitative data collection methods are used (exploratory interviews, focus group interviews and document analysis) to determine the *content* of the intervention. In part II, the strengths and weaknesses of an existing text are evaluated. Secondly, representative audience members participate in the design process in order to determine how the content of the HIV/Aids prevention intervention should be *presented*. The product of our research in part I and part II is an HIV/Aids prevention text aimed at young African South Africans that is based on a high level of participatory audience analysis. A logical and essential next step would be to empirically test whether our text, which is based on a high level of participatory audience analysis, is more *effective* than a text that is based on a low level of participatory audience analysis. The results obtained from such a test could provide proof as to the extent to which the use of the qualitative research method participatory audience analysis contributes to designing more effective HIV/Aids prevention interventions. Unfortunately, due to time and space constraints, we were unable to conduct such empirical research within the framework of this thesis. In chapter 8, we will provide suggestions for further research.

Part I: Determining the Content of our Aids Prevention Intervention

Part I: Introduction Research

Writing effective interventions is both an art and a science. According to Bartholomew et al. (2001), an intervention's effect can be increased if the content anticipates the audience's information needs. Therefore, this part focuses on researching which determinants help or hinder young African South Africans to use contraceptives. In part II we will focus on the creative aspect of writing and investigate how to effectively communicate this content.

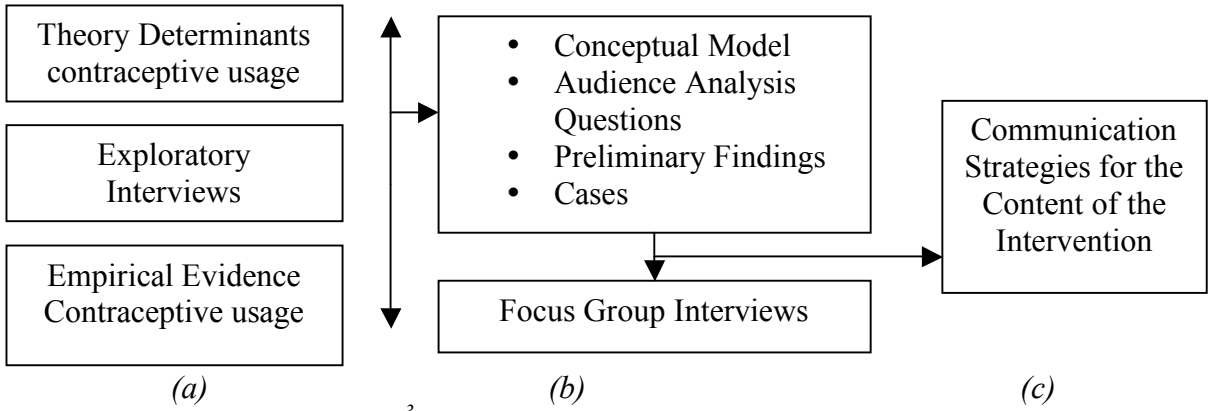


Figure 1: Research Model Part I[3]

The pre-production aim of part I is *'to investigate how participatory audience analysis can contribute to the design process regarding the content of the HIV/Aids prevention document targeted at young African South Africans in South Africa.'* To meet this aim, three research stages will be executed. In the first, preliminary stage *(a),* determinants relevant to young African South Africans contraceptive usage are identified from familiar behavioral change theories, exploratory interviews, and empirical studies. This insight is integrated in a comprehensive conceptual model that illustrates the linkages between these determinants and predicts how these determinants influence a person's contraceptive usage (chapter 2). Identified gaps in data will help define audience analysis questions (research questions) of what needs to be further researched in focus group interviews (section 2.7). On the basis of the exploratory interviews, *cases* or role model stories (the research instrument used for the focus group interviews) can be established (chapter 3). In the second stage *(b)* two focus group interviews will be conducted to test the preliminary findings of our audience's contraceptive usage (chapter 4). With the insight obtained from our findings, we enter the final stage of our research *(c)*. In this third stage, we will draw conclusions from our findings on the audience's contraceptive usage. These conclusions will subsequently lead to recommendations for the *content* of our Aids prevention intervention (chapter 5).

[3] This presentation is based on Verschuren & Doorewaard (2004)

Chapter 2 Determinants of Contraceptive Usage among Young African South Africans: a conceptual framework

2.1. Introduction

Why do people do the things that they do? Since the purpose of part I is to determine the content of our HIV/Aids intervention, we need to investigate what determinants exert influence on our audience's contraceptive usage. Equipped with this insight, we can translate our findings into an HIV/Aids intervention that is proposed to better comply to the audience's information needs. This chapter seeks to identify the determinants relevant to young African South African's contraceptive usage which need to be further researched in the focus group interviews. In section 2.2, we will first establish a simple conceptual model of determinants of contraceptive usage based on several considerations. Within the three main components of this simple conceptual framework the interpersonal influence (section 2.3), the individual motivation (section 2.4), and the sexual arena (section 2.5), we will seek to answer our first central research question: *'What might be according to a preliminary investigation of theory, exploratory interviews and empirical evidence relevant determinants of contraceptive usage of young African South Africans, and to what extent do these determinants influence their contraceptive usage?'* The goal of this chapter is to develop a more comprehensive second version of our conceptual model of contraceptive usage in which the insight obtained from the preliminary investigation is integrated (section 2.6). This preliminary investigation will also help to answer our second central research question: '*What data gaps can be identified in the preliminary investigation, and what audience analysis questions can be posed in order to guide the data collection of the focus group interviews?* (section 2.7).

2.2 A Simple Conceptual Framework

Rather than to rely on one favourite theory in explaining human behavior, theories from multiple disciplines will be reviewed that have proven their usefulness in identifying factors relevant to contraceptive usage. These factors are defined in this research as 'determinants of behavior'. This section will first provide an overview of the frequently referred to Integrated Model of Behavioral Prediction (IMBP) of Fishbein & Yzer (2003). We will then briefly motivate the use of the IMBP as a source of inspiration in establishing a first version of our conceptual framework of determinants of contraceptive usage. This first version will be presented at the end of this section.

With its holistic overview of the determinants that influence behavior, the IMBP offers an ideal point of departure in exploring relevant determinants of contraceptives. The IMBP incorporates the main determinants of three cognitive decision theories that have been widely cited in health behavior research: the Health Belief Model (Janz & Becker, 1984), Social Cognitive Theory (Bandura, 1997) and the Theory of Reasoned Action (Ajzen & Fishbein, 1980). The IMBP model was extensively tested in numerous (mostly quantitative) studies and its underlying theory has proven to be valid.

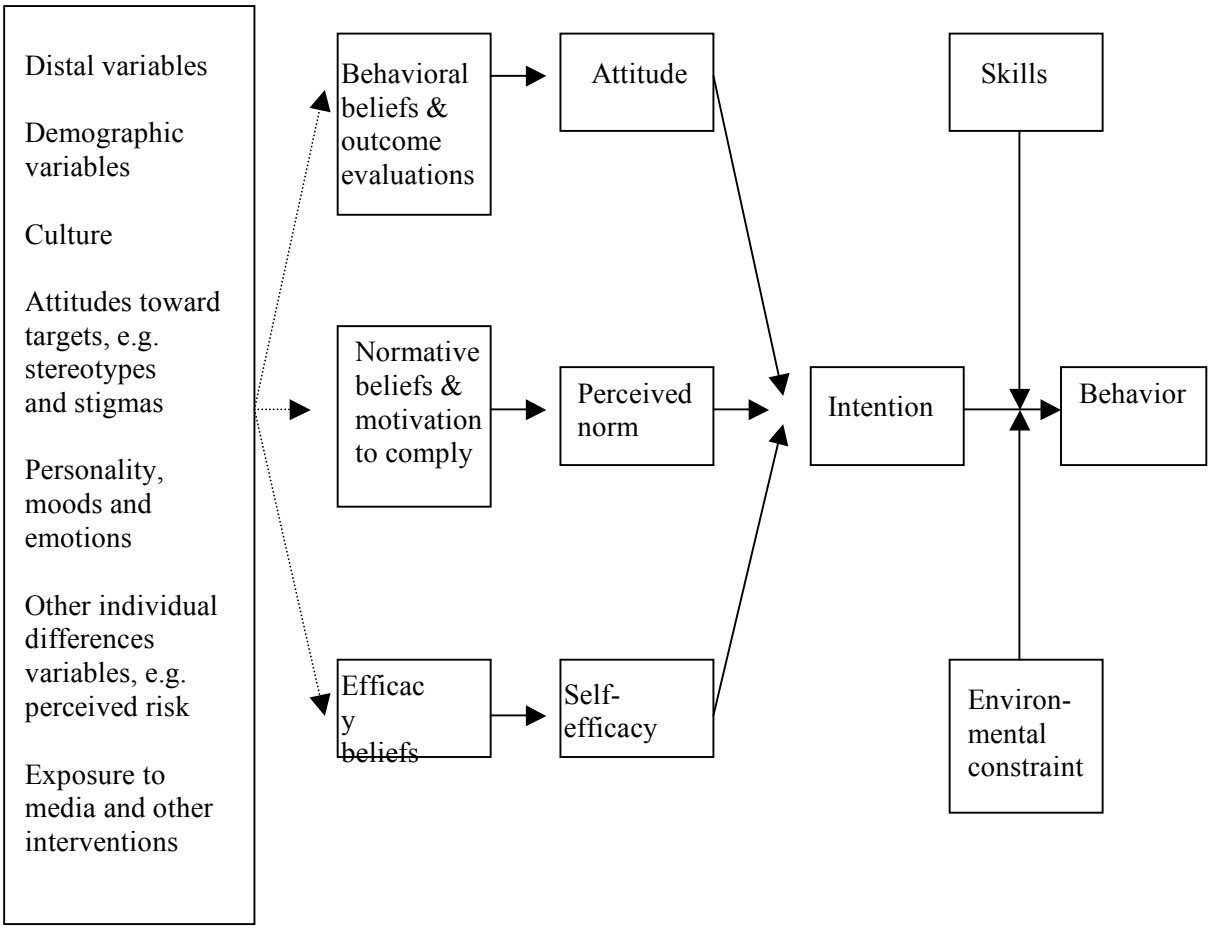


Figure 2.1 *An Integrated Model of Behavioral Prediction (Fishbein & Yzer, 2003, p. 167)*

Like other cognitive decision models, human beings are perceived in the IMBP as rational and the model proposes that a cognitively established 'behavioral intention' is the best predictor of behavior. In figure 2.1, the key determinants of the IMBP are illustrated. Fishbein & Yzer (2003) have divided the key determinants of the IMBP into *proximal variables* and *distal variables* (Fishbein & Yzer, 2003). *Proximal variables* (e.g. attitude, perceived norm and self-efficacy) are expected to have a more direct influence on the behavioral intention. *Distal variables* (e.g. demographic variables, culture and personality), on the other hand, are

suggested to have an indirect effect on the underlying beliefs of the proximal variables (Fishbein & Yzer, 2003).

The three primary determinants of the behavioral intention are attitude, perceived norm and self-efficacy (Fishbein & Yzer, 2003). Fishbein & Yzer (2003) define attitudes as 'the person's feelings towards performing the behavior', which are based upon two elements: one's 'beliefs' about the positive and negative consequences of performing a specific behavior and the 'evaluation' of these consequences. For example, the more a person perceives that the positive outcomes of using a condom (e.g. reducing risk of HIV transmission) outweigh the disadvantages that he or she believes condoms have (e.g. reduced sensitivity), the more favourable one's attitude towards using contraceptives will be.

The second determinant of behavioral intention is the perceived norm. Perceived norm is defined by Fishbein & Yzer (2003) as 'the extent to which an individual perceives that significant others think that he or she should or should not perform the behavior'. Perceived norm is based upon two elements: the perceived 'normative beliefs' projected by significant others, and the person's 'motivation to comply' with these beliefs. For instance, the more a person is motivated to comply with the projection of a friend's social norms regarding the usage of condoms, the stronger the 'perceived norm' will be and the greater influence it will have on the behavioral intention.

The third determinant, self-efficacy, is also expected to have a more direct influence on the behavioral intention. Self-efficacy originally derives from Bandura's Social Cognitive Theory (1977), and is defined by Fishbein & Yzer (2003) as 'the person's perception that he or she can perform the behavior under a variety of challenging circumstances'. For instance, the more a woman perceives that she is efficacious in convincing her partner to use contraceptives, the more likely it is that she will successfully act according to her perceptions and try to convince her partner.

Looking at the IMBP, we see that the determinants 'skills' and 'environmental constraints' moderate a positive behavioral intention. According to Fishbein & Yzer (2003), a positive behavioral intention does not necessarily imply that the person will act on his/her intentions. For instance, if the 'environment' does not support positive health behavior (e.g. condoms are not accessible) this will negatively effect a person's contraceptive usage. Moreover, if a person lacks sufficient 'skills' and does not know how to properly use a condom, a positive behavioral intention can negatively be modified. Hence, the person will not use contraceptives and might risk HIV/Aids transmission and/or unwanted pregnancies.

In the context of predicting sexual behavior, several limitations of IMBP's theory stimulated us to establish a new conceptual model. In order to ensure that the content of our intervention complies to the audience's information needs, we need to obtain an in-depth understanding of the factors that influence the audience's contraceptive usage. The fact is that in this exploratory stage of our research we know little about the audience's complex underlying motivations for not using contraceptives. This encourages us to welcome theoretical and empirical perspectives that complement IMBP's theory when applied to sexual decision making. We stress that in this stage the presented elaboration is very basic, but it will be elaborated on in detail in the preliminary investigation that appears in section 2.3 and onward.

A first and crucial limitation of the IMBP is that it largely overlooks the fact that the act of sexual decision-making involves more than one individual. As Parker (2004) points out, the IMBP (as other cognitive behavioral change theories) ignores the fact that in sexual interactions an individual's intent to use contraceptives is mediated by the partner. In our conceptual model, the component *the sexual arena* is proposed to exert the most direct influence on an individual's behavior. Within the component *sexual arena,* we will complement IMBP's moderating determinants 'skills' and 'environmental constraints' by emphasizing the interpersonal aspect of sexual interactions.

A second limitation we found in the IMBP is that the theory does not acknowledge the role of 'affect' in the decision-making process of using contraceptives. The IMBP approaches humans as if they always rationally reason whether or not they will perform a certain behavior. Whereas when people engage in sex, they often tend to suppress such rational thought patterns since they fear that this will reduce their feelings of intimacy and connectedness. Moreover, particularly in the context of sex, the best of cognitively formed intentions can easily be overtaken by emotions such as lust and desire. Thus, as Perloff (2001) points out, not acknowledging the affective nature of sexual activity might explain why "rational" cognitive decision models (such as the IMBP) experience difficulties in predicting contraceptive usage. In the component *individual motivation* of our conceptual model, we will further investigate the division between cognitive and spontaneous, "unplanned" driven sexual decision making by examining how factors such as 'affect' and 'attitude strength' exert an influence on an individual's intention to use contraceptives before entering the sexual arena. To obtain a broader perspective on the determinants that influence this decision-making process at the individual level, we will also complement IMBP's determinants attitude and self-efficacy with other determinants of individual motivation for using contraceptives.

Thirdly, when it comes to sexual behavior, IMBP's theory provides a fairly limited explanation of how a person's socio-cultural context influences his or her sexual behavior. Only IMBP's 'perceived norm' and the distal variable 'culture' refer to the influence of the socio-cultural context. Whilst Bartholomew et al. (2001) acknowledge that all individuals are embedded in social contexts, including families, communities and organizations. Moreover, Somma & Bodiang (2003) argue that it is important to understand an individual's social-cultural context since sexual behavior and sexuality itself are culturally determined. Parker (2004) contributes to this notion and states that without a social environment that supports and enables healthy sexual behavior, it is extremely difficult for individuals to persevere with the desired behavior. Within the component *interpersonal influence* of our first conceptual model, we will complement IMBP's existing determinants 'perceived norm' and the distal variable 'culture' in order to examine to what extent underlying socio-cultural beliefs influence a person's motivation to use contraceptives.

To conclude, IMBP's limitations imply that we need to establish a new, more comprehensive conceptual model of sexual behavior. In this stage, we integrate the above-mentioned considerations into a first version of our conceptual model. As we can see in figure 2.2, in this first version of our conceptual model we identified three distinct components of influence on a person's contraceptive usage: 1) interpersonal influence 2) individual motivation, and 3) the sexual arena. The determinants in the component 'interpersonal influence' refer to a person's socio-cultural context. These determinants are proposed to indirectly influence a person's underlying motivation to use contraceptives (section 2.3). Secondly, the determinants within the component 'individual motivation' refer to a person's intention to use contraceptives *before* being confronted to make such decisions at 'le moment suprême' (section 2.4). Finally, the determinants in the component 'sexual arena' are suggested to be of the greatest influence on a person's contraceptive usage. These determinants refer to the availability of contraceptives, the knowledge on how to use them correctly and the sexual negotiation with the partner (section 2.5).

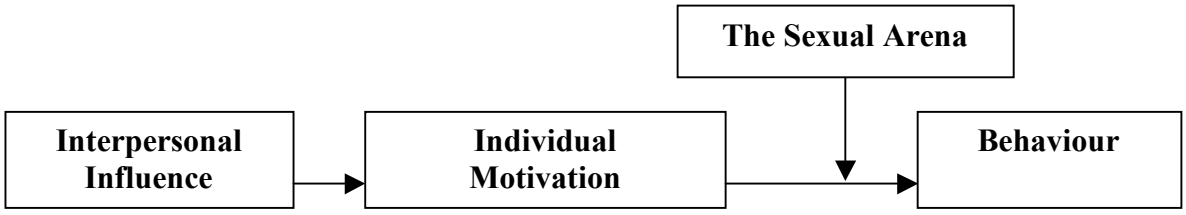


Figure 2.2 *First version of Conceptual Model of Contraceptive Usage*

This first version of our conceptual model will function as a framework for our preliminary investigation. Within this framework we intend to identify determinants relevant to the audience's contraceptive usage based on a preliminary investigation of: 1) theory, 2) exploratory interviews, and 3) empirical evidence. These three processes of collecting data are referred to by Bartholomew et al. (2001) as 'the three core processes of Intervention Mapping'. Bartholomew et al. (2001) stress that by applying these three processes a better understanding of why the audience performs the risky behavior can be obtained. The theoretical insight extracted from this preliminary research will be integrated into a definite, and more comprehensive version of our conceptual model contraceptive usage (section 2.6). Moreover, this preliminary investigation will help to determine what requires further research. Based on this insight, we can formulate audience analysis questions (section 2.7) which will guide the data collection of our second, main research stage: the two focus group interviews.

The methodological details on how this preliminary investigation was conducted are discussed in chapter 3. This is in keeping with the classic 'five chapter structure' used to present theses (Perry, 1998). In this approach, chapter 2 identifies research variables and discovers research questions by reviewing literature, while chapter 3 describes the methodology used to collect the data in order to answer the research questions, and in chapter 4 the analysis of the findings is presented (Perry, 1998). When applied to this thesis, as part of Bartholomew's et al. (2001) three processes of collecting data, chapter 2 additionally reviews the findings obtained from the exploratory interviews that were held to identify the determinants of the audience's contraceptive usage. In order to emphasize the analysis of our main research in chapter 4, the focus group findings, we structured this thesis to fit the 'five chapter structure'. Therefore, the methodological justification of both our preliminary investigation (including the exploratory interviews) and focus group interviews are presented in chapter 3.

In section 2.3 to 2.5, the findings of our preliminary investigation will consistently be presented in the same order. Firstly, we will review *behavioral change theories* that complement the IMBP's theory. Secondly, we will present the results of three *exploratory interviews* with seven representative audience members. The first of these interviews was held with three boys (mean age: 17), the second interview was held with two boys (mean age: 14), and the third interview, was held with two girls who were on average sixteen years old. On the basis of the exploratory interviews, the content of the *cases* or role model stories will be determined. These cases will be used in the focus group interviews to generate discussion among participants (see chapter 3 for methodological details). The exploratory interviews

reflect our participatory audience analysis approach of systematic and frequent contact with the individuals for whom the intervention is intended. Finally, we will present *empirical evidence* from studies on African adolescent sexual decision making which were previously carried out. The findings obtained from our preliminary investigation and our focus group interviews are intended to contribute to meeting our aim: to determine the content for our HIV/Aids intervention.

2.3 Interpersonal Influence

How do people view, experience and behave in a sexual relationship? As briefly elaborated in the previous section 2.2, people are embedded in social contexts. To a certain extent, a person's sexual behavior is influenced by the people with whom he or she affiliates. In this section, we will first review theory in order to specify what we refer to as the audience's social-cultural context (see 'Ingroup: parent and peers'). After doing so, we will proceed with our preliminary investigation of theory, exploratory interviews and empirical evidence within the determinants s*ocio-cultural influence* and *interpersonal communication*. Through this investigation we seek to deepen our understanding of the audience's socio-cultural norms regarding appropriate sexual behavior and to obtain insight into the manner in which communication about sexual matters occurs within the audience's social context. These two determinants are part of the component 'interpersonal influence' that is proposed to indirectly influence a person's motivation to use contraceptives.

Ingroup: Parents and Peers

The interpersonal context and its inherent culture is a rather broad concept. This concept can be more specifically defined by applying Tajfel & Turner's (1979) Social Identity Theory (as cited in Hewstone et al., 2002). Social Identity Theory proposes that people perceive themselves to belong to a certain group (our *ingroup*): "I am a student at the RU Nijmegen" or "I am an African" (as South Africa's President Mbeki proudly proclaims). The more we identify ourselves as members of our ingroup, the more we believe that we should act in accordance with the perceived social norms of this group (Tajfel and Turner, 1979, as cited in Hewstone et al., 2002). Empirical evidence was found to support this theory, particularly in the field of organizational studies focussing on corporate mergers and their effects on the personnel involved (see Leeuwen et al., 2003).

In this research, parents and peers are perceived as influential (ingroup) members of young African South Africans that transmit the appropriate socio-cultural norms of sexual

behavior and contraceptive usage. The influence of *parents* is researched, because recent research conducted in the Netherlands by the Rutgers NissoGroep and Soa Aids Nederland indicated that youth who grow up in a stable, affectionate family situation in which they feel comfortable discussing sexual relationships with their parents, are less likely to have unsafe sex, and are less likely to engage in sex against their will (Graaf et al., 2005). The influence of *peers* is researched, because peer pressure is identified by Stanton, Li & Pack (2002) as one of the major factors why youth in South Africa engage in sex at an early age increasing HIV risk (as cited in Pettifor et al., 2004). Peer-pressure is found to stimulate social norms that accept or encourage high numbers of sexual partners (Abt Associates Inc, 2001). At this point, we will present the results of our preliminary investigation of theory, exploratory interviews and empirical evidence in relation to the determinants s*ocio-cultural influence* and *interpersonal communication*.

Socio-cultural Influence

The reasons *why* we are motivated to comply with the norms of our ingroup, and *how* we get acquainted with these norms are not elaborated in detail in Fishbein and Yzer's IMBP (2003). According to Baumeister and Leary (1995), complying with the norms of our ingroup presumably has an evolutionary basis since some survival tasks are best accomplished by group cooperation. Baumeister and Leary (1995) propose in their 'need to belong theory' that seeking affectively positive interaction with ingroup members can be considered as a fundamental human motivation. Being deprived of this need can result in lack of self-esteem, and other severe ill-effects such as depression (Baumeister & Leary, 1995). The script approach (Metts & Spitzberg 1996) proposes that people learn the appropriate rules on how to initiate and consume sexual activity (their culture's *sexual script*) from their ingroup. The role ingroup members play in this sexual script can vary in accordance with their gender-orientation (Metts & Spitzberg 1996, as cited in Perloff, 2001). For example, the traditional sexual script is for men to initiate sexual activity and for women to be more passive (Edgar & Fitzpatrick, 1993, as cited in Perloff, 2001, p. 39). We will now present recent data on 'socio-cultural influence' from our exploratory interviews with five boys and two girls.

Exploratory interviews regarding the 'socio-cultural context' of young South Africans

The agenda of youth's parents was marked by the struggle for democracy. Due to this struggle, many parents were deprived of the possibilities that their wealthier (white) counterparts could attend and are now poorly educated. Living in separate assigned areas

(townships), parents passed on the traditional upbringing of segregated gender norms to their children which they had done for centuries. These townships are a dangerous place where violence and criminality, drugs and alcohol are part of youth's everyday reality. As one fourteen-year-old boy said: 'We have to be inside the house before dark, at eight o'clock in the evening, because the *robas* (rapists) might get their hands on us. My step-dad is a good man from Monday to Friday 5 pm. From Friday to Sunday people in Kayamandi drink non-stop.'

Culture is not a static construct. After apartheid ended in 1994, traditional African culture was rapidly 'westernized'. In the words of a girl aged sixteen: 'People are more and more influenced by the media, and the traditional cultural values and ceremonies are more and more disappearing.' For instance, one of the two interviewed girls said that nowadays the initiation rite *Ntonjane* for females around the age of 21, in which older women teach the girl her responsibilities as a woman and how she should take care of her child, only takes place in the rural areas of South Africa. However, some cultural practices such as *polygamy,* remain present. In the interview with the three sexually active males, it became clear that it is not uncommon for males to have one 'steady partner' and additional casual girl friends. As one seventeen-year-old male said: 'If I love more than one girl at the same time, I have to make a plan to see them all.' At first glance, young African's interpersonal context does not seem to support and enable healthy behavior. We will now review what was found about township life in the literature.

Empirical evidence regarding the 'socio-cultural influence' of young South Africans

Varga (1997) studied the socio-cultural context of sexual behavior of African youth in Kwazulu-Natal, South Africa's hardest hit province by Aids. According to Varga (1997), culturally accepted *segregated gender roles* are an important determinant of African youths sexual behavior, a view that is in accordance with Metts & Spitzberg (1996) script approach (as cited in Perloff, 2001). For example, the gender constructs of traditional, masculine Zulu culture, encourages men to seek multiple sex partners, whilst females fear of being seen as promiscuous and are culturally dictated to remain submissive and silent (Varga, 1997). Traditionally, women were not allowed to initiate and enjoy sex (Shillinger, 1999). As said by a young Xhosa female in Wood et al. (1998) study: 'We have been brought up to think that "it is a man's place".

Peer-pressure to engage in sex is an omnipresent phenomenon in the lives of both males and females. In Kwazulu-Natal, young men experience pressure from their male friends

to become a prestigious *isoka*. *Isoka* is the Zulu-term used to refer to the yardstick by which a man's intelligence and success are measured (Varga, 1997). Failing to win a woman is perceived as being a social failure, and the social stigma attached to *isishimane* (the opposite status to *isoka*) is experienced worse than 'an organic disease' (Varga, 1997, p. 59). Seeking *isoka* status (for males), might explain the forced nature of sexual relationships and be related to the high reported rate of rape.

The influence of female peers on young Xhosa females sexual behavior was studied by Wood et al. (1998). They found that young females who had not yet become sexually active, were excluded from the group since they were not able to contribute to the discussion. In the words of a young girl; "If you want to belong to that group you end up doing it, otherwise you become isolated and nobody wants that" (as cited in Wood et al., 1998). A recent study conducted by Pettifor et al. (2004) found that when youth aged 15-19 were asked 'How much pressure do you get from friends to have sexual intercourse?' Males (43%) were more likely to report that they experienced pressure from their peers to have sex than their female (28%) counterparts (Pettifor et al., 2004).

The westernisation after apartheid legislation evolved and loosened the sexual norms of traditional African culture (Varga, 1997). Today, the post-apartheid generation feels stuck between two cultures and experiences confusion about the appropriate norms of sexual behavior (Varga, 2000, as cited in Reproductive Health Outlook (RHO), nd). For example, Varga (1999) found that youth in Kwazulu-Natal combine contemporary attitudes like "sex is a must" with traditional mores such as "condoms are for prostitutes" (as cited in Shillinger, 1999). This is a dangerous tendency, resulting in high-risk sexual behavior. A recent study by Pettifor et al. (2004) tried to obtain some measure of ingroups social norms. Youth were asked whether or not they thought their friends agreed with a number of statements. Similar to their own opinions, youth indicated that having many sexual partners was disproved by 90% of their friends, 97% of their friends disproved with pressuring someone into sex, and 85% of their friends thought they should use a condom every time they have sex.

To conclude, the focus group interviews will have to provide information on the extent to which cultural segregated gender roles and social norms still prevail. In the conceptual model, the concept 'social influence' will be used to refer to the extent young African South Africans perceive that parents and peers influence their sexual behavior and contraceptive usage.

Interpersonal Communication

> *'The government [loveLife, SvdL] says "let's talk about it", but there is no way I can talk about sex with my parents,'* as said by a male aged 17 (see appendix A).

In South Africa, the text 'talk about it' is predominately featured on all campaign material of *loveLife*. 'Talk about it' is based on the premise that open communication about sexuality and HIV/Aids will challenge social norms and stimulate a positive behavior change (Pettifor et al., 2004). Recently, a special campaign targeted at parents 'Love Them Enough to Talk about Sex' has been designed by *loveLife* in order to improve communication about sexual matters between parents and children (Harrison & Steinberg, 2002). The above cited comment was made by a boy in one of the three exploratory interviews. His comment increased our interest in interpersonal communication of sexually matters with parents and peers.

Interpersonal communication with parents and peers about adolescent contraceptive usage does not receive much attention in Fisbhein & Yzer's (2003) IMBP. Research has shown that talking about sex and contraceptive usage makes people more aware of their 'personal risk' of contracting HIV/Aids, and helps partners to decide on mutually acceptable and safe sexual practices (Waldron, Caughlin, & Jackson, 1995, as cited in Perloff, 2001, p. 37). Recent research conducted in the Netherlands confirms that children who are encouraged by their parents to talk about contraceptive usage, are more likely to delay sexual debut, are better informed about correct contraceptive usage, and tend to use contraceptives with a greater consistency (Graaf et al., 2005).

Exploratory interviews regarding 'Interpersonal Communication'

In general, the seven participants in the exploratory interviews pointed out that an inhibiting taboo precludes youth to discuss sexual matters with their parents. Two female participants stated that female figures such as their cousins, peers and their twenty-seven-year old aunt, had informed them about sexual practices. Two not sexually active boys, both aged fourteen, were clearly influenced by their mother's perception regarding sexual matters. One of these boys said that his mother explicitly made clear that sex was only appropriate for young people aged eighteen and older, *after* the marriage ceremony had been fulfilled.

Empirical Evidence regarding 'Interpersonal Communication'

Traditionally, talking with parents about sexual matters was perceived as a taboo in African culture (Varga, 1999, as cited in Shillinger, 1999). Unmarried aunts and older sisters informed

girls about the appropriate rules of sexuality and intimate relationships, whilst uncles and older brothers did the same for boys (Varga, 1999, as cited in Shillinger, 1999). Due to the westernisation of African culture, these traditional initiation mechanism are gradually disappearing. According to Rojas (1999), a World Health Organisation representative, this leads to sex that has 'no aspects beyond the instinctive physical' (as cited in Shillinger, 1999).

Although a recent study by the African Strategic Research Corporation (2002) found that 40% of parents cite HIV/Aids as their major concern for their children, and a further 21% stated that fear of sexual abuse caused them great anxiety, only half (46%) talked often to their children about HIV/Aids (as cited in Harrison & Steinberg, 2002). Such lack of communication contributes to youths feelings of being on their own in an aggressive and evolving sexual environment (Varga, 1999, as cited in Shillinger, 1999). Pettifor's et al. (2004) study confirmed that youth often feel that their parents are absent and neglect talking with them about sexual matters: 47% of boys perceived that they were able to ask their parents questions about sex compared to 59% of girls aged 15-19.

Sexual matters are mostly discussed with peers (Pettifor et al., 2004). However, African youth reported that peers were not perceived as credible informants since only 2% indicated that they had learned most about HIV/Aids from their peers (Pettifor et al., 2004). Pettifor et al. (2004) found that these talks frequently referred to pressure to engage in risky sex. A study carried out by Wood et al. (1998) found that female peers reinforced the legitimacy of sexual coercion and stated that silence was the only appropriate response to such practices. As stated by a female participant in Wood's et al. (1998) study, "They told me that you don't tell that he forced you."

The concept 'interpersonal communication' will be used to identify how information with regard to contraceptive usage is transmitted from parents and peers to young African South Africans. In the focus group interviews, it will be researched to what the extent these feelings of not being able to talk with parents and peers are confirmed. Subsequently, insight is obtained in how participants feel about discussing this topic with their parents and peers. It is important to investigate this, since poor information transmission stimulates the forming of myths and misconceptions about how to protect one selves against HIV/Aids. In the conceptual model, the determinant 'interpersonal influence' will be implemented as following:

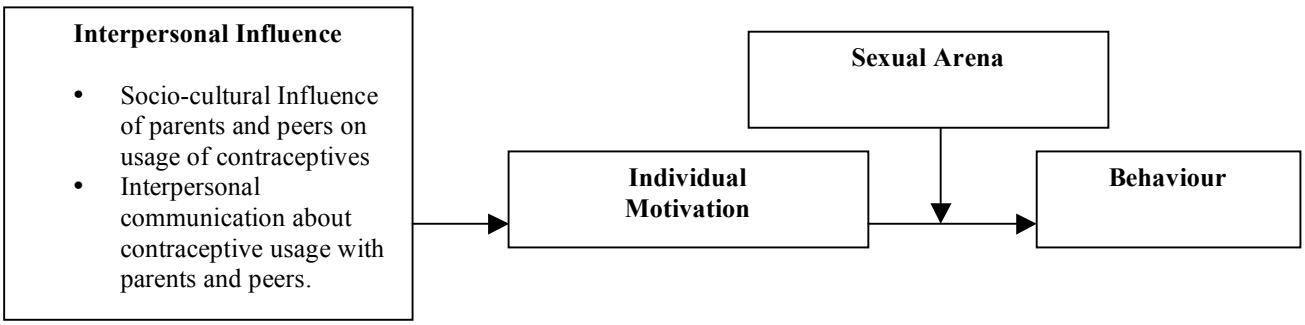


Figure 2.3 *Interpersonal Influence*

2.4 Individual Motivation

In the previous section (2.3), we reviewed socio-cultural determinants within the component 'interpersonal influence' that are proposed to underlie a person's motivation for using contraceptives. In this section, we focus on determinants on the individual level that are proposed to influence a person's intention to use contraceptives. As indicated in section 2.2, the IMBP falls short in acknowledging the role of affect in sexual interactions. Therefore, we will first seek to establish a more comprehensive theoretical perspective on IMBP's concept 'attitudes' and the conditions under which attitudes predict behavior. Furthermore, we will integrate determinants that complement IMBP's *attitude* and *self-efficacy* in the conceptual model's component 'individual motivation'.

Attitudes

Through decades attitudes have been one of the most researched determinants in Social Psychology due to the apparent attitude-behavioral relationship (Bohner & Wänke, 2002). In the IMBP of Fishbein & Yzer (2003), the concept of attitudes has been placed in a less prominent position. Instead of solely focussing on the attitude-behavioral relationship, the IMBP perceives attitudes as being one among various proximal determinants (e.g. self-efficacy, environmental constraints) and it has conceptualised the behavioral intention as being the main predictor of behavior. The theory of the IMBP proposes that if a person has cognitively evaluated the costs and benefits of, for instance, contraceptive usage, and has formed a positive behavioral intention to use contraceptives, a greater consistency with the actual behavior can be expected (Fisbhein & Yzer, 2003). But do we always go through the hassle of knowing (and even wanting to know) all the costs and benefits of our actions? It is clear that if a person is intoxicated by alcohol or drugs, cognitive thought prompting one to use contraceptives is more likely to be discarded. Recent research has devoted attention to the *conditions* under which an attitude predicts behavior (see Bohner & Wänke, 2002).

This research has shown that attitudes based on evaluations such as *direct experience*, *repeated expression* or *personal involvement* are more accessible (Fazio, Chen, McDonel & Sherman,1982, as cited in Bohner & Wänke, 2002). *Accessibility* with respect to attitudes is defined by Bohner & Wänke (2002) as 'the ease with which an attitude comes to mind'. Accessible attitudes are relatively strong attitudes and are found to be more consistent with behavior than attitudes that are not accessible (Bohner & Wänke, 2002). In the context of our research, this implies that if an individual knows someone personally who has HIV in his or her immediate environment (personal involvement) or is frequently exposed to the deaths of Aids victims (repeated exposure), or is habituated to using condoms (direct experience), there is a greater probability that the person will have a strong, positive attitude towards using contraceptives. In turn, the person's positive attitude towards using contraceptives is more likely to be *accessible* at 'le moment suprême', which increases the chance that the person will act on his/her intentions and use contraceptives during the sexual encounter.

Engaging in sex is a rather affective activity and generally does not require much effortful cognitive processing. Fazio and Towles-Schwen's MODE Model of Attitude-Behaviour Processes (1997) provides insight into why people are not always motivated to make an effort to analyse all of the costs and benefits of contraceptive usage. According to the dual-process MODE model, which is an acronym for "Motivation and Opportunity as DEterminants", two main determinants (*motivation* and *opportunity*) determine whether people process information in a rather unconscious, spontaneous elaboration or in a more deliberative, rational way (Fazio and Towles-Schwen, 1997). The theory proposes that a more rational and systematic elaboration (such as proposed in IMBP's theory) is conducted if a person is *highly motivated* to reflect upon attitudes relevant to the behavioral decision and the *opportunity* exists to do so (Fazio and Towles-Schwen, 1997).

Empirical evidence has been found to support the validity of the moderating components 'motivation' and 'opportunity' in an experiment by Sanbonmatsu and Fazio (1990) (as cited in Fazio and Towles-Schwen, 1997). In their study, participants received information about two department stores: "Brown's" and "Smith's", and were asked to indicate in which store they would buy a camera. "Brown's" was portrayed with a positive overall image, but a poor camera department, whereas "Smith's" was portrayed quite negatively overall, but as having a camera department that was supposed to be superior to "Brown's". The results of this study indicated that when the participants were required to *validate* their decision (e.g. 'Why did you choose to buy your camera at this store?'), and they had the opportunity to do so (enough time, resources and cognitive capacity), participants

were more likely to indicate that that they would choose to buy a camera at "Smith's". After all: despite "Smith's" negatively displayed image, "Smith's" had a superior camera department. However, if either 'opportunity' or 'motivation' were lacking, participants were more likely to buy a camera at department store "Brown's". In other words, cognitive attitudes are more likely to be formed if a person is motivated and has the opportunity to engage in the effort of cognitively processing the information. The main notion of the MODE model is visually illustrated in figure 2.4 below:

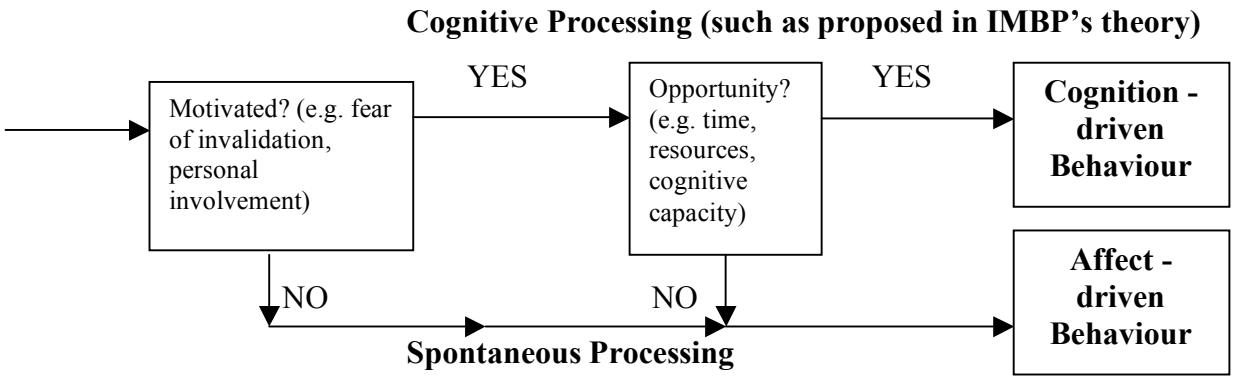


Figure 2.4 *The MODE Model, Fazio and Towles-Schwen (1997)*

The MODE Model acknowledges that it is unlikely for sexual decision-making to be based on a "rational" costs-benefits analysis. Most people tend to suppress cognitive thought patterns in the bedroom, since it will psychologically distance and reduce the extent to which the actors feel connected to each other in the heat of the moment. In the sexual arena, the best of intentions can easily be overtaken by emotions such as lust and desire. It is therefore not surprising that cognitive costs-benefits models such as the IMBP have difficulty explaining why some people succeed in acting on their intentions to use contraceptives, whilst others fail (Sheeran et al, 1999, as cited in Perloff, 2001, p. 30).

In the conceptual model, the concept's *accessibility* and *affect* will be included in the component 'individual motivation' since they complement Fishbein & Yzer's (2003) conceptualisation of attitudes. The concepts accessibility and affect are expected to influence a person's motivation to use contraceptives for *all* determinants of 'individual motivation'.

Attitudes towards Sex, Contraceptives and Pregnancy

With one in three females (33%) under nineteen self-reporting ever having been pregnant, and an average age of 18.5 for females to conceive their first child (Pettifor et al., 2004), it seems essential that a broader perspective needs to be taken on the issue of safe sex. To investigate

why African youth may be unconcerned about pregnancy and Aids, we will examine: 1) their attitudes towards sex, 2) their attitudes towards contraceptives, and 3) their attitude towards teenage pregnancy.

Attitude towards Sex

Individuals are more likely to be motivated to use contraceptives consistently if they accept their own sexuality and explicitly acknowledge that their relationship has a sexual character (Rademakers, 1991, as cited in Terpstra, 2002). For instance, in some religious communities talking about sex is perceived as taboo and premarital sex disapproved of. When youth in these contexts *do* engage in premarital sex, they will often be less prepared since they have little knowledge about sexual issues, and experience feelings of guilt. Because they are afraid to admit to themselves that their relationship has a sexual aspect, they are less likely to take individual responsibility and take on an assertive role regarding contraceptive usage. In turn, this negatively affects the quality of their contraceptive usage (Rademakers, 1991, as cited in Terpstra, 2002). In the Netherlands, the taboo surrounding sexual matters in religious communities might explain the five times higher rate of teenage pregnancy (aged 15-19) among non-western, mostly Muslim minorities (23 out of 1000) compared to pregnancy among Dutch teenagers (4 out of 1000), whose parents experienced the sexual revolution in the 1970s and are more open towards discussing these matters (Garssen, 2002).

Exploratory Interviews regarding 'Attitude towards Sex'

In the three held exploratory interviews, it seemed that pre-marital sex was socially accepted by most participants. Although the *mothers* of two not sexually active, fourteen- year-old boys said that 'sexual relationships are only appropriate for adults', the *boys* thought there was nothing wrong with having sex before eighteen. Not quite surprising, the three sexually active males perceived women who wanted to maintain their virginity until marriage as dull and uninteresting. Attitudes towards sex at a young age were implicitly asked by the question 'Is it ok for a girl to take the injection (hormonal method) at fifteen years of age?' The girls in the exploratory interviews replied that it depends on the relationship with the boyfriend. Use of the injection at fifteen years of age was accepted if it was a 'steady' (perceived long-term) relationship.

Empirical Evidence regarding 'Attitude towards Sex'

Traditionally, many African cultures frowned upon premarital sex (Shillinger, 1999). In traditional Zulu culture for instance, young girls were to retain their virginity until their *lobola* had been paid and they could get married (Varga, 1997). *Lobola* is the marriage gift that a potential husband had to pay to the bride's family as a financially compensation for the family's loss of labour (Ngcobo, personal communication, March 2005). Nowadays, traditional marriage structures have undergone drastic changes (Varga, 2000, as cited in RHO, nd) and few families require *lobola* for their daughters (Ngcobo, personal communication, March 2005).

A recent study conducted by Pettifor et al.(2004) found that significantly more males (43%) than females (25%) agreed that it is okay for youth their age (15-19) to engage in sex. As can be expected, due to acquired sexual experience, the older age groups (20-24) reported higher rates of sexual acceptance: males (81%) and females (69%). Despite these findings, there were no major gender differences found in the sexual experience of youth aged 15-19: 50% of males reported ever having had sexual intercourse (either vaginal or anal sex) compared to 47% of females (Pettifor et al., 2004). Sexual debut in the age group 15-19 was also comparable: males self-reported a mean age of 16.4, and females self reported a mean age of sexual debut at 16.7 (Pettifor et al., 2004).

These findings seem to indicate that segregated gender-constructs still prevail, and determine that females are less likely to openly acknowledge their sexual relationships. On the other hand, the age of sexual debut of both males and females seems to indicate that premarital sex is widely spread among African youth. In the focus group interviews, it will be investigated to what extent youth perceive that it is acceptable to take personal responsibility with respect to using contraceptives at 15 years of age.

Attitude towards Contraceptives

Before narrowing our focus on attitudes towards male condoms, we examine African adolescents' attitudes towards barrier methods (e.g. the male and female condoms, cap) and hormonal methods (e.g. contraceptive pills, injections).

Exploratory Interviews regarding 'Attitude towards Contraceptives'

'Girls who are on the injection, are less likely to use condoms with their boyfriends', according to a sixteen-year-old female participant. None of the participants thought fifteen years of age was too young for a girl to be on the injection. As one fourteen-year-old boy said:

'There are girls who are only twelve years old who have a sugar daddy.' Sugar daddies, often teachers, give girls money or clothes in exchange for sex. In the interview with the two fourteen-year-old boys, one of the boys stated that these girls were better off using an injection in order to prevent unwanted pregnancy from such relationships. The two girls in the exploratory interviews pointed out that culture is often used as an *excuse* to justify certain behavior, such as *flesh on flesh* (not using condoms) and having more than one girlfriend. None of the participants were familiar with barrier methods such as the cap or the intrauterine device. The three sexually active boys that were interviewed did not know of the existence of the morning-after pill or regular oral contraception. However, the *female condom* is becoming increasingly popular, as one of the three sexually active boys remarked. Personal attitudes towards using contraceptives were not asked, since this would be rather too direct. Furthermore, four participants reported not being sexually active, and hence lacked personal experience to argue about such attitudes.

Empirical Evidence regarding 'Attitude towards Contraceptives: Barrier methods'
Paradoxically to the success of contemporary social marketing methods, condoms suffer from stigmatisation, and are often associated with HIV, infidelity, promiscuity and prostitution (Varga, 2000, as cited in RHO, nd). According to Varga (1997), engaging in unsafe sex is a *rational decision* for many people. Benefits of unsafe sex, such as emotional intimacy, trust, and even economic stability subdue the perceived disadvantages of condom usage (Varga, 1997). The disadvantage of condom usage was pointed out by an African male participant in Varga's (1997) study in Kwazulu-Natal: 'Condoms take away sexual control both physically and psychologically. They take away [a man's] control of the process'. In other words, condoms made sexual intercourse an impersonal and uncontrolled experience (Varga, 1997). Varga (1997) found that if condoms were used, they were not used with any regularity. Similar evidence was found in a recent study of Pettifor et al.(2004) among youth (aged 15-24). Pettifor et al.(2004) found that 31% of youth still believed that using condoms is a sign of not trusting your partner. Although 33% of youth who had sex in the past 12 months reported always using a condom, 66% percent still reported not using condoms consistently (Pettifor et al., 2004).

Empirical Evidence regarding 'Attitude towards Contraceptives: Hormonal methods'
In Wood's et al.(1998) study conducted among Xhosa girls in the Eastern Cape, a girl who had been to the clinic indicated that her partner disagreed with her attempts to use a hormonal

contraception. He angrily tore up her contraceptive card, saying that contraceptive methods caused infertility, 'disabled babies', and vaginal 'wetness' (believed to diminish male sexual pleasure), as said by the girl in Wood et al.(1998). A recent study conducted by Pettifor et al.(2004), found that among young sexually active females, the injection (hormonal method of contraceptive) was more popular to prevent pregnancy, than the male condom. Respectively, 58% of young sexually active women reported using the injection, 34% reported using the male condom, and 13% reported using oral contraceptive pills to prevent pregnancy (Pettifor et al., 2004).

Attitude towards Teenage Pregnancy

All of the participants in the exploratory interviews pointed out that teenage pregnancy is very common in South Africa. In most cases the mothers of these teenage girls helped them with the upbringing of their babies. According to the two fourteen-year old boys, pregnant girls who are rejected by their family, will go the man that impregnated her and hope that he will take care of her and the baby. Abortion is 'not-done' or taboo, according to all of the participants. It is perceived as unnatural to kill an unborn child. A seventeen-year-old boy pointed out that in the Xhosa culture, ancestors will punish you and your family if you end an unwanted pregnancy.

Despite the commonness of teenage pregnancies, and this taboo on termination, youth are not encouraged to have a child at a young age. All of the participants said that their parents would be furious if they would fall (or make a girl) pregnant. The two girls who attended the more 'posh' mixed race school, said they would be forced to enrol in the township high school of Kayamandi. The regulations of their current school expelled pregnant teenagers and teenage mothers. The government provides financial support (*ubonelelwa*) of 150 rand a month in the upbringing of these children. This is far too little, according to a seventeen-year-old boy: '500 rand would be better. A baby makes a lot of noise and you have to take care of it all the time.'

Empirical Evidence regarding 'Attitude towards Teenage Pregnancy'

There is little up to date literature available about youth's attitudes towards teenage pregnancy and how their ingroup conceives of teenage pregnancy. In traditional masculine Zulu culture, motherhood (which is the ultimate form of femininity) was highly valued (Varga, 1997). For some women, motherhood is an attractive means of increasing ones self-esteem, since it allows women to demonstrate feminine skills such as love and fidelity (Varga, 1997; Wood et

al., 1998). In view of such reasoning, a young girl may be induced to engage in early, unprotected sex, and *intentionally* attempt to fall pregnant. In the focus group interviews, the underlying motivations for teenage pregnancies will be further investigated. Attitudes held by the ingroup of parents, partners and peers regarding the appropriateness of these teenage pregnancy will also be researched.

Self-efficacy

The remaining second primary determinant of Fishbein & Yzer's (2003) IMBP is self-efficacy. Self-efficacy refers to the extent that we believe to have control over the behavior we attempt to perform. For example, a women with a low-perceived sense of self-efficacy is more likely to yield and obey in not using condoms when her partner resists her suggestion to use a condom. Thus, in this study self-efficacy indicates the perceived control people believe to have over their contraceptive usage. In the conceptual model, self-efficacy will refer to taking initiative in carrying condoms and to perceived control to use contraceptives in the sexual arena.

Exploratory Interviews regarding 'Self-efficacy'

When asked in the exploratory interviews 'Who is responsible for condoms?', all of the participants agreed that it was the mutual responsibility of both sexual partners to provide condoms. As one seventeen-year-old sexually active male said: 'It is a right thing when a girl has a condom in her purse'. However, none of the seven participants self-reported having condoms on them at the time. Not carrying condoms was justified by a sexually active male since male condoms are for free in South African and are widely available: 'In case of an emergency, you can always get them at a public toilet or at the clinic.' Although the girls did not carry condoms, they provided a remarkable justification for girls who did in the following myth. 'If someone wants to rape you, you can ask him if he would please use a condom to prevent Aids…'

Empirical Evidence Self-efficacy

In Pettifor's et al. (2004) study, the vast majority of youth (96%) agreed that safer sex is the shared responsibility of both partners. However, females aged between 15-19 perceived having a lower self-efficacy and were significantly less (94%) likely to agree to this statement than males (97%). Among youth, 70% perceive themselves to be able to refuse sex if their partner would refuse to use a condom. A further 74% of youth perceived they were confident

to use a condom every time they had sex. Drinking or taking drugs is an important moderator of a person's self-efficacy to use contraceptives. Pettifor et al. (2004) found that 43% of youth reported that alcohol and drug use decreased their self-efficacy to use condoms (Pettifor et al., 2004).

Perception of Risk

The determinant *perceived risk* is a proximal determinant of the Health Belief Model (as cited in Fishbein & Yzer, 2003). The Health Belief Model proposes that when people believe that they are highly susceptible of, for instance, contracting HIV/Aids or becoming pregnant, they are more motivated to take precautions to protect themselves (as cited in Perloff, 2001, p. 56). According to Fishbein & Yzer (2003), there is limited empirical evidence that supports the theory that 'perceived risk' directly influences the behavioral intention. Therefore, the IMBP defines 'perceived risk' as a *distal variable*. However, when we reflect upon the previously obtained theoretical insight regarding the conditions under which attitudes influence behavior (see attitudes, p. 30), we can see that there are clear similarities between the concept 'perceived risk' and the concept 'personal involvement' or 'direct experience' that are expected to increase attitude accessibility. For instance, a person can perceive being more at risk (perceived risk) to contracting HIV, if he or she knows someone personally with HIV (personally involvement). In the context of this research it is proposed that the more young African South Africans who perceive themselves as being at risk of becoming pregnant or contracting HIV/Aids, the more motivated they will be to use contraceptives.

Exploratory interviews regarding 'Perception of Risk'

'Sex is a tricky game. You risk getting pregnant, contracting Aids or an STD, as a sixteen-year-old girl commented. When asked 'Do you know someone personally with HIV/Aids?', most of the participants indicated that they knew Aids was in their townships, but few people would come out openly claiming they had a positive HIV status. According to two fourteen-year old boys, 'only families that are very strong say that someone in their family has Aids.' However, the fourteen-year old boys pointed out that many people suffer from tuberculoses (TB). TB is a disease that occurs frequently among HIV positive patients (VOX, April 14, 2005). Thus, the stigma attached to Aids might in some cases induce people to *say* they have TB, whilst in fact they are HIV positive.

Empirical Evidence regarding 'Perception of Risk'

The perception of a female's fertility is hardly discussed in the literature available. The perception of HIV/Aids-risk has acquired more attention. In general, the social stigma attached to HIV/Aids results in ignoring the existence of the disease (Varga, 1997). This can partially be explained by the fact that all too often HIV/Aids is associated with immoral segments of society (e.g. homosexuals and prostitutes) and inappropriate sexual behavior (e.g. infidelity and promiscuity) (Varga, 1997). For instance, males in Varga's (1997) study in Kwazulu-Natal commonly perceived that HIV or STD infection could only derive from 'dirty, promiscuous women'. This is a seemingly two-sided moral, considering males pursuit of *isoka* status that encourages them to seek multiple sex partners. Other alarming findings were that 33% of the female participants mistakenly believed that a person could not be HIV infected without displaying physical signs such as 'looking sick' (Varga, 1997). Of all of the youth (aged 15-24) who indicated never using a condom with their sexual partner, 54% felt that they were at low risk of infection (Pettifor's et al., 2004). Startling, since 45% of youth reported that they knew someone personally who had died of Aids (Pettifor et al., 2004). These findings can be explained by Perloff's (2001) theory of 'illusion of invulnerability' that argues that youth have a tendency to be unrealistically optimistic about their chances of susceptibility for pre-mature death and severe illnesses. It seems that many people prefer to view themselves as 'safe' rather than face the psycho-social consequences of a possible HIV infection and hence, fail to internalise their personal risk.

Outlook on Life

With nothing to lose in the future, youth has nothing to risk in the present. A theory as to why youth in South Africa engage in risky sex is that they have no clear defined perspective of their future (due to poverty, crime, Aids related deaths of loved ones, etc.) (Mathur et al., 2001, as cited in Pettifor et al., 2004). This idea stimulated South Africa's Aids prevention organization *loveLife* to promote a *positive lifestyle* (Harrison & Steinberg, 2002). *loveLife's* strategy aims to increase youth's feelings of personal control, their sense of purpose (establish future goals), and promote a positive attitude towards life in general.

This notion fits in our theoretical framework quite handsomely. In view of Fazio and Towles-Schwen's MODE Model (1997), it is proposed that if a person has a negative outlook towards life (e.g. feelings of hopelessness) the person will be less motivated (e.g. feelings of carelessness) to validate their behavioral decision and to cognitively analyze the costs and benefits of contraceptive usage. Hence, the individual will be more likely to indulge in short-

term, affect-driven 'fun' (e.g. alcohol, unsafe sex) in which they put themselves at risk instead of depriving themselves from these instant pleasures.

Exploratory Interviews regarding 'Outlook on Life'

'Because people are afraid to die alone of Aids, they rather infect ten other people.' This was said in an interview with three sexually active males. According to the three males, people who are HIV positive generally neglect the governments advice to 'eat healthy'. Some people go beyond not taking proper care of themselves and indulge in excessive drinking. For some people a positive HIV status is a legitimate reason to commit suicide, as indicated by the three males. The detrimental role alcohol played in various scenarios is illustrated by a comment of a seventeen-year-old male: 'Alcohol is the cause of many problems in South Africa.'

'What do you want to become in life?' This question was asked since a clear defined future perspective such as aspiring a career can be a motivational factor for youth to use contraceptives consistently in order to achieve that goal. The two fourteen-year-old boys said that they wanted to become a health worker or a pilot. The girls both wanted to become a doctor. When the interviewer asked the sixteen-year-old girls about their opinion on the 'outlook on life' theory, they perceived the theory as being rather awkward. According to the girls 'Everyone always has the slightest bit of hope, even if you live in Kayamandi.' In other words, the fact that youth live in a township does not necessarily make them depressed or foster views of limited future possibilities and living a worthless life.

This positive outlook did not account for everyone. The girls pointed out that some of their peers act like they are predestined for a career in crime. These peers are already making an effort to learn the rituals of the three prominent gangs in South Africa's prisons: 26s (robbery), 27s (murder) and 28s (rape). By learning these rules, peers perceive they will receive the gangs' protection when they do end up in prison. Prisons in South Africa are known to be the equivalent of a war zone (with estimated HIV rates of 41%), so protection is vital in order to survive (see Reuters health Report 2003, as cited in Kaisernetwork.org, 2003). Passing on the rules from former prisoners to a minority of males in townships was confirmed by an African student from Kwazulu-Natal studying at Stellenbosch University (Ngcobo, personal communication, May 2005). The girls disapproved of some of these behavioral perceptions: 'You are responsible for your own life, and with discipline and goals in your life you can accomplish a lot.'

Empirical Evidence regarding 'Outlook on Life'

The positive outlook of the girls in the exploratory interview above was shared by a vast majority of youth in Pettifor's et al.(2004) study. In a series of questions about future goals and aspirations, 92% of youth reported that they had established long range goals for themselves and 82% of youth had a good idea of where they were headed in the future (Pettifor et al., 2004). The top priority for most youth is getting a good education (63%) (loveLife, 2001, as cited in Harrison & Steinberg, 2002, p. 27). However, 28% of the youth were less optimistic and did *not* perceive their future opportunities to prosper and succeed as being limitless (Pettifor et al., 2004). When youth were asked to report perceived personal control over what happens to them in their live, females (35%) were more likely to report than males (27%) that they did not feel like they had total control over their lives (Pettifor et al., 2004). Possible explanations for the females' low perceived control could lie in the violent nature of sexual relationships (see Wood et al., 1998). In the focus groups, we will further explore explanations for these differences and feelings of perceived control.

When we summarize the findings of our preliminary investigation in this section, we can implement the following determinants in the component 'individual motivation' of the conceptual model (see figure 2.5):

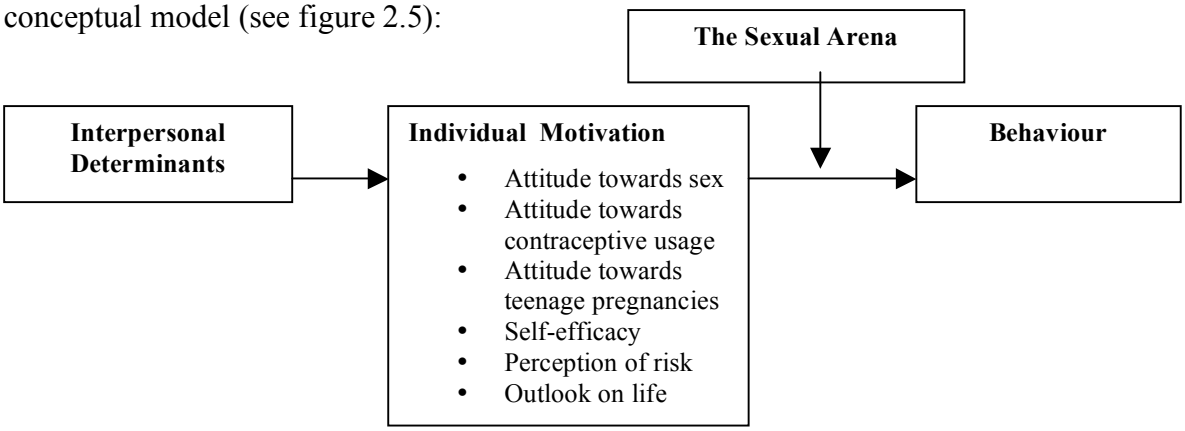


Figure 2.5 *Individual Motivation*

2.5 The Sexual Arena

In a sexual relationship 'it takes two to tango'. Many traditional behavior change theories applied in the HIV/Aids context, ignore the fact that individual intent to use contraceptives is mediated by the cooperation of the partner in the sexual arena. In the complex terrain of sexual relationships there are multiple factors at play that overwhelm rational choice-making. This section will provide a theoretical foundation for the determinants *sexual negotiation* (section 2.5) which refers to the interpersonal dynamics with the partner, and *opportunity*

(section 2.6) which refers to access and knowledge about contraceptives. These two determinants define the component 'the sexual arena', and are proposed as moderating a person's motivation to use contraceptives.

2.5.1 Sexual Negotiation

In this section, we go beyond focussing on the individual level. The previously defined determinants, socio-cultural influence and interpersonal communication (see section 2.3), will be adjusted to fit within the sexual arena. Again, the insight obtained from *theories* (about how interpersonal interaction influences attitudes), findings from the *exploratory interviews* and *empirical evidence* will be integrated to define the component 'the sexual negotiation'.

Social Influence of the Partner

To use contraceptives or not to use contraceptives cannot be approached as the rational choice-making of buying a tube of toothpaste in the supermarket. It is crucial to acknowledge that in sexual interactions social beings are involved, which evidently activates social concepts (Bargh, 1999). The fact that we are dealing with our loving partner induces the chance that our decisions are more driven by affect (that is: not a "rational" costs-benefit analysis) and our decision is more likely to occur outside our conscious awareness (Bargh, 1999). In social interactions, *mimicking,* the unconscious aspect of mirroring another individual's posture, adopting speech accents and even moods, has obtained substantial evidence in recent Social Psychology research (see Baaren et al., 2003). Findings of Knippenberg & Baaren (*in press*) support that the more we like a person, the more we mirror his or her behavior. Mimicry is seen as an invisible social 'glue' that helps individuals get along with others and adopt the ways and habits (cultural patterns) of their ingroup (Van Knippenberg, & Baaren, *in press*).

Does this imply that in the context of sex we mimic the other person, we are driven by lust and desire and cannot be held responsible for our actions? Such conclusions are premature. Although recent Social Psychology research estimates that 95% of our behavior is automatic (not planned), the 5% of our behavior that *is* deliberately planned, is extremely important (as cited in Tiggelaar, 2005, p. 21). This 5% refers to long-term decisions (e.g. life goals) in which we consciously shape our future. Note that this idea is similar to 'the outlook on life theory'. In other words, the more we are motivated to rationalize our behavior in order to achieve long-term future goals, the more we will withdraw from unsafe sexual practices.

It must be acknowledged that most people want their attitudes to be consistent with their behavior and seek reinforcement of their established attitudes (Bohner & Wänke, 2002). This notion is in accordance with Festinger's (1957) Cognitive Dissonance Theory that proposes that if our behavior does not resemble our attitudes, we often simply adjust our attitudes (as cited in Bohner & Wänke, 2002). The interplay between cognition and affect in the sexual arena is illustrated in the following example involving two lovers, Nancy and Paul.

> *If Nancy really likes Paul, a large array of affectionate emotions are activated. By having sex with Paul, she might feel more connected to him, reduce loneliness and obtain self-enhancement.*[4] *If Paul replies to her affectionate attempts, cognitive thought does not play a prominent role and they subsequently automatically engage into (unprotected) sexual action. However, if Nancy is cognitively activated*[5]*, this will stimulate the likeliness that she would suggest condom usage, and make a more rational attempt in analysing her situation.*

In two different ways this fairy tale story could have a not-so-happy-ending. First, for Paul, if he does not adapt to Nancy's favourable attitude towards using condoms, he might be kicked out of bed. Or, for Nancy, if she decides to adjust her own favourable attitude towards condoms and complies to Paul's desire to neglect condom usage, because, for instance, Paul says "Don't you trust me? Are *you* having an affair?" As a result, Nancy may end up contracting an STD or even worse: the fatal HIV virus.

To conclude, up until now, we have seen that 'the sexual arena' is merely a place in which affective evaluations of the situation are made. These evaluations (e.g. feelings of sexual desire and emotional attachment) are very likely to interfere and negatively moderate a cognitively formed intention to use contraceptives.

Exploratory Interviews regarding 'Social Influence of the Partner'

In South Africa, the social influence of the partner regarding sexual matters occurs in a less friendly context than is illustrated above. Not uncommonly, influence goes far beyond verbatim offence, and includes physical force. According to the two fourteen-year-old boys, it is not advisable for a young, white female to wander around alone in their townships, because

[4] This is in accordance with the 'need to belong theory', Baumeister & Leary (1995)
[5] For instance, she was recently confronted with a close friend living with full blown Aids. This internalized perceived risk is now highly accessible.(Bohner & Wänke, 2002).

there are many men who "are up to no good". Just recently, a little girl, only nine years old, had been raped by an eighteen-year-old boy. The girl informed her mother about the incident, and soon the rapist was arrested and sentenced to 14 years of *bosmos* (prison).

One sexually active seventeen-year-old male did explicitly make comments illustrating the violent nature of his sexual relationships. According to him, girls often cry when he has sex with them and sometimes, he would lock the door. The only time when boys experienced pain was when the girl is still a virgin, but then they just had to use extra force, as stated by the three sexually active boys. In the words of a seventeen-year-old sexually active male: 'I don't care if they cry because they feel pain. She must be stronger. I know I won't stay with her forever and they will get pregnant from another guy. The pains they will have to face when giving birth to that child will be greater than the pains they feel now.'

Empirical Evidence regarding 'Social Influence of the Partner'

South Africa has the highest reported rate of rape per capita in the world for a country not at war (Duke 1997, as cited in Varga, 1997). Remarkably, male participants in Varga's (1997) study conducted in Kwazulu-Natal did not view their sexual behavior as violent or abusive, but as 'culturally appropriate practice'. As one young male said: '[Sex] is a symbol of power in the affair. Once you have sex with a woman, you have a strong say of the running of the relationship' (Varga, 1997). Half (55%) of the females in Varga's study indicated that there were times they had refused their boyfriends sexual advances, but only 29% of these females reported to be successful. Varga (1997) found that females who refused sex were physically abused by their partner and/or their partner had threatened to abandon them. A study by Wood et al. (1998) in Eastern Cape found that sexual coercion was such common practice among female Xhosa participants, that some even perceived it as an 'expression of love'. A more recent study conducted by Pettifor et al. (2004) found that 11% of females aged between 15-19 reported ever being physically forced to have sex, compared to 1% of their male counterparts. It is clear that in such coercive relationships, the girls have little influence on how and when sex takes place, thus increasing their vulnerability to HIV.

We will now examine the second determinant *interpersonal communication with the partner* of the component 'sexual arena'.

Interpersonal Communication with the Partner

Perloff (2001) offers an explanation for not talking about contraceptive usage. Talking is avoided, according to Perloff (2001), because relationships reduce the pain of loneliness, give

young people enormous joy and satisfaction, and they boost self-esteem. These vital needs are all in contrast to a relatively small perceived risk of contracting HIV/Aids. Besides, as Baxter & Wilmot (1985) argue, bringing up the topic of contraceptive usage touches on other intimate emotional areas of the relationship that people feel uncomfortable talking about (as cited in Perloff, 2001, p. 38). These emotional areas include the state of the relationship, prior relationships, and extra relationship activity (Baxter & Wilmot, 1985, as cited in Perloff, 2001, p. 38). Talking, as it seems, is perceived as having a negative effect on the harmony of a relationship that is still in an immature phase.

Exploratory Interviews regarding 'Interpersonal Communication with the Partner'

Not much attention was devoted to discussing contraceptive usage among partners in the exploratory interviews because most participants (4 out of 7) were not yet sexually active. In the interview with the three males it became clear that if refusing sex already leads to rape, negotiating contraceptive usage is probably not an option for their female partners. The three sexually active males indicated that condoms are only used with 'casual' girlfriends. With 'steady partners' (in essence a serial monogamous relationship) they go to the clinic to get tested for HIV. In 'steady relationships' suggesting condoms implies that the relationship is not perceived as being serious.

Empirical Evidence regarding 'Interpersonal Communication with the Partner'

> *'No, we don't discuss AIDS. I'm scared of him because he used to beat me. So I don't want to talk about things that might make him upset.'*

The remark above was voiced by a nineteen-year-old girl in a study conducted by Varga (1997, p. 54) in Kwazulu-Natal. It illustrates the complexity of discussing contraceptives with the partner. Varga (1997) studied adolescent sexual negation and found that condom usage was not a topic of discussion among partners. Participants were afraid that talking about sexual histories might destabilize their relationship (Varga, 1997). Several studies found that suggesting condom usage in monogamous relationships can be interpreted as insulting, suggesting infidelity, lack of love and disrespect of partners (Sobo, 1993; Bajos et al. 1997, as cited in Varga, 1997). In turn, this helps us understand why many people rationally decide not to use contraceptives. In a study by Wood et al. (1998) in Eastern Cape, two female participants indicated that 'the only talking their partners did about sexual matters was when they told them to remove their clothes.' Thus, sex communication among African partners is

poor, limiting the individual's self-protection against unwanted sexual intercourse, pregnancy and HIV/Aids.

To conclude, the *social influence of the partner* and *interpersonal communication with the partner* are vital determinants of contraceptive usage to explore in the focus group interviews. When two lovers interact in the bedroom, it is proposed that the extent to which they are motivated to comply to their partner's perceived (and experienced) sexual wishes influences whether or not these lovers are going to use contraceptives.

2.5.2 Opportunity

As has become clear up till now, the relationship between an individual's motivation to use contraceptives and his or her actual behavior is rather complex, and not as straightforward as it might seem at first glance. This section focuses on two factors (*knowledge* and *environmental constraints*) which are proposed to directly exert influence and modify a person's motivation to use contraceptives. These factors are placed within the determinant *opportunity*, which in turn is placed within the component 'the sexual arena'. We decided to define this determinant 'opportunity' since both factors *knowledge* and *environmental constraints* can be linked to this term. We will elaborate on this in the following sections.

Knowledge

Even if consensus between both partners has been reached to use contraceptives, a person has to have correct *knowledge* about how to use contraceptives in order to translate mutual intent into action. The IMBP proposes that the component *skills* has a moderating effect on the actual behavior (Fishbein & Yzer, 2003). For instance, if a person does not *know* how to properly use a condom, s/he will fail to protect him/herself from contracting HIV. The MODE model of Fazio & Towles-Schwen's (1997) acknowledges that besides being motivated, a person needs to have the *opportunity* to engage in the effortful cognitively processing the information (see section 2.3 attitudes). *Opportunity* in the MODE model refers to 'time' (e.g. Does the person have the time to reflect upon the information provided?), 'resources' (e.g. Is the information available to the person?), and 'cognitive capacity' (e.g. Does the person have the intellect to understand the information?).

When we reflect upon IMBP's definition of *skills* and Fazio & Towles-Schwen's (1997) definition of *opportunity*, we can see that the term 'knowledge' can apply to both theories. For instance, before a man can obtain the 'skills' (moderating determinant of the IMBP) on how to use a male condom properly, he has to have the correct information

'available' (opportunity MODE-model) to him. Without correct information, he will more likely fail to act upon his positive intentions to use a condom. Secondly, he has to have the 'time' (opportunity MODE-model) to read the information and to be able to 'understand' (opportunity MODE-model) the information in order to increase the chance of translating this information into knowledge. Therefore, we will further use this general term 'knowledge' as one of the modifying determinants of the behavioral intention.

Exploratory Interviews regarding 'Knowledge'

'If I suspect a girl to have HIV/Aids, *I use two condoms to be extra safe',* said one of the male participants. It is rather tragic that a person who has the intention to use contraceptives, and wants to protect himself against HIV/Aids, fails to do so because of incorrect knowledge. The use of two condoms increases HIV risk, since the friction of latex on latex increases the condom's chance of breakage. Another seventeen-year-old male commented that many young people believe in the myth that when a female washes her vagina after sexual intercourse with *Dettol,* it will protect her from becoming pregnant. (*Dettol* is an antiseptic soap and in advertisements in supermarkets it is stated that *Dettol* has established an Aids Trust. For people who have HIV/Aids *any* infection can be fatal, therefore washing your hands with *Dettol* is necessary to prevent the spread of germs). The three boys from Cloetesville also believed that Aids can be contracted by people who are coughing in a minibus (public transport). But the disease they were referring to is TB.

None of the male participants had ever heard about the morning after-pill (emergency contraception) or 'the pill' (oral contraceptive), the cap (barrier method for females) and intrauterine device (female contraception). The only alternatives to the male condom participants were familiar with was the female condom and the injection (hormonal contraceptive). Thus, although male participants typically responded with "Use a condom" to all my questions concerning preventing pregnancy and HIV/Aids, when probed, their knowledge about *how* to use a condom proved insufficient.

Lack of high quality institutionalised sex education partially explains the males' incorrect knowledge. All male participants said they had participated in a so-called 'Life Orientation' course at their high school. This course is given in 7th grade (when they are about twelve years old) and deals with sex education and health behavior. There are a proximately 45 students in one class, and the education for boys and girls is equal. With so many students in class, it is not hard to imagine that teachers experience difficulty maintaining control over their pupils. Perhaps this results in avoiding controversial topics such as sex education.

In comparison, the two girls who were enrolled in a mixed-race high school were much better informed about sexual matters. According to the girls, many parents wished that they could afford to send their children to a mixed-race school, because the school had more financial resources for Aids prevention education. For instance, every year a female counsellor came to the girls' school to explain to them about safe sex. Furthermore, a permanent psychologist was affiliated with their school to give counselling for girls who were traumatized by incest or rape. The girls knew about the morning-after pill, and how to use condoms correctly, since they had practiced this in class on a phallus object.

Empirical Evidence regarding 'Knowledge'

> *"There is no conclusive evidence that condoms prevent transmission of Aids, and it's only 70 to 75% effective in preventing pregnancy," as said by Cardinal Napier (Cape Times, 2005b)*

It is incredibly sad that someone with such influence, especially in townships, is preaching such an ignorant message. Comments such as these set back years of hard work educating people to make well-informed sexual decisions. In order to disseminate a consistent "safe sex" message, an integrative approach is crucial. At the end of 2003, all high schools in South Africa were obliged to implement sex education in their curriculum by the South African government. Although it remains unclear how implementation and quality of these courses is monitored, a recent study found that 32% of youth reported that they had learned the most about HIV/Aids from school (Pettifor et al., 2004). When youth were asked to describe all of the possible measures for preventing from contracting HIV/Aids, 77% reported condom usage during sex, 41% reported abstinence, 10% having one faithful partner, and 7% reported not having multiple sex partners (the classic 'ABC'). Nonetheless, 6% reported that there is nothing you can do to avoid HIV/Aids (Pettifor et al., 2004). Since few studies have explored the level of *correctness* of youth's knowledge on contraceptive usage, HIV transmission and pregnancy, this will be further researched in the focus groups.

Environmental Constraints

'Environmental constraints' is the second determinant that moderates the behavioral intent in the IMBP of Fishbein & Yzer (2003). It is proposed that when the environment does not support and enable the desired behavior (e.g. condoms are very expensive, and difficult to access) it will negatively affect a person's usage of contraceptives.

Exploratory Interviews regarding 'Environmental Constraints'

In the exploratory interviews it became clear that condoms are often provided free of charge in South Africa and widely available at multiple venues, such as clinics and public toilets. With regard to health care services, there are two clinics in Stellenbosch, one in Cloethesville and one in Kayamandi, according to the two fourteen-year-old boys. The two boys pointed out that the clinic in Cloethesville was more professional and had more capacity (staff) than the clinic in Kayamandi.

Empirical Evidence regarding 'Environmental Constraints'

In Pettifor's et al. (2004) study, a vast majority of 87% said that it was very easy to get condoms if they needed or wanted them. Several studies found that the negative attitudes shared by the health care staff formed a barrier mentioned by youth to seeking health care (Mmari & Mgnani, 2003; Speizer, Hotchkiss, Magnani, 2000, as cited in Pettifor et al., 2004, p. 57). Contrary to these findings, Pettifor et al. (2004) found that 85% of youth who had attended health care services during the past 12 months said they were treated well or very well.

In the conceptual model (see section 2.6), it is proposed that the component 'opportunity' can directly be influenced by external sources. The level of our audience's *knowledge* about contraceptives, for instance, can be increased by institutionalised school programmes that focus on improving the technical skills of contraceptives and sexual negotiating skills. Secondly, *environmental constraints* that inhibit our audience from using a condom can be overcome with a policy in which condoms are freely disseminated at a wide variety of venues (see figure 2.6).

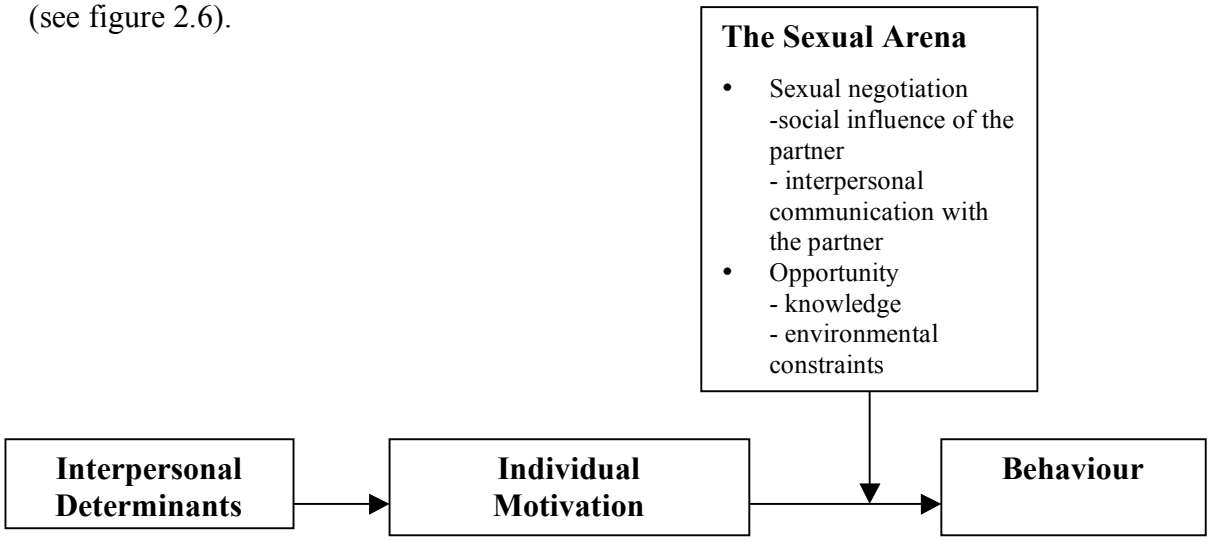


Figure 2.6 *The Sexual Arena*

2.6 Conclusions Preliminary Investigation

In section 2.2 we established a first version of our conceptual model of contraceptive usage. This first conceptual model functioned as a framework for our first central research question: *'What might be according to a preliminary investigation of theory, exploratory interviews and empirical evidence relevant determinants of contraceptive usage of young African South Africans, and to what extent do these determinants influence their contraceptive usage?'* In this section, we attempt to answer this research question and present the product of this chapter: the second, definite version of our conceptual model of contraceptive usage (section 2.6.1). The second research question we aimed to answer in this chapter was: '*What data gaps can be identified in the preliminary investigation, and what audience analysis questions can be posed in order to guide the data collection of the focus group interviews?*' By means of our preliminary investigation, we could identify what needs to be further researched in the focus groups. In section 2.6.2, we present our audience analysis questions that will guide this data collection. Finally, in section 2.6.3, we will provide a schematic overview of the main findings of our preliminary investigation. We believe that this preliminary investigation will help us interpret our focus group findings and contribute to adjusting the content of our intervention to the audience's information needs.

2.6.1 Conceptual Model of Determinants of Contraceptive Usage

In this section, we will discuss the theory of our definite conceptual model of contraceptive usage. This second version of our conceptual model is more comprehensive and integrates the insights obtained from our preliminary investigation on relevant determinants of the audience's contraceptive usage. As we can see in figure 2.7, our conceptual model visually illustrates the determinants that are proposed to influence a person's contraceptive usage. The determinants of the model are placed within three components: 1) the sexual arena, 2) individual motivation, and 3) interpersonal influence.

In discussing the theory underlying the conceptual model, we will start with the component that is proposed to exert the greatest influence on a person's contraceptive usage: 'the sexual arena'. The model proposes that a person's 'individual motivation' to use contraceptives is modified by the determinants within the component 'sexual arena'. Secondly, we will reflect on the component 'individual motivation'. 'Individual motivation' refers to a person's intention to use contraceptives *before* entering 'the sexual arena'. Finally, we will discuss the determinants within the component 'interpersonal influence'. The component 'interpersonal influence' refers to a person's socio-cultural context and is

suggested to have an indirect effect on the underlying beliefs of a person's motivation to use contraceptives.

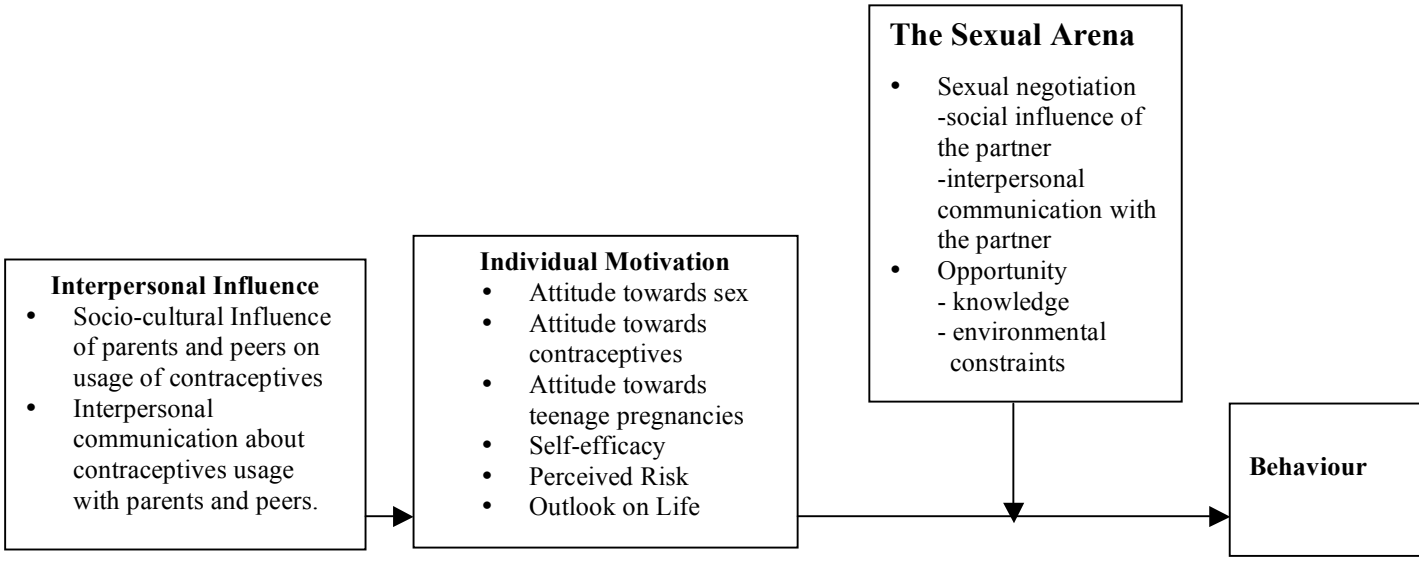


Figure 2.7 *Conceptual Model of Determinants of Contraceptive Usage*

The Sexual Arena

The conceptual model proposes that the determinants within the component 'the sexual arena' exert the greatest influence on a person's contraceptive usage. A person's motivation to use contraceptives is proposed to be modified by two determinants: 1) *sexual negotiation*, and 2) *opportunity*.

Firstly, the determinant 'sexual negotiation' refers to the *social influence of the partner* and the *interpersonal communication with the partner*. Many behavioral change theories ignore the fact that individual intent to use contraceptives is mediated by cooperation of the partner in the sexual arena (Parker, 2004). The decision to use contraceptives cannot be approached as the rational choice making of buying a tube of toothpaste in the supermarket. It is crucial to acknowledge that human beings are involved in sexual interactions, which evidently activates social concepts (Bargh, 1999). These social concepts increase the chance that affective evaluations such as emotional attachment and sexual desire guide the outcome of the sexual decision-making process. For instance, a person's fear to destabilize the harmony of the relationship might keep the person from suggesting condom usage to the partner. The person might have experienced that the partner interpreted the suggestion to use condoms as an insult, implying 'lack of trust'. Influenced by this (psychological) pressure, the person is expected to "rationally" adjust his or her own favourable intention towards using

condoms (Bohner & Wänke, 2002), and comply to the partner's desire to neglect condom usage. This illustrates that for many people engaging in unprotected sex is a rational decision.

In the context of South Africa, which is infamous for its extraordinary high rate of rape (Duke, 1997, as cited in Varga, 1997), it is clear that in relationships that are dominated by male sexual coercion the female partner is left powerless to negotiate safe sex. The determinant 'interpersonal communication with the partner' specifically refers to the extent to which the partners feel comfortable discussing contraceptive usage, since this enhances their chances of mutually deciding on safe sexual practices (Waldron, Caughlin, & Jackson, 1995, as cited in Perloff, 2001, p. 37). To conclude, the success of the sexual negotiation with the partner highly determines whether or not contraceptives will be used during the sexual encounter.

Secondly, even if consensus to use contraceptives is reached between both partners, the person should have the 'opportunity' to do so. The determinant 'opportunity' refers to *environmental constraints* and *knowledge.* For instance, if a person's environment does not support using contraceptives (e.g. condoms are very expensive and/or difficult to access) it will negatively effect the desired behavior. Moreover, if information on how to protect one selves against HIV/Aids cannot be accessed by a person, or the person's *knowledge* is incorrect, this will negatively affect protection against HIV/Aids or pregnancy (Fishbein & Yzer, 2003, Fazio & Towles-Schwen's, 1997). When either the requirements of successful *sexual negotiation* or *opportunity* cannot be met, the person will be more likely to fail in using contraceptives, thus increasing HIV/Aids transmission.

Individual Motivation

Before entering the sexual arena, most individuals have already determined whether or not they will use contraceptives during a possible sexual encounter. In our conceptual model, we conceptualised 'individual motivation' as the main predictor of individual behavior. 'Individual motivation' is formed by six determinants (e.g. attitude towards sex, perceived risk, outlook on life, etc.) and resembles the 'behavioral intention' of Fisbhein & Yzer's IMBP (2003) that is formed by three primary determinants (attitudes, perceived norm and self-efficacy). The most important difference between our conceptual model and other cognitive decision models (such as the IMBP of Fishbein & Yzer, 2003), is that we acknowledge the role *affect* plays in the decision-making process of contraceptive usage. After all, engaging in sex is a rather affective activity, and generally does not require much "rational" cognitive processing.

Whether a person will cognitively analyse all costs and benefits of his/her action depends on two factors according to the MODE-model of Fazio and Towles-Schwen (1997): 1) motivation, and 2) opportunity. Applied to sexual decision-making, it is clear that a person's *motivation* to rationalize the outcomes of his/her behavior is very low. Most people tend to suppress rational thought patterns in the bedroom since they fear that this will reduce their feelings of bonding during the heat of the moment. This might explain why "rational" cognitive decision models (such as the IMBP) experience difficulties in predicting contraceptive usage (Perloff, 2001). A person is proposed to be more motivated to deliberately analyse the outcomes of his/her behavior if he or she is personally involved with the decision (e.g. the person perceives that the decision has immediate consequences for his or her life) or the person fears invalidation of his/her decision (e.g. the person has to provide a justification for his/her actions) (Fazio and Towles-Schwen, 1997).

The second factor, *opportunity,* refers to the extent to which a person has enough time, resources, and cognitive capacity to analyse all costs and benefits of the decision at stake. For instance, if a person is intoxicated by alcohol or drugs, the opportunity for cognitive decision-making on contraceptive usage is close to non-existent. To conclude, when either motivation or opportunity are lacking, the MODE-model proposes that a decision is more likely to occur outside a person's conscious awareness, and to be driven by affect. Importantly, the decision to use contraceptives can both be based on affective or cognitive processing. We will now elaborate on this further.

Recent Social Psychological research suggests that the *accessibility* of an attitude (that is based on cognition or affective evaluations) at 'le moment suprême' highly influences whether a person will act on his/her intentions (Bohner & Wänke, 2002). Bohner & Wänke (2002) define accessibility as 'the ease with which an attitude comes to mind.' As pointed out earlier, we move beyond the narrow attitude-behavioral relationship, and we conceptualised 'individual motivation' (that is formed by six determinants) as the main predictor of individual behavior. Accessible attitudes (in our case: *determinants* of individual motivation) are found to be relatively strong attitudes that show a greater consistency with behavior than attitudes that are not accessible (Bohner & Wänke, 2002). The accessibility of an attitude is often based on factors such as direct experience, repeated expression, or personal involvement (Fazio, Chen, McDonel & Sherman,1982, as cited in Bohner & Wänke, 2002). In the context of our research, this implies that determinants that are based on personal involvement (e.g. an individual knows someone who has HIV in his or her immediate environment), repeated exposure (e.g. a person has frequently been exposed to the deaths of Aids victims) or direct

experience (e.g. a person is habituated to using condoms) are more likely to be accessible in a person's mindset. In turn, an affect-driven or cognition-driven motivation to use contraceptives that is accessible during the sexual encounter, will increase the likeliness that the person will negotiate safe sex with his or her partner and -hopefully- succeed in preventing HIV/Aids.

The conceptual model proposes that six determinants form the component 'individual motivation'. These six determinants are: 1) attitude towards sex, 2) attitude towards contraceptive usage, 3) attitude towards teenage pregnancy, 4) self-efficacy, 5) perceived risk, and 6) outlook towards life. The first determinant 'attitude toward sex' refers to a person's feelings towards engaging in sexual practices. For instance, according to Rademakers (1991), individuals who experience feelings of guilt about being sexually active, will often be less informed on how to use contraceptives correctly and neglect to take personal responsibility with regard to contraceptive usage. This negatively affects a person's motivation to use contraceptives. When unexpectedly confronted with sexual decision making, this person is more likely to engage in unprotected sex (Rademakers, 1991, as cited in Terpstra, 2003).

Secondly, the determinant 'attitude towards contraceptive usage' refers to a person's feelings towards using barrier methods (male and female condoms) and hormonal methods (injection, the Pill). For instance, the more a person believes that the advantages of using contraceptives outweigh the disadvantages (e.g. HIV risk), the more likely the person will be favourably inclined to use contraceptives (Fishbein & Yzer, 2003).

Thirdly, the determinant 'attitude towards pregnancy' refers to a person's feelings towards having a child at a young age. For instance, the more a person believes that the disadvantages of becoming pregnant (e.g. limited future possibilities) outweigh the benefits of becoming pregnant, the more the person is expected to have a negative attitude towards pregnancy, and hence the person will be more motivated to use contraceptives (Fishbein & Yzer, 2003).

Fourthly, the determinant 'self-efficacy' refers to the control a person perceives to have over his/her contraceptive usage (Fishbein & Yzer, 2003). For instance, the more a person believes to be efficacious in carrying contraceptives on him/her, and the more a person believes to be capable of consistently using contraceptives in the face of challenging circumstances, the more likely the person is proposed to act on his/her intentions.

Fifthly, the determinant 'perceived risk' derives from the Health Belief Model. The Health Belief Model proposes that the more a person perceives to be at risk of becoming

pregnant or contracting HIV/Aids, the more motivated the person will be to use contraceptives in order to prevent such detrimental causes (Health Belief Model, as cited in Perloff, 2001, p. 56).

Finally, the determinant 'outlook on life' refers to the extent to which a person perceives to have control over his/her life (Mathur et al., 2001, as cited in Pettifor et al., 2004). For instance, the more a person has a positive, clear defined perspective of his/her future and has established future goals, the stronger the person's motivation will be to use contraceptives in order to achieve that goal (Mathur et al., 2001, as cited in Pettifor et al., 2004).

Interpersonal Influence

In our conceptual model we acknowledge that individuals are embedded in social contexts, including families, communities and organizations (Bartholomew et al., 2001). Tajfel & Turner (1979) propose in their Social Identity Theory that the more we identify ourselves as a member of our *in-group* (the group to which we perceive to belong), the more we believe that we should act in accordance with the perceived social norms of this group (as cited in Hewstone et al., 2002). Based on several studies, we propose that *parents* and *peers* are influential in-group members in transmitting the appropriate socio-cultural norm of sexual behavior and contraceptive usage to the audience (see Graaf et al., 2005; Abt Associates Inc, 2001; Stanton, Li & Pack., 2002, as cited in Pettifor et al., 2004). The component 'interpersonal influence' refers to the socio-cultural context of a person's in-group, and is proposed to indirectly influence the underlying beliefs of a person's motivation to use contraceptives. The two determinants of 'interpersonal influence' are: 1) socio-cultural influences of parents and peers, and 2) interpersonal communication about contraceptive usage with parents and peers.

Firstly, the determinant 'socio-cultural influence of parents and peers' refers to the perceived social norms of how to view, experience and behave in a sexual relationship. For instance, the traditional sexual scripts regarding the appropriate rules of sexual behavior is for men to initiate sexual activity and for women to be more passive (Edgar & Fitzpatrick, 1993, as cited in Perloff, 2001, p. 39). Such norms may prohibit a female to take on an assertive role regarding the usage of contraceptives.

Secondly, the determinant 'interpersonal communication about contraceptive usage with parents and peers' refers to how information on contraceptive usage is transmitted between the individual and parents and peers. Research has shown that open communication

on sexual matters challenges social norms and can contribute to a social environment that supports healthy sexual behavior (Pettifor et al., 2004; Parker, 2004). In contrast, in cultures in which discussing sexual matters is taboo, the person will more likely experience feelings of guilt regarding his/her sexually active status, which is proposed to have a negative effect on the individual's motivation to use contraceptives (Rademakers, 1991, as cited in Terpstra, 2003). We will now present our audience analysis questions.

2.6.2 The Audience Analysis Questions

Our preliminary investigation helped us to identify what needed to be further researched in the focus groups. To ensure that our data collection in the focus groups is driven by Social Science theories, these audience analysis questions are connected to the determinants of our conceptual model. For instance, the audience analysis question 4a ('What does the audience perceive as the benefits of using a barrier method?') stems from the determinant 'attitude towards contraceptives' that is part of the 'individual motivation' component. In this way, by answering the audience analysis questions in chapter 4, our focus group findings can be linked to the determinants of our conceptual model of contraceptive usage. Hence, it will immediately become clear to what extent the findings are proposed to exert influence on an individual's contraceptive usage.

Component I : Interpersonal Influence Questions

1. Social Influence:

1a) To what extent do perceived socio-cultural norms of parents influence the audience's sexual behavior and contraceptive usage?

1b) To what extent do perceived socio-cultural norms of peers influence the audience's sexual behavior and contraceptive usage?

2. Interpersonal Communication:

2a) To what extent does the audience perceive to be efficacious in communicating with parents about sex and the usage of contraceptives?

2b) To what extent does the audience perceive to be efficacious in communicating with peers about sex and the usage of contraceptives?

Component II: Individual Motivation Questions:

3. Attitude towards Sex:

3a) Does the audience perceive it as socially acceptable to be sexually active at 15 years of age?

4. Attitudes towards using contraceptives:

4a) What does the audience perceive as the benefits of using a barrier method?

4b) What perceived disadvantages prevent the audience from using a barrier method?

4c) What does the audience perceive as benefits of using a hormonal method?

4c) What perceived disadvantages prevent the audience from using a hormonal method?

4d) What does the audience perceive as the benefits of ending an unwanted pregnancy?

4e) What perceived disadvantages prevent the audience from ending an unwanted pregnancy?

5. Attitude towards Teenage Pregnancies:

5a) What does the audience perceive as being beneficial to becoming pregnant at a young age?

5b) What perceived disadvantages prevent the audience from having a child at a young age?

6. Self-efficacy:

6a) To what extent do members of the audience perceive to have personal control in carrying contraceptives on their person?

6b) To what extent does the audience perceive to have personal control in consistently using contraceptives?

7. Perception of Risk:

7a) To what extent does the audience perceive to be at risk of contracting HIV/Aids or pregnancy if they do not use any contraceptives?

8. Outlook on Life:

8a) To what extent does the audience's perception of the future and their outlook on life influence their usage of contraceptives?

Component III: Sexual Arena Questions:

9. Social Influence of the Partner:

9a) To what extent is youth pressured by their partner to engage in sex?

9b) To what extent is youth efficacious in communicating contraceptive usage with their partner?

10 Knowledge:

10a) To what extent is information on the usage of contraceptives accessible for our audience?

10b) To what extent is their knowledge on contraceptive usage and sexual matters correct?

11. Environmental Constraints:

11a) Are contraceptives and health care services accessible for our audience?

2.6.3 Schematic Overview

On the next page, in table 2.1, a schematic overview is presented that summarizes the main research findings of our preliminary investigation.

Table 2.1 *Schematic Overview Preliminary Findings Determinants Audience's Contraceptive Usage*

Socio-cultural Influence Parents	Social Influence Peers	Interpersonal Communication Parents	Interpersonal Communication Peers	Attitude towards Sex
• Traditional African cultural is rapidly 'westernizing' due to the transition after apartheid legacy (Varga, 1997). • Traditional gender norms encourage men to seek multiple partners, while women are culturally dictated to remain silent and submissive (Varga, 1997). • Post-apartheid generation youth experience difficulties combining traditional norms ("condoms are for prostitutes") with contemporary attitudes ("sex is a must") (Varga, 1999, as cited in Shillinger, 1999).	• Peers encourage boys and girls to engage in sex at an early age (Varga, 1997). • Peer pressure for men: having many girlfriends is a yardstick of status among friends (Varga, 1997). • Peer-pressure for females: not sexually active girls are isolated from the group, since they can not contribute to the discussion (Wood et al., 1998). • Peer-pressure for men is slightly higher than for females (43% vs 28%) (Pettifor et al., 2004).	• Cultural taboo inhibits youth from discussing sex with parents (exploratory interviews; Varga, 1999, as cited in Shillinger, 1999). • Former traditional mechanisms that taught youth about appropriate rules of sexual relationships are gradually disappearing (Varga, 1999, as cited in Shillinger, 1999). • Although parents are concerned about Aids and sexual matters, only 46% claim to talk often to their children about this. (African Strategic Research Corporation, 2002, as cited in Harrison & Steinberg, 2002).	• Sex is mostly discussed with peers, but only 2% of youth said they had learned most about HIV/Aids from their peers (Pettifor et al., 2004). • Communication with peers refers to pressure to engage in sex. For girls, peer pressure often reinforces the legitimacy of sexual coercion (Pettifor et al., 2004, Wood et al., 1998).	• Pre-marital sex was frowned upon in traditional culture (Shillinger, 1999). • Marriage structures have undergone drastic changes in contemporary society (Varga, 2000, as cited in RHO, nd). • Males (43%) are more likely to indicate it is "ok" to have sex for youth their age (aged 15-19) than females (25%) (Pettifor et al., 2004). • Average age of sexual debut among youth aged 15-19 is 16.4 for males, and 16.7 for females (Pettifor et al., 2004).

Attitude towards Barrier Methods	Attitude towards Hormonal Methods	Attitude towards Teenage Pregnancy	Self-efficacy to carry Condoms & to use Condoms	Perception of Risk
• 'Culture' is often used as an excuse for not using condoms, which is referred to as *flesh to flesh* (exploratory interviews). • The female condom is becoming increasingly popular (exploratory interviews). • Condoms are often associated with infidelity, prostitution and HIV (Varga, 2000, as cited in RHO, nd). • Condoms are believed to take away men's control of the process and reduce sexual pleasure (Varga, 1997). • 31% of youth believe using condoms is a sign of distrusting your partner (Pettifor et al., 2004). • 66% of youth do not use condoms consistently (Pettifor et al., 2004).	• Males thought it was acceptable for girls aged 15 to have an injection (hormonal contraceptive). Two girls indicated it depended on if the relationship status was 'steady' (exploratory interviews). • Hormonal methods are believed to cause infertility, disabled babies and vaginal wetness (reduces male sexual pleasure) (Wood et al.,1998). • 58% of sexually active women report using injection, 34% the male condom, and 13% oral contraceptive pills to prevent pregnancies (Pettifor et al., 2004).	• Traditionally, motherhood was highly valued (Varga, 1997). • Abortion is a greater taboo than teenage pregnancy (exploratory interviews). • 33% of sexually experienced females aged 15-19 report ever having been pregnant (Pettifor et al., 2004). • Mean age of first child birth for females is 18.5 years (Pettifor et al., 2004). • Mothers of the females often take care of their children while they go back to school (exploratory interviews). • Government supports teenage mothers with a bursary of 180 SAR (exploratory interviews).	• All participants stated that providing condoms is the shared responsibility of both partners (exploratory interviews). • For females, this matter was more complicated due to the fear of being perceived as promiscuous. The 'rape myth' justified carrying condoms for girls (exploratory interviews). • 70% of youth believed they could refuse sex if their partner did not want to use a condom (Pettifor et al., 2004). • 74% of youth claimed to be confident to use condoms every time they had sex (Pettifor et al., 2004). • Drugs and alcohol was noted by 43% as factors that decreased condom efficacy (Pettifor et al., 2004).	• 33% of females mistakenly believed that a person could not be HIV infected without displaying physical signs such as 'looking sick' (Varga, 1997). • 45% of youth reported they had known someone personally who had died of Aids (Pettifor et al., 2004). • 54% of youth who reported *never* using a condom felt that they were at a low risk of infection (Pettifor et al., 2004). • Stigmatization of Aids might induce people to refer to their disease as TB (exploratory interviews). • People prefer to view themselves as 'safe' rather than face psycho-social consequences of a possible HIV infection. (Varga, 1997).

Outlook towards Life	Social Influence of the Partner	Interpersonal Communication with Partner	Knowledge	Environmental Constraints
• General trend of positivism among youth: 92% of youth have established long range goals for themselves, 82% of youth state they have a good idea where they headed in the future (Pettifor et al., 2004). • 28% of youth *do not* perceive their future to prosper and succeed as limitless (Pettifor et al., 2004). • Only a minority of males perceive themselves to be destined for a career in crime. They are already learning the three major prison gangs' rules (exploratory interviews). • Females (35%) are more likely to report limited personal control over their lives than males (27%) (Pettifor et al., 2004). • Some infected people would rather infect ten other people because they are afraid to die alone (exploratory interviews). • Some infected people cope with their positive status by excessive drinking, some commit suicide (exploratory interviews).	• South Africa has the highest reported rate of rape per capita in the world for a country not a war (Duke 1997, as cited in Varga, 1997). • By men, violence and coercion is perceived as a 'culturally appropriate practice' (Varga, 1997). • 55% of females reported ever having refused sex, only 29% said to be successful (Pettifor et al., 2004). • Females fear of being abused or abandoned if they refuse sex (Wood et al., 1998). • 11% of females reported ever being physically forced to have sex compared to 1% males (Pettifor et al., 2004). • Girls aged 12 are already engaged in transactional relationships with 'sugar daddies' (exploratory interviews).	• Unsafe sex is a rational decision for many people (Varga, 1997). • People are afraid that talking about contraceptives might destabilize the harmony of their relationship (Baxter & Wilmot, 1985, as cited in Perloff, 2001, p. 38). • Suggesting condoms can be interpreted as insulting, infidelity and lack of love for the partner (Sobo, 1993; Bajos et al. 1997, as cited in Varga, 1997).	• Alarming lack of knowledge in exploratory interviews: using two condoms over each other (assuming to be extra safe) and using *Dettol* to prevent pregnancy (exploratory interviews). • Only other alternative contraceptives that the participants mentioned to the male condom were: female condom and injection (exploratory interviews). • 32% of youth reported they had learned the most about HIV/Aids at school (Pettifor et al., 2004). • Most youth receive sex education in grade 8 when they are twelve years old (exploratory interviews). • High number of participants in these classes (45) decreases effective HIV/Aids education. (exploratory interviews). • Classic ABC is often referred to as methods to prevent HIV/Aids by youth (exploratory interviews). • The extent to which the audience's knowledge on preventing HIV and pregnancy is correct is unknown. • 6% of youth report there is nothing you can do to avoid HIV/Aids (Pettifor et al., 2004)	• Male condom can often be accessed free of charge at a large array of public venues in South Africa (exploratory interviews; Pettifor et al., 2004). • Quality of health care services differs in Stellenbosch: C. is well equipped, K. is not (exploratory interviews). • Some studies point out negative attitudes of health care staff was a barrier to youth to seek health care (Mmari & Mgnani, 2003; Speizer, Hotchkiss, Magnani, 2000, as cited in Pettifor et al., 2004, p. 57). • 85% of youth who reported to have attended services at last 12 months said they were treated well or very well (Pettifor et al., 2004).

Chapter 3 Methodology of the Pre-Production Phase

"One must talk little and listen much"
-African Proverb

In chapter 2, we reviewed theory, exploratory interviews and empirical evidence on relevant determinants of the audience's contraceptive usage and integrated our insights into a second conceptual model of contraceptive usage (section 2.6). In this chapter, we will provide the methodological details of how this preliminary investigation was executed and how the focus group interviews were conducted. First, we will explain why we predominately used a qualitative research strategy in this pre-production phase. Then, in section 3.1, we will elaborate on the methodological details of how we conducted our preliminary investigation. The gaps in data that we identified in our preliminary investigation helped determine what needed to be further researched. In the second research stage of this study, we conducted two focus group interviews in order to answer our audience analysis questions (see section 2.7 for overview questions). The methodological details on how these focus groups were conducted will be provided in section 3.2 to 3.8. In chapter 4, we will present the analysis of the focus group findings. Our insight obtained from the focus group interviews and the preliminary investigation will help meet our aim for part I: investigate the contribution of participatory audience analysis in determining the content of our intervention.

Qualitative Research

In this research stage, a qualitative research strategy seemed the most suitable research strategy. Although empirical evidence was available for a similar audience of African adolescents, there was *no data* available on the specific audience that we segmented (see section 1.2 for rationale audience segmentation). According to Baarda, de Goede & Teunissen (2001), qualitative research is the most appropriate strategy to use when seeking to obtain an in-depth understanding of a complex and 'new' phenomenon. In this stage, a qualitative research strategy allowed us to explore which determinants might possibly be involved in the audience's contraceptive usage. In this thesis, we integrated the insight obtained from this investigation into a conceptual model of contraceptive usage (see section 2.6.1). In a later stage, another researcher can quantitatively test the validity of the proposed relationship between the determinants of our conceptual model. Most importantly, we chose a qualitative research strategy since it reflected our principle of participatory audience analysis. That is: systematic, and frequent contact with the audience in order to determine the content of our intervention. To conclude, conducting new, qualitative research was vital in order to obtain a

more accurate understanding of the audience's underlying motivations for not using contraceptives.

We will now continue with providing the methodological details of our preliminary investigation of which the results were presented in chapter 2.

3.1 Preliminary Investigation

The purpose of the preliminary research was three-fold. Firstly, it helped us gain a comprehensive perspective of the determinants relevant to contraceptive usage (conceptual model 2.7). Secondly, it determined what needed to be researched further in the focus groups (audience analysis questions). Thirdly, it contributed to the establishment of the cases; the research instrument for the focus groups. Three types of sources were consulted: theory, empirical evidence, and new data (exploratory interviews). This use of multiple data sources is called triangulation (Baarda et al., 2001). Because more perspectives were taken into account by using triangulation, we increased our chances of uncovering 'the truth' about our audience's sexual practices. This section provides insight into the methodological details of the preliminary investigation.

Theory & Empirical Evidence

Some practitioners debate the benefits of using theory in the design of health interventions. Most scholars, however, agree that social and behavioral science theories increase our understanding of how determinants cause a specific behavior (see Bartholomew et al., 2001, p. 4; Perloff, 2001). In this research theories helped to generate ideas, and empirical evidence and new data were sought to verify this idea.

With empirical evidence we refer to data from research studies as represented in scientific journals. The qualitative studies reviewed in this research (i.e. Varga, 1997; Wood et al., 1998) focus primarily on the coercion used by men to force women into sexual practices. It should be pointed out that these studies were carried out approximately eight years ago, during the transition following apartheid legislation. Thus, the possibility exists that such practices are not representative for our audience of post-apartheid youth. Secondary literature, in which empirical evidence was cited, was retrieved through internet articles from credible sources such as Reproductive Health Outlook & the Boston Globe Newspaper (e.g. Shillinger, 1999). In addition, five issues of *loveLife's* UNCUT magazine (issues January-May 2005) were briefly analysed. These analyses may provide us with some indication of the topics which preoccupy our audience. Furthermore, quantitative support was derived from a

study carried out in 2004 by the Reproductive Health Research Unit (see Pettifor et al., 2004). This study provided a more recent picture of African youth and their contraceptive usage.

Exploratory Interviews

Since youth culture evolves very rapidly and largely differs per geographic area (e.g. urban or rural), we needed to empirically acquire new data. Two different kinds of exploratory interviews were held: interviews with audience members and interviews with key figures that had contact with audience members. By interviewing audience members, we obtained first hand insight into the potential receivers of our intervention's views towards sexual matters. These interviews with the audience members helped us in becoming familiar with the audience's use of language and helped us to develop the *cases*; the research instrumentation for the focus group interviews (see section 3.3).

The additional interviews with key figures were held since Bartholomew et al. (2001) pointed out that 'some factors cannot be measured by just asking the population because perceptions may be different from realities' (p. 62). This is particularly true when reporting sexual behavior, since people tend to exaggerate or give socially acceptable responses concerning their sexual practices (Perloff, 2001). Although the views that the key figures expressed enhanced our cultural reference frame, the results are not discussed in chapter 2. The data obtained from key figures is perceived as of subordinate importance to the data obtained from audience members that are the potential receivers of our intervention. This section elaborates on the methodological details of these exploratory interviews.

Participants Exploratory Interviews

Seven representative members of our audience were interviewed in three exploratory interviews consisting of 3 males, 2 females, and 2 males. The five African boys were on average 15.6 years old, and the two African girls had an average age of 15.5. All participants were from townships in the surroundings of Stellenbosch. The three boys were from Cloetesville, whereas all of the other participants lived in Kayamandi.

Additional interviews were held with four key figures. All four key informants were African, and some were interviewed more than once. Our key informants were: 1) Mr Mavovana, the principal of Kraaifontein high school. He supplied background information concerning teenage pregnancies at his school, formal teaching methods of HIV/Aids prevention at high schools, South Africa's educational system and the English proficiency of our audience. 2) Zodwa, a female counsellor at 'ABC get tested', an organisation for

voluntary HIV testing. She was interviewed because of her expert knowledge on psycho-social barriers to testing and expertise on how to use contraceptives. 3) a student of the University of Cape Town. He lives in Kayelitsha, a township of Cape Town, and elaborated on the role of health care for our audience. He wrote his PhD on the conditions under which inhabitants of townships prefer to visit a traditional healer (*sangoma*) or seek institutionalised health care. 4) A close collaboration was established with Bongi, a student at Stellenbosch University. Bongi has lived in the township Kayamandi all his life, and attended the same high school as did most of the participants in this study. He has become very involved in educating youth about safe sex, since he himself became a father at a very young age. He took on the role as 'pre-testing expert' for our cases, and arranged an exploratory interview with two of the girls. Since these key figures only provided background information, no further details will be provided on how these interviews were conducted.

Interview Strategy Audience Members

A topic list was used in the exploratory interviews to ask participants about determinants related to sexual behavior. This topic list included: attitudes and opinions about HIV/Aids, contraceptive usage, teenage pregnancy and preferred sources of information on HIV prevention. The interviewer (see section 3.5 'moderator' for more details) took precautions to address these personal and emotional issues of sexual behavior in a discrete and respectful manner (Baarda et al., 2001). An effort was made not to display any authority, but instead to stimulate equality. In all interviews, the interviewer first listened and observed closely what each participant had to say. In an attempt to clarify information and to stimulate the interviewees to give more information, a probing and paraphrasing method was used (Gorden, 1998). Probing refers to the use of short words such as 'really?' and asking further questions about a reported issue. At all times the interviewer took care not to obtrude the natural conversation flow of the participants and was cautious not to make the participants feel uncomfortable or embarrassed (Gorden, 1998).

Procedure Explorative interviews

As part of our preliminary investigation we conducted several exploratory interviews. These exploratory interviews helped determine the content of the cases, the research instrument that was used when we conducted the two focus group interviews. All off the exploratory interviews were conducted in Stellenbosch, South Africa in May 2005. To create a natural environment and informal atmosphere, drinks and food were provided. The three boys from

Cloetesville were approached at a petrol station and asked if they were willing to talk about 'township life' for a research project. The meeting with the two fourteen-year old boys from Kayamandi was arranged by a friend who had contacts in Kayamandi. With all of the male participants, the interviews took place outside in a public park where there was enough privacy to talk about these matters. Bongi (see key figure 4) arranged the interview with the two girls from Kayamandi, since they were his relatives. The interview with the girls took place in a quiet restaurant. The girls were able to talk freely, without people unintentionally overhearing the conversation. After the interview, the participants were thanked for their efforts and treated to ice-cream.

3.2 Research Strategy: Focus Group Methodology

Up until this point in the pre-production phase of our research, the contact with our intended audience had been limited to interviewing seven audience members. This number of participants was far too few to obtain an accurate picture of our audience. In order to investigate the extent to which the preliminary findings were supported by a larger group, two additional focus group interviews were conducted. This section provides the methodological justification for our focus group interviews.

Focus group methodology

Focus group methodology or group discussions, is a very flexible data collection method of which the strength lies in the *interaction* between individual group members. Through this interaction, discussion is generated and multiple perspectives on sexual matters, the subject in this case, can be identified. As a consequence, insight can be gained into the groups 'norms' regarding sexual practices and into individual diverting beliefs and perceptions. Because discussions take place in a group ("safety in numbers principle"), individuals are not put on the spot as is the case in in-depth individual interviews, and as a result, they may feel more comfortable disclosing their opinions (Puchta & Potter, 2004).

In this research, the use of focus groups seemed like the appropriate research strategy for three reasons. First, in the exploratory interviews we became aware of the fact that our audience was not very fond of reading and that they had a strong oral tradition. Clearly, our audience had little experience with 'western' quantitative evaluation mechanisms such as surveys and the use of Likert-scales. An advantage of focus group methodology is that it is an *oral* method. We realized that not all participants would be equally proficient in *reading* or *writing* in English. An oral method overcomes such language barriers by allowing participants

to communicate in their every day language during the discussions. For us, this meant that we could tap into their vocabulary and expressions, and use this vital insight of their natural language use to discuss sexual matters for the design of our intervention. Secondly, although some researchers might perceive conducting focus groups as an indiscrete way to explore sexual behavior, several studies disagree with that position and proved the contrary. The following studies successfully used focus group methodology in the HIV/Aids context: De Negri, B. & Thomas E., 2003, for African and Latin American studies; Terpstra, 2003, for the Netherlands). Finally, the method resembles the natural context in which evaluations on such topics take place in everyday life; in conversations with others. Participants often find it is a pleasurable experience and feel honoured that such an interest is shown regarding their opinions (Puchta & Potter, 2004).

3.3 Data Retrieval: Cases & Questionnaire

To stimulate the discussion that took place in the focus groups, five *cases* (or role model stories) were used in order to collect audience data and to simultaneously answer the audience analysis questions. In each *case*, the main character of the story dealt with complicated issues of sexual decision making. This case approach resembled the African tradition of storytelling (Perloff, 2001), and stimulated participants' identification with the main characters. More importantly, the method allowed participants to speak in the third person (referring to the characters) which facilitated personal disclosure.

The use of cases in this research was inspired by a study conducted by Terpstra (2002), a student of Health Education at the University of Maastricht, the Netherlands. Terpstra (2002) researched the determinants of using 'the pill', the hormonal pregnancy prevention method, among teenage girls from the Antilles and Suriname in the Netherlands. To retrieve this audience data, Terpstra (2002) used eight cases. Reflecting on her work, Terpstra (2002) found this approach very useful for stimulating openness and discussion in the conducted focus group interviews.

Rationale Cases

To stimulate identification among all participants, three female characters and two male characters played a prominent role in the five cases that were discussed. This deviates from the *eight* cases of Terpstra (2002) in which solely female characters were portrayed. Five cases were used in this research since asking too many questions can be tiresome for the participants, and can negatively affect the quality of the collected data (Coulson et al., 1998).

According to Coulson et al. (1998), it is better to focus on a few questions and use probing methods to obtain additional information. In the content of the cases, we articulated provisional findings that were obtained in our preliminary research. This allowed us to test our expectancies among a larger audience. Pictures were added to make the cases more vivid and to increase the participants' level of identification. Originally, these pictures derived from Terpstra's (2002) study. Pre-tests in the exploratory interviews with the three male audience members and principal of Kraaifontein high school indicated that the pictures were perceived as being realistic and representative for African models. All cases were pre-tested by Bongi (see key informant 4, section 3.1). Bongi helped to ensure that the cases resembled the audience's "reality" and that the level of English was appropriate in view of the audience's frame of reference. In appendix B, the rationale for the final version of the cases and Bongi's pre-testing feedback is extensively described. The following passage gives an impression of the cases that were used in the focus group interviews:

Case 1

> *Natasha is 15 years old and has been seeing Siya who is 19 years old for three weeks now. Siya would like to have sex with Natasha. Natasha is not sure, and she would like to get tested first. She tried to discuss it with Siya, but he does not want to talk about it. Natasha thinks it is really cool to have an older boyfriend and does not want to lose him, so she does not talk about it anymore and agrees.*
>
> *What do you think about this?*

In everyday conversation one story leads to another. In a similar manner, the data in our focus group interviews were retrieved. The following table 3.1 provides a schematic indication of the audience analysis questions that were answered per case:

Table 3.1 *Schematic indication of audience analysis questions studied per case in focus group interviews*

Case #	**Measured Audience Analysis Questions**
Case 1	3a; 9a-b, & 10a-b.
Case 2	4a-e; 6a-b; 7a; 8a, & 10a-b.
Case 3	1a-b; 2a-b; 4a-e, & 11a.
Case 4	9a-b; & 10a-b.
Case 5	5a-b.

Questionnaire

To obtain quantitative support for our focus group findings, participants were asked to fill in a brief questionnaire at the end of the session. This questionnaire referred to their sexual behavior and contraceptive usage. We perceived it as more discrete to ask these personal and private questions outside the focus group setting. When I gave instructions for filling in the questionnaire, I stressed the fact that the participants' answers would be treated as strictly confidential. This induced the participants to answer more honestly. The questionnaire consisted of the following sections (see Appendix B for complete questionnaire):

- Age, gender, ethnic background and economic indicators (questions 1-4)
- Sexual debut ever, age of sexual debut (question 5, question 6)
- Multiple sex partners (question 7)
- Recall of protection at last sexual encounter (question 8)
- Specification protection at last sexual encounter (question 9)
- Teenage pregnancy (question 10, 11)
- Additional remarks (open question 12)

Questions 1, 3, and 11 were open questions. For all of the other questions, the participants were asked to circle or tick their answers.

Pre-test of the questionnaire

To test whether the questions in the questionnaire were understood by the participants, they were pre-tested by Bongi. In the initial version, question 8 ('If you used protection the last time you had sex, what did you use?') provided *Dettol* as additional option to the injection, male condom and female condom. The myth of preventing pregnancy for females by washing their vagina with *Dettol* after intercourse, was mentioned in the exploratory interviews. Bongi warned that *Dettol* should be excluded as an option in the questionnaire, because the participants might change their existing (correct) knowledge and perceive *Dettol* as a genuine contraceptive. In Bongi's words '*If you come into their class with this questionnaire, asking them questions about their sexual health, they will think that this white lady from Europe is the expert. And if she says 'Dettol' is good, they will use it next time as a protection method'*. Not wanting to be responsible for such a detrimental cause, we decided to exclude this option. After rephrasing some questions in order to adjust them to the participants' educational level, Bongi approved the questions. They can be found in Appendix B.

3.4 Participants

Recruitment of the Sample

Participants were recruited and selected by the principals of two predominately black high schools in Kraaifontein and Kayamandi, Western Cape, South Africa. Contact with both principals was established through the Matie Community Service, an organization that does social and other support work in the community and therefore has access to high schools. The principals were contacted and asked for permission to conduct the focus group interviews. An official letter from the Language Center of the Stellenbosch University was shown to prove the validity and necessity of this research project.

Group Size

In total, sixteen young African South Africans were interviewed in two focus group sessions, one at Kraaifontein and one at Kayamandi. Each group consisted of eight participants: four males and four females. Kitzinger (1995) recommends a focus group size of eight members since it would allow the participants to interact with each other, whilst still being small enough to increase the participants' 'sense of belonging to the group'. A sense of belonging makes participants feel at ease and stimulates them to express their attitudes (Coulson et al., 1998). From our perspective, a group of eight allowed the moderator to encourage introverted participants to interact and express their opinions, and moderate (if necessary) the influence of the more dominant participants (Puchta & Potter, 2004).

Characteristics Participants

The sample of participants consisted of eight males and eight females. All participants spoke Xhosa as mother tongue, and English as a second language. The geographical location of the high schools in the townships Kraaifontein and Kayamandi indicates low economic status of the participants. The educational level of the participants (referring to their intelligence) in this sample is likely to be very varied, because there is no division in educational level in South Africa's high school system. The age range of the sixteen participants in the focus group interviews varied from 14 to 19 years of age, with an average age of 16.3. The participants in Kraaifontein were on average older (mean 17.3) than the participants in Kayamanandi were (mean 15.4). In Kraaifontein the age of the participants ranged from 16 to 19, and in Kayamandi from 14 to 16. In the questionnaire given at the end of the interview, we found that the reported sexual experience varied per gender. Seven male participants

(85.5%) reported to have had sex, and three female participants (37.5%) did so. In chapter 4, these findings are presented in table 4.1.

3.5 Moderator

The moderator in the focus group interviews was the author of this thesis, at the time a 23-year-old white female from the Netherlands. As the moderator, I perceived that despite the cultural differences, the relatively small gap in age between the participants and myself increased the participants' identification. For instance, in the focus groups, most of the participants seemed to feel at ease when disclosing their views on sexual matters as if they were talking to a peer. I believe that if I were a middle-aged researcher, this would more likely arouse perceptions of inequality of social class among the participants. In turn, this could lead to a more formal, distant interpersonal interaction during the focus group interviews because the researcher could display that he or she faced difficulties relating to the lives of young people, which might hinder the participants from feeling comfortable to discuss sexual matters. Moreover, the participants might be more suspicious in disclosing such confidential information because they might fear that the middle-aged researcher would have the power to report this information on the participant's intimate relationships and sexual activity to the principal or worse, their parents.

To bridge this social gap and stimulate equality, I understood that my main role as a moderator was to generate discussion among the participants, rather than to display personal opinions and lecture on safe sex education (Coulson et al., 1998). In the curriculum of my studies, I had gained experience with in-depth interviews and I had developed qualitative interview skills such as listening and observing. In addition, I gained practical experience in facilitating discussions for groups of eight people, while being a communication and marketing trainer for telecommunication purposes. I did not, however, receive formal training in focus group methodology. I became acquainted with the specific method by studying a number of books and articles (e.g. Coulson, et al., 1998; De Negri. & Thomas, 2003, Puchta & Potter, 2004; Kitzinger, 1995; Smith Romocki et al., 2004; & Terpstra, 2002). Thus, to a certain extent, I was trained to reflect, clarify and summarize the opinions expressed by the participants in the focus group.

3.6 Procedure

All of the interviews were conducted in English and took place in June 2005. An interpreter of isiXhosa was present to overcome any language or cultural barriers. Few participants needed help when translating their opinions from isiXhosa to English. The vast majority of participants (14 out of 16 participants) were able to express themselves in English. The interpreter had the same cultural background as the target group. He was a very introverted person and did not interfere with the discussions. The presence of the interpreter made the participants feel more at ease with me, the 'outsider' moderator, whereas I felt more confident in the interpreter's presence.

At the beginning of the session I introduced the interpreter and myself. I stressed that all of the information discussed in this focus group would be handled as strictly confidential and only used for the purpose of this research. The terms 'HIV and Aids' were avoided in the introduction because of the negative connotations attached to these terms. The more general term 'health issues' was used to indicate the purpose of the session. I emphasized that I was interested in the genuine views of the participants and expressing social acceptable answers would neither help me, nor them, to improve health messages targeted at youth. After this initial introduction, the cases were discussed.

As I was conscious of the delicacy for the participants discussing these matters, I arranged that both in Kraaifontein and Kayamandi, a separate room was provided in order to ensure that the participants' expressed opinions would remain within this room. I wore casual clothes to decrease any possible perceptions of a social gap and took care not to display any unnecessary authority during the session. In all the interviews, all of the participants, including the interpreter and me, sat in a circle stimulating equality rather than authority (Coulson, et al.,1998). Drinks and snacks were served to stimulate informality and to make the focus groups more of a social gathering rather than a clinical research project.

One noticeable obtrusive factor may have been the presence of a video camera that recorded the interviews. To minimize the hindering effects of its presence, the camera was positioned on a tripod. Overall, both the focus group interviews in Kraaifontein and Kayamandi were very pleasurable experiences with lively discussions among the members of the focus group. After the focus group interviews had been conducted, the participants were thanked for their contributions and given *loveLife*'s UNCUT magazine and a loveFACTS brochure with important information about the usage of contraceptives. Each session lasted approximately three hours (including breaks), since an existing text of *loveLife* was also evaluated (see Part II). In Appendix B the protocols of both focus groups can be found.

3.7 Analysis of the Data

This section describes how we prepared the raw data of the focus group interviews for further analysis. The results of our analysis are presented in chapter 4. In both focus group sessions, five cases were used to generate discussion. Each case contained several complex issues on sexual decision making (see section 3.3, table 4.1). The cases stimulated a natural manner of communication in which the interaction between the participants determined the order in which these issues were discussed. Both focus group interviews were recorded on videotape with a camera, and videotapes were then converted to DVD. The recordings on these DVD's were completely transcribed in two protocols that verbally reflected the focus group interviews. Non-verbal communication in these recordings, such as participants nodding their head to confirm they agreed with a specific issue, were verbally transcribed. Hence, in these two protocols all observations and comments made by the participants remained in context (see appendix B: outcomes focus group interviews).

To prepare this rich and often overlapping material for further analysis, we first roughly structured participant's comments per determinant of the conceptual model. Then, we structured participant's answers per audience analysis questions that are based on these determinants. This resulted in an overview of participant's answers per posed audience analysis question. By comparing participants' response for each audience analysis question, we could identify minority opinions and group consensus. In chapter 4, we answered our audience analysis questions by presenting the results of our analysis of the focus group interviews per audience analysis question. First key findings of our preliminary investigation were presented to facilitate comparison with our focus group findings. To create a more vivid description of our results, the focus group findings are illustrated with expressed remarks made by the participants.

Chapter 4. Analysis Focus Group Interviews

In the chapter 3, we provided the methodological details of how we conducted the two focus group interviews. We explained that during the focus group sessions we used five cases (role model stories in which the main character is confronted with complex issues in sexual decision making) to stimulate discussion among the participants (see section 3.3 for more information). The participants' responses were all recorded on videotape with a camera. Verbal and non-verbal communication was then transcribed, resulting in two protocols. The details on how we prepared this rich, descriptive data for further analysis can be found in section 3.7 'analysis of the data'.

In this chapter, the analysis of the two focus group interviews, which are part of our participatory audience analysis strategy, are presented. This analysis will help answer our third research question: *'To what extent do the findings in the focus group interviews support the preliminary research on the audience's determinants of contraceptive usage?'* In total, sixteen African adolescents were interviewed in two focus group interviews at high schools in the townships of Kraaifontein and Kayamandi. Each focus group consisted of an equal division of gender: four male and four female participants. The age of the participants ranged from 14 to 19, with a mean age of 16.3. Quantitative evidence was obtained by means of a questionnaire given at the end of the focus group session. The self-reported sexual activity of the participants differed by gender: 85.5% of males self-reported to have had sex, and 37.5% of females self-reported their sexual activity.

In presenting the analysis of our focus group findings, we will follow the defined audience analysis questions (see section 2.6). These audience analysis questions are linked to the 11 determinants of our integrated conceptual model (see section 2.7). Thus, guided by the conceptual model's theory, we will move from determinants that are proposed to indirectly influence the audience's contraceptive usage (e.g. determinants within the component interpersonal influence), to determinants that are expected to exert a more direct influence on the audience's contraceptive usage (e.g. determinants within the individual motivation and the sexual arena component). For each determinant, we will first provide key findings that stem from our preliminary investigation of theory, exploratory interviews and empirical evidence.

4.1 Interpersonal Influence

This section presents the findings of the interpersonal influence component. This component is proposed to indirectly influence the formation of an individual's motivation to use

contraceptives. Interpersonal influence consists of two determinants: *social influence* of parents and peers and *interpersonal communication* with parents and peers.

4.1.1 Social Influence

The perceived social norms of how to view, experience and behave in a sexual relationship are elaborated in this section. The focus will be on the influence of parents and peers (our audience's ingroup) in transmitting these norms.

1a) *To what extent do perceived socio-cultural norms of parents influence the audience's sexual behavior and contraceptive usage?*

Our preliminary research illustrated that after apartheid legislation ended, the traditional African cultural norms of appropriate sexual behavior rapidly evolved and loosened (Varga, 1997). Although today's youth do not have to struggle for democracy like their parents, they have to fight another battle: HIV/Aids. Varga (1999) indicated that post-apartheid youth often feels stuck between two cultures and experience confusion in combining contemporary norms ('sex is a must') with traditional norms ('condoms are for prostitutes') (as cited in Shillinger, 1999). The way African parents traditionally raised their children underlined the segregated (masculine) gender norms. These norms encourage men to seek multiple sex partners (polygamous practices) while females are culturally dictated to remain silent and submissive (Varga, 1997). It is clear that in today's era of the HIV pandemic such norms increase the risk of contracting HIV/Aids.

In the focus groups, two male participants in Kraaifontein said that seeking more than one relationship is a 'cultural thing'. The males stated that it was something their *parents* did and that it is something they have inherited as black people. With respect to sexual practices, most parents of the participants were not a positive role model for their children. This can be concluded from the remark of a nineteen-year-old male in Kraaifontein: 'Most of us just came because it happened.' This unplanned character of their parents' pregnancies contributes to an underprivileged family situation that is portrayed by broken families, single mothers and dozens of (half) siblings. The confusion youth experiences of dealing with two different cultural sets of norms, as Varga (1999) pointed out (as cited in Shillinger, 1999), is displayed in the following comment by a nineteen-year-old male in Kraaifontein: 'They [our parents, SvdL] always say that they want to raise us the way they were rissen by their parents, but they forget the point that THIS is not THEN, we are the next generation.'

Although the participants noted that their parents stimulated them to complete high school, it remained unclear to what extent parents' expectations guided them in a positive direction such as furthering their studies and pursuing a career. From the impression the moderator got from the focus group interviews, youth sought adult mentors outside the family situation (e.g. school teachers). We can conclude that although new generations bring hope of change in existing sexual practices, the transition of these risky social norms is a very gradual process.

1b) *To what extent do perceived socio-cultural norms of peers influence the audience's sexual behavior and contraceptive usage?*

In this study, it seemed that the influence of socio-cultural norms was transmitted to a greater extent by peers. Peer-pressure is identified in several studies as one of the major factors that induce youth to engage in sex and that stimulate social norms that encourage high numbers of sexual partners (e.g. Stanton, Li & Pack, 2002, as cited in Pettifor et al., 2004; Abt Associates Inc, 2001). According to Pettifor et al. (2004) males experience a slightly higher level (43%) of peer-pressure than females (28%).

Both focus groups confirmed that there was peer-pressure to engage in sex. Fear of group exclusion stimulates youth to engage in sex. For instance, in Kayamandi participants said that the main issue was to be able to say 'I've been there, I have experienced sex'. This is in accordance with the 'need to belong theory' of Baumeister & Leary (1995) and Wood's et al. (1998) findings for females in Eastern Cape. A not-sexually active sixteen-year-old male in Kayamandi stated: 'If you are a virgin, and you are a boy, they keep you out of the group. You feel like an outsider if you don't have sex.' Later he added: 'And they always bring their sex subject every time. And then they ask your opinion on the sex issue.' A sixteen-year-old female in Kayamandi provided details on how pressure was executed: 'If you say no, they just say that you are a sissy.'

The social norms displayed in the focus groups regarding appropriate sexual behavior reflected the segregated gender construct that Varga (1997) identified. Thus, for males, sexual relationships are a way to prove their manhood. As one sixteen-year-old male in Kayamandi said: 'Sometimes sex is about a test […] like how man enough are you?' In view of this sexual script, females are expected to display femininity and stimulate their male counterparts to take on a masculine, assertive role. In the words of a nineteen-year-old male in Kraaifontein: 'Once the girls find out that a boy is a virgin, then SHE wants to have sex with him and she puts the pressure on him. She makes silly comments that so and so […]. You feel

the pressure, ah sugar: I must prove my manhood!' Similar to Pettifor's et al. (2004) findings, a high number of multiple partners was only confirmed for males in the questionnaire given at the end of the interview: 2 out of 8 male participants (25%) self-reported casual sexual relationships. The vast majority (80%) of self-reported sexually-active participants claimed to be faithful to one partner. In the following remark of a nineteen-year-old male in Kraaifontein it became clear that 'stable relationships' are based on an fallacious notion of trust, while casual relationships merely have a sexual character: 'You can have a stable relationship [...] and you know that this person will not leave me. And you do have this relationship [casual relationship, SvdL] for [...] yeah for sex.'

In Kraaifontein, three female participants were not to keen on men's behavior in seeking multiple sex partners. In Kayamandi, however, a sixteen-year-old was well aware that her boyfriend was engaging in additional relationships. This can be concluded from her comment: 'He [her boyfriend, SvdL] does not want his mother to know about the other girlfriends so I have to sneak...' Later in the discussion it became clear that 'sneak' referred to secretly entering his house through the window instead of the front door. Overall, most participants did not debate males' behavior of seeking multiple partners but more or less acknowledged it as a fact.

It must be pointed out that male participants never mentioned the possibility of combating peer-pressure. Four female participants (3 in Kraaifontein, 1 in Kayamandi) took a very outspoken stance and stressed the individual choice not to engage in sex. As a seventeen-year-old girl in Kraaifontein said: 'Although you get peer-pressure from your friends, the thing is: the decision is YOURS at the end of the day. You have to live with the consequences, […] no matter what your friends or your boyfriends say.' Although such comments do signify a trend towards a more emancipated outlook of individual responsibility and equality, these comments cannot be generalized. An equal number of female participants were more introverted and did not support this notion of emancipation. There is a huge difference between *saying* that one is able to fight peer pressure and *acting* upon such premises.

4.1.2 Interpersonal Communication

"Talk about it" is the entry line on all campaign material of *loveLife*, South Africa's major Aids prevention organisation. Indeed, research has shown that openly talking in society about sexual matters contributes to the awareness of personal HIV/Aids risk and helps partners to mutually decide on safe sex practices (Waldron, Caughlin, & Jackson, 1995, as cited in

Perloff, 2001, p. 37). This section investigates how communication on contraceptive usage occurs between the audience and his/her parents and peers.

2a) *To what extent does the audience perceive to be efficacious in communicating with parents about sex and the usage of contraceptives?*

Research in the Netherlands revealed that children who feel comfortable discussing contraceptive usage with their parents are more likely to use contraceptives consistently (de Graaf et al., 2005). A study by the African Strategic Research Corporation (2002) found that although 40% of parents cite HIV/Aids as their major concern for their children, and a further 21% stated that fear of sexual abuse caused them great anxiety, only 46% of parents claimed to talk often to their children about HIV/Aids (as cited in Harrison & Steinberg, 2002).

Most participants in the focus groups would like to discuss sexual matters with their parents, but cultural taboos referred to earlier (e.g. Varga, 1999) prohibits this (as cited in Shillinger, 1999). A seventeen-year-old female in Kraaifontein stated: 'We don't get the opportunity to speak about those things at home. If you speak about condoms to my mother [turmoil in focus group] you will get a big hiding! Later she explained why: 'Our parents are not open about this, because they were never taught about sex. They were never comfortable talking about sex.' One nineteen-year-old male displayed his frustration and disappointment in his parents for not communicating about sexual matters: 'I feel that for our parents it is not easy for them to change the way that they are. But [...] they must compromise something, whether it is culture or anything, because I mean: young people are dying because of their attitude.' Later he stated: 'I won't raise my children the way my parents have raised me. I would speak to them about these things from a very young age.' When probed, he underlined the necessity of the information in order to make well-informed decisions: 'Then they can choose for themselves'.

Despite clear evidence of sexual activity, parents neglect discussing sexual matters with their children. A fifteen-year-old girl in Kraaifontein said: 'Even though they know that we are doing these things, they don't want to admit to themselves that we ARE doing these things.' It seems that parents mistakenly believe that silence will curb their children's sexual activity. Talking about sex is believed to promote *promiscuous b*ehavior, a negatively connotated word. In the words of a sixteen-year-old girl in Kraaifontein: 'They feel like when they discuss sex with you, they are sending you to do this.'

Parents communicated their fear of losing their child from HIV/Aids in alternative, indirect ways. 'When your parents find out you have a boyfriend. She or he will say: go to the

clinic and get an injection. And they won't talk to you about sex or anything. But maybe, she will tell you please carry a condom, or maybe you will find a condom in your bag', as a seventeen-year-old female commented in Kraaifontein. Two participants (1 male,1 female) perceived this as promoting sex. As illustrated by a nineteen-year-old male in Kraaifontein: 'From an early age my mother never spoke to me about condoms and sex. Now, why now? This sudden interest to put condoms in my bag. Obviously she is saying to me: go and have sex, you are now ready.'

In Kayamandi, two participants indicated that discussing sexual matters depends on the parents. A sixteen-year-old girl remarked: 'Some people have strict parents, some people have open parents like my mother, not my dad, he is very strict. So I can talk to my mom.' Pettifor's et al. (2004) confirmed this pattern and found that 47% of boys perceived that they were able to ask their parents questions about sex compared to 59% of girls aged 15-19. Neither participants in Kraaifontein, nor in Kayamandi commented on the former initiation mechanism that traditionally taught youth about the appropriate norms of sexual behavior. This can firstly be explained by the fact that initiation rites are gradually disappearing and more common in rural Eastern Cape. Secondly, most participants in the focus groups have not yet undergone the rite, since it occurs for females at age 21 and for males between 15-25. Most of all, it is a very sacred initiation rite and youth are not allowed to talk about it to people outside their community (personal communication Ngoboco, June 3, 2005).

2b) *To what extent does the audience perceive to be efficacious in communicating with peers about sex and the usage of contraceptives?*

Pettifor et al. (2004) pointed out that youth discuss sexually matters mostly with peers. Interestingly, only 2% of youth self-reported to perceive peers as a credible source of information about sexual matters (Pettifor et al., 2004). According to Pettifor et al. (2004) youth (32%) said they learned most about HIV/Aids from school.

Youth in both focus groups confirmed frequently talking with peers about sexual matters. A sixteen-year-old girl in Kayamandi indicated that specific talks on contraceptive usage such as 'condoms and injections' only occurs sporadically. Another fourteen-year-old girl in Kayamandi pointed out that if you characterize yourself as an expert on contraceptives, this makes you stand out from the group. This is not appreciated as illustrated in her words: 'They say she has high opinion, she is not like us.' A sixteen-year-old male peer-educator in Kayamandi pointed out information from peers was often coloured by myths and misconceptions: '[When you ask your friends, SvdL]: What's it like? What happens first?

What's the first move? They tell you everything. But when you supposed to do it… Then… That's where the problem lies. You don't know where to start.' With his comment he supported Pettifor's et al.(2004) findings that knowledge on how to use contraceptives correctly hardly derives from friends. Later he indicated that in masculine African culture talking about contraceptives is not a topic to discuss among male peers: 'There are also boys talking about condoms, relationships and love. That's what breaks relationship to us guys. They say it is a girl's thing.'

The focus group in Kayamandi had a very negative attitude towards friendships. A sixteen-year-old male said: 'We just call them friends because we know them and we communicate. Friendship is not something that's real these days. Some friends use you to get something.' How friends take advantage of each other is illustrated by a fifteen-year-old girl: 'Maybe this guy comes he has money and stuff, and he ask me out… Then my friends say: just say "yes", cause we are going to eat his money and stuff, and then I will be the one who will be sleeping with the guy and they [my friends, SvdL] just eating the money … so they use me.' An another fifteen-year-old girl commented: 'Some say that there isn't a good friend. It's either smoking, drinking or having sex…'

4.2 Individual Motivation

In our conceptual model, a positive 'individual motivation' to use contraceptives is proposed to be the greatest predictor of *individual* behavior. If a person has a positive intent to use contraceptives before entering the sexual arena, the person is more likely to negotiate safe sex with the partner. Six determinants form the component 'individual motivation': 1) attitude towards sex, 2) attitude towards contraceptives, 3) attitude towards teenage pregnancy, 4) self-efficacy, 5) perceived risk, and 6) outlook on life.

4.2.1 Attitude towards Sex

> *'Oh girls, you have to be sexually active like me, and then you are going to know [about contraception pills, SvdL].'* Nineteen-year-old male, Kraaifontein

3a) *Does the audience perceive it as socially acceptable to be sexually active at 15 years of age?*

Through the above noted statement a nineteen-year-old male in Kraaifontein was in the moderator's perception teasing and implicitly trying to seduce female participants in the focus group. But actually his statement is correct: research has shown that youth who feel

comfortable with their status of being sexual active (e.g. do not experience feelings of guilt), are more likely to use contraceptives consistently (Rademakers, 1991, as cited in Terpstra, 2003). Factors that indicate acceptance of sexuality are determined by the openness participants approach sexual matters. According to Varga (1997), traditionally, African culture frowned upon premarital sex. Nowadays youths' age of sexual debut have not changed much in comparison with the age traditionally youth engaged in sex. This is illustrated by a male aged nineteen: 'Our forefathers got married when they were fourteen, when they were twelve. But obviously, they got married so they could have sex.'

The focus groups confirmed the concept of masculine African culture and segregated gender norms. The majority of males were more eager to respond positively to the above noted question, while the three females that self-reported being sexually active remained silent. Females who did react vividly indicated that they perceived fifteen years as too young for a girl to have sex: 'It is young. Maybe sixteen, but fifteen is young,' as stated by a seventeen-year-old girl in Kraaifontein. The risk of teenage pregnancy was a reason for a male participant in Kayamandi to state it is wrong for a fifteen-year-old girl to have sex: 'If you're fifteen years old like a girl, ne? And a guy like Siya [the main character in case 1, SvdL], who is nineteen and doesn't have work and she is gonna have sex with him. Then nine months later, like in a week, she'll get pregnant.' These findings resemble Pettifor's et al. (2004) study, who found that males (43%) are more likely to indicate that it is "ok" to have sex for youth their age (15-19) than females (25%).

When asked: 'Do you think fourteen is too young to get an injection?' A similar pattern erode as to the 'right age to have sex' in which the male participants were more eager to agree it is "ok" to engage in sex than females. In Kraaifontein, all four male participants did not perceive fourteen years of age as being too young to have sex. A nineteen- year-old-male commented: 'In the society that we live in ... Guys, I mean there are twelve years old [girls add: sugar daddies] [who already engage in sex, SvdL]. In Kayamandi, a girl and a boy explicitly stated that fourteen years of age was acceptable for a girl to take an injection. Only one fifteen-year-old girl said that having sex at age fourteen was disgusting and 'totally wrong'. She argued: 'She can end up hating sex, you know … when she is already married.' At the end of the interview, participants had to opportunity to write down their questions about things they wanted to know more about referring to sex, pregnancy and HIV/Aids in the questionnaire. In the questionnaire it (again) became clear that the appropriate age to engage in sex is on the audience's minds, as a fifteen-year-old girl in Kayamandi noted 'What is the right age to have sex?'

Through this questionnaire, it became clear that the majority of 87.5% of the African males (7 out of 8) reported to have had sex. Female participants self-reported a lower rate of sexual activity: 37.5 % of the African females (3 out of 8) reported to have had sex. None of the participants reported ever being pregnant, and none of the males reported ever having made a girl pregnant. The fact that participants in Kraaifontein were slightly older than in Kayamandi (age range 16-19 vs 14-16) accounts for their having accumulated more sexual experience.

Table 4.1 *Comparison Self-reported Sexual Activity Participants and Findings from Pettifor et al.(2004)*

Sexually Active		**Sexual Debut (aged 14-19)**	**Pettifor et al. (2004) Sexual Debut (aged 15-19)**
Males:	87.5%	Males: 12% less than or equal to 14	Males: 13% less than or equal to 14
Kraaifontein:	4 part.	Mean age sexual debut: 13.3	Mean age sexual debut: 16.4
Kayamandi:	3part.	Females: 0% less than or equal to 14	Females: 7% less than or equal to 14
Females:	37.5%	Mean age sexual debut: 15.3	Mean age sexual debut: 17
Kraaifontein	2 part.	Total: 6% less than or equal to 14	Total: 10% less than or equal to 14
Kayamandi :	1 part.	Mean age sexual debut: 14.1	Mean age sexual debut: 16.7
Total:	62.58%		

In table 4.1, we can see that our findings on reported sexual activity are supported by Pettifor's et al. (2004) findings. Our findings differ in the sense that we found a sexual debut at a younger age than in Pettifor's et al. (2004) study. In this study, the average reported age for males to engage in sex is 13.3 (vs 16.4 by Pettifor et al. (2004)) For females, the average age to engage in sex is 15.3 (vs 17 by Pettifor et al. (2004)). It must be pointed out that our sample (n=16) is too small to generalize and that three out of seven sexually active males (37.5%) did not report their age of sexual debut, of which one male noted "I don't know". At the end of the focus groups session, participants concluded that there is no age label attached to sex. As one male in Kraaifontein commented: 'If people think that they are ready for sex, it is their own personal decision.'

4.2.2. Attitudes towards using contraceptives

This section presents the findings obtained in the focus groups on participants' attitudes towards barrier methods (male and female condoms), hormonal methods (pill, injection) and emergency contraception (morning after-pill, abortion).

Attitudes towards using contraceptives: Barrier Methods

Condom usage is one of the few interventions that can protect against HIV/Aids transmission. In the exploratory interviews, a male participant from Cloethesville pointed out that female condoms were increasingly becoming more popular. To gain better understanding of the audience's feelings towards using barrier methods, we defined the following audience analysis question:

4a) *What does the audience perceive as the benefits of using a barrier method?*

A major advantage of the male condom is that it can be accessed for free at a large array of venues. In all focus group interviews, the participants indicated that the male condom prevents unwanted pregnancies and STDs and HIV/Aids transmission. In the questionnaire given at the end of the interview, participants were asked to indicate what contraceptives they used during their last sexual encounter. Of the seven sexually active males; five males (71.4%) self-reported to have used a male condom, and one male admitted not having used protection (14.3%) during his last sex encounter. All three sexually active females self-reported to have used the male condom. It must be noted that although this question is a valid measure of recall of contraceptive usage, it does not measure the *consistency* of its use, an essential element of its effectiveness.

The female condom is one of the few barrier methods that empowers women to protect themselves against HIV/Aids. Contrary to the male condoms, females can insert the female condom in advance (that is: before sexual activity) and are not dependent on their partner in using it. In Kayamandi, a fifteen-year-old girl heard from friends that the female condom is more safe than the male condom. A male participant in Kayamandi said 'you can use it eight times without changing it', and another male noted that 'you can wear it eight hours'. In general, the attitude towards the male condom was more positive than towards the female condom.

4b) *What perceived disadvantages prevent the audience from using a barrier method?*

In the preliminary findings we saw that condoms are often associated with infidelity, prostitution and HIV (Varga, 1997). A common remark concerning male condoms was that it reduced the intensity of the male's sexual pleasure (e.g. Varga, 1997). In the exploratory interviews, two girls from Kayamandi stated that 'culture' is often used as an excuse for not using condoms. When asked 'What are the disadvantages of using a condom?', the following discussion arose in Kraaifontein:

R1: Male, aged 19: The disadvantages… Most of the times girls say it is better if you don't use a condom than if you use a condom, because a condom makes it even more sore than it is sore. [...] *And they say it makes the penis even bigger than it is.*
R2: Girl, aged 17: Oww.. [displays horrified look]
R3: Interpreter: That's the myth…[6]
R2: Girl, aged 17: You can't eat a banana with it's cover, you have to peel it first.
R3: Interpreter: Flesh to flesh.

These above noted findings from respondents 1, 2 and 3 were confirmed in Kayamandi. Participants in Kayamandi stated that a typical comment of a male (and occasionally a female) partner would be that s/he preferred 'flesh to flesh' that 'you cannot eat a banana with its skin' or 'you cannot eat a sweet without taking off the paper'. It must be noted that respondent R3, the nineteen-year-old male in Kraaifontein, said that he had not personally experienced the disadvantages that he mentioned. Peers had told him that condoms can enlarge a male's penis and make sex more painful. Since this disadvantage is only mentioned by one participant and not confirmed in any other (empirical) studies, we perceive this finding as unique and not representative for the larger audience.

One male in Kraaifontein confirmed the disadvantage which Varga (1997) found that condoms take away men's control of the activity. As a nineteen-year-old male said: 'We as boys strongly believe […] that when you spermalate [ejaculate, SvdL], you need to feel that you are spermalating [ejaculating, SvdL]. And when you are using a condom it is almost like, *iooooh* what happened?!' The common myth that condoms can be too small was refuted by a female participant: 'There is a saying that says: No matter how big it is, the condom fits'.

Female condoms were a less popular contraceptive in both focus groups. Most focus group participants did not have any personal experience with the female condom because of its costs: it can only be purchased at the pharmacy. When asked: 'Have you ever tried a female condom?' A seventeen-year-old female in Kraaifontein said: 'Like actually that was the thing we were kind of like debating: [shouts out] 'We don't know how to use the female

[6] This is one of the very few times the interpreter interfered in the discussion. His remark refers to the fact that it is untrue that a condom can enlarge a male's penis. By mentioning 'the myth', the girl aged 17 (R2) is stimulated to elaborate on this myth.

condoms!' Only one male in Kraaifontein self-reported having used the female condom in the questionnaire. A girl in Kayamandi confirmed that female condoms are not use frequently by stating: 'But it is usually the male condoms.' A disadvantage of the female condom was its form. Participants in Kayamandi indicated that the form was hilarious: very big and round. The notion of trust and its negative influence on condom usage will be further elaborated in section 4.7 'the sexual negotiation'.

Attitudes towards using contraceptives: Hormonal Methods

The hormonal method protects almost up to 100% to unwanted pregnancies. Wood et al. (1998) found in their study in Eastern Cape that participants believed that hormonal methods caused infertility, disabled babies and vaginal wetness. The exploratory interviews indicated that the injection was often used in 'stable relationships' to prevent pregnancy. In the exploratory interview with the two fifteen-year-old girls, one girl pointed out that when a girl uses the injection, condom usage tends to stop. Pettifor et al. (2004) found that 58% of sexually active women report using the injection, 34% the male condom and 13% oral contraceptive pills to prevent pregnancy. We will now present our focus group findings on the audience's attitude towards using a hormonal method.

4c) *What does the audience perceive as benefits of using a hormonal method?*

Benefits mentioned of the hormonal method by the participants in the focus groups were that it protects against pregnancy and overcomes disadvantages of condom usage (e.g. reduced male pleasure). As a nineteen-year-old male in Kraaifontein said:

> "*Most of the time [girls secretly go to the clinic, SvdL] because the pressure of us guys: Girl, you do need to go to the clinic. Because as we just said about stable relationships: you do tend to forget using a condom. The only thing you fear of is getting this girl pregnant. You do not fear of other sicknesses like Aids. The only thing that we want to prevent against is getting someone pregnant."*

This evidence that pregnancy was feared more than HIV will be further examined in section 4.2.5 'perceived risk'. In Kraaifontein, one girl stated that in the past, the injection helped her cope with menstruation pains. The injection was the most frequently used hormonal contraceptive method against pregnancy since it can be obtained for free in South Africa.

4d) *What perceived disadvantages prevent the audience from using a hormonal method?*
In the questionnaire, none of the three sexually active females self-reported using a hormonal method. Three female participants in Kraaifontein said that if they would use a hormonal contraceptive, they preferred the injection over the oral pill. They argued that the oral pills are less reliable as contraceptives since they have to be taken everyday which increases the risk of accidentally forgetting one pill, thus affecting its protection. Only two females (one in Kayamandi and one in Kraaifontein) correctly pointed out the main disadvantage of the hormonal method: 'Going for an injection does prevent you from getting pregnant, but doesn't prevent you from HIV/Aids'. Some girls (3 out of 8) indicated that their boyfriends did not want them to use the injection, because they believed that it would make them gain weight. 'They say no, your body will be shaky', according to the three female participants. According to a nineteen-year-old male in Kraaifontein, a disadvantage of the injection was that it promoted promiscuous behavior: 'The injection is a chance for them to go and cheat, because they know: *aaah*… I won't get pregnant, I can sleep with whoever I want to sleep with.' All female participants displayed worries about the hormonal method since it stopped their menstruation. This was also noted by a seventeen-year-old male, because he asked: 'Some people say that the injection makes your blood dirty, is that true?' It seems that most participants still believe in the myth that the hormonal method causes infertility (see Wood et al., 1998).

Attitudes towards using contraceptives: Emergency Contraception
The morning after pill is a hormonal emergency contraception that prevents pregnancy when taken within 72 hours. If this time is exceeded, an abortion can be carried out within three months to terminate an unwanted pregnancy. Beyond this period, abortion is a complex operation that can only be carried out under aesthetics in a hospital in severe cases (e.g. if the girl is raped by her father). The focus group findings on the audience's attitude towards emergency contraception are presented below.

4e) *What does the audience perceive as the benefits of ending an unwanted pregnancy?*
After the moderator explained what the morning after pill is, participants in the focus groups indicated that the benefits of ending an unwanted pregnancy would be that the person's education would not be in jeopardy. Girls in particular did not want their parents to know they were sexually active. Conceiving a child would come as a rather unexpected surprise for their

parents. Thus, by ending an unwanted pregnancy, the girls would not have to fear their parents' reaction.

4f) *What perceived disadvantages prevent the audience from ending an unwanted pregnancy?* Fifteen out of sixteen participants were not familiar with the morning after pill. Only one nineteen-year-old male in Kraaifontein knew that the morning after pill could be taken to prevent an unwanted pregnancy. According to the interpreter, clinics do not always have morning after pills in stock. Forgetting to take an oral pill or a condom that broke was referred to by most participant as accepting their destiny of having a child. In the words of a fifteen-year-old girl in Kayamandi: 'You can't do anything, you must have the baby…' After introducing the morning after pill she stated: 'If you know that you are pregnant and you take a pill, it is the same thing as doing an abortion.'

Aborting an embryo is a greater social taboo than teenage pregnancy. When asked: 'Would you consider an abortion when pregnant?', a lively discussion arose about the beginning of life, in which terms as 'sacrilege' and 'sin' were mentioned. Most participants had little knowledge about abortions (which are legalized in South Africa) and were scared that it would negatively affect their fertility and health: 'Isn't it risky to get an abortion?' Another fifteen-year-old girl stated: 'If you have an abortion, you will never have a child again' This risk indeed is legitimate if an abortion is carried out illegally.

The *sangoma* (Xhosa word: the traditional healer) plays an important role in ending an unwanted pregnancy. This is illustrated in a question posed by a male participant in Kraaifontein: 'Which option is right: making an abortion or a miscarriage? Like to kill a baby? Because […] most of the girls take what we call *amon sisi* (Xhosa word) they take three pills, which kills the baby.' Not surprisingly, participants confirmed that this drink was very dangerous and could have a fatal effect on the girl drinking it. In Kayamandi, a fifteen-year-old girl gave an elaboration on how her friend ended an unwanted pregnancy: 'They chew *stool* [Xhosa word: a soft, silver wire that you use for cleaning the toilet pot, SvdL] and then they drink Oros squash (a typical South African soft drink which contains sulphur dioxide and sodium benzoate) to push the *stool* down and it kills everything.' The girl ended her elaboration with saying: 'But sometimes it is dangerous.' When explicitly asked if her friend did not make this story up she stated: 'No, she was not lying! […] I don't know how that girl did it, but it happened and she got rid of the baby, but she survived.' According to a fifteen-year-old girl in Kayamandi: 'The most thing they use is alcohol [interpreter: To kill the baby?] Yes'.

4.2.3. Attitude towards Teenage Pregnancies

In African culture it is not uncommon for a girl to conceive a child at a young age. Pettifor's et al. (2004) study found that the mean age of first child birth was 18.5 and 33% of all females aged 15-19 reported ever having been pregnant. Traditionally, motherhood was highly valued in African culture (Varga, 1997). In the focus groups, it was explored to what extent girls are induced to *intentionally* fall pregnant. Several studies indicated that pregnancy increased young girls' self-esteem and allows them to demonstrate their love and fidelity (e.g. Varga, 1997; Wood et al., 1998). The focus group findings on the audience's attitude towards having a child at a young age are presented below.

5a) *What does the audience perceive as being beneficial to becoming pregnant at a young age?*

Teenage pregnancy is an omnipresent phenomenon in the lives of our audience. Most participants personally knew peers (e.g. classmates) who had become pregnant. A nineteen-year old-male pointed out 'three babies and only eighteen years old.' One sixteen-year-old male peer-educator in Kayamandi said that last year 25% of the girls at Kayamandi high school were pregnant. Most teenage pregnancies are not planned, but a 'mistake', as indicated by three participants in Kraaifontein. In the words of a seventeen-year-old girl: 'it is always the *oops*!' The perceived benefits of friends who fell pregnant at a young age generally referred to 1) status among female peers, 2) financial gain 3) emotional intimacy with the partner and 4) parents' support with the upbringing.

Female peer-pressure was mentioned by participants in Kraaifontein as a reason for girls to fall pregnant and enter the so-called 'competition'. This competition referred to showing off with the physical appearance of the baby ('my baby is more beautiful than yours'), the visibility that the baby is well taken care off ('my baby is nicely dressed') and displaying intimacy with the partner ('I am close with my boyfriend'). According to the participants in Kraaifontein, close female friends are stimulated to both become pregnant to share the experience and to bond with each other. A seventeen-year-old male in Kraaifontein whose girlfriend tried to get pregnant against his will stated: 'She saw her friend is pregnant, [and] then she tend to stop the injection. She want[s] to get the competition with the other friend…' One girl in Kraaifontein mentioned that some girls even go to the *sangoma* [Xhosa word, traditional healer] to use *mutti medicine* [Xhosa word, supposed to increase fertility, SvdL] to fall pregnant. Hence, 'competition' is entangled with the three aforementioned reasons of status, financial benefits and emotional intimacy with the partner.

Financial gain is obtained since teenage mothers receive a monthly grant of 180 South African Rand (SAR) from the government. 'What you usually hear is the girls that get pregnant, they want money from the grant', as we summarized the remarks of five participants (two in Kraaifontein and three in Kayamandi). Some girls *intentionally* fall pregnant with a partner who is in a good position to provide child support. A sixteen-year-old male in Kayamandi noted: 'There are these ladies who do have sex with a man just to have a baby and that the money returns.' Often this money is not spent on the baby: 'They don't use it for their baby, just for clothes', as stated by a seventeen-year-old male in Kraaifontein. This economically-motivated pattern was confirmed by three other female participants in Kraaifontein. In Kayamandi, a fifteen-year-old girl said: 'My other cousin, she is turning twenty this week. She already has two babies and she gets money from this thing called grant. Her mother keeps the children […] and then she eats the money: she buys jeans, cell phones, doing her hair and stuff and she still going out with boys. She doesn't care, she doesn't know what's going on with her baby.' Only one fifteen-year-old girl in Kayamandi criticized this behavior: 'Girls are really dependent on guys, that's a real problem.'

In the preliminary research, it was proposed that some girls intentionally fell pregnant to ensure their boyfriend's future commitment. Such girls believed that when they fell pregnant, their boyfriends would have to help them with the upbringing of the baby for the next eighteen years. In the focus groups it became clear that all of the participants did not believe this was very realistic. Only one fifteen-year-old girl in Kraaifontein indicated: 'When you say you want to sleep with him and have a baby, [your boyfriend, SvdL] will also think that because it is cute and stuff.' We will elaborate on the illusion of commitment under disadvantages.

Most teenage mothers eventually receive their *mother's support* with the upbringing of their child. 'That's why we have a lot of babies, […] because our parents help us. If I get pregnant my mother would say: shame, my baby my child... and she'll take care of me and the baby […] and then I come with another baby!,' stated a seventeen-year-old girl in Kraaifontein. Another girl in Kayamandi said: 'Some [parents, SvdL] tell you that if you get a baby they will kick you out of the house, but they don't.' A fifteen-year-old girl added: 'They just say it to make you scared […] They will keep you out for only two days!' When asked if teenage mothers would be able to continue their education, a male in Kayamandi indicated that it depends on the time of the year the girl conceives her child. In his words: 'Like if it is the middle of the year of the school… She will try, but she cannot come back.' According to a fifteen-year-old girl in Kayamandi, most girls stay at home for two weeks before returning to

school. Thus, it seems that teenage pregnancy does not really hinder a young girl from continuing her high school education since her mother supports her in the upbringing of her child.

5b) *What perceived disadvantages prevent the audience from having a child at a young age?* Unanimously, all participants in the focus groups had a negative attitude towards teenage pregnancy. The disadvantages outweighed the possible benefits and referred to 1) limiting futures possibilities 2) parents' reaction 3) perception of a non-supportive partner.

The disadvantages of having a child at a young age were that it would negatively effect participants' future aspirations of having a career and continuing their studies. As a nineteen-year-old male said: 'If I make a girl pregnant, obviously my future and her future would be in jeopardy. Because now there is a baby coming and now we need to become adults for this baby in order to bring this baby up.'

Some of the girls (three out of eight) feared their parents reaction if they would fall pregnant. A seventeen-year-old girl stated: 'If I keep it, my parents are going to kill me with that baby!' Parents would not be happy about feeding another mouth. In the words of a male in Kayamandi: 'Like if a daughter is pregnant… She [The mother, SvdL] will just say: go back to that man that made your baby!' The participants indicated that in general, parents had a negative attitude towards teenage pregnancy since it would be difficult for them to complete their studies.

The 'benefit' of becoming pregnant in order to ensure their boyfriends' commitment, was perceived by all participants as 'very stupid'. In Kraaifontein, the moderator received the impression that two of the male participants had personally experienced that their girlfriends' intentionally had tried to become pregnant for such reasons. One seventeen-year-old male indicated that his girlfriend stopped the injection without him knowing and explicitly said: 'And I don't want her to be pregnant.' From the facial expressions of a nineteen-year-old male a similar scenario in which he felt betrayed could be concluded. Being taken advantage of as a male partner is illustrated in the words of the nineteen-year-old male in Kraaifontein: '[Girls tell you that, SvdL]: No I use injection, so you don't have to use condoms with me.' Female participants (five out of eight) pointed out that securing the future of the relationship by becoming pregnant was very ignorant. In the words of a sixteen-year-old girl in Kraaifontein: 'That's cheating yourself.' Another girl added: 'If you get pregnant, he will run away. He'll say: I'll be back now in five minutes, but you won't see him again. A fifteen-year-old girl in Kayamandi indicated that pregnancy is not a realistic 'bonding mechanism':

‘There are few girls that still go out with the father of the baby. Few, few, few. […] He’ll leave you and look for sexy girls who don’t have babies.’ Most males do not support their girlfriend with the upbringing of their child as a male participant in Kayamandi explained: ‘Cause if a guy make a girl pregnant, he could pretend that it never happened.’

4.2.4 Self-efficacy

Research has shown that contraceptives are more likely to be used if a person has the perception that he or she can perform the behavior under a variety of challenging circumstances (Fishbein & Yzer, 2003). Pettifor et al. (2004) found that 70% of youth believed they could refuse sex if their partner did not want to use a condom. A further 74% of youth claimed to be confident to use condoms every time they had sex. Drugs and alcohol were noted by 43% of youth as factors that negatively affect condom efficacy (Pettifor et al., 2004). In this research, self-efficacy is measured by 1) the extent to which a person perceives to have personal responsibility by carrying contraceptives on their person, and 2) the extent to which a person believes to be capable of using contraceptives in the sexual arena. We will now present our focus group findings on the audience’s self-efficacy.

6a) *To what extent do members of the audience perceive to have personal control in carrying contraceptives on their person?*

If a person carries a condom in his/her pocket, it can easily be accessed. This increases the chance that condoms will be used in the sexual arena. In both focus groups, participants offered a socially desired response of ‘shared responsibility’ when asked: ‘Who is responsible in a sexual relationship for providing contraceptives?’ When probed: ‘Who has a condom is his purse now?, ’ neither male nor female participants positively confirmed this question. Although this question is rather direct, participants gave insightful explanations which enhances our understanding of why youth do not carry condoms on them.

Gender norms (e.g. fear of promiscuity) prohibited females to take on an assertive role in carrying condoms. As illustrated by a comment of a seventeen-year-old girl in Kraaifontein: ‘You can’t carry condom. When you carry a condom, someone is saying that maybe you are looking for sex.’ […] Why can’t he [the partner, SvdL] have condoms at his house?’ Again, as found in the exploratory interviews, ‘the rape myth’ was offered as a justification to carry condoms by girls in both focus groups (four out of eight girls). Only one seventeen-year-old girl in Kraaifontein indicated that this was not realistic: ‘A person who is about to rape you […] won’t ask you: do you carry a condom? Another girl in Kraaifontein

said that if you would want to take the rapist to court, asking him to use a condom could be perceived as accepting the sexual act. In Kayamandi, only one sixteen-year-old girl said that having condoms in your pocket does not necessarily indicate that you plan to engage in sexual activity. These results indicate that females take on passive roles and rely heavily on their male partner for providing condoms. It can be concluded that females have a low perceived self-efficacy with regard to carrying condoms.

Four out of eight males in this study strongly disagreed with this perception of their female peers and thought it was a good idea for females to carry condoms. A seventeen-year-old male in Kraaifontein noted: 'What if a mistake happen? If you meet a girl and you want to have sex and you don't have condoms? She will have to provide some condoms. Meaning that: I am responsible for the sex and she is also responsible for the sex.' In Kayamandi, a sixteen-year-old male offered a strategy to persuade a partner to use a condom: 'If you really love that person, you would have to be worried about her health, so I think you should both [carry, SvdL] the condoms.'

6b) *To what extent does the audience perceive to have personal control in consistently using contraceptives?*

Alcohol was noted as a moderator of self-efficacy to use contraceptives during sexual encounters by participants in Kayamandi. A fifteen-year-old girl in Kayamandi said that: 'Most girls drink than guys… they drink too much.' She elaborated a story about girls who get drunk at the *shabeen* [Xhosa word, bar] and are picked up by older men, who bring them to their houses for sex. A fifteen-year-old male participant in Kayamandi confirmed that alcohol decreases the self-efficacy to use condoms in the sexual arena.

Contrary to this low perceived self-efficacy in regard to using contraceptives, participants in Kraaifontein scattered empowering sentences that indicated self-efficacy to prevent HIV/Aids. As a seventeen-year-old girl said: 'You read about HIV/Aids every day: If we want HIV to end, we must end it.' Another male in Kraaifontein stressed that condom usage allows you to influence your own destiny: 'No choice, no gain, […] you always have choice, condom choice.'

4.2.5 Perception of Risk

According to the Health Belief Model, the extent to which a person believes that he or she is susceptible to contracting HIV or becoming pregnant influences his/her motivation to use contraceptives. Perception of female fertility is hardly discussed in the articles regarding

youth sexuality (see Varga, 1997; Wood et al., 1998). As can be expected in the midst of the Aids pandemic in South Africa, susceptibility to HIV/Aids has received more attention. Despite South Africa's high rate of HIV infections, Pettifor et al. (2004) found that 54% of the youth who reported never using a condom, felt that they were at a low risk of being infected. Perloff (2001) states that especially young people believe in the 'illusion of invulnerability' and fail to internalise their personal risk for HIV/Aids. We will now present our focus groups findings on the audience's 'perceived risk'.

7a) *To what extent does the audience perceive to be at risk of contracting HIV/Aids or pregnancy if they do not use any contraceptives?*

Participants perceived a greater susceptibility to pregnancy than to HIV/Aids. As a nineteen-year-old male said, and later confirmed by a sixteen-year-old girl in Kraaifontein: 'The only thing we fear of is getting a girl pregnant. You do not fear of other sicknesses like Aids et cetera. The only thing that we want to prevent against is pregnancy.' In Kayamandi, participants feared pregnancy, but they did not articulate their fear of pregnancy as strongly as in Kraaifontein. Participants' fear of pregnancy is not surprising in view of the large number of young mothers in their immediate environment. Contrary to HIV, pregnancy is something which is difficult to hide and has immediate consequences on a person's life. Unfortunately, a high rate of teenage pregnancy indicates that the audience is having unprotected sex.

'Do you know anyone who is HIV positive?' In the conceptual framework it was proposed that if a person knows someone personally who has HIV/Aids, the person will be more likely to use contraceptives. In both focus groups all of the participants positively confirmed that they knew people who had died of Aids or were HIV-positive. In Kayamandi, participants were acquainted with a young girl who had attended their high school and recently died of Aids. Since it is difficult to see if a person is HIV positive, a person's positive status was merely based on rumours. As one fifteen-year-old girl in Kayamandi said: 'If they [people, SvdL] see that the person is all around cars and boys, they say that she is HIV positive.' From her response, HIV seems to be associated with promiscuous girls.

In Kraaifontein it became clear that the participants had a false perception of safety with regard to HIV transmission. A nineteen-year-old male indicated that he used condoms 75% of the time. When asked: 'What about the other 25%?', he replied: 'I would say the 25% is the trust.' This is alarming considering the fact that he later admitted that he had casual relationships. A sixteen-year-old girl rightfully criticized his behavior by stating: 'That's why we die young! Because of people like you we die of Aids.' In response, he said: 'I won't mind

because I have experimented.' His comment indicates that he fails to internalise his personal risk. He is driven by instant satisfaction of lust and the urge to say 'I've been there, I've lost my virginity' (as noted in section 4.2.1). Thus, by ignoring the negative long-term effects of a positive HIV status, he believes in an 'illusion of invulnerability' as Perloff (2001) would point out.

In Kayamandi, participants had a relatively high perception of HIV risk. In the focus group the moderator asked: 'What do you think Andile's (the main character in case 2) chance is of getting HIV in percentages from the girl from the *shabeen* after having unprotected sex?' Of the participants that replied, most (three out of five participants) said that there was a fifty-fifty percent chance of HIV transmission. One girl thought it to be 90%, and one male said: 'You will get HIV, definitely.' In the words of a fifteen-year-old girl: 'I think it is 50-50, because maybe one [one of the partners, SvdL] does have Aids.'

Testing for HIV is the only measure that can be taken to know the truth about one's status. When a person knows his/her status, the person can take precautions not to infect other people. Two male participants in Kraaifontein indicated that they had just recently attended the clinic with their girlfriends and both tested HIV negative. The reasons for peers not going for a test were explained by a male in Kayamandi: 'Some of my friends tell me: What's the use of going and having an HIV test, while you know that you still are going to die one day. […] So they rather neglect it, that's how they do it.' The stigma attached to Aids is still present, as became clear after asking 'What would your friends do if they found out that they were HIV positive?' A fifteen-year-old male in Kayamandi responded, 'they [their friends, SvdL] will keep it a secret, because if you tell one of them, it would spread.'

4.2.6 Outlook towards Life

Youth in townships are underprivileged. Youth's social environment forces them to live in a 'survival mode', and the youth are constantly confronted with tough decisions that can have life-changing impact (e.g. dealing drugs, prostitution). With limited financial resources, they are deprived of high-quality education. As a consequence, they have fewer career opportunities than their wealthier counterparts. Nevertheless, a recent study by Pettifor et al. (2004) found a general tendency towards optimism among the youth regarding their future. In our conceptual model it is proposed that if a person has a clear perspective of his/her future, he or she will be more motivated to use contraceptives in order to achieve that goal. We will now present our focus group findings on the determinant 'outlook towards life'.

8a) *To what extent does the audience's perception of the future and their outlook on life influence their usage of contraceptives?*

In general, participants had an admirable positive outlook towards life. When asked: 'Do you feel that you have the possibility to become whatever you want in life?', contrary to what might be expected, the vast majority agreed with this statement. Direction was obtained through multiple sources. A seventeen-year-old male in Kraaifontein found direction through his religious affiliations and stated: 'Having money, having no money is not the mean thing. You can do these things if we do right decisions. […] If we submit and obey, then you will be able to receive your goals.' In the words of a fifteen-year-old girl in Kayamandi: 'If you concentrate on the bad things [of society, SvdL], you will never be what you wanted to be.' This reflects participants' motivation to achieve their goals.

Participants commonly aspired to careers with which they could contribute to their township, such as becoming a lawyer, a doctor or a health nurse. As one nineteen-year-old male in Kraaifontein said: 'I would like to be a lawyer only for black people and try and help some. Most of our black people come from townships who are lost and don't have the finances to afford lawyers.' The audience's ambitions to prove themselves and succeed is perhaps influenced by their perception of emerging possibilities after the apartheid era.

The participants were realistic and said that achieving their goals required hard work and discipline. A seventeen-year-old girl in Kraaifontein indicated she intentionally did not want to get involved in a relationship since boyfriends would just interfere with her plans: 'You have to concentrate on what you want. You can't concentrate on two things [studying and having a boyfriend, SvdL]. I have to get A's and B's in my matric to get a bursary to go to university.' In Kayamandi, a sixteen-year-old male realistically commented: 'Money talks in a way, you gonna have to further your studies […] to get a job.' Later he indicated: 'We all have dreams, but not all of us are going to relive our dreams.' A fifteen-year-old girl in Kayamandi rightfully pointed out that the careers young people dream of (e.g. becoming a fireman or a social worker) are often subject to change during the course of their lives.

When probed, it became clear that lack of direction in South Africa's society *does* negatively affect some youth. As one nineteen-year-old male said: 'We as the future of today are so lost and we need direction from our parents and from the media. I don't think the media is trying to give us any sense of direction. The media is making us more confused and more lost.' With his comment he confirms earlier findings that today's youth live in a confusing environment in which the traditional cultural messages clash with contemporary messages that are broadcast through the media. This outlook on South Africa's problems was shared in

Kayamandi, as a fifteen-year-old girl indicated: ‘We live in a bad world: everything is just collapsed, people are dying of Aids, drinking and stuff...’A male peer in Kraaifontein commented: ‘The world is cruel and we have to submit we are a lost generation. Times are changing.’

Sex in particular is a cheap and easy form of entertainment, as a nineteen-year-old male in Kraaifontein indicated. A sixteen-year-old female peer supported his remark and said: ‘Young people have sex without a condom just for the fun of it.’ The nineteen-year-old male in Kraaifontein elaborated on his comment by saying: ‘Look at us. We live in the township […]. We usually have sex when our girlfriends come and visit and we are bored, we have nothing to do or anything. […] If maybe we could have cinemas and beaches close to us, than we could do exiting things. [But] if you want to take your girlfriend out you think: *iooooh* I can save money, money for the taxi, money to go in for the movies, money for the popcorns and ice creams…’ Thus, for some youth, risky sex helps coping with boredom.

Other alarming forms of entertainment that negatively affect condom usage are large substances of alcohol. According to a fifteen-year-old girl in Kayamandi: ‘More girls drink than guys … they drink too much […] It’s like a fashion or something.’ This was confirmed by her fellow peers who added that ‘alcohol is driving people crazy!’ Obviously, with too much to drink, cognition to use contraceptives is most likely to be thrown out of the window. A fifteen-year-old male in Kayamandi indeed confirmed that drinking makes it more difficult to act on intentions to use a condom. The reasons why youth drink and seek risky forms of entertainment cannot directly be ascribed to a negative outlook towards life. It is typical for adolescents to experiment with drugs, alcohol and sex during their teens. In part, the problem lies in the fact that the socio-economic situation of African youth does not offer many positive alternatives.

4.3 Sexual Arena

Solely harbouring an intention to use contraceptives is not sufficient in preventing HIV/Aids and pregnancy. The youth also must have the capacity to successfully negotiate safe sex with their partner (sexual negotiation) and the correct knowledge and skills regarding contraceptive usage (opportunity). The focus group findings for these two determinants within the component ‘sexual arena’ are presented in this section.

4.3.1 Sexual Negotiation

In our conceptual model we stress that using contraceptives is not an individual decision, but highly dependent on the cooperation of the partner in the sexual arena. Two determinants are believed to influence the success of the sexual negotiation: *social influence of the partner* and *interpersonal communication with the partner*. In this section, we will present our focus group findings for these two determinants of sexual negotiation.

Social Influence of the Partner

South Africa is infamous for having the highest reported rate of rape per capita in the world for a country not at war (Duke 1997, as cited in Varga, 1997). According to Varga (1997), who studied adolescents sexual decision making in Kwazulu-Natal, males perceive sexual coercion as 'culturally appropriate practice'. In traditional African culture, the socio-cultural norms condone male sexual coercion, whilst females are dictated to remain submissive (Varga, 1997). Varga (1997) found that of the 55% of females who reported having ever refused sex, only 29% claimed to be successful. We will now present our focus group findings on the 'social influence of the partner' which refers to the physical and the psychological pressure to engage in (unprotected) sex.

9a) *To what extent does the audience experience pressure from their partner to engage in sex?*

Due to the sensitive nature of this topic, few girls in the focus groups articulated violence or coercion to engage in sex. A seventeen-year-old female in Kraaifontein did disclose signs of coercion by indicating: 'When you're with an older boyfriend, then he'll put pressure on you and you must do what he wants. Then you think: I can't say "no" to him, because he is older than me, [whispers] he might beat me or something.' A sixteen-year-old female peer confirmed that males seem to dictate what happens in relationships: 'They come to us and they want us. When they say jump, you must ask: how high?' In Kayamandi, the pressure of the partner to engage in sex was more psychological, and was linked to fear of abandonment. As one fifteen-year-old girl said: 'Most of the girls, if you're going out with a boy, and he says he wants to sleep with you. You don't want… they [the girls, SvdL] just think that... he's gonna leave you or something. So they just do it, if he says that you must do it. Because they think that he is going to leave you or something.' Later it became clear that insecurity (or the 'need to belong' as Baumeister and Leary (1995) would argue) made her comply with her boyfriend's wishes: 'You think that he loves you and he tells you stuff like you're beautiful

[smiles] and that you have big brown eyes.' Only three girls (two in Kraaifontein, one in Kayamandi) stressed the personal decision to engage in sex. To sum it up in the participants' words: 'You have to tell yourself this: If I don't want to do this, no one can force me.'

The male participants in Kraaifontein stressed how important it was for them to engage in sex. As one nineteen-year-old male remarked: 'The sex thing is always important for us as boys to strengthen a relationship.' His seventeen-year-old peer commented: 'Sex is the foundation of love. If you intend to have a relationship, you should make sex.' According to these two males, sex usually takes place after four days. Female sexual partners who are not capable of complying with their sexual needs were not seen as interesting, as stated by a male aged seventeen: 'I will dump you, if you won't satisfy me'. These results support Varga's (1997) findings that 'sex is a must' for males and indicates that males do not view a relationship as legitimate and serious if sex does not take place.

In Kraaifontein, female and male participants clashed on what the word "no" means. As indicated in the following fragment:

> *R1: Female, aged seventeen: They take NO as a Yes [points at R2 and R3]*
> *R2: Male, aged nineteen: The thing is there is a NO! and a no... (suggesting that a female can be seduced to engage in sex, SvdL)*
> *Moderator: What would you like to say? [to R3, who is eager to respond]*
> *R3: Male, aged seventeen: The thing is, if you are going to give me some rules, rules are there to be broken. And secondly, why kissing me? You can't start a car if you don't know how to drive it… Why kissing me? [R2 adds: 'go on, go on']. If you kiss me than you have to be ready for anything that can happen.*
> *All four girls: NO!*

A third male supported the comments of the above-mentioned male peers. He also confirmed that a kiss indicates willingness to engage in sex. These findings support Wood's et al. (1998) study that forced sex or rape, occurs most frequently in intimate relationships in which the actors are familiar with each other. As in the words of a fifteen-year-old male in Kayamandi: 'But you see, rape is not when you see a girl in the streets. There is rape in your home. Let's say if I'm your uncle and when your mother is at work, I will just come near you and touch your body or something like that, and do stuff.' At the end of the interview, females' need for skills to negotiate sex was also reflected in the questionnaire. A girl noted: 'How do you convince a guy that you are not ready to have sex, besides saying "no"?'

Rape does not solely victimize females. In Kayamandi, a female and male participant pointed out that males are also being raped. As the moderator found this difficult to imagine, a sixteen-year-old male participant told a gruesome story. According to him, his cousin who lived in rural Eastern Cape, was raped by his aunt during the mourning period (after her husband passed away). Being raped demolished his cousin's penis, which was never going to work again. He continued: 'The financial compensation for this loss and family embarrassment was one thousand South African Rand.' Although male rape must be acknowledged, such incidence are only incidental compared to the astronomical rate of females that are being raped in South Africa.

To conclude, the 'mixed signals' males referred to do not create an environment that enables open communication about how and when sex occurs. Most of all, the coerced nature of sexual relationship leaves females relatively powerless to negotiate safe sex.

Interpersonal Communication with the Partner

Several studies found that not discussing condom usage is a rational decision for many people (Varga, 1997). According to Perloff (2001), many people are afraid that talking about contraceptives might destabilize the harmony of their relationship. The second determinant of 'sexual negotiation' is 'interpersonal communication with the partner', and refers to the extent partners feel comfortable discussing sexual matters. In presenting our focus group findings for this determinant, we will specifically reflect on 'trust and emotional intimacy', 'trust and visibility of the contraceptive method', and 'talking about contraceptives with the partner'.

9b) *To what extent does the audience perceive to be efficacious in communicating contraceptive usage with their partner?*

Trust and Emotional Intimacy

'Trust' and 'contraceptive usage' seem to be conflicting terms in the focus groups. Based on the participants' remarks it seems that neglecting to use condoms illustrates that emotional intimacy and trust have been established. In the focus group in Kraaifontein, one male participant admitted that he used condoms only 75% of the times. When asked about the other 25% he replied: 'I would say the 25% is the trust'. Trust in this sense, refers to trust within stable relationships. This can be extracted from his words: 'If [..] your girlfriend finds out that you have condoms in your pocket, […] then she will ask: What are you doing with those condoms? She is insecure. She thinks that you always want to cheat.' By making this comment, he would seem to have admitted to have multiple partners and to having used

condoms within these casual relationships. In accordance with earlier findings (e.g. Varga, 1997), his steady girlfriend would be offended if he would suggest using condoms with her. She would interpret this gesture as if her partner did not perceive the relationship as being legitimate and serious.

For girls, it proved difficult to convince their partners to use condoms. In the focus group in Kraaifontein, a sixteen-year-old girl illustrated this dilemma by the following remark: 'But what do you say to a guy that says: I don't use a condom, I don't have that…?' When a relationship is perceived as 'stable', girls are often pressured by their partner to use the hormonal method (injection) to prevent pregnancy. In stable relationships, partners feel the pressure to 'prove their love' by not using condoms. This is illustrated in the following fragment:

> *Male, aged 19: If your girl goes to the clinic and have this injection. I mean for... for the both of you it is a huge step that you have taken, cause ... now that is the point where I will go to a stable relationship... that's the point where you need to tell yourselves – even if you are fooling yourselves- tell yourselves that ok, I mean: this is it. We need to concentrate in this relationship, no matter how hard, because we have taken a huge step in order for us to ... to prove our love, so to say.*

When explicitly asked: 'Do you think that by using a condom it shows you distrust someone?' A nineteen-year-old male offered a promising response by stating: 'That's what most people THINK, but that is not true. You actually care for that person… You care enough for now and the future.'[…] You are looking up for yourself.' An extroverted female responded: 'We agree at last, ' which resulted in overall laughter. In general, our results confirm Varga's (1997) findings that not using condoms is often a rational decision made by participants.

Trust and visibility of the contraceptive method

In Kraaifontein both a male and a female participant noted that they had trusted their partners in using contraceptives, but, unfortunately, they were mislead. Although a male condom appears to be a visible form of contraception at first glance, a seventeen-year-old female participant indicated that this is not always the case. This is illustrated in her remark: 'If I say I want to use a condom and you don't want to use a condom, eventually you [the male, SvdL] are going to open the condom and you are going to sit on the other side of the bed, because

you don't want me to SEE. And then you PRETEND to put on the condom, but in the end, the condom is not on. So you guys also cheat on us.'

Male participants indicated that they felt betrayed by girls who said that they had used the injection. In the end, it turned out that they had not. A nineteen-year-old male stated that the invisibility of the hormonal method was a reason for him not wanting girlfriends to use this contraceptive: 'If she were to ask me to use a condom, she would have an assurance […] Now I would like to have an assurance that comes from the clinic that she is actually going to the clinic and having this injection.' Later in his monologue he elaborated on his point of view: 'All we want to do is to get it on, and that's all. We just want to satisfy our own...' From the context, it can be perceived that he preferred using a condom in order to allay his own fears of getting her pregnant.

Talking about contraceptives with the Partner

At the end of the discussion it was asked: 'Would you discuss getting an injection with your boyfriend?' At this point in the focus group in Kraaifontein, both females and males participants indicated they would. A nineteen-year-old male in Kraaifontein stated: 'I feel that it is our responsibility as guys, seeing that we are the most ones who propose sex to the girls to know about these things [contraceptives etc. SvdL] and to advise them about using these things'. To conclude, although participants indicated that they would discuss using contraceptives with their partner, most remarks (e.g. multiple relationship) suggest the contrary.

4.3.2 Opportunity

Opportunity refers to barriers that can be eliminated by external sources. Two determinants are part of the component 'opportunity': *knowledge* and *environmental constraints*.

Knowledge

In the exploratory interviews we found that the audience's level of knowledge on contraceptive usage was extremely low. It was striking that one male reported using two condoms over each other, assuming that he would then be even safer. Another male noted that many people believe that *Dettol* (an antiseptic soap) protects against pregnancy. According to Pettifor et al. (2004), 32% of youth reported that they had learned most about HIV/Aids at school. In this section we will first present our findings on the accessibility of knowledge to the audience, and then reflect on the extent to which the audience's knowledge is correct.

10a) *To what extent is information on the usage of contraceptives accessible to the audience?*
The participants in Kraaifontein indicated that the previously mentioned 'Life Orientation Course' only takes place in grade 8 when they are about twelve years old. A seventeen-year-old girl explained that by the time they are sexually active and need specific information, there are few adults who can inform them. In Kayamandi, participants indicated that they loved watching the soap operas of *Soulcity* on the television channel *SABC 123*. The long-term character of the series allows participants to identify with certain actors, who function as role models. Often participants adapt their own behavior to such characters. Soulcity has internationally been recognized and won prizes for their 'edutainment' programmes. Soulcities' 'edutainment' approach combines entertainment with education and achieved outstanding results. In this way, through entertainment, the programme anticipates on the audience's emotions, and through education, the audience is informed. Unfortunately, none of the participants recognized the *loveLife* brochure that was evaluated. We will now present the findings obtained concerning the audience's level of knowledge.

10b) *To what extent is the audience's knowledge concerning contraceptive usage and sexual matters correct?*
The extent the audience's knowledge on preventing HIV and pregnancy is correct remains unknown in the reviewed articles (see Pettifor et al., 2004; Varga, 1997, Wood et al., 1998). This section elaborates on the participants' level of knowledge on 1) HIV transmission and pregnancy, 2) barrier method, 3) hormonal methods and 4) ending an unwanted pregnancy.

1. HIV transmission and Pregnancy
All of the participants knew that by having unprotected sex they would risk becoming HIV infected. However, the exact details of transmission, which increase their susceptibility, were unclear to the participants. In both focus groups there was a discussion about the difference between sperm and the fluid which comes out before a male ejaculates and can contain sperm cells that can make a girl pregnant and/or transmit HIV. In case 4, the main character Tumi ejaculates outside his girlfriend's vagina because his friends told him this prevents pregnancy and transmission of HIV/Aids. Most of the participant stated that this behavior was risky, without giving any details. In Kraaifontein, one female could not get her facts right and replied that Tumi was *not* at risk of contracting HIV. Only the nineteen-year-old male in Kraaifontein and the sixteen-year-old peer educator in Kayamandi stated, as paraphrased: 'He

is at risk, because it is not the sperm that causes HIV/Aids, it is the fluid, so he is at risk. […] Tumi is not making a very wise decision.' Although Tumi's behavior is risky, the male's response is factually incorrect since both body fluids contain the virus and transmission should be avoided at all times by using a barrier method.

In section 4.3.1 'trust and emotional intimacy', a nineteen-year-old male in Kraaifontein admitted that he only used condoms 75% of the times. A male peer reacted on his comment by saying: 'I know my girlfriend is not HIV positive.' Both males indicated that they went for an HIV test at the clinic this month and were found to be HIV negative. However, none of the males mentioned 'the window period' and were not aware that their results do not represent their status during the past three months.

At the end of the interview, preconceptions of HIV transmission and pregnancy of an existing prevention text of *loveLife* were discussed. The first statement was: 'You can get pregnant the first time you have sex.' The participants stated that not everyone knew that this statement is correct. As stated by a seventeen-year-old male in Kraaifontein: 'Because what actually happens is that those who start sex, they use that small time that they were not [menstruating, SvdL] yet. They use it more, they over use it. Without even protection. They want to impress their feelings ('prove their love', SvdL). That is a way for them to get pregnant',. When asked: 'Can you get pregnant from having sex standing up?', a seventeen-year-old girl replied: 'Ja, that was my question.' Her peers in the focus group indicated that the position of the sexual act does not eliminate the risk of becoming pregnant.

2. Barrier method (male and female condoms, diagraph)

As we have seen in our preliminary research, the church in South Africa is preaching mixed messages and claims that condoms only protect 70% against pregnancy. Yet, a male participant in Kraaifontein asked: 'How safe is one condom?' A female participant said it was 90% safe, and according to a male participant it was 75% safe. It seems that the audience's attitudes towards using contraceptives have been influenced by the sources of information they are able to obtain (e.g. religious institutions, safe sex lectures at their school).

In case 2 (see appendix B) the main character (Andile) went to the *shabeen* (bar) and used two condoms over each other. When asked if using two condoms at once was correct, in both focus groups a lively discussion occurred. This incorrect knowledge seemed to be a preconception which was prevalent among all of the participants. Few participants knew the reason why it is not safe, which is illustrated in the following fragment:

R1: Male, aged fifteen: 'I think it is good to use two condoms. […] Because one condom is not 100 percent.'
R2: Female, aged fifteen: 'I don't think it is right [using two condoms is incorrect, SvdL]'
R3 Female, aged sixteen: 'I mean: the guy was drunk, there must be a mistake…'
R2: Female, aged fifteen: 'I'm not sure, but I think he's being extra careful or something. I don't know… I'm not saying it is right or wrong, but what if he uses one condom, what if it blasts?

The fact that participants are not very knowledgeable about the proper use of condoms is illustrated by participant R2: the fifteen-year-old female. At first she thought this usage was incorrect, but later she changed her opinion. In Kraaifontein, a sexually active nineteen-year-old male even had his doubts: 'That's my question: how safe is one condom? Therefore I say use two condoms.' Later he displayed his uncertainty by asking additional confirmation: 'So it's safer to use one condom?' Girls in Kraaifontein pointed out that if two condoms are used, one condom will 'get lost' in their vagina. A seventeen-year-old girl in Kraaifontein pointed out males' highly egotistical attitude with regard to contraceptive usage and the little interest in their girlfriends' health: 'Boys can agree that it is ok to use two condoms, but they know the problem won't happen to them. It is me who will suffer. They'll finish what they wanted to do and then I'm the one left with the [other girl adds: pains].' In all interviews, participants did not know how to open the package: 'I want to know, what's wrong with opening a condom with your teeth?', as asked by a seventeen-year-old male. Additional question which were asked were: 'What happens when you use a condom and it has expired?' Participants were not familiar with the word 'barrier method', and never heard of a diagraph.

3. Hormonal method (pill, injection, intrauterine device?)
The participants had limited knowledge regarding the usage of hormonal methods. 'Do you know what an intrauterine device is?' A typical reaction was: 'A what?!' None of the participants were familiar with this method that prevents pregnancy. In Kraaifontein it was asked: 'But do you know what to do when you forget one pill?*'* All participants articulated their confusion and lack of knowledge. A seventeen-year-old female stated 'Go to the clinic to get an injection.' Her female peer correctly commented: 'No, you can't get an injection if you take the pill. They say that if you have missed your pill, than … I don't know… you can't

take it after you have missed your time. And you have to wait for the next day and you can't have sex for that day.'

'Do you know how an injection works, what it does with your body? None of the participants could mentioned the pill's hormonal substances of oestrogen and testosterone. Only one girl in Kraaifontein knew that the injection makes you gain weight, because you want to eat all the time. Nevertheless, she did not link this correct knowledge to the hormonal substances of the pill. A nineteen-year-old male had not personally experienced this, indicating that his girlfriend did not gain weight from using the injection.

The participants asked additional questions about hormonal methods such as:

- Do you get sick from not menstruating?
- Can you use the morning after pills and the injection?
- Some people say the injection makes your blood dirty, is that true?
- Why don't they make pills that can prevent pregnancy and also protect against HIV/Aids?
- Are we guys given access to use an injection in order for us not to make the ladies pregnant? […] In order to decrease the rate of the sperm?

4. Ending an unwanted pregnancy (emergency contraception, abortion)

When asked in Kraaifontein 'Do you know anything about the morning after pill?', female participants said: 'We don't know anything about pills and stuff.' Of all sixteen participants, only one nineteen-year-old male in Kraaifontein was familiar with the morning after pill.

Questions asked by participants with regard to ending an unwanted pregnancy were:

- I want to know, if you have an abortion today, do you stay at the hospital or do you come back?'
- If you have an abortion, will you be able to make another baby again?
- How much does an abortion it cost?

In sum, the focus groups made clear that although the participants are bombarded with factual information on HIV/Aids and told to "use a condom", they are not equipped with the specific skills to use condoms correctly. In Kraaifontein, this urgent need for basic knowledge on how to protect oneself against HIV/Aids was displayed by a young girl: 'You ask us these

questions and we say we don't know, why don't you tell us? […] What prevention do you believe is good for you?' Based on these findings we can conclude that efforts to educate adolescents are never complete and require constant renewal.

Environmental Constraints

Our earlier findings indicated that there are little environmental constraints that hinder the audience from using a male condom since the male condom can easily be obtained free of charge at various public venues in South Africa. Some studies point out that the negative attitudes of the health care staff were a barrier to those youth who sought health care (Mmari & Mgnani, 2003; Speizer, Hotchkiss, Magnani, 2000, as cited in Pettifor et al., 2004).

11a) *Are contraceptives and health care services accessible to the audience?*

Hormonal methods such as the pill, the injection and morning after pills are freely distributed and can be obtained at the clinic. Abortions are legal in South Africa and are carried out for free. In the focus groups, the majority of participants did not know this. Morning after pills can also be purchased at the pharmacy for 50 South African Rand, but for most of the audience members this is quite a lot of money.

In Kayamandi, participants indicated that clinics are not 'youth-friendly' and high-quality medical aid is so highly priced that they cannot afford it (100 SAR per visit). The queues in regular clinics are incredibly long and people can wait for hours before they get help, *if* they do get help. As one sixteen-year-old female said: 'As young people we don't get much help at the clinic.' Some participants did not trust the staff working at the clinic in Kayamandi and doubted their personal safety: 'Maybe they are using the same needles', as noted by a fifteen-year-old female and sixteen-year-old male. The sixteen-year-old male confirmed reckless behavior based on his personal experience. According to him, the nurse at the clinic almost forgot to use a new needle when he wanted to get tested for HIV: 'I asked them (the nurses, SvdL): can you use another one? And they said, oh I forgot. And I said 'how can you forget about this?' This is my health, this is my life, it could be destroyed by your carelessness!' The following fragments illustrate the remarks of participants in Kayamandi:

R1: male aged sixteen: At the clinics they are shouting!

R2: female aged fifteen: You are too young to have sex!

R3 female aged fifteen: They tell you to bring your parents.

Another sixteen-year-old male stated: ‘You know what I think about those people? I think they are just gossiping and they are just after the money of the government, because they don’t buy enough stock for the people.’ Although the participants in Kraaifontein did not comment on the health care services, nor did they criticize them, we still must take the comments made in Kayamandi seriously.

Chapter 5. Conclusions, Discussion & Recommendations

To design an intervention of which the content is more likely to reflect the audience's information needs, we employed *participatory audience analysis* as a research strategy. Participatory audience analysis (systematic and frequent contact with members of the audience in various stages of the design process) helped us to gain an in-depth understanding of the audience's perspective. In contrast to other audience analysis strategies from the field of Document Design (see Schriver, 1997), we strove to conduct our research scientifically and to base our methodology on sound Social Science theories. In this study, participatory audience analysis was conducted in two research stages.

In the first research stage, we explored possible determinants of the audience's contraceptive usage in a preliminary investigation of theory, exploratory interviews and empirical evidence. Participatory audience analysis was briefly conducted by interviewing seven audience members. Based on this preliminary investigation, we integrated the insights obtained into a new, more comprehensive conceptual of model contraceptive usage (see section 2.6.1). Furthermore, our preliminary investigation helped us to determine what needed to be further researched in the focus groups. To ensure that our data collection was driven by theory, we formulated research questions stemming from the determinants of our conceptual model (see section 2.6.2). In the second research stage, participatory audience analysis was conducted more thoroughly and on a larger scale. Sixteen representative members of the audience were interviewed in two focus groups. The findings of the focus groups contributed to a more in-depth understanding of the determinants that influence the audience's contraceptive usage (see chapter 4).

In this final chapter, we will first reflect upon our main aim and draw conclusions from our research findings (section 5.1). Then, in section 5.2, the reliability and validity of our research will be discussed. Finally, based on our conclusions, we will give recommendations regarding the content of our HIV/Aids intervention (section 5.3).

5.1. Conclusions

The aim of part I was: *' to investigate how participatory audience analysis can contribute to the design process regarding the content of an HIV/Aids prevention document targeted at young African South Africans in South Africa.'* Apart from determining the content of our intervention, the findings of our study have implications for two other scientific disciplines: Document Design and Social Science. Therefore, we will first reflect on the contribution of

participatory audience analysis to the field of Document Design. Secondly, we will reflect on how the establishment of our new conceptual model of contraceptive usage, which ensured that our research was driven by theory, contributed to the Social Science discipline. Finally, we will draw conclusions from our research findings on the audience's determinants of contraceptive usage. These conclusions will lead to recommendations regarding the content of our intervention (see section 5.3).

Contribution of Participatory Audience Analysis to the field of Document Design

Up until this point, remarkably little research has been carried out on the participation of the target audience in health campaigns in South Africa. In section 1.3 of this thesis, we defined participatory audience analysis as: *'Systematic, frequent contact and collaboration with representative members of the audience, carried out scientifically and driven by theory in order to determine the appropriate content and form of the message.*' Participatory audience analysis was carried out in this study by interviewing seven audience members in exploratory interviews, and interviewing a further sixteen audience members in two focus groups. In this section, we will generalize our conclusions on how participatory audience analysis contributed to the design process in our study to draw implications for the field of Document Design. We believe that participatory audience analysis has been extremely beneficial in determining the content of our intervention since it allowed us:

1. To obtain accurate, up-to-date data on the determinants of the audience's contraceptive usage.

Firstly, to the best of our knowledge, there was *no data* available on sexual decision making of the particular audience that we segmented. To design an intervention that is better tailored to the audience's needs, we segmented an, as homogenous as possible, audience of African adolescents from the townships of Kraaifontein and Kayamandi. Although there was empirical data available on similar audiences (e.g. Wood et al., 1998, Varga, 1997), this data was at a high risk of being out-dated. Ever since apartheid legislation ended in 1994, traditional African culture's view of dealing with sexual matters has rapidly evolved and 'westernized' (Varga, 1997). As a result of this cultural shift, we expected that the new, post-apartheid generation would have developed different views regarding sexual matters. Moreover, particularly youth culture is known not to be static and to differ largely per geographic area (e.g. urban or rural). By means of participatory audience analysis, we were able to obtain first hand insight into the potential receivers of our intervention's underlying

motivations to use contraceptives. To conclude, we believe that document designers who conduct participatory audience analysis, can obtain a more accurate, in-depth and up to date image of the audience.

2. To determine at an early stage of the research the most effective strategy to collect the audience data.

Secondly, by means of the contact with the audience members in the exploratory interviews, we could determine the most appropriate research strategy to collect data for our main research. In the exploratory interviews we became aware of the fact that our audience had little experience with 'western' quantitative evaluation mechanisms such as surveys and the use of Likert-scales. We found that the audience was not particularly fond of reading, and not all members of the audience were equally proficient in reading or writing in English. Therefore, we perceived that it would not make much sense to conduct quantitative research, since the questionnaires were at high risk of being filled in incorrectly. This would lead to a biased, not representative image of the audience. By using an oral strategy such as focus group methodology, we would overcome the language barriers and low-experience with surveys since it allowed the participants to communicate in their everyday language.

Moreover, the exploratory interviews stressed the need to further investigate the appropriate method for retrieving audience data in the focus groups in order to answer our research questions. The use of *cases* in the focus groups (role-model stories on complicated issues of sexual decision making) was inspired by a study conducted by Terpstra (2002) in the Netherlands. Reflecting on her research, Terpstra (2002) stated that she found this approach very useful for stimulating openness and discussion in the focus groups among the adolescent, female participants from the Antilles and Suriname on the determinants of pill usage. In the content of our cases, we articulated provisional findings that were obtained in our preliminary research. In this way we could test whether the findings from our preliminary investigation were supported among a greater audience. Furthermore, this case approach resembled the African tradition of storytelling (Perloff, 2001).

We believe that this case approach was more effective in obtaining a representative view of the audience than simply posing questions. Firstly, personal disclosure was facilitated by means of the cases since participants were able to speak in the third person (referring to the case's characters). Secondly, the issues of sexual decision-making displayed in the cases stimulated *interaction* between the participants of the focus groups. This particular aspect of interaction is unique to focus group methodology and allowed us to identify group norms and

diverting beliefs and perceptions of the audience on sexual matters. By holding in-depth interviews or conducting surveys it is less likely to obtain this insight into the audience's group norms as relatively quick and easy as holding focus groups. Thirdly, unexpected data was revealed by the use of these cases because the participants were able to pursue the direction of the discussions according to their interests. Furthermore, the cases facilitated the moderator to take on the role of observer and listener most of the time, which minimized the intervening effects of the moderator's presence. To conclude, we believe that the use of participatory audience analysis can contribute to determining a more appropriate research strategy to collect the audience data in an early stage of the research. This is believed to lead to more authentic and higher quality audience data. In turn, this will allow document designers to gear the content of the intervention to the audience's "real world", increasing the intervention's effect.

3. To facilitate a bottom up approach in determining the content of our intervention.
Thirdly, the interaction between the audience and the document designer facilitated a *bottom-up approach* in determining the content of our intervention. Consciously or unconsciously writers tend to write from their own perspective (Longo, 1995; Schriver, 1997). Since we differed largely from the audience in age, cultural background and knowledge-level on the topic, we perceived that our perspective on the needs and interest of our 'imagined audience' was likely to clash with the information needs of the real audience. We believe that participatory audience analysis can help give the audience a voice in 'what' should be said in the intervention. In turn, document designers can adapt the content of their intervention to the real audience's concerns and information needs regarding sexual matters.

To conclude, we believe that participatory audience analysis highly contributed in this study to help us design a more user-centred intervention, which evidently is expected to increase the intervention's impact. Participatory audience analysis helps bridge the social gap between the audience and the document designer, and allows document designers to gear the content of their intervention to the audience's interests and information needs. We therefore stress the necessity for document designers to frequently and systematically meet the flesh and blood receivers of their interventions in various stages of the design process.

Contribution to the field of Social Science

In this section we will briefly reiterate why we perceive that the conceptual model we established in section 2.6 contributes to the body of knowledge of the Social Sciences on predicting contraceptive usage. Our conceptual model ensured that the data collection of the focus groups was driven by theory.

When reviewing current conceptual models of behavior, we found that most models were insufficient in predicting contraceptive usage. For instance, Perloff (2001) notes that when "rational" cognitive decision models (such as the IMBP of Fishbein & Yzer, 2003) are applied in the context of sexual decision-making, they experience difficulty in explaining why some individuals who harbour positive intentions to use contraceptives fail to act on their intent. According to Perloff (2001), such cognitive models neglect to acknowledge the role of affect (e.g. emotional attachment, sexual desire) on a person's motivation to use contraceptives. Furthermore, Parker (2004) points out that most decision models (such as the IMBP) ignore the fact that the cooperation of the partner in the sexual arena modifies individual intent to use contraceptives. These limitations stimulated us to establish a new conceptual model of contraceptive usage.

To establish this model, we took on an interdisciplinary approach. In our preliminary investigation, we examined theories from multiple disciplines, reviewed empirical evidence, and collected new audience data by interviewing audience members. Bartholomew et al. (2001) refers to the use of these three data collection methods as the 'three core processes of Intervention Mapping'. The insights obtained from this preliminary investigation are integrated in our conceptual model of contraceptive usage. In section 2.6, the conceptual model's theory is articulated and the relationship between the various determinants of the audience's contraceptive usage is illustrated. To ensure that the data collection in the focus groups was driven by theory, our research questions (or audience analysis questions) stem from the determinants of the conceptual model's theory (see section 2.6.2 for further details).

To conclude, with regard to the contribution of this study to the field of Social Science, we perceive that in the context of sexual decision-making, this model complements current cognitive decision models such as the IMBP.

Suggestions for Further Research

By using a qualitative research strategy, we were able to explore which determinants might possibly be involved as factors that influence the audience's contraceptive usage. The insight obtained from this exploration led to the establishment of a new, more comprehensive

conceptual model of contraceptive usage. In order to empirically test whether or not the proposed theory of our conceptual model is valid and can be generalized, we would like to offer the following suggestions:

1. **Establish a reliable and valid research instrument to test the theory**

In order to empirically test the validity of the model's theory, it is first crucial to design a valid research instrument. A typical research method to investigate this is to conduct a survey, and to design a questionnaire as a data collection instrument. This questionnaire is advised to consist of various statements that are intended to measure the extent to which a determinant (e.g. 'attitude towards condom usage') exerts influence on a person's contraceptive usage.

Before doing so, researchers are recommended to first carefully operationalize the determinants or 'variables', as they are often referred to in quantitative research, of the conceptual model. For each of these 11 'variables', a number of statements are suggested to be formulated. We stress that the formulation of these statements should be geared to the frame of reference of the audience selected. If, for example, a researcher would decide to conduct a study on the audience of African adolescents in Western Cape that we have selected for this research project, we would strongly advise researchers to carefully study our qualitative research conclusions (see section 5.1), and derive their statements from these conclusions. This could increase the chance that relevant questions will be asked and that the researcher will be able to gauge the determinants that help or hinder the audience from using contraceptives.

In formulating the statements or scales, researchers are advised to use multiple scales to measure the same singular variable. In this way, a more reliable investigation can be made since the researcher can investigate whether or not the same set of statements elicits the same response from the same participant. For instance, in order to measure a person's 'attitude towards condom usage' the following questions could be asked, for instance, by using a five-point Likert Scale. This Likert Scale could range from 1 (strongly disagree) to 5 (strongly agree).

1. Using a condom during sexual intercourse reduces sexual pleasure:
2. Using a condom during sexual intercourse is a sign of distrusting your partner:
3. Using a condom during sexual intercourse reduces the intensity of an orgasm:

We stress that a number of studies must be conducted among a large sample of audience members in order to determine whether or not the set of statements reliably represents the ascribed variable. The statistical analysis programme SPSS offers the opportunity to investigate the internal consistency among the scales by investigating whether or not the scales identified contain a reliable Cronbach's Alpha (see Korzilius, 2000). If this is the case, the statements can be considered reliable in measuring the particular variable. To conclude, we encourage researchers to design a reliable questionnaire in order to test our conceptual model's theory.

2. **Test whether the proposed theory of our conceptual model is valid among a large sample of representative audience members.**

If a reliable research instrument has been designed, researchers can actually start the empirical testing of our conceptual model's theory. The main aim of this empirical research is to obtain significant quantitative evidence that would prove that the proposed relationship between the determinants of our conceptual model is indeed valid. By asking a large sample of participants to fill in the questionnaire, researchers can analyse participants' responses in a statistical analysis programme (such as SPSS 11.0). In turn, researchers can conclude whether a coherent pattern between the determinants of the conceptual model exists. For instance, a researcher could investigate whether the six proposed determinants of individual motivation (e.g. outlook on life, attitude towards sex etc.) indeed displays a significant relationship concerning a person's behavioral intention to use a condom before entering the sexual arena. The results of such a study could lead to the refinement and adjustment of our conceptual model. Ultimately, this investigation would lead to a more accurate conceptual representation of the determinants of contraceptive usage than the current Social Science models of behavioral prediction. This, in turn, could assist planners of health interventions in determining the focus of their intervention.

We will now continue with presenting our conclusions on the determinants of the audience's contraceptive usage.

Conclusions on Determinants of the Audience's Contraceptive Usage

This section draws conclusions from the research question described in chapter 4: *'To what extent do the findings in the focus group interviews support the preliminary research on the audience's determinants of contraceptive usage?*' Our conclusions are presented by answering the audience analysis questions which stem from the determinants of our

conceptual model (see section 2.7). Previously, we provided a detailed schematic overview of the 11 determinants of contraceptive usage that we had examined in our preliminary research (see table 2.1, p. 62). In this section, we will present a brief summary of the audience's basic characteristics in table 5.1, and then elaborate per determinant on the extent to which our focus group findings were supported by earlier research findings. As we realize that these conclusions are very extensive, and somewhat lengthy, we would like to point out that in section 5.3, four of the 11 determinants researched, were selected. These four determinants have been recommended for serving as the focus of our intervention's content.

Table 5.1 *Summary Characteristics Target Audience*

	Characteristics Target Audience
Audience	African South Africans aged 12-19 who live in townships in Western Cape. Differ in sexual experience: some are already sexually active, some are not.
Educational	Low educational status (high school): speak Xhosa as their mother tongue, English as a second language.
Economical	Low economic status: this fuels high-risk behavior (younger sexual debut, transactional sex).
Cultural	Tendency towards western norms ('sex is a must'). Traditional norms encourage males to have multiple sexual partners, while females fear being perceived as promiscuous.

Interpersonal Influence

The component interpersonal influence is proposed to indirectly influence the formation of an individual's motivation to use contraceptives. Two determinants are part of this component: the perceived *social influence* of parents and peers (the audience's ingroup) and the *interpersonal communication* about sexual matters within the audience's ingroup.

Social Influence

1a) *To what extent do perceived socio-cultural norms of parents influence the audience's sexual behavior and contraceptive usage?*

In general, the participants in the focus groups indicated that parents exert less influence on their socio-cultural norms of sexual behavior than peers do. However, the participants' remarks did indicate that the participants often feel stuck between two cultures: the traditional African culture of their parents and the contemporary 'western' post-apartheid culture that highly appeals to their peers. For instance, two male participants in the focus groups justified their polygamous practices by stating that it was something they 'inherited culturally'.

Whereas on the other hand, rejection towards the traditional upbringing of parents was displayed by a male who stated that today's youth are part of a new generation and that times have changed. Our findings on the audience's confusion in dealing with these two sets of cultural norms is confirmed in Varga's (1999) study on post apartheid youth in Kwazulu-Natal (as cited in Shillinger, 1999). Varga (1999) found that still existent traditional norms (e.g. having multiple partners) were combined by youth with western norms (e.g. sex is a must) (as cited in Shillinger, 1999).

1b) *To what extent do perceived socio-cultural norms of peers influence the audience's sexual behavior and contraceptive usage?*

Peer-pressure is identified by Stanton et al. (2002) as one of the main determinants for African youth to engage in sex at an early age (as cited in Pettifor et al., 2004). In the focus groups, we indeed found that fear of group exclusion encouraged the audience to become sexually active. In the focus groups, participants stated that not yet sexually active peers were seen as 'outsiders': individuals who were not able to contribute to discussions on sex. Our findings that premarital sex is encouraged by peers was supported in Varga's (1997) study on African youth in Kwazulu-Natal, and Wood's et al. (1998) study on Xhosa females in Eastern Cape. The reason why youth comply with peer pressure to engage in sex can be explained by Baumeister & Leary's (1995) 'need to belong theory'. Applied to our research, this theory argues that youth seek affectively positive interactions with their peers, because being deprived of such interactions can result in lack of self-esteem, and other severe ill-effects such as depression (Baumeister & Leary, 1995).

In the focus groups we found that peers reinforce the appropriate traditional norms of sexual behavior. According to Varga (1997), the traditional norms of African culture dictate females to remain submissive towards males' sexual practices and to fear being seen as promiscuous. In the focus groups, this might explain why females were more eager to criticize peer pressure to engage in sex than their male counterparts. Males on the other hand, are traditionally encouraged to take on an assertive role with regard to initiating sex since having multiple partners is supposed to increase a male's social status (Varga, 1997). In the focus groups, some males indeed pointed out that sex can be a way for them to prove their manhood. This pressure for males to obtain respect among their ingroup members might explain why Pettifor et al. (2004) found that males (43%) self-reported to experience more peer pressure to engage in sex than females (28%) did.

Our focus group findings seem to signify that the male traditional practice of polygamy is to a great extent socially accepted among the audience. The double-sided moral within so-called 'stable relationships' was elaborated on by two male participants who stated that females were expected to remain faithful within 'stable relationships', while males were excused from being monogamous. Similar findings were displayed in the questionnaire given at the end of the interview: two out of eight males self-reported to have had casual relationships. Although four out of eight female participants criticized such polygamous behavior of males, an equal number of females more or less acknowledged it. This is an alarming tendency, considering the fact that having multiple sexual partners increases youth's risk to contracting HIV/Aids.

Interpersonal Communication

2a) *To what extent does the audience perceive to be efficacious in communicating with parents about sex and the usage of contraceptives?*

Recent research in the Netherlands has shown that children who feel comfortable with communicating with their parents about sexual matters are more likely to use contraceptives consistently (de Graaf et al., 2005). In this study, we found that all of the participants in the focus groups indicated that they would like to discuss sexual matters with their parents but a taboo prohibited this for most participants. This result was also found in a study conducted by the African Strategic Research Corporation; only 46% of parents reported that they talked often to their children about HIV/Aids and sexual abuse (as cited in Harrison & Steinberg, 2002). According to Varga (1999), this is due to the 'cultural taboo'. Traditionally, parents never spoke about sexual matters with their children (as cited in Shillinger, 1999). Unmarried aunts and older sisters informed girls about the appropriate rules of sexuality and intimate relationships, whereas uncles and older brothers did the same for boys (Varga, 1999, as cited in Shillinger, 1999). In the focus groups, however, the participants offered other explanations.

According to the participants, their parents are reluctant to discuss sexual matters because they mistakenly believe that talking about sex promotes 'promiscuity'. It seems that parents believe that their silence will curb their children's sexual activity. Furthermore, the participants suggested that their parents feel that they lack the communication skills to discuss sexual matters because they did not receive any sexual health education under the apartheid regime. Fear of losing their child to HIV/Aids was communicated by parents in alternative ways such as putting condoms in their children's bags, as said by the participants.

To conclude, we believe that parents' attitudes towards discussing sexual matters reinforce the taboo surrounding sexual matters. The taboo makes it more difficult for youth to accept their sexuality. Hence, youth are more likely to experience feelings of guilt about being sexually active. According to Rademakers (1991), such feelings have a detrimental effect on the consistency of youth's contraceptive usage (as cited in Terpstra, 2003).

2b) *To what extent does the audience perceive to be efficacious in communicating with peers about sex and the usage of contraceptives?*

Although sex is a popular topic for the audience to discuss, peers are not seen by the participants as reliable sources of information on the topic of contraceptives. This results is confirmed in Pettifor's et al. (2004) study which found that only 2% of youth views peers as a credible source of information concerning sexual matters. According to Pettifor et al. (2004), although youth reported that they talked frequently about sexual matters with peers, these talks generally referred to the pressure they felt to engage in risky sex. In the focus groups, males in particular indicated that talking about contraceptive usage with their peers is a taboo. It is seen as 'a girl's thing'. Female participants, on the other hand, did indicate that they sporadically discussed contraceptive usage. Caution was needed in such discussions so as not to profile oneself as 'an expert on contraceptive usage', which a female participant in Kayamandi was keen to point out. Such behavior is undesirable, as it makes a person stand out from the group. In Kayamandi, participants had a negative overall attitude towards friendship and emphasized the bad influence peers can have on each other (e.g. smoking, drinking, or engaging in sex).

Individual Motivation

A person will be more likely to successfully negotiate safe sex if he or she harbours a positive intention to use contraceptives *before* entering the sexual arena. In the conceptual model it was proposed that the following six determinants are part of the component individual motivation: 1) *attitude towards sex* 2) *attitude towards contraceptives* 3) *attitude towards teenage pregnancies* 4) *self-efficacy* 5) *perceived risk* 6) *outlook towards life*.

Attitude towards Sex

3a) *Does the audience perceive it as socially acceptable to be sexually active at fifteen years of age?*

In general, at the end of both focus group interviews, all of the participants agreed that being sexually active at fifteen years of age is a matter of personal preference. Our findings confirmed that the 'Western' tendency to have premarital sex is nowadays more or less accepted among African youth (Varga, 2000, as cited in RHO, nd). However, it must be pointed out that female participants were more eager to debate on what was the 'right age' to engage in sex. Females were also less likely to self-report whether they have had sex in the questionnaire given at the end of the interview (three out of eight self-reported to have had sex: 37.5%), than their male counterparts (seven out of eight self-reported to have had sex: 87.5%). Moreover, females self-reported to be relatively older at their sexual debut (mean age 15.3), than their male counterparts (mean age of sexual debut 13.3). Overall, females in the focus groups were less outspoken, and less informed about sexual practices than the male participants in this study.

An explanation for why females were more reluctant to admit being sexually active might lie in the previously mentioned appropriate sexual norms of traditional African culture (Varga, 1997). Applied to our focus groups, females' fear of being seen as 'promiscuous' by their ingroup might prohibit them from displaying themselves as being sexually active. For instance, female participants stated that they could not carry condoms on them because this would indicate that they were 'looking for sex'. Whereas male participants were perhaps more open towards discussing sexual matters since traditional norms encourage males to be sexually active. Our results are supported by Pettifor's et al. (2004) study that found that more males (43%) than females (25%) were likely to indicate that it is "ok" to have sex for youth their age (15-19). To conclude, the traditional norms regarding appropriate sexual behavior hinder females from fully accepting their sexually active status. According to Rademakers (1991), females' feelings of guilt about their sexually active status will negatively affect these females' contraceptive usage (as cited in Terpstra, 2002).

Attitudes towards using contraceptives:

This section presents our findings for audience analysis question 4a to 4f on attitudes towards barrier methods, hormonal methods and emergency contraception. In order to present a coherent picture of the audience's attitude towards each contraceptive, we drew generally from the audience's perceived benefits and disadvantages per form of contraception. Overall, the male condom was perceived by the participants as being the most appropriate contraceptive to prevent unwanted pregnancy and HIV/Aids.

4a-4b) *What is the audience's attitude towards using barrier methods?*

The male condom was found to be the most popular method of contraception among all of the participants. In the questionnaire given at the end of the interview, participants were asked to recall their contraceptive usage during their last sexual encounter. Of all the ten sexually active participants, 88.9% self-reported having used a male condom during their last sexual encounter. The popularity of the male condom can be explained by the fact that male condoms are easily accessible since they are freely available at a large array of public venues in South Africa. This is in contrast to the female condoms which can only be purchased at the chemist's. Few participants said to have had personal experience with the female condom. Only one male self-reported to have used the female condom at last sexual encounter in the questionnaire. Importantly, we must note that 'recall' does not measure the consistency of the participants' contraceptive usage, whereas this is the essential element in order for contraceptives to be effective. For instance, in a recent study by Pettifor et al. (2004), 66% of youth self-reported not using condoms consistently.

Negative attitudes that kept youth from using a barrier method referred to: 1) males' fear of reduced sexual pleasure 2) the belief that condoms can be too small, and 3) the perception that condoms take away men's control of the sexual activity. For instance, a typical remark in the focus group was that males preferred 'flesh to flesh' or that 'a banana cannot been eaten with its skin'. These remarks refer to the male's fear of reduced sexual pleasure. One disadvantage of the female condom was made in reference to its form. Participants in Kayamandi said that the form of the female condom was hilarious: very big and round. In the section 'the sexual negotiation', we will elaborate further on the role of the partner when using contraceptives.

4c-4d) *What is the audience's attitude towards using hormonal methods?*

The injection was the hormonal method with which participants were most familiar. This contraceptive protects up to 100% against unwanted pregnancy. According to a male participant, males often exert pressure on their girlfriend to take the injection. The focus groups supported our exploratory interview findings which found that condom usage tends to stop in relationships in which the girl used the injection. The benefits mentioned from having the injection were that this hormonal method overcomes the disadvantage of reduced sexual-pleasure which is assumed to be related to condom usage, whereas it protects against unwanted pregnancy. This is alarming considering the fact that most relationships are not

monogamous as male partners commonly seek additional 'casual' sex partners. Thus, being on the injection increases a girl's susceptibility to HIV/Aids.

Negative attitudes that keep youth from using hormonal methods refer to the myths of infertility and weight gain. Our results did not support Wood's et al. (1998) findings that youth believe that hormonal methods cause 'disabled babies' and 'vaginal wetness'.

4e-4f) *What is the audience's attitude towards using emergency contraceptives?*
The participants were not familiar with the morning after pill, a hormonal emergency contraception that has to be taken within 72 hours to prevent pregnancy. Accidental unprotected sex (e.g. a condom that broke, or an oral pill that was forgotten) was referred to by most participants as accepting their fate to have a child. Another more drastic measure for terminating an unwanted pregnancy is to have an abortion. Abortions are legalized in South Africa and can be carried out up to the first three months of pregnancy. Participant noted that the benefits of terminating an unwanted pregnancy would be that their future aspirations would not be endangered. Girls perceived that by terminating an unwanted pregnancy they would not have to fear their parents' reaction. In general, girls felt uncomfortable with their parents knowing that they were sexually active and their being pregnant would come as a rather unexpected surprise.

The negative attitudes that prevented youth from terminating unwanted pregnancies proved that most participants perceived abortion to be a sacrilege. Moreover, the youth was scared that having an abortion would negatively affect their fertility and health (e.g. 'If you have an abortion, you will never have a child again.'). This fear indeed is legitimate if abortions are carried out illegally. According to the participants, most peers consulted the *sangoma*, the traditional healer, for terminating unwanted pregnancies. The participants noted that the sangoma would give three pills (*amon sisi*) or a drink to pregnant girls to kill the baby. Other methods mentioned for terminating an unwanted pregnancy were alcohol and a thing called 'stool'. It is clear that females who undergo such unprofessional practices are risking their own lives. In general, aborting an embryo was believed to be a greater social taboo by the audience than teenage pregnancy.

Attitude towards Teenage Pregnancies
This section presents our findings in regard to the audience analysis questions 5a to 5b concerning the audience's attitudes towards teenage pregnancies.

5a-5b) *What is the audience's attitude towards teenage pregnancies?*

Generally, all of the participants held a negative attitude towards having a child during their teens. Participants in the focus groups were afraid that their parents would be angry with them and would force them to leave their homes. Moreover, the participants believed that pregnancy would jeopardize their future plans, their study and their career aspirations. Nevertheless, all of the participants personally knew peers at their high school who had become pregnant. This result confirms Pettifor's et al. (2004) finding that teenage pregnancies are an omnipresent phenomenon in South Africa (with a startling mean age of first child birth at age 18.5). Although we estimated that seeking emotional intimacy with the partner would be a reason for girls to become pregnant, this was not supported in the focus groups. The participants noted that they found it rather unrealistic to think that your boyfriend would stay with you if you were to become pregnant. Reasons that were mentioned by the participants for their peers to become pregnant can be summarized in by the following three benefits: 1) status among female peers, 2) financial gain and 3) parents' support with the upbringing of their child.

First of all, the participants indicated that some girls experience pressure from close female peers to become pregnant. Pregnancy in this sense, contributes to these females' personal *status*. In the focus groups, the participants noted an element of so-called "competition" that is attached to these pregnancies. Peers often quarrel over financial competition (e.g. whose baby appears to be the best looking and best taken care of) and competition of emotional intimacy (e.g. which teenage mother displays to be the closest to their partner). Moreover, according to the participants, these girls perceive that sharing the experience of being pregnant will deepen their friendships.

Secondly, the participants stated that the pursuit of financial gain was a reason for some peers to fall pregnant. According to the participants, these peers were eager to receive the monthly governmental grant of 170 South African Rand. Often this money was not spent on the baby's health, but on personal luxuries such as mobile phones and clothes, as some of the participants remarked.

The third reason for youth to fall pregnant, and what we believed to be the most plausible explanation for the high rate of pregnancy, is that teenage pregnancies are more socially accepted than abortion. All of the participants believed that if they would become pregnant, they could eventually count on their mother's support in the upbringing of their child.

Self-efficacy

6a) *To what extent do members of the audience perceive to have personal control in carrying contraceptives on their person?*

If a person carries a condom in his/her pocket, the condom can easily be accessed, which increases the partner's chances of using condoms during the sexual encounter. At first, all of the participants in the focus groups gave the socially desirable response that the use of contraceptives is a 'shared responsibility'. However, when further questioned, none of the participants stated that they were carrying a condom on their person at the moment. Although we must admit that this is a rather direct question, participants gave insightful explanations for why members of the audience fail to carry contraceptives on their person.

In the focus groups, we found that particularly females have a low-perceived self-efficacy with regard to carrying condoms. Female participants were afraid that carrying condoms would be perceived as a sign of promiscuity. Carrying condoms would indicate that the girl was 'looking for sex'. Only the 'rape myth' socially justified carrying a condom on their person for females. According to this rather unrealistic myth, a woman who is about to be raped, can beg the rapist to use a condom in order to prevent HIV/Aids transmission. Females' low perceived self-efficacy with regard to providing condoms is in accordance with the traditional African cultural norms that prohibit females from taking on an assertive role in regard to sexual matters (Varga, 1997). Interestingly, four out of eight males in the focus groups criticized their female counterparts for relying too heavily on their male partner for providing condoms. This might indicate a shift in the traditional gender norms, and that it might also prove to become more socially acceptable for females to carry condoms on their person in the future.

6b) *To what extent does the audience perceive to have personal control in consistently using contraceptives?*

Alcohol was mentioned most frequently by the participants as a factor that negatively influences a person's self-efficacy to use contraceptives consistently. This finding is confirmed in Pettifor's et al. (2004) study. Pettifor et al. (2004) found that 43% of South African youth noted that drugs and alcohol are factors that decreased their efficacy in using condoms. In the section on 'sexual negotiation', we will further elaborate on the influence of the partner in consistent contraceptive usage.

Perception of Risk

7a) *To what extent does the audience perceive to be at risk of contracting HIV/Aids or pregnancy if they do not use any contraceptives?*

In the focus groups, the participants feared pregnancy more than HIV/Aids transmission. This fear of pregnancy is not surprising in view of the large number of pregnant peers in the audience's immediate environment. Research by Pettifor et al.(2004) found that 33% of South African females under nineteen self-reported ever having been pregnant. In contrast to pregnancy, the signs of a positive HIV-status are not as clearly visible. Nevertheless, a high number of teenage pregnancies indicates that youth are having unprotected sex, increasing HIV/Aids risk.

Despite the fact that all of the participants knew someone personally who had died from HIV/Aids, most of the participants in the focus groups failed to internalise their personal risk. In the focus group in Kraaifontein, a male participant (who admitted to have multiple relationships) said that he used condoms 75% of the time. When asked about the other 25%, he replied that the other 25% was based on 'the trust' between him and his partner. This false perception of safety was also found in Pettifor's et al. (2004) study. Pettifor et al. (2004) found that of the youth who reported *never* using a condom, 54% believed that they were at low risk of HIV infection. This is quite remarkable considering the fact that 45% of these youth reported to have known someone personally that had died from Aids (Pettifor et al. 2004). In our exploratory interviews we found that most people keep a positive HIV-status secretly to themselves, and refer to their disease as 'tuberculosis'. Varga (1997) states that this tendency to neglect the existence of the disease can be ascribed to the social stigma attached to HIV/Aids. To conclude, our findings support Perloff's (2001) 'illusion of invulnerability theory' that youth have a tendency to be unrealistically optimistic about their susceptibility to contract a severe illness such as HIV/Aids.

Outlook on Life

8a) *To what extent does the audience's perception of the future and their outlook on life influence their usage of contraceptives?*

In general, the participants in the focus groups had a clear perception of their future and a positive outlook towards life. A positive, clearly defined perspective of the future is seen by Mathur et al. (2001) as an important motivational factor for youth to use contraceptives in order to achieve that goal (as cited in Pettifor et al., 2004). Most participants aspired a career in which they could contribute to their township, such as being a lawyer, a health nurse, or a

doctor. Our results confirmed Pettifor's et al. (2004) findings of a general tendency towards optimism among youth. In Pettifor's et al (2004) study 92% of the youth stated that they had established long range goals for themselves, and 82% of the youth reported that they had a good idea where they were headed in the future.

Nevertheless, the findings in the exploratory interviews and focus groups indicated that a minority of the audience members suffers from a lack of direction. For these youth, sex, drugs and alcohol were seen as short-term, instant forms of satisfaction. A male participant in the focus groups remarked that sex was perceived by him and his peers as a cheap and easy form of entertainment to cope with boredom. Unfortunately, the socio-economic situation of youth living in townships offers few healthy alternatives. Although it is quite typical for young people to experiment with sex, drugs, and alcohol, this is a fatal combination in view of its detrimental effect on the audience's cognitive motivation to use contraceptives, thus increasing their susceptibility to HIV/Aids.

The Sexual Arena

The component 'sexual arena' is proposed to exert the greatest influence on a person's contraceptive usage. The determinant *sexual negotiation* and *opportunity* are proposed to modify a person's individual motivation to use contraceptives.

Sexual Negotiation

Contraceptive usage highly depends upon a person's success in negotiating safe sex with his or her partner. *Sexual negotiation* is formed by the determinants *social influence of the partner* and *interpersonal communication with the partner*.

9a) *To what extent does the audience experience pressure from their partner to engage in sex?*

Our results in the focus groups supported Varga's (1997) findings that for males in particular, 'sex is a must', and that males only perceive a relationship as legitimate and serious if sex has taken place. South Africa's astronomically high rate of rape (Duke, 1997), seems to be related to the frightening mindset that sexual coercion is a 'culturally appropriate practice' (as cited in Varga, 1997). In the focus groups, this mindset became clear by males' remarks that indicated that girls were giving them 'mixed signals'. Males clashed on the meaning of the word "no", and stated that if a girl would offer them a simple kiss, it would indicate her willingness to engage in sex. This was heavily debated by the female participants in the focus

groups. Apart from being physically forced to engage in sex, females also felt psychological pressure from their male partner to engage in sex due to threats of abandonment. This result was supported in Wood's et al. (1998) study. Clearly, sexual coercion and violence used by males leaves females powerless to negotiate safe sex.

9b) *To what extent does the audience perceive to be efficacious in communicating contraceptive usage with their partner?*

Not discussing condom usage was found to be a rational decision for most participants in the focus groups. Female participants in particular said to experience difficulties in communicating about contraceptive usage with their partner. However, few female participants in the focus groups articulated their fear of physical abuse. The commonness of sexual coercion used by males has received more attention in empirical studies by Wood et al. (1998) and Varga (1997) on the sexual decision making of adolescents in Eastern Cape and Kwazulu-Natal.

A male participant in the focus groups referred to not using condoms with his partner as 'a proof of their love'. 'Trust' seems to be the key word in these incidences, but nevertheless it proved to be a misleading concept. This became clear by means of the anecdotes several participants in the focus groups told. A female participants made a general remark that males 'pretend' to slide on a condom, while in fact the condom was not on. Male participants on the other hand, felt betrayed by their female partner for saying she had used the injection as a hormonal contraceptive, while in fact she had not. Our focus group findings supported earlier findings that suggesting condom usage can be interpreted as being insulting, showing infidelity and lack of love for the partner, and that not using condoms indicates that the relationship is perceived as being serious (Sobo, 1993; Bajos et al. 1997, as cited in Varga, 1997). Evidently, such factors hinder the communication about contraceptive usage between sexual partners.

Opportunity

Two determinants are part of the component 'opportunity': *knowledge* and *environmental constraints*. External sources (e.g. governmental policy) are believed to eliminate the possible barriers within the component 'opportunity' .

10a) *To what extent is information on the usage of contraceptives accessible to the audience?*
According to a study by Pettifor et al. (2004) high schools are seen by 32% of youth as the most credible information source regarding safe sex information. This would seem to indicate the effectiveness of the measure the South African government took in 2003 to oblige all high schools to give a 'life orientation course', in which issues regarding sexual health are taught. However, the participants in this study pointed out that the 'life orientation course' is only given in grade 8, when the audience members are about twelve years old. At that age, most adolescents are not yet sexually active, and they lack the interest to seriously commit themselves to understanding the 'safe sex' information. The participants stated that they had consulted other sources and enjoyed watching the soap operas of *Soulcity*, one of the major HIV/Aids prevention organizations in South Africa. Nevertheless, our findings indicate that the accessibility of health information that is geared to the specific information needs of the audience can be improved.

10 b) *To what extent is the audience's knowledge concerning contraceptive usage and sexual matters correct?*
Although the audience has been bombarded with factual information on HIV/Aids and told to "use a condom", we found that the participants in our focus group interviews were not equipped with the specific skills needed to use condoms correctly. In general, the audience's level of knowledge on contraceptives was alarmingly low. For instance, in the exploratory interviews, a seventeen-year-old male said that he had used two condoms, believing to be *extra protected*, when he suspected a causal sex partner to have Aids. Unfortunately, friction of latex on latex increases the chance that the condom will break. When this issue of using two condoms was proposed in the focus group interviews, participants were hesitant to reply and even debated on the safety of a single condom. Another example of how the participants lacked fundamental basic knowledge on contraceptives was that some participants did not even know that opening a condom package with their teeth can damage the condom.

To conclude, our findings indicate that sex education aimed at youth needs constant renewal to fit their needs. It is therefore of great importance that high schools implement a continuing safe sex education programmes in their curriculum. Youth can only choose to make a well-informed decision on how to protect themselves against HIV/Aids if they have the basic knowledge on how to use contraceptives properly.

Environmental Constraints

11a) *Are contraceptives and health care services accessible to the audience?*

Male condoms are freely distributed and available at a large array of public venues in South Africa. Hormonal methods such as the pill, the injection and the morning after pill, can be accessed for free at the clinic. In the case of female condoms, sufficient financial funds must be available to purchase them at a pharmacy. In Kayamandi, participants noted that the staff at clinics were not very helpful to youth, and that extraordinary long waiting lines at provincial clinics were not compatible with youths' school schedule. The health care staff's negative attitudes, that the participants in Kayamandi pointed out, was also found in another studies as a barrier to youth to seek health care (Mmari & Mgnani, 2003; Speizer, Hotchkiss, Magnani, 2000, as cited in Pettifor et al., 2004, p. 57). It seems that professionalism can be improved at provincial clinics in South Africa.

5.2 Discussion

The quality of any empirical study is reflected by the extent to which the researcher is capable of presenting convincing evidence from his or her findings. In section 1.3 of this thesis, we voiced our criticism of various audience analysis approaches (see Schriver, 1997). We stated that in practice, many approaches fall short when scientifically conducting audience research and few are driven by Social Science theory when collecting their audience data. Therefore, we concluded that in such studies the *reliability* and *validity* (the two main research criteria for presenting convincing evidence that must be met at all times) of the translation of their findings into the established intervention is questionable. This section discusses the measures that we took in our preliminary investigation and focus groups in order to ensure that our interpretation of the data was reliable and valid. We note that in *quantitative* research, these two terms are interpreted differently than in qualitative research (see Bergsma, 2003, for a detailed elaboration on these differences).

Reliability

The reliability of the research method employed refers to the extent to which another researcher would have drawn similar conclusions if he or she had replicated this study under similar circumstances (Baarda et al., 2001, p. 98). One weakness in qualitative research that has been conducted by a single researcher, is that the findings are only interpreted from a singular, thus subjective perspective. To increase the objectivity of this study, several measures were taken into account.

1.Conscientious registration. All of the focus group findings and the exploratory interviews were conscientiously registered and described in order to ensure that the conclusions could be drawn from factually expressed opinions. At a later stage, this prevented the analysis from being based on the moderator's (subjective) memory of the sessions. Data were systematically retrieved from the focus groups since each case was designed to answer two or three audience analysis questions. Thus, to a certain extent, the method was standardized.
2. Triangulation. Subjective interpretations of the data by a singular researcher were verified by using the triangulation data collection method. In this research, triangulation refers to the repeated measurement of multiple (qualitative and quantitative) sources: theory, empirical evidence and exploratory interviews. As a consequence, this enhanced our study's reliability.
3. Avoiding preconceptions and prejudices. Exposing prejudices (if any) was avoided by listening closely and asking open questions. Because the participants were able to pursue the discussion according to their interests in the focus groups and exploratory interviews, the generated discussions led to unexpected pathways, revealing unexpected data (see validity).

Validity

Internal validity refers to the extent to which the research method truly measured and investigated the intended phenomenon (Baarda et al., 2001). According to Baarda et al. (2001), this is one of the strengths of a qualitative research since the method focuses on describing the situation from the perspective of the participants researched. To increase the *internal validity* several measures were taken into account.

1.Feedback Participants. The gap in cultural background between the moderator and our audience required the moderator to take on the role of observer and listener. As an 'outsider', we might intimidate our audience, asking all the 'wrong' questions and hence, we would fail to capture a representative picture. The provisional findings from the preliminary research were tested by articulating them in the cases as problems of sexual decision-making. The participants' feedback on the cases tested the extent to which our provisional findings were correct. While the interactivity of the focus group method allowed the participants to comment on each other's views and to ask the 'right' questions based on their everyday experience. To gain in-depth knowledge, the moderator probed and asked for clarification. In conclusion, this approach substantially contributed to the validity of the audience data obtained.

2.Triangulation. A representative view of the phenomenon researched has been captured if the point of information saturation has been reached, thus if no new data had emerged (Baarda et al., 2001). Due to the relatively homogenous focus group make-up and the use of triangulation that was used to verify the results, we believe that sufficient data were obtained in quite at early stage of research in this study.

The *external validity* refers to the extent to which the results of this study can be generalized (Baarda et al., 2001, p. 101). Baarda et al. (2001) point out that a researcher should be aware of *elite bias*: drawing conclusions based on a sample of outspoken, well-informed participants. To increase the external validity of the sample, the following consideration was taken into account: Two principals were asked to randomly select four males and four females for the focus group. In this way, our chances of selecting only extroverts (since extroverts are socialites and tend to place themselves in the forefront) were minimized. The principals' selection resulted in a 'young' group aged 14 to 16, and an 'older' group whose ages ranged from 16 to 19. As the latter group is slightly older, they were more sexual experienced (75% self-reported having had sex), which increased the likelihood that participants in this group had accepted their sexuality to a greater extent. In the focus group interviews, the latter group indeed displayed a more positive attitude towards sex. The latter group was verbally more expressive and their discussions were livelier than the discussions that took place in the younger group (of which 50% self-reported having had sex). To ensure that the introverts point of view was taken into account, the moderator encouraged shy, introverted participants to contribute to the discussion by asking them specifically for their opinions. Thus, this research may be regarded as valid in the sense that the sample captured a close to representative view of our audience. It must be pointed out, however, that results might not be representative for a general population of young Africans in South Africa.

5.3 Recommendations

In this section we will answer our final research question: *'How can the findings of part I be translated into communication strategies for the content of an Aids prevention text targeted at young African South Africans?'* According to Schriver (1997), a text has more impact on its audience if it concentrates on a few key messages. Therefore, based on our conclusions in section 5.1, we will select four determinants from the 11 different determinants that we researched in this study. These four selected determinants of the audience's contraceptive usage are recommended to be emphasized in the content of our intervention. In this section,

we will first explain the two sets of criteria we used to select these four determinants. Then, we will justify why we have chosen to focus on these determinants, and to set up specific objectives for each determinant that we aim to communicate in our intervention. By setting up clear, attainable communication objectives, we can continuously check whether the drafts of our intervention do indeed reflect the recommended content. For instance, to stimulate the audience to have a more positive 'attitude towards sex', we formulated the following more narrow objective: 'acknowledge that it is not realistic to imagine that youth are never going to have sex'. In this way, more direction can be provided when designing our intervention. In part II, we will further investigate the best strategy to communicate these objectives to the audience (e.g. language, tone of voice) by evaluating an existing Aids prevention text and collaborating with four audience members in the design process of our intervention.

Selection criteria

The essence of good writing is sacrifice – deciding what not to say. To increase our intervention's effect, we selected four determinants that we recommend to be emphasized in the content of our intervention based on the following two criteria: 1) the determinants can realistically be changed, and 2) the determinants reflect the audience's information needs.

Bartholomew et al. (2001) offer a very practical criterion for selecting our determinants: the intervention should focus on determinants that *realistically* can be changed. 'Realistically' refers to fixed factors such as the resources available and the reality of the audience's everyday lives. With respect to the financial resources available, we were not in a position in which we could establish an ambitious five-year ongoing HIV/Aids campaign that would integrate multiple communication channels for disseminating a consistent 'safe sex' message. We were well aware that such a large-scale campaign is more likely to have an impact on the audience. *Realistically*, producing one HIV/Aids prevention text was a goal that we could achieve. In determining the content of our HIV/Aids intervention, we anticipated on the reality of the audience's everyday lives. For instance, we felt it would make sense if we would encourage youth to use the male condom, since male condoms are widely available and can often be accessed free of charge by the audience.

Our second criterion was that the determinant should reflect the *audience's information needs and interests*. Several studies suggest that in order for an intervention to be effective, the content should reflect the topics in which the audience is interested (see Schriver, 1997; Moody, 1991; Bartholomew et al., 2001). For instance, in our focus groups we found that the audience was not familiar with the morning after pill. Most participants

perceived accidents such as a 'forgetting' to use a condom or a condom that broke as their destiny of becoming pregnant. The participants were greatly interested when the moderator noted that 'the morning after pill' can easily prevent unwanted pregnancies.

Based on the considerations mentioned above, the following four key determinants were selected: 1) attitude towards the male condom 2) attitude towards sex 3) knowledge 4) sexual negotiation. In the following section we will justify why we have chosen to focus on these four determinants by applying the two previously mentioned criteria of 'realistic to change' and 'reflects the audience's information needs'. For each determinant, we will display the objectives that we aim to communicate in the content of our intervention.

1. Attitude towards the Male Condom

In our conceptual model, the determinant 'attitude towards the male condom' is conceptualised as one of the six determinants that form the component 'individual motivation'. A person who harbours a positive motivation to use contraceptives *before* entering the sexual arena is expected to be more likely to negotiate condom usage with the partner, and more likely to refuse to engage in unprotected sex. The decision to focus on the male condom in our intervention is influenced by three factors. Firstly, it makes sense to focus on the usage of the male condom in our intervention since the audience's environment positively supports condom usage. In South Africa, male condoms are freely distributed at a large array of venues as part of government policy. Secondly, the findings in the focus groups made clear that if audience members perceive their relationships as being 'stable', and the female partner uses the injection as a contraceptive, condom usage tends to stop. In view of the fallacy that stable relationships are monogamous (as the male participants made clear in the focus groups), being on the injection (and thus not using condoms) increases the risk of contracting HIV/Aids. Therefore, we did not want to promote the injection in our intervention and decided to focus on condom usage. Importantly, the male condom is one of the few interventions that protects against HIV/Aids and unwanted pregnancy.

In our intervention we aim to meet the following objectives for this determinant:

- To encourage the audience to use condoms consistently and correctly each time they have sex.
- To reinforce that the health-related advantages of condom use outweigh the disadvantages.
- To change negative attitudes towards male condoms:

- association of distrust
- misperception that a condom can be too small
- perception that condoms reduce sexual sensitivity

2. Attitude towards sex

In the focus group interviews a frequently asked question was: 'What is the right age to have sex?' In view of the audience's interest in this question, this topic should receive attention in the content of our intervention. The question of 'the right age' to engage in sex has different aspects that are all connected to the determinant 'attitude towards sex'. Moreover, research in the Netherlands has shown that youth who have a positive attitude towards sex and do not experience feelings of guilt about being sexually active, are more likely to use protection during sexual encounters (as cited in Terpstra, 2002; Graaf et al., 2005). The determinant 'attitude towards sex' is one of the six determinants that has been proposed to form the component 'individual motivation' in our conceptual model.

We aim to meet the following objectives with respect to this determinant:

- To acknowledge that it is not realistic to imagine that youth are never going to have sex.
- To encourage the audience to practice other safe sex behaviors that delay sexual intercourse such as (mutual)masturbation, kissing & hugging.
- To reinforce the idea that engaging in sex is a personal decision.

3. Knowledge

In our conceptual model, the determinant 'knowledge' has been placed within the component 'sexual arena' and is believed to modify individual intent to use contraceptives. In the focus groups, it became clear that the audience lacked fundamental knowledge on how to protect themselves against HIV/Aids and unwanted pregnancy. This, for instance, became clear when the participants posed questions such as 1) What's the best way to protect yourself against HIV/Aids and pregnancy? 2) How do you correctly use condoms? 3) What should you do after having had unprotected sex? Obviously, without possessing the correct knowledge, the audience is not able to make a healthy, well-informed sexual decision. With respect to this determinant, we aim to meet the following objectives:

- To increase the audience's knowledge level on correct condom usage and emergency contraception in order to make a safe, healthy, and well-informed decision.

- To inform the audience about the HIV/Aids and pregnancy risk attached to various sexual acts.
- To introduce information on emergency contraception as a last measure to prevent teenage pregnancies.
- To change incorrect knowledge of usage and treatment of the male condom:
    - using two condoms over each other
    - opening package with teeth
    - not checking expiry date
    - keeping condoms in a warm place
    - using oils as a lubricant
- To promote visits to clinics for emergency contraception, condoms and HIV tests.
- To reiterate that male condoms are available for free at clinic and public venues, and female condoms can be purchased at chemist or pharmacy.

4. Sexual Negotiation

'How do you convince your partner to use condoms?' This question was frequently asked mainly by female participants in the focus groups. As stated earlier, it takes 'two to tango' in the sexual arena. In our conceptual model, we propose that a person's intent to use contraceptives is mediated by the cooperation of the partner. Since another social being (the partner) is involved in the sexual decision making process, a person's decision to use contraceptives is more likely to be based on affective evaluations (Bargh, 1999). For our intervention, this implies that we will need to anticipate on the affective nature of sexual interactions (e.g. emotional attachment, sexual desire).

We aim to meet the following objectives with respect to this determinant:

- To provide strategies that can be used to convince the partner to use a male condom.
- To promote core values of shared responsibility, care and respect.
- To stress that all South African youth are personally responsible for stopping HIV/Aids by engaging in safe sex.

In part II, we will further investigate how to communicate these objectives to the audience.

Part II: Determining how to present the content of our Aids Prevention Intervention

Part II: Introduction Research

In part I, we researched which determinants exert influence on the audience's contraceptive usage. These outcomes lead to design decisions regarding the content of our intervention. To increase our intervention's effect, it is crucial to present the intervention's content in a form that reflects the audience's communication preferences (e.g. media channel, tone of voice and style) (Smith Romocki et al., 2004). In this part, we investigate how to communicate our message to the audience.

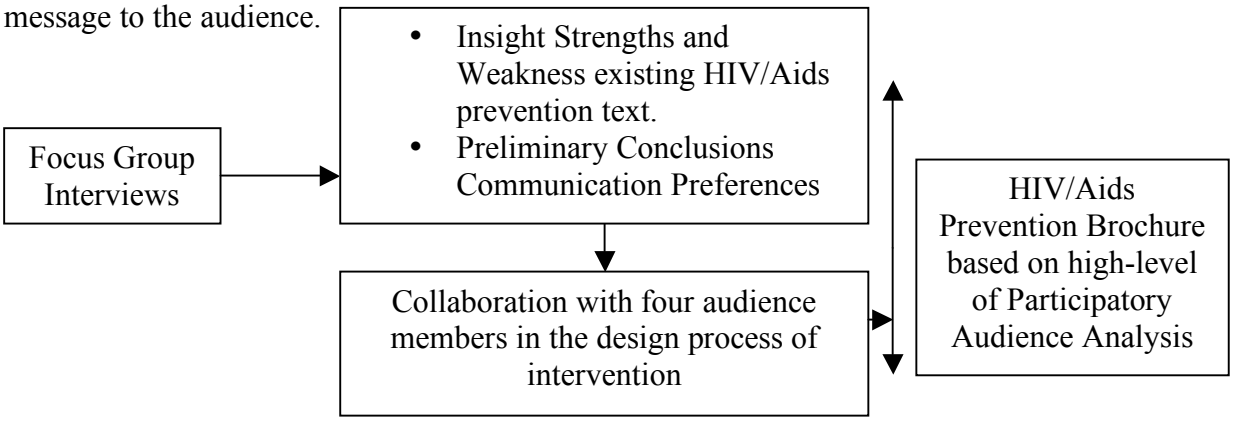


Figure 1: Research Model Part II[7]

The aim of part II is *' to investigate how participatory audience analysis can determine how the content should appear in the HIV/Aids prevention document targeted at young African South Africans in South Africa'.* To meet this aim, we will carry out three stages of research. In the first, preliminary stage *(a)*, an existing Aids prevention text of *loveLife* is evaluated by the target audience by means of two focus group interviews. The lessons learned from the text's strengths and flaws will be implemented in our own intervention (chapter 6). In the second stage *(b)*, we enter the actual design process of our intervention. In this design process, we closely collaborate with four representative audience members ('experts'). The experts' feedback on drafts of our intervention allows us to test our preliminary findings on the audience's communication preferences. This will help ensure that the content of our intervention is communicated in a way that the audience finds appealing and comprehensible (chapter 7). In the final stage of our research *(c)*, we will present our brochure and conclude to that extent the qualitative research method participatory audience analysis contributed to meeting our aim (chapter 8).

[7] This presentation is based on Verschuren & Doorewaard (2004)

Chapter 6 Evaluating an Existing text of *loveLife*

This chapter seeks to answer the first research question of part II: '*What can we learn about the audience's communication preferences by evaluating an existing Aids prevention text aimed at young South Africans of loveLife through participatory audience analysis (focus group interviews intended audience)?'* The methodological details of this evaluation will be discussed in section 6.1. In section 6.2, the results of this preliminary research are presented. Finally, in section 6.3, we will draw preliminary conclusions from these findings and give recommendations for designing a new HIV/Aids prevention text.

6.1 Methodology

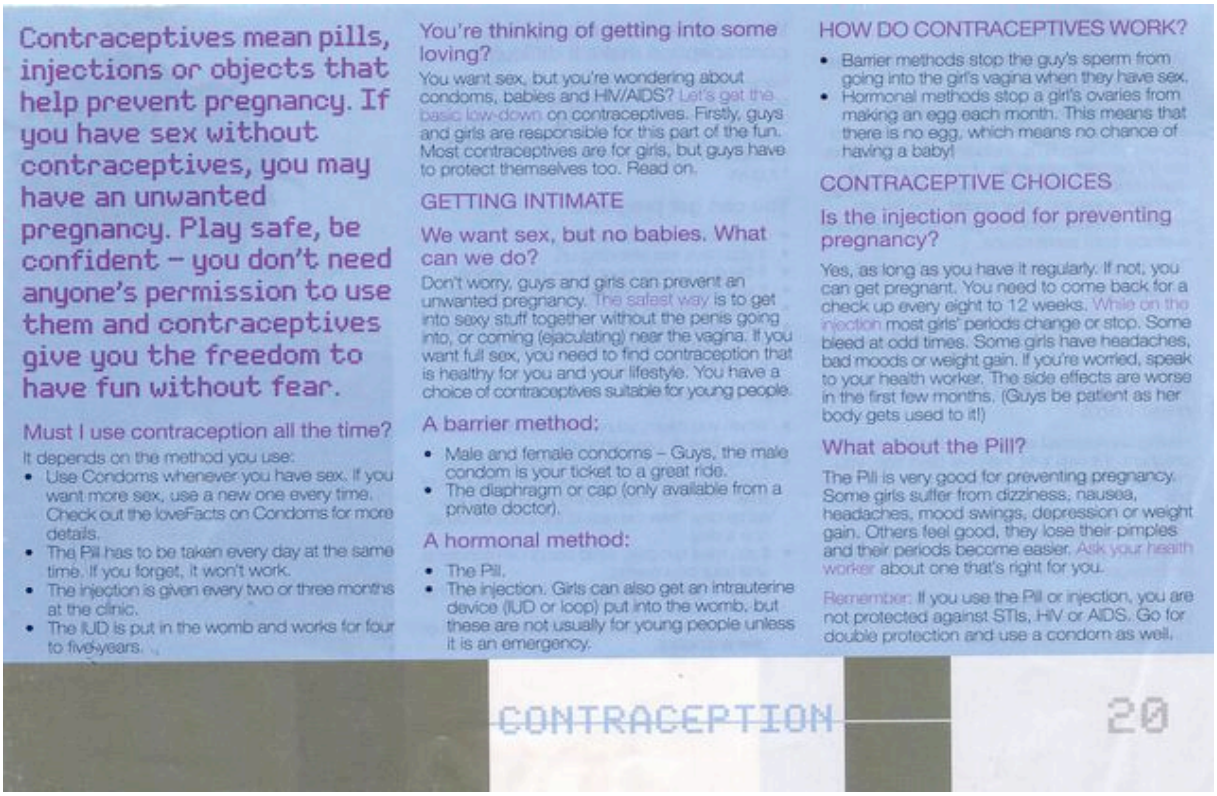
This section provides the methodological details of the evaluation of an existing HIV/Aids prevention text. Firstly, we will justify why we have chosen to evaluate this specific text. Subsequently, we will discuss the specific methodological details which refer to how we evaluated this text in the two focus group interviews.

Selecting an Aids Prevention text: *loveLife* on contraception

The text we selected, which is presented below (see fig 6.1), was written by the *loveLife* consortium. The text's focus is on contraceptive usage and is presented on pages 20-21 in *loveLife*'s LOVEFACTS-brochure According to Botha Swarts, *loveLife's* media-manager, this brochure was launched in 2000, the initial phase of *loveLife*'s founding (Swarts, personal communication, 3 June 2005). We decided to evaluate this particular text in the focus groups for the following reasons: 1) the text is aimed at a similar target audience 2) the text is based on a low-level of participatory audience analysis 3) the text has an unconventional style to communicate the content, and 4) the text's content focuses on contraceptive usage.

Our main reason for selecting this specific HIV/Aids prevention text is the similarity in target audience: *loveLife* also aims to persuade youth to use contraceptives. *LoveLife* differs in its approach since it targets *all* South African adolescents (e.g. African, White, Indian, Coloured) aged 12-17 in *all* provinces of South Africa. Furthermore, according to Swarts, *loveLife's* text has been written from the viewpoint that a *secondary audience* of parents might also read the text (Swarts, personal communication, 3 June 2005). We on the other hand, carefully selected a more homogenous audience (African South Africans aged 12-19 who live in the townships Kayamandi and Kraaifontein in Western Cape) since a more homogenous audience allows us to tailor the design of our message to the specific audience's

needs in a better way. Nevertheless, by evaluating *loveLife'*s text, we were able to investigate the degree to which *loveLife's* strategies worked well with the audience members of our intervention.



Contraceptives mean pills, injections or objects that help prevent pregnancy. If you have sex without contraceptives, you may have an unwanted pregnancy. Play safe, be confident – you don't need anyone's permission to use them and contraceptives give you the freedom to have fun without fear.

Must I use contraception all the time?

It depends on the method you use:

- Use Condoms whenever you have sex. If you want more sex, use a new one every time. Check out the loveFacts on Condoms for more details.
- The Pill has to be taken every day at the same time. If you forget, it won't work.
- The injection is given every two or three months at the clinic.
- The IUD is put in the womb and works for four to five years.

You're thinking of getting into some loving?

You want sex, but you're wondering about condoms, babies and HIV/AIDS? Let's get the basic low-down on contraceptives. Firstly, guys and girls are responsible for this part of the fun. Most contraceptives are for girls, but guys have to protect themselves too. Read on.

GETTING INTIMATE

We want sex, but no babies. What can we do?

Don't worry, guys and girls can prevent an unwanted pregnancy. The safest way is to get into sexy stuff together without the penis going into, or coming (ejaculating) near the vagina. If you want full sex, you need to find contraception that is healthy for you and your lifestyle. You have a choice of contraceptives suitable for young people.

A barrier method:

- Male and female condoms – Guys, the male condom is your ticket to a great ride.
- The diaphragm or cap (only available from a private doctor).

A hormonal method:

- The Pill.
- The injection. Girls can also get an intrauterine device (IUD or loop) put into the womb, but these are not usually for young people unless it is an emergency.

HOW DO CONTRACEPTIVES WORK?

- Barrier methods stop the guy's sperm from going into the girl's vagina when they have sex.
- Hormonal methods stop a girl's ovaries from making an egg each month. This means that there is no egg, which means no chance of having a baby!

CONTRACEPTIVE CHOICES

Is the injection good for preventing pregnancy?

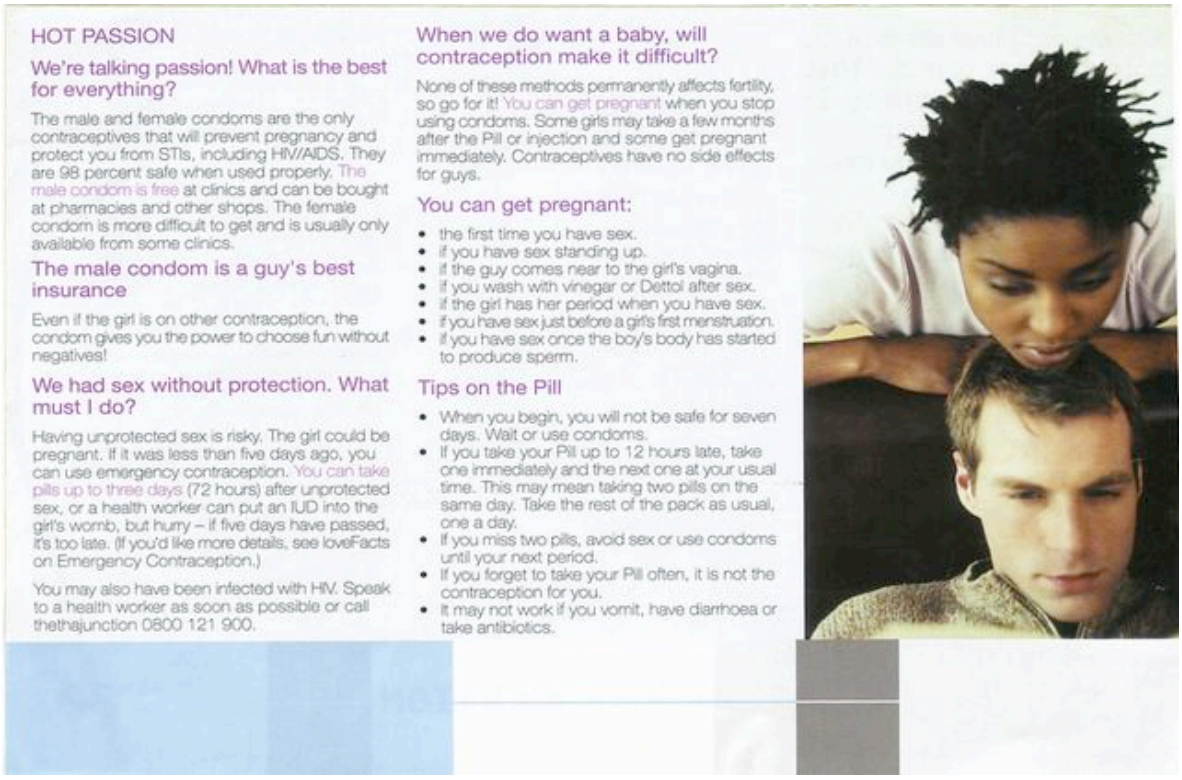
Yes, as long as you have it regularly. If not, you can get pregnant. You need to come back for a check up every eight to 12 weeks. While on the injection most girls' periods change or stop. Some bleed at odd times. Some girls have headaches, bad moods or weight gain. If you're worried, speak to your health worker. The side effects are worse in the first few months. (Guys be patient as her body gets used to it!)

What about the Pill?

The Pill is very good for preventing pregnancy. Some girls suffer from dizziness, nausea, headaches, mood swings, depression or weight gain. Others feel good, they lose their pimples and their periods become easier. Ask your health worker about one that's right for you.

Remember: If you use the Pill or injection, you are not protected against STIs, HIV or AIDS. Go for double protection and use a condom as well.

CONTRACEPTION 20



HOT PASSION

We're talking passion! What is the best for everything?

The male and female condoms are the only contraceptives that will prevent pregnancy and protect you from STIs, including HIV/AIDS. They are 98 percent safe when used properly. The male condom is free at clinics and can be bought at pharmacies and other shops. The female condom is more difficult to get and is usually only available from some clinics.

The male condom is a guy's best insurance

Even if the girl is on other contraception, the condom gives you the power to choose fun without negatives!

We had sex without protection. What must I do?

Having unprotected sex is risky. The girl could be pregnant. If it was less than five days ago, you can use emergency contraception. You can take pills up to three days (72 hours) after unprotected sex, or a health worker can put an IUD into the girl's womb, but hurry – if five days have passed, it's too late. (If you'd like more details, see loveFacts on Emergency Contraception.)

You may also have been infected with HIV. Speak to a health worker as soon as possible or call thethajunction 0800 121 900.

When we do want a baby, will contraception make it difficult?

None of these methods permanently affects fertility, so go for it! You can get pregnant when you stop using condoms. Some girls may take a few months after the Pill or injection and some get pregnant immediately. Contraceptives have no side effects for guys.

You can get pregnant:

- the first time you have sex.
- if you have sex standing up.
- if the guy comes near to the girl's vagina.
- if you wash with vinegar or Dettol after sex.
- if the girl has her period when you have sex.
- if you have sex just before a girl's first menstruation.
- if you have sex once the boy's body has started to produce sperm.

Tips on the Pill

- When you begin, you will not be safe for seven days. Wait or use condoms.
- If you take your Pill up to 12 hours late, take one immediately and the next one at your usual time. This may mean taking two pills on the same day. Take the rest of the pack as usual, one a day.
- If you miss two pills, avoid sex or use condoms until your next period.
- If you forget to take your Pill often, it is not the contraception for you.
- It may not work if you vomit, have diarrhoea or take antibiotics.

Figure. 6.1 The *loveLife* text (page 20, with the blue back ground, is the cover page)

The low-level of audience analysis in the design process of *loveLife's* text was a second reason why we decided to select this text. In a telephone interview with Botha Swarts, the text's low-level of participatory audience analysis was confirmed (Swarts, personal communication, 3 June 2005). According to Swarts, the text was developed by document designers such as *loveLife*'s CEO David Harrisson, Balk, the RHU Witwatersrand, Jonathan Stadler and several other document designers in the United States (Swarts, personal communication, 3 June 2005). This indicates that the document designers themselves were not representative members of the audience. The western document designers were all middle-aged, highly educated, and thus their frame of reference differed largely from that of the adolescent, low-literate African target audience. Swarts made it clear that the document designers had based the content and form of the text on the results of several national surveys. Moreover, Swarts stated that only a few quick pre-tests on the audience were conducted *after* the text had already been produced (Swarts, personal communication, 3 June 2005). This use of pre-testing is criticized by Schriver (1997) and referred to as 'the crash-test'. From Swarts' information, we can conclude that the document designers had no personal contact with the 'flesh and blood' members of the audience, and that audience members did not collaborate in the design process of the intervention.

Thirdly, the unconventional style of the text was another reason to select this specific text. This text on contraception displays *loveLife*'s signature style of communicating to the youth in an entertaining and positive way. The language used in the *loveLife's* text is presented in a very informal and 'cool' style. Examples of *loveLife's* informal language usage are the following:

- "We're talking passion! What's is the best for everything?"
- "Guys, the male condom is your ticket to a great ride."
- "Contraceptives give you the freedom to have fun without fear."
- "Let's get the basic low-down on contraceptives."
- "You want sex, but you're wondering about condoms, babies and HIV/Aids?"

We propose that *loveLife* has chosen to use this rather informal language in order to reduce perceptions of a social gap between the reader and the sender of the text, an effort to accommodate the target audience. When reading the text, we estimate that the audience might get the impression that a friend or someone close to them who cares about their personal

health, has taken the time to communicate to them in clear and direct terms. Within the framework of the EPIDASA-project, *loveLife's* manner of presenting the content in this informal way has been criticized. For instance, de Stadler and Jansen argued that preventing HIV/Aids might be too serious a topic to communicate in such 'slangish' terms (personal communication, February 25, 2005). In our view, *loveLife* has used this tone of voice to make the 'safe sex' message more appealing, and make it easier for the audience to understand the content. It must be pointed out that there is a risk attached to this approach. Slang evolves very rapidly and therefore 'outsiders' (e.g. document designers who are not representative members of the audience) easily risk revealing their true identity by using words that are not considered by the audience as slang. Evidently, this will have a negative effect on the sender's integrity and affect how serious the reader will take the message the sender conveys in the text.

In view of such arguing it is rather awkward that if *loveLife* indeed intended to use this informal strategy, that this strategy has been used inconsistently in *loveLife's* text. In our opinion, the text displays 'expert' authority by using complicated terminology such as the terms 'intrauterine device', 'barrier methods' and 'contraceptives'. Instead of emphasizing equality, this formal language usage stresses differences in social class between the sender and the audience of the text. We speculate that the readers will get the impression that the person who wrote this text is very knowledgeable, but not someone who understands youth living in townships (e.g. a white person doing desk research) and that the style used does not ring true. The following example illustrates terminology that we perceive as complicated for the audience:

- "Girls can also get an intrauterine device (IUD or loop) put into the womb.
- "Hormonal methods stop a girl's ovaries from making an egg each month."
- "Some girls suffer from dizziness, nausea, headaches, mood swings, depression or weight gain."

A final, fourth reason to select the particular text was the text's content. *loveLife's* text covers a large array of information on barrier methods (male and female condoms, diagraph and cap) and hormonal methods (the pill, the injection, intrauterine device, emergency contraception). Furthermore, the text's content contains basic tips on how to use contraceptives properly and it aims to correct misconceptions. Therefore, we expected that

this text would appeal to both male and female audience members. Our suspicion of poor pre-testing regarding the content of the text is displayed in the following example:

- "When we do want a baby, will contraception make it difficult?"

We wondered whether adolescents at age fifteen would really be interested in falling pregnant.

Research Design

In evaluating *loveLife's* text, we used the following pre-testing questions that derived from Moody (1995):

Variable	Pre-testing question
General first reaction	1. Do you feel like reading the text when you look at it now? [does the text attract attention] 2. Did the audience read the whole message? Or were they distracted and bored? [does the text hold the reader's attention, information density] 3. What did you think about the material you just saw?
Relevance	4. Is this message useful for someone like you?
Comprehensibility	5. Do you think the message in this text was easy to read or hard to follow? 6. What do these words mean (mention words: IUD, contraceptives, barrier method)
Appeal	7. Do you think the text is appealing? 8. What do you think of the graphic? Can you identify with it? 9. Was there anything that your friends and family would be offended by?
General suggestions	10. Do you have any suggestions you would like to make to the team who produced this text on how to improve it?

Sample

The *loveLife's* text was evaluated at the end of the two focus groups that were held for the purpose of part I. We therefore refer to part I, chapter 3 for further details on the recruitment

of the sample and the sample's characteristics and of the eight male and eight female participants that were interviewed.

Procedure

At the end of every focus group session (see part I, chapter 3 for further details on the procedure of the focus groups), participants were asked to take a brief look at *loveLife's* text. For approximately five minutes, the moderator, the author of this thesis, did not interrupt the participants, but closely observed whether the text captured the reader's interest and if the text was able to hold the audience's interest. After the participants had individually examined the text, I asked pre-testing questions 1, 2 and 3 for the variable 'general first reaction'. While the participants were looking at the text, I asked the pre-testing questions that covered the variables 'relevance' (question 4), 'comprehensibility' (questions 5 and 6), 'appeal' (questions 7, 8, and 9). At the end of the session, participants were asked pre-testing question no. 10: 'Do you have any suggestions you would like to make to the team who produced this text on how to improve it?' During the evaluation, a probing method was used to obtain additional information.

Data Analysis

The data was analyzed in a similar manner as elaborated in part I section 3.7. All focus group sessions were recorded on videotape with a camera. The recordings of the participant's verbal and non-verbal communication were then fully transcribed resulting into two protocols. These protocols verbally reflected the focus group interviews and facilitated further analysis (see Appendix C). Subsequently, we structured the answers of the participants per pre-testing question. From this overview, we could identify minority opinions and group consensus on the audience's communication preferences. In section 6.3, we present the results of the evaluation of *loveLife's* text per variable. Our focus group findings are illustrated with remarks that were made by the participants.

6.2 Results evaluation *loveLife's* text

In the previous section 6.1, we provided the methodological details on how we evaluated *loveLife's* text in the two focus groups. We explained that we first asked the participants to individually take a quick glance at the text. This way we could observe the audience's first impression of the text. After several minutes, we continued with posing our pre-testing questions. At the end of the session, the participations were asked for advice on how to improve this text (pre-testing question no. 10). In this section, we present the results of the audience's evaluation of *loveLife's* text, that is part of our participatory audience analysis strategy. *LoveLife's* text covers a large array of information on contraceptives and is based on a low-level of participatory audience. The results of the audience's evaluation of *loveLife's* text will be presented per variable. The obtained insight on the text's strengths and weaknesses will contribute to designing a text that is more likely to reflect the audience's communication preferences.

General first reaction

Most of the participants reported that they had received a negative first impression of the text. The participants stated that they did not find the text appealing and in addition, they found it rather overwhelming: 'This text does not make me interested… It is a lot of words', as said by a nineteen-year-old male in Kraaifontein. A seventeen-year-old girl stated: 'If we look at the page, people will think that it is boring.' Interestingly, none of the participants said that they had ever seen this *loveLife* text before. In our perception, this finding can be interpreted in two distinct ways: either *loveLife* failed to effectively disseminate the brochure to all high schools in South Africa, or the text was not capable of creating a long lasting impression in the participant's memory. In sum, the participants' comments made it clear that the audience is discouraged from reading a text when it contains a high information density. In other words, a text will be less effective in conveying a 'safe sex' message if the text's information density resembles the number of words per page of a regular newspaper.

Relevance

The audience is more interested in preventing pregnancy than in preventing HIV/Aids. When asked about the relevance of the topic of the text 'contraception', all of the participants confirmed that these are "the facts", and that they were curious to know the truth about contraceptives. 'It is such little things that we don't know that could determine like our whole future. So it is very much relevant', as stated by a nineteen-year-old male in Kraaifontein.

However, later in the discussion, it became clear that this 'relevance' referred to preventing pregnancy. The audience's low-interest level in preventing HIV/Aids was displayed in the following comment made by a nineteen-year-old male: 'You do not fear of other sicknesses like Aids. The only thing that we want to prevent against is getting someone pregnant.' This lack of interest in preventing HIV/Aids was also found in an exploratory interview with a sixteen year old girl (see part I chapter 3 for methodological details). The sixteen year old girl said that when ever she saw the 'red ribbon' on television, the international symbol for Aids, she would change the channel. She said that conventional HIV/Aids interventions were "depressing". Males also displayed less interest in female contraception. A fifteen-year-old male participant in Kayamandi said that he did not find the information on 'pills and stuff' relevant. As can be expected due to their personal relevance, females were more interested in acquiring this type of information.

The fact that the brochure is about sex, makes it more interesting for the participants. As stated by a fifteen-year-old female: 'For me it is interesting, because once I look at it and I see the word SEX…. Mmm, loving, mmm, so I get interested.' It is not surprising that information on sexual matters interest the audience since they are at an age in which they will sooner or later become sexually active.

Comprehensibility

In general, *loveLife's* informal language usage positively contributes to the audience's understanding of the text. When asked about the comprehensibility of the text a girl aged seventeen replied: 'It is easy to read'. However, when probed, and the definition of specific words such as 'barrier method', 'contraceptives' and 'intrauterine device' were asked, it became clear that none of the participants knew the meaning of these words. This signifies that *loveLife* failed to extensively pre-test the text, and confirms that the text is based on a low-level of participatory audience analysis.

The difficulties the participants experienced with this text can partially be explained by the audience's low level of knowledge on contraceptives and sexual matters. During the focus groups, participants stated that they had only obtained sex education in grade 8, approximately four years ago. Hence, the audience lacks a contextual frame of reference on contraceptive usage. Nevertheless, if *loveLife* would have collaborated with the audience in the design process of the text, they could have adapted the text to the audience's knowledge level and could have replaced complicated terminology such as 'intrauterine device' and contraceptives' with easier to comprehend equivalents.

Appeal

LoveLife's unconventional and entertaining way of providing information on contraception highly appeals to the audience. A nineteen-year-old male stated that the reader's interest was increased through headings which suggested sex: 'This topic brings you 'hot passion!' It's … it makes you want to ready it.' Not surprisingly, it seems that the well-known strategy in advertising 'sex sells', also appeals to young Africans in Aids prevention brochures. Furthermore, the parts of the text in which the reader was addressed personally (e.g. a question) were found to be more appealing by the participants. Such questions increase the reader's personal involvement with the topic and create a bond between the reader and the sender of the text. Headings which received the audience's approval were:

- We *want sex, but no babies. What can we do?*
- *We're talking passion! What's the best for everything?*
- *The male condom is a guy's best insurance*

All participants generally liked the latter heading 'the male condom is your ticket to a great ride'. Only one male participant, who claimed not to be sexually active, was offended by this sentence. This male participant said he disliked being addressed in this direct way since engaging in sex was his own personal business. One female was objected against the sentence 'fun without fear' that promotes the usage of 'the pill' to prevent unwanted pregnancy. 'It is not right, they [pills, SvdL] won't protect you against HIV/Aids, why are they saying that you can have fun without fear?'

The only visual in *loveLife's* text was a couple of mixed race: a White male and an African girl (see figure 6.2). We perceived this picture as rather unrealistic and political correct. When asked if the participants could identify with this couple, a nineteen-year-old male commented that: 'It is strange... I wouldn't say they are in a relationship. Maybe [the girl, SvdL] works there in this white man's house… Or maybe they are friends.' One girl stated that the picture did not add any extra appeal to the text; 'they [the couple on the picture, SvdL] are bored.' In all of the focus groups, the participants speculated that the couple portrayed were experiencing 'problems'.

Figure 6.2 *Visual loveLife*

In general, according to the participants, the visual did not complement the text. The visual failed to make the text more appealing and failed to aid in understanding of the text. Thus, the visual only created more confusion among the reader's of the text.

General suggestions

The participants offered various suggestions on how to improve the text. For instance, a nineteen-year-old male suggested making the text more visually attractive: 'The information is good, but for ja, younger people like us, they like reading things that have pictures.' Another girl added: 'If you could make maybe like make it like a little bit more fun…' These comments seem to imply that the audience does not particularly enjoy reading, that it wants to be entertained and that it is perhaps more visually orientated.

6.3 Preliminary Conclusions and Recommendations

Our findings indicate that the audience has a short span of concentration with regard to reading. Sarah Binos from the *loveLife* consortium confirmed this (personal communication, 15 June 2005), and explained that only recently did *loveLife* change the format of its UNCUT magazine into small chunks of information that are easier to digest for the reader.

	Strengths	*Weaknesses*
General first reaction		• Text fails to interest youth due to overwhelming information density • Text has a poor balance between written info and visual aids. • Text is not attractive.
Relevance	• Mixed level of interest: - 'Sex and preventing pregnancy' are perceived as very relevant topics by participants. - The audience is less interested in preventing HIV/Aids.	

Comprehensibility	• *loveLife's* positive, tone of voice is easy to understand for participants	• The text contains difficult terminology such as contraceptives, IUD, barrier methods that are not comprehended by the audience.
Appeal	• The entertaining, unconventional way in which *loveLife* tries to inform youth about sexuality and contraceptives highly appeals to youth. • Headings that personally address the reader are perceived as appealing by the audience.	• The only visual in the text fails to be appealing, since the audience cannot identify with it. • Some participants are offended by *loveLife's* direct use of language.

On the basis of this brief evaluation the following recommendations should be taken into account when designing a new text:

- Make the text more visually appealing through the use of interesting pictures
- Present the information in an entertaining way.
- Use a comprehensible tone of voice that appeals to the target audience
- Use headings which stimulate the personal involvement of the reader
- Present information in clear and easy-to-digest-chunks
- Avoid the use of unfamiliar and complicated terms
- Avoid information density, focus only on a maximum of four ideas

Chapter 7 Creating a New Text

In chapter 6, we drew preliminary conclusions concerning the audience's communication preferences based on how the audience evaluated an existing HIV/Aids prevention text in two focus group interviews. In this chapter, we seek to answer our second research question: *'How can participatory audience analysis (collaboration four representative audience members) contribute to presenting the content of the Aids prevention text in an appealing way (e.g. language, tone of voice, and form)?'* Firstly, we will discuss the methodological details on how we collaborated with four representative members of the audience ('experts') in the design process of our intervention (section 7.1). Then, in section 7.2, we will chronologically describe how the experts' input in each audience participation session led to certain design decisions. Finally, in chapter 8, we will draw our conclusions regarding the extent to which participatory audience analysis has contributed to determining the form of our intervention and we will present the product of our research in part I and part II: the final version of our HIV/Aids prevention brochure.

7.1 Methodology

The following section offers a detailed elaboration of the methodological details concerning of the audience participation sessions that were held.

Research Strategy: Feedback

In order to determine the most appropriate form for presenting the content of my intervention, I employed a feedback driven audience analysis. According to Schriver (1997), a feedback driven audience analysis is an ideal research strategy that can be used to obtain accurate, up-to- date data on the audience's communication preferences. As Schaalma et al. (2000) previously pointed out, I experienced myself first hand, that data on successful communication strategies among a particular audience are rarely documented. To the best of my knowledge, there was none empirical data available on the communication preferences of an adolescent African South African audience. Moreover, a feedback-driven research method reflected our principles of participatory audience analysis and allowed us to continuously test whether or not the audience found drafts of our intervention appealing and comprehensible. This *bottom-up approach* is expected to increase the user-centeredness of the text, which in turn is believed to increase the intervention's effect.

Participants

Three different parties participated in the design of the intervention: 1) the four experts, 2) the document designer, and 3) a graphic designer.

Experts

All four fifteen-year-old 'experts' were recruited by means of the focus group that was held in Kayamandi (see part I, chapter 3 for further methodological details). At the end of the focus group interview, I asked who would be willing to help me design an Aids prevention brochure aimed at informing their peers. Two fifteen-year-old males, and two fifteen-year-old females indicated their willingness to voluntarily participate in the project. All four 'experts' were representative members of the audience - they were students of Kayamandi high school, spoke Xhosa as a first language and English as a second language. One of the males was particularly fit to be an 'expert'. He fulfilled a position as a peer-educator at Kayamandi high school and had been trained to communicate to peers about preventing Aids. I prefer to call these four audience members our 'experts', since they greatly contributed to determining which strategies would be most effective for communicating the content of our intervention.

Document Designer

I, the writer of this thesis, was the document designer of the text. Detailed information on my background can be found in part I, chapter 3 under the heading 'moderator'.

Graphic Designer

Since I was not familiar with the design computer programme *Corell,* I collaborated with a graphic designer who worked for the center of Document Design at the University of Stellenbosch. The graphic designer was a White African female who had lived in South Africa all her life.

Procedure

This section describes how the four experts, the graphic designer, and I as a document designer, collaborated in the design process of our HIV/Aids intervention. In total, four audience participation sessions and two graphic design sessions were held, which resulted in the design of our definite intervention. All sessions took place in the period from 6 June 2005 to 22 June 2005. The four audience participation sessions were held in restaurants in the city

center of Stellenbosch. During all of the sessions, drinks and food were provided in order to create an informal atmosphere.

To increase the experts' commitment to the project, I stressed that the four representative audience members were seen as 'the experts' in communicating with their peers. Since the experts were familiar with the audience's literacy level of English, I specifically asked them to focus on any complicated terminology and language use they might perceive as being language or words that their peers might not understand. In order to establish an effective HIV/Aids prevention text, I emphasized that I highly valued the experts' honest opinions on the appeal and comprehensibility of our drafts. The general procedure during all of the audience participation sessions was that I would generate the discussion among the experts. To trigger this discussion in the first session, we re-examined *loveLife's* text on contraception. In the following sessions, the draft versions of our intervention generated this discussion among the experts. A probing and paraphrasing method was used to stimulate the experts to provide more information and clarify their evaluation of the drafts. At all times, I took care not to obstruct the natural interaction between the experts, but instead I would first listen closely and observe the experts' responses during all of the audience participation sessions. In my opinion, the interaction between the experts and me helped generate more ideas on how to effectively present the content to the audience.

In total, the experts commented on three drafts. In our first audience participation session we brainstormed over strategies for effectively communicating our intervention to the audience. I implemented this insight into a *first draft* that was printed on two A4 pages. This first draft presented examples of sentences that we had perceived as appealing when communicating the content of our intervention to the audience. After the second audience participation session had ended, I drew a first hand-made sketch of the text's layout in which the experts' feedback had been implemented. In order to facilitate the mass production of our intervention at a later stage in the design process, the graphic designer subsequently helped to translate this sketch into the computer programme *Corell*. This *second draft* was formatted in black and white. After the third audience participation session had ended, the graphic designer again assisted me in implementing the experts' adjustments and recommendations into a full-color *third draft*. This third draft was printed at a copy center on half an A3 sheet. When folded, this resulted in a four-page illustrated brochure. In the fourth audience participation session, the experts commented on the brochure's visuals, the brochure's color scheme and the brochure's layout.

After the fourth audience participation session had ended, two experts helped by taking pictures that illustrated the correct usage of the male condom. Two other representative members of the audience gave advice on the most appealing picture for the cover of the brochure. Before printing the definite brochure of our intervention at the copy center, a native speaker of English checked the grammar and spelling of the intervention. Minor typing errors were rectified at the copy center.

Analysis of the Data

This section describes how we analyzed the experts' feedback during the audience participation sessions and how we implemented the expert's input into draft versions of our intervention. We minimized the risk of a subjective, culturally biased interpretation of the data since the experts provided direct feedback on the appeal and comprehensibility of draft versions of our intervention. As previously mentioned, all four experts were representative members of the audience. In order to establish a first draft on which the experts could comment, we used a triangulation method. Hence, our first draft was based on the following sources: 1) the defined objectives for the content of our intervention in part I, 2) our preliminary findings on the audience communication preferences, and 3) the experts' recommendations for communicating to the audience obtained in the first audience participation session.

After each audience participation session ended, brief notes were jotted down concerning the experts' feedback (see Appendix F). In order to secure a cumulative improvement for our intervention, each new draft incorporated all of the experts' recommendations from the previous draft. For drafts two and over, most of the experts' feedback was immediately corrected on the draft itself. In this later stage in the design process, the experts primarily focussed on adjusting the language, the layout and visuals of our intervention. It should be pointed out that the experts' feedback found on drafts would only led to a specific document design decision if the remark had been supported by at least one other expert. This was done in order to increase the extent to which our definite intervention would reflect the audience's communication preferences. In section 7.2, we extensively describe the chronological design process of our intervention. Per audience participation session, the experts' feedback on draft versions of our intervention will be marked with a bullet point (•) per sentence or passage. This way, we can clearly illustrate how the usage of participatory audience analysis has contributed to the design process regarding the form of our intervention.

7.2 Results Collaboration Audience Members

In section 7.1, we provided the methodological details on how the three different parties cooperated in the design process of our intervention: 1) the four 'experts' (two males and two females from the township Kayamandi with an average age of fifteen who were representative members of the audience) 2) the document designer (the writer of this thesis) and 3) the graphic designer (who worked for the center of Document Design at the University of Stellenbosch). We explained that as part of our participatory audience analysis approach, four audience participation sessions were held in which the four experts commented on the draft versions of our intervention. After each audience participation sessions ended, notes were made of the experts' feedback and their input was implemented in a new draft. The graphic designer assisted the document designer twice with the designing the draft versions for our intervention in the computer programme *Corell.*

In this section, we focus on how the experts' input determined the appropriate form (e.g. style, language, tone of voice) for presenting the content of our intervention to the audience. To illustrate the experts' contribution, we chronologically describe the design process and the experts' input from the first to the final audience participation session. From audience participation session two and thereafter, the experts' feedback is shown per draft version. Each session ends with brief recommendations we made for a new draft. In chapter 8, we will finally present the product of our participatory audience research: the final version of our HIV/Aids intervention.

Audience Participation Session 1: Determining content and form of our intervention

Based on our research in part I, we selected four determinants that we recommended to be emphasized in the content of our intervention (see section 5.2 for a detailed elaboration). For each of these four determinants, we set up objectives that specified the message that we aimed to communicate to the audience. By setting up clear objectives, we were able to benefit from more guidance in the design process of our intervention, since we could continuously check whether our drafts indeed reflected the recommended content.

The purpose of the first audience participation session was predominately to check whether the experts supported our decision with respect to the content of our intervention. Secondly, the experts were asked for their advice regarding which medium would be the most appropriate for communicating this message to the target audience. This feedback was vital in order to ensure that our intervention would satisfy the audience's information needs and communication preferences. We stimulated the discussion on these topics by taking a second,

more in-depth look at *loveLife's* text on contraception (see section 6.1 for more details on this text.)

Content

The experts supported our decision to focus on three of the four determinants in the content of our intervention. The only determinant that was not pointed out by the experts as a topic for our intervention was the determinant 'attitude towards sex'. Nevertheless, in both of the focus groups which were held for the purposes of part I, the audience's interest in the 'right age to engage in sex' was clearly displayed. Moreover, research in the Netherlands has shown that youth who harbour a negative attitude towards sex, and experience feelings of guilt about being sexually active, are less likely to consistently use contraceptives (Rademakers, 1991, as cited in Terpstra, 2002; de Graaf et al., 2005). Thus, it seemed evident to address the determinant ' attitude towards sex' in our intervention. We will now elaborate the experts' input for the determinants: 1) attitude towards the male condom 2) knowledge, and 3) sexual negotiation.

Firstly, all of the experts supported the decision to focus on the determinant 'attitude towards the male condom' in our intervention. In section 5.2 of part I, we noted that the male condom is one of the few interventions that protects against HIV/Aids. Moreover, we argued that the usage of the male condom is supported in youth's environment, as male condoms can easily be accessed at a large array of venues. The experts also supported our third argument to promote the usage of the male condom: when a female partner uses a hormonal contraceptive, condom usage tends to stop, as we found in our research in part I. Therefore, we did not want to promote the usage of these hormonal contraceptives since the youth who use these contraceptives would be more susceptible to HIV/Aids. In addition, a female expert stressed the necessity to use a male condom by stating: 'Your boyfriend will not always stay with you and it is best to protect yourself against HIV by using the male condom.' Her remark emphasizes that 'stable' relationships have a serial monogamous character, increasing the risk of HIV/Aids.

'Knowledge' is the second determinant that we recommended to focus on in our intervention. In the focus groups we found that although the members of the audience are keen to remark "use a condom" when they are asked about ways to prevent HIV/Aids and unwanted pregnancy, they lack the fundamental knowledge on how to use condoms correctly. It is clear that without this correct knowledge, the audience is not capable of making a healthy, well-informed sexual decision. The experts confirmed the need to provide correct

information concerning the usage of the male condom, and stressed to anticipate on false preconceptions. The *loveLife* text we briefly evaluated did not deal with the specific myths held by the audience as we had found in our research in part I (e.g. condoms can be too small, and using two condoms at the same time for extra protection). Furthermore, we aim to inform the audience about emergency contraception. In our focus groups we found that the audience was not aware that emergency contraception can be used as a relatively safe, and easy form of contraceptive to prevent unwanted pregnancy. This knowledge regarding emergency contraceptives might reduce the astronomically high pregnancy rate among members of the audience.

The third determinant the experts confirmed that should be emphasized in our intervention was 'sexual negotiation'. A frequently reoccurring question in the focus groups was: 'How do you convince your partner to use a condom?' The experts also advised that we provide strategies in the intervention which dealt with (peer) pressure to engage in sex. We will now continue with the experts' recommendations concerning which form our intervention should take.

Form

The audience wants to be entertained. This is the key notion the experts emphasized with respect to the audience's communication preferences. The experts' recommendations on how to present our 'safe sex message' to the audience can be summarized in the following three strategies: 1) present the information in a visually attractive way 2) use a comprehensible, appealing tone of voice 3) put the information in positive way.

Firstly, the experts' remarks indicated that they were not of the opinion that a text was a preferred medium for communicating to the audience. For instance, when we asked the experts what they perceived as an appropriate medium for conveying an Aids prevention message to their peers, the experts mentioned *oral* strategies such as performing a play on HIV/Aids, or organizing a festival with free food and a famous DJ to promote safe sex. Unfortunately, time and money constraints prevented us from transforming these ideas into reality. This result confirms our focus group findings on *loveLife's* text in which the participants said they were "turned off" by a text that contains a high information density. Nevertheless, an important advantage of written educational material over other channels of communication is that the material can be taken home and can be re-examined at a later, more convenient point in time (Schriver, 1997). To conclude, it seems that the audience is more visually-orientated, and the information should be put in a visually attractive way.

Secondly, despite the fact that our focus group findings indicated that the audience has a low literacy level of English (e.g. most of the participants were not even familiar with the word 'contraceptives'), the experts stressed that English was the most appropriate language to address the audience. According to the experts, their peers were more proficient in reading and writing in *English* than in Xhosa. It seems that Xhosa, the audience's mother tongue, is merely used as an oral language. This was confirmed by Phumlani Sibula, who accompanied us as a interpreter of isiXhosa during the focus group sessions, and who had previously worked as a teacher of Xhosa at Kayamandi High School (personal communication, June 2005). Since the experts indicated that they were highly interested in American Popular Culture (e.g. soaps, and MTV: Music Television aimed at youth), and their use of English reflected the slang used in such programmes, we decided to communicate the content of our intervention in the audience's slang. We believe that this use of informal language will increase our intervention's effect since it diminishes the perception of a social gap between the reader and the sender of the text. We speculate that perceptions of inequality in social class between the reader and the sender of the text might hinder the audience in accepting the message conveyed. Most importantly, this use of language was found to be more appealing and easier to understand for the audience.

Thirdly, the experts' comments made it clear that the HIV/Aids information should be put in a positive way. In the exploratory interviews in part I, a sixteen-year-old girl stated that she found the conventional HIV/Aids messages "depressing" and unattractive. Whenever she was confronted with the red ribbon (the international symbol for Aids), she would change the television channel or she would avoid looking at the prevention material. This is not surprising, considering the fact that during the past decade youth has been bombarded with governmental HIV/Aids interventions. Most of these interventions were based on the premise that scaring youth with facts on HIV-risk would change youth's unsafe sexual practices. Recently, *loveLife* took on a new approach in which a *positive lifestyle* is promoted to the youth. Through this 'positivism', *loveLife* aims to increase youth's feelings of personal control and their sense of purpose in life, and promote a positive attitude towards life in general (Harrison & Steinberg, 2002). According to Mathur et al. (2001), youth who have a clearly defined perspective of their future will be more motivated to use contraceptives consistently so as to achieve that goal (as cited in Pettifor et al., 2004).

Audience Participation Session 2: Feedback first draft

After the first audience participation session had ended, the document designer translated the experts' recommendations for the content and form into a first draft of our intervention. This first draft consisted of two pages with examples of sentences (see Appendix E for full text). These sentences were proposals of strategies for communicating our defined objectives for the content of our intervention to the audience (see section 5.2 for a detailed elaboration). For instance, for the determinant 'attitude towards sex', we had set up the objective: 'acknowledge that it is not realistic to imagine that youth are never going to have sex.' To meet this objective, the following sentence was formulated in our draft: 'The best protection is no sex, but it is probably not realistic to imagine that you're never going to have sex'.

Now, in presenting the experts' feedback on the sentences and passages of our first draft, a bullet point (•) will be used to mark the experts' input. In this way, the experts' contribution to the design process of our definite intervention can be clearly displayed. For the more complex passages, we will first briefly explain our underlying motivations and point out how the passage is connected to the determinant that we selected.

Title: 'You can easily avoid getting HIV/Aids & pregnancy'

- The experts suggested that the term 'avoid' in the title should be replaced with 'prevent'. 'Preventing' is a verb that is more commonly used in combination with the nouns HIV/Aids & pregnancy.

Text under title: 'Sex is great, but it is not worth your life (…) never going to have sex.'

- All experts approved the sentence that stated: 'The best protection is NO SEX, but it is probably not realistic to imagine that you're never going to have sex'. This sentence was written in order to meet objective no. 1 for the determinant 'attitude towards sex'.

Graph that displays risks' attached to various sexual acts

To meet objectives 3 and 4 for the determinant 'knowledge', we established the following 'risk meter graph' that visually summarizes all of the important information on risky sexual behavior (see figure 7.1). The graph's heading states: 'Where do you lie on the risk meter?' By addressing the reader personally by posing this question, we aimed to increase the reader's involvement with the text. For clarity's sake, we intend to display the graph's four different zones in four different colors in the final version of our brochure.

Where do you lie on the risk meter?			
NO RISK	LOW RISK	MEDIUM RISK	HIGH RISK
• No sex • Masturbation • Kissing • Hugging	• Mutual masturbation	• Oral sex • Vaginal sex with a condom • Anal sex with a condom	• Vaginal sex no condom • Anal sex no condom • Sharing razor blades, needles • Sex with multiple partners

Figure 7.1 *Risk Meter Graph*

The most dangerous of all four zones is the 'high risk' zone. In this zone, we mentioned 'sharing razor blades'. According to Ngcobo, an African student from Kwazulu-Natal who was at the time studying at Stellenbosch University, few African adolescents know that sharing razor blades increases the risk of contracting HIV. Ngcobo pointed out that brothers often use the same razor blade for shaving, not being aware of the HIV-risk attached to this use (Ngcobo, personal communication, May 2005). In the graph, vaginal sex with a condom and anal sex with a condom were displayed as 'medium risk'. In the focus groups it became clear that the audience lacks fundamental knowledge on the proper way to use a condom. This detrimentally affects a condom's protective power. Moreover, even when condoms are used properly, there is a 2% risk attached that the condom will fail to protect against HIV/Aids and/or pregnancy. In the 'no risk zone', we described the term 'abstain' with 'no sex'. We avoided the use of the term 'abstain' in our intervention due to the negative association attached to South Africa's old governmental, "ABC" campaign, that primarily focuses on promoting abstinence. We will now review the experts' feedback on this risk meter graph:

- The experts indicated that in the high risk zone the meaning of the words 'vaginal sex no condom' and 'anal sex no condom' were not clear. The experts suggested changing this into for instance, 'vaginal sex without a condom'.
- The experts stated that 'mutual masturbation' was a term used in the risk meter graph that the experts and their peers were not familiar with. The experts suggested that this should be replaced with a term that describes the behavior.

Quote: 'Choosing not to have sex doesn't mean you never feel horny!'
We defined this quote mentioned above to reinforce the message that is conveyed on this first page. In our next draft, we would like to state such one-liners at the bottom of every page.

- The experts suggested replacing the term ‘horny’ with the term ‘sexy’ in the above-mentioned quote. According to the experts, ‘horny’ was not a term that exists in the audience’s vocabulary.

Heading of the first passage: ‘What’s the right age to have sex?’

The first passage covers the objectives for the determinant ‘attitude towards sex’. In the focus groups it became clear that the audience is highly interested in knowing ‘the right age to have sex’. In our text we aim to acknowledge that for most of the youth, abstinence is probably not a realistic strategy for preventing HIV/Aids and pregnancy. This was confirmed in the findings we obtained from the questionnaire that was given at the end of the focus groups in part I: seven out of eight male participants (87.5%) self-reported to be sexually active and three out of eight female participants (37.5%) self- reported to be sexually active. In our opinion, solely promoting abstinence fosters a taboo surrounding sexuality. This taboo is connected to experiencing feelings of guilt about being sexually active, which in turn is proposed to have a detrimental effect on youth’s contraceptive usage (Rademakers, 1991, as cited in Terpstra, 2002; de Graaf et al., 2005). Therefore, we aim to discuss sexuality in an honest and open way in our intervention, and offer tools to the youth in order to make a safe, healthy and well-informed decision.

- The experts said the heading ‘What’s the right age to have sex?’ was “too boring”. Alternative sentences suggested by the experts were: ‘What’s the right age to be gettin’ it on mommy?’ or ‘What’s the right age to be gettin’ your freak on!’ We agreed on the heading: ‘What’s the right age to get your freak on?’
- The experts agreed with our strategy to promote masturbation as ‘the safest way to have sex’ in this passage. In the preliminary investigation it became clear that many African males experience difficulty controlling their sexual urges, and that sexual coercion is seen by males as ‘culturally appropriate practice’ (Varga, 1997). In our intervention, we promoted masturbation as a strategy to deal with lust without the risks attached to intercourse, and without being dependent on other individuals for satisfying personal sexual urges.
- The experts were not familiar with the western sms symbol **‘ ;-)**’, used to simulate a person blinking in this passage. This can be explained by the fact that most of the audience members do not have the financial funding to own a cell-phone. The experts suggested that it should be left out since it would be confusing for their peers.

Heading of the second passage: 'I feel shy talking about condoms.'

This passage was aimed to cover the objectives for the determinant 'sexual negotiation'.

- Experts did not like the heading 'I feel shy talking about condoms'. They said that this was not 'manly' enough, and their male peers would never say this. They suggested changing the text and stating something such as 'My guy prefers flesh on flesh, how do I convince him to use a condom? Or: 'Many guys prefer flesh on flesh, but …'
- In the body of the text it originally stated 'Avoid arguing when both of you are feeling hot and passionate'. The experts advised to change 'hot and passionate' into the audience's slang: 'feel like rolling it on!'
- In the following sentence 'If your partner doesn't trust you, it could mean that he or she doesn't truly care for you or has something to hide'. The words 'truly care' did not occur in the expert's vocabulary, the experts suggested replacing it with 'give a damn'. The document designer found this rather direct, and gave it some thought.
- According to the experts, the word 'complain' should be replaced with the slang term 'whine' in the sentence 'Many people who complain about condoms have never even tried them.' The experts said that they like this strategy to motivate youth to use condoms.

Heading of the third passage: 'We're talking hot passion! What's the best for everything?'

This passage predominantly deals with the determinants 'knowledge' and 'attitude towards the male condom'. The second part of the heading, the question 'What's the best for everything?' is to the point. This question signals to the reader that this passage covers information on the best way to protect oneselves against HIV/Aids and unwanted pregnancy.

- All of the experts liked the above-metnioned heading. This was also found in the focus groups in which we evaluated *loveLife's* text.
- One expert suggested changing the sentence: 'No matter how well you know, trust and love your partner' into: 'Love them all, but trust no one'. This sentence covered objective no. 2 of the determinant 'sexual negotiation'. However, the document designer perceived the expert's suggestion as a little too harsh.
- The experts pointed out that we should add that female condoms can be bought at the pharmacy or chemist to this passage.

Heading of the fourth passage: ‘Ok, I heard about condoms. What are the facts about PROPER use?’

- The experts advised changing the sentence ‘What are the facts about proper use?’ into: ‘But what’s the proper way to use them?’
- One expert pointed out that ‘check the expiry date’ should be added to the list of things to do before using a condom.

Heading of the fifth passage: ‘Help, we’re desperate! We had sex and did not use a condom – am I pregnant?’

- All of the experts approved of this passage.

Recommendations for second draft

A general recommendation the experts made in this second audience participation session, was to visually illustrate the correct usage of the male condom. The experts suggested that a human being or a cartoon in a picture story should be displayed who would demonstrated how to use a condom. The experts recommended to statements such as ‘First things first’ should be used and bullet points such as how to open the package ‘no nails’, etc. The experts indicated that in their townships people even use scissors and knives to open the package, because they do not know that they should tear the curved part of the package in order to open the package correctly. This is connected to our objectives for the determinant ‘knowledge’. The experts also stressed that the text should contain facts which include comments such as ‘a condom is never too small’ and ‘condoms do not take away sexy feelings’. These suggestions are connected to the determinant ‘attitude towards the male condom’.

Audience Participation Session 3: Feedback second draft

Based on the feedback of the experts in these two sessions, the document designer drew a first sketch of the text’s layout (see figure 7.2 below for details of sketch). A graphic designer helped to translate this handmade sketch into the computer programme *Corell.*. In this way, we could eventually print our final brochure at the copy center.

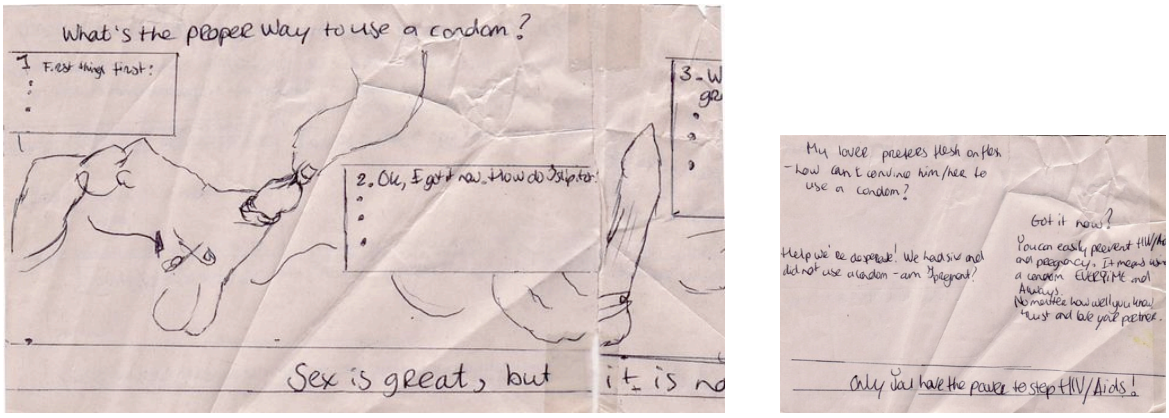


Figure 7.2 *Details of Sketch*

In the third audience participation session, the audience commented on a formatted black and white draft that was made by using the computer programme *Corell.* The experts' feedback on this third draft is systematically illustrated from the drafts' cover to the back page of our text. Again, we will first elaborate our motivations for the more complex passages, and display the experts' feedback after the bullet (•).

Cover-page

Title: 'You can easily prevent getting HIV/Aids & pregnancy'

- The experts pointed out that the title 'You can easily prevent getting HIV/Aids & pregnancy' was not appealing. According to the experts, their peers would not be interested in reading this text as it immediately signified that the text dealt with 'HIV and Aids'. In a following audience participation session, we will have to find a more catchy title.

Heading of the first passage: 'What's the right age to have sex?'

- The experts helped define a description for masturbation. We agreed on: 'sexily touching your penis or vagina for pleasure'.
- The experts disliked the sentence: 'Why not wait until you're sure that this relationship will last and is not just a moment of pleasure?' One of the experts suggested the following alternative: 'You're body might look ripe and ready for a ride, but it's not ready to risk its future for a moment's pleasure!' This sentence has a certain appealing rhythm to it, and captures the essence of the text.

Heading of the second passage: ‘We’re talking hot passion! What’s the best for everything?’

- One of the experts indicated that, the acronym STD’s (sexually transmitted diseases) are commonly referred to in South Africa as STI’s (sexually transmitted infections). Therefore we replaced ‘STD’s’ by ‘STI’s’.

Statement of the first page: ‘Choosing not to have sex does not mean you never feel sexy!’ The above-mentioned one-liner intends to reassure youth who are delaying sexual intercourse that they are perfectly normal. For those youth who have experienced peer-pressure, we believe that this statement will reinforce their view that they are making a healthy sexual decision. The statement acknowledges that a person can feel sexually aroused, but deliberately decide not to engage in sex. This one-liner is connected to the determinant ‘attitude towards sex’.

- The experts said that this was the best statement for the first page.

Center-page

In the center-fold of the brochure, four numbered text blocks are displayed which provide a step-by-step explanation on how to use the male condom. A separate text box on the right-hand page of our brochure states ‘reality about condoms’. This text box corrects myths and preconceptions among the audience. Per text block, three information bullets are presented which give key information points that should be taken into consideration. We limited the number of information bullets to three, because our participatory audience analysis findings indicated that too much information can be perceived as being overwhelming to the audience. This might inhibit the main message from coming across. In our next draft, we intend to illustrate each of the text blocks on condom usage by showing six visuals. These six visuals are intended to communicate a condom demonstration for people who do not feel like reading the text or who experience literacy barriers.

Text box 1. First things first:

In the focus groups of part I, we found that the audience has a negative attitude towards carrying a condom in their purse. We tried to combat this attitude by strengthening the association between ‘loving’ and ‘using condoms’. This is illustrated in particular in the underlined part of the sentence: ‘Be sure that you always have a condom in your purse (you never know when you’ll get some loving)’.

- With respect to the proper way to use condoms, the experts suggested that it should be explained that you should never put condoms in a warm place. You should keep condoms below 25 ° Celsius, since keeping them in a warm place has a negative effect on the condoms lubricant.
- The experts suggested that the first text-box should be illustrated with a picture of someone who looks at the expiry date and a person who opens the condom's package.

Text box 2. Ok, I got it now, But how do I slip it on?

- The experts gave their approval on the heading of the second text box 'Ok, I got it now. But how do I slip it on?'
- The experts advised changing the word 'partner' in the second text box into 'lover', as this the term 'lover' is more appealing and sexy according to the experts.

Text box 3. What to do for a great, safe ride:

When we evaluated *loveLife's* text in the focus groups, we found that the majority of the participants thought the sentence 'Guys, the male condom is your ticket to a great ride', was very appealing. The sentence was our source of inspiration for the heading of text box 3.

- The experts agreed on the above-mentioned heading of the third text box.
- According to the experts, the audience are not interested in a 'scientific' explanation of why condoms can break. Initially, the first bullet stated: 'Don't use two condoms over each other (friction of latex on latex will make them BREAK!). The experts said that their peers were not familiar with terms such as 'friction of latex on latex', and the sentence would only lead to confusion. Moreover, the experts noted that their peers would appreciate it more if the text only provided plain information on how to prevent HIV/Aids and unwanted pregnancy. This illustrates how we were biased by our 'academic mindset' of always wanting to know the reason behind a certain cause. The experts advised changing 'friction of latex …' into the simple: 'it will make them break!'
- The experts suggested adding the word 'guys' to the beginning of the sentence of the second bullet. Hence, in the next draft it will state: 'Guys, never re-use a condom and ALWAYS use a new condom when you're ready for some extra loving'. This increases personal relevance, since the reader is personally addressed.
- The third bullet initially stated: 'If you lose your erection (after you have come), hold the ring of the condom with your hand and pull it out (otherwise it can slip inside your lover).' The experts stated that this use of language was too formal. Not many peers were

familiar with the terminology ‘erection’. Therefore, they suggested changing it into: ‘After getting heavy, (and after you have come).’ For clarity purposes, ‘otherwise it can slip’ was changed into ‘otherwise the condom can slip’.

Text box 4. What to do after getting heavy:

- The fourth text box (no 5 on the paper) stated: ‘What to do after getting heavy.’ After brainstorming, we agreed to change this heading into: ‘What to do after arriving alive’. The discussion with the experts generated the concept of ‘arrive alive’. We will elaborate this further in the recommendations presented at the end of this audience participation session.
- The third bullet of the fourth text box stated: ‘Put it in a tissue and throw it away!’. The experts heavily criticized the content of this sentence. In the Netherlands, it is always stressed to throw used condoms in the garbage container. The experts said that they had seen a two-year-old girl on the streets who was chewing on a used condom she had found in the trash. The expert, who was a peer-educator, said he was told to throw condoms in the toilet. The bullet was therefore changed into: ‘flush it down the toilet!’

Text box 5: The reality about condoms:

This text box was aimed at correcting misconceptions on condom usage. The determinant ‘attitude towards male condom’ was addressed in this text box.

- The experts agreed on the content and style of the above-mentioned text box.

Quote: ‘Sex is great, but it is not worth your life!’

The experts said that they liked this quote. This quote on the center-page of the intervention was aimed at motivating the youth to delay sexual intercourse, or to use condoms when they do engage in sex.

Back-page

Heading third passage: ‘My lover prefers flesh on flesh – how can I convince him/her to use a condom?’

- The experts liked the first anecdote: ‘my lover prefers flesh on flesh – how can I convince him/her to use a condom?’

Heading fourth passage: Help, we're desperate! We had sex and did not use a condom - am I pregnant?

- With respect to the second anecdote ('Help, we're desperate! We had sex and did not use a condom – am I pregnant?'), the experts pointed out that the text should add the recommendation to 'go for an HIV test'. When the document designer asked the experts whether on ART should and antibiotics should be added, the experts replied that this information would make the content too complicated for the audience.

Determining a quote for the back page.

- The experts advised that we use the quote 'Only YOU have the power to stop HIV/Aids' for the back page. This quote reinforces youth's personal responsibility to use condoms in order to prevent HIV/Aids transmission.

Recommendations for third draft

The discussion on the visual condom demonstration generated the 'arrive alive concept'. 'Arrive Alive' refers to the South African governmental campaign to fight the mindset that driving under the influence of alcohol is socially acceptable. In our intervention, we will link the 'ride' which was displayed in *loveLife's* text 'guys, the male condom is your ticket to a great ride' to the act of sexual intercourse. The text will point out to the reader that in order to 'arrive alive', condoms should be used correctly and consistently when engaging in sex.

According to the male expert who was a peer-educator, most prevention material does not show the reader how to unroll a condom. The male expert said that he had learned that it was best to put your index finger in the condom and hold the upper part. According to the experts, most participants were not familiar with the term 'index finger'. Therefore, the experts suggested to change it into: 'Put the finger that you point with in it'.

Audience Participation session four: Feedback third draft

We were aware that in order to capture a potential reader's interest, the brochure had to look professional, as if the brochure had been designed by an acknowledged Aids prevention organization such as *loveLife*. Therefore, our third draft was printed on two sides in full color at a copy center on half of an A3 sheet. When folded, this resulted in a four-page brochure. In the fourth audience session, we investigated whether the experts liked our brochure's visuals, the brochure's color scheme's and the brochure's layout. We will first explain why we have

chosen the specific appearance of our brochure. Then, we will present the experts' feedback on this last draft in a similar manner as in the other session.

Overall appearance of the brochure

The cover page of our brochure has a pink background, the center pages have a yellow background, and the back page of our brochure has been presented in blue. To create a coherent style, our brochure is consistently composed of these three colors. All headings of the text are printed in white, which makes them standout against the colored background. Only the heading on the yellow center pages ('Arrive Alive: What's the proper way to use a condom?') was printed in pink to facilitate readability. Words in the text that require emphasis are consistently printed in white. For instance, in order to attract the reader's attention, we printed the text 'READ ON!' on the cover page in white. At the bottom of every page, there is a white box, which contains a statement in the same color used as the background of the page. For instance, on the cover-page this sentence states in pink: 'Choosing not to have sex does not mean you never feel sexy'.

Cover-page

Title: Ripe and Ready, but worth the Risk?

- The experts said that our new title mentioned above was an improvement compared to our previous title: 'You can easily prevent getting HIV/Aids & pregnancy.'

Graph: risk meter

As we can see in this full-color draft, the heading of the 'risk meter graph' states in yellow letters against a black background: 'Risk of Getting HIV/Aids' (see figure 7.3).

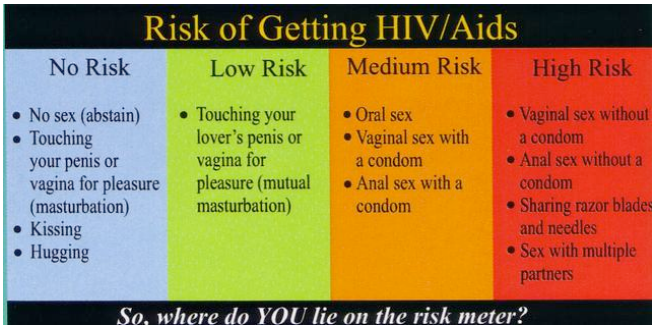


Figure 7.3 *Risk Meter Graph*

We have chosen to display this in black and yellow as this is a classical combination for displaying danger (e.g. leopard, wasp). In the graph, the four danger zones of sexual behavior are placed on a color continuum that ranges from red to orange, to green and to blue.

The most alarming zone ‘high risk’ is displayed in red, and the ‘no risk’ zone is displayed in blue. Under the graph, a sentence in white letters displayed in a black box states: ‘So, where do YOU lie on the risk meter?’ By addressing the reader personally, we aim to create a sense of interactivity and stimulate the reader to reflect on his or her personal risk of contracting HIV.

- The experts advised us not to place this risk meter graph on the cover page. Initially we presented this graph on the cover page, because the graph visually summarizes all of the important information regarding the risks attached to sex. According to the expert, this graph makes the cover less appealing and ‘scares’ the readers. All of the experts suggested that the back page was the best place for this information. After brainstorming, we agreed that we would guide the readers to the back page in our next draft by means of an arrow and the text ‘Check your risk of getting HIV/Aids on the back page! ’

Center-pages

Visuals

Figure 7.4 *Visuals Condom Demonstration*

- All experts indicated that they did not like the pictures presented above in figure 7.4 of the condom demonstration. The experts said that the pictures were unclear and not appealing. Only the first picture that illustrated the expiry date on the package of condom was clear, according to the experts. The document designer had downloaded these pictures from the internet. Originally, the pictures illustrated the hands of a white person, but I manipulated this skin color in Photoshop.

Text box 1. First things first:

- The experts said that ‘scissors’ should be added to the sentence: ‘Don’t rough it opening the package: never use your teeth and watch out for those sexy long nails’.

- The experts suggested placing the text ‘EXP.DATE’ after the bullet point ‘always check the expiry date’. This is in accordance with how the text occurs on the package of a real condom.

Text box 2. Ok, I got it now, But how do I slip it on?

- The second text block did not contain any bullets, which was a typing error. The experts mentioned that the part ‘roll it all the way down boy’ should be displayed in white to give more emphasis to the text.

Text box 3. What to do for a great, safe ride:

- According to the experts, the sentence: ‘hold the ring of the condom with your hand and pull it out’ of this text block was unclear. The experts advised changing this into ‘hold the ring of the condom with your hand while you pull your penis out’.

Text box 4. What to do after arriving alive

- The experts mentioned that we should add in this text block that fingers can transmit semen (thus the virus) and underline the fact that youth should avoid contact between the vagina & semen on the penis and fingers. Therefore, we changed the sentence into:s ‘Hold the ring tight with your hand so it won’t get lost inside your lover and gently pull it out (avoid contact between the vagina and semen on the penis or fingers).

Text box 5: The reality about condoms:

- In the text box ‘the reality about condoms’, a typing error was erased. The sentence: ‘It’s crap that a condom is too small guys!’, was changed into: ‘It’s crap that a condom can be too small guys!’.

Back-page

Visual

We downloaded the visual presented in figure 7.5 from the internet of an African couple that was lying on the bed.

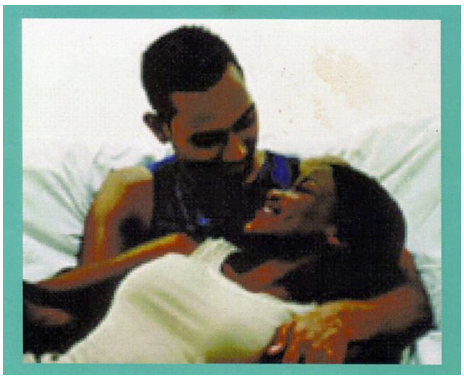


Figure 7.5 *African Couple*

- The experts disliked this visual of the couple on the back-page. According to the experts, the picture was not "sexy" enough. The experts said that the picture resembled a couple that were planning their week-schedule. The experts suggested to present a picture of a kissing couple on the cover (instead of the graph).

Heading third passage: 'My lover prefers flesh on flesh – how can I convince him/her to use a condom?'

- The experts suggested that instead of printing the words 'before you start' in white, we should only print the word 'before' in white.

Heading fourth passage: Help, we're desperate! We had sex and did not use a condom am I pregnant?

- The participants mentioned that for extra emphasis the word 'morning-after pill' should be printed in white in this passage.

Summary: Got it now?

In three catchy sentences, the main message of the brochure is repeated on the brochure's back page. This was done to make this main message more accessible in the reader's memory, and to increase the reader's comprehensibility of the message.The text states: 'Got it now? You can easily prevent HIV/Aids and pregnancy. It means using a condom every time. No matter how well you know, trust and love your partner.'

- The experts pointed out that to emphasize that condoms should be used consistently, the words 'and always' should be added after 'every time'.

Creating our fourth draft

In designing our definite draft we still had to determine the following: 1) an appropriate picture for the cover page, 2) an appealing title, and 3) pictures of a condom demonstration.

Picture Cover Page

The cover page is the first impression the reader receives from the brochure. Therefore, to increase the reader's interest in the text, it is of utmost importance that the cover page is visually attractive and that it stimulates the reader to take a closer look at the brochure. In order to determine the best picture for the cover-page of our brochure we asked Bongi and Vuh for their advice. Bongi was our pre-testing expert (see part I) and Vuh was a student from Kwazulu-Natal who was currently studying at Stellenbosch University. Apart from a five-year age difference, both were representative members of the audience. Unanimously, from the three pictures below (figure 7.6), Bongi and Vuh chose the first picture on the left of the girl who is smiling, while a male with a naked-torso is suggestively biting or whispering in her ear, as the best choice for the cover of our brochure.

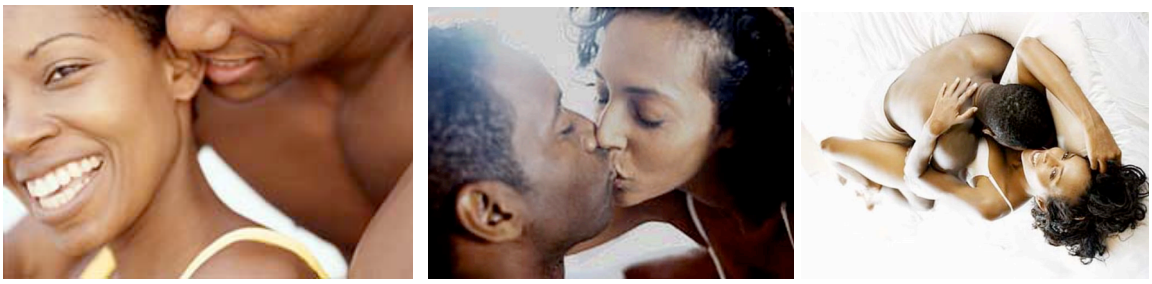


Figure 7.6 *Cover Illustrations*

As we can see, this picture is less explicit than the other pictures, and has something very suggestive. It is generally acknowledged that people tend to approach things from which they get a pleasant feeling and avoid things that make them feel miserable. We propose that the girl's smile, which reflects feelings of happiness, will invite potential readers to pick up the brochure, and take a closer look at the text. In the brochure, the edges of the text have a soft, white-outline, which has been manipulated with Photoshop. This creates a stronger contrast with the pink background and the model's brown skin color.

Title

We decided to define the title for our brochure: 'Ripe an Ready for a Ride, but is it Worth the Risk?'. This derives from audience participation session 3, in which a male expert came up with the sentence 'your body might look ripe and ready for a ride, but it is not ready to risk its future for a moment's pleasure'. The title stimulates the reader to think about their own personal risk when engaging in sex by the question that has been formulated in the second part of the sentence: 'but is it worth the risk?' The contrast between 'being ripe and ready for

a ride, and ‘worth the risk’ (the risk attached to engaging in sex) was stressed by placing the font of the latter in italics.

Pictures of a Condom Demonstration.

In audience participation session 4, the experts indicated that the pictures downloaded from the internet were unclear and did not visually illustrate what was stated in the text. Therefore, we agreed that we should take our own pictures. One of the experts (the peer-educator) was able to bring a pink dildo. On this dildo, two male experts demonstrated the proper usage of the male condom in order to shoot pictures for the brochure. To make the pictures more appealing, I manipulated them with Photoshop. For the picture on checking the expiry date of the condom, we emphasized ‘EXP. DATE 01/2009’ with Photoshop. For the picture on opening the package of the condom, attention was drawn to the curved part of the condom. By manipulating this aspect in Photoshop, we were able to stress the correct way of opening a condom’s package.

8. Conclusions, Discussion & Recommendations

In this part, a participatory audience analysis was conducted in two research stages in order to determine the appropriate form for communicating the content in our intervention to the audience. In the first stage of our research, we evaluated an existing HIV/Aids prevention text made by *loveLife* during two focus group interviews (see chapter 6). In the second stage of our research, we collaborated with representative members of the audience in the design process of our intervention (see chapter 7). In this final chapter, we will first reflect upon our main aim and draw conclusions from our research findings on the audience's communication preferences. After this, we will finally present the final version of our HIV/Aids prevention intervention (section 8.1). Subsequently, in section 8.2, we will discuss the reliability and validity of our research. Then finally, in section 8.3, we will reflect on our research in part I and part II, while at the same time providing recommendations for further research and practical recommendations for planners of health interventions.

8. 1 Conclusions

The aim of part II was *' to investigate how participatory audience analysis can determine how the content should appear in an HIV/Aids prevention document targeted at young African South Africans in South Africa'.* Therefore, we will first conclude what implications our findings might have for the field of Document Design. Secondly, we will briefly reiterate our conclusions on the audience's communication preferences and present the product of our research in part I and part II: the final version of our HIV/Aids prevention brochure.

Contribution of Participatory Audience Analysis to field of Document Design

In the context of designing HIV/Aids prevention campaigns in South Africa, remarkably little research has been carried out on the participatory role of the target audience in the design process. In section 1.3 of this thesis, we defined participatory audience analysis as: *'Systematic, frequent contact and collaboration with representative members of the audience, carried out scientifically and driven by theory in order to determine the appropriate content and form of the message.'* A participatory audience analysis was carried out in this study by interviewing sixteen audience members in two separate focus groups in order to determine how the audience evaluated an existing HIV/Aids prevention text, and by collaborating with four representative members of the audience in the actual design process of our intervention. In this section, we will generalize our research findings on how participatory audience

analysis contributed to the design process in this study in order to draw implications for the field of Document Design. In our view, participatory audience analysis has been extremely beneficial in determining the form of our intervention since it allowed us to achieve the following goals:

1. To obtain accurate, up-to-date data on the audience's communication preferences.
Firstly, as Schaalma et al. (2000) pointed out, we experienced first hand that effective strategies on how to communicate to a particular audience are rarely documented. However, we must acknowledge that strategies that have proven successful in the past are no guarantee for future success. Particularly the communication preferences belonging to a specific youth's culture (e.g. language, expressions used to discuss sexual matters and slang) are known not to be static, and to evolve very rapidly. In this study, by means of participatory audience analysis in this study, we were able to obtain direct feedback from the potential receivers of our intervention. This feedback obtained from the members of the audience led to a better understanding of the audience's literacy and knowledge level on sexual matters. For instance, by evaluating an existing text and by collaborating with the four experts, we became aware that the audience generally dislikes reading and is more visually-orientated. This insight stimulated us to implement many pictures that complement the textual elaboration. To conclude, we believe that document designers who employ participatory audience analysis are able to obtain a more accurate 'image' of the real readers of their text. Hence, these document designers can adapt the form of their intervention to the specific needs of their audiences, which is subsequently believed to increase the intervention's effect.

2. To tap into the audience's language to discuss sexual matters.
Secondly, our participatory audience analysis research strategy allowed us to tap into the audience's everyday language used to discuss sexual matters. As part of this qualitative research strategy, we held two focus group interviews, three exploratory interviews (see part I), and we closely collaborated with the four experts in the design process of our intervention. This offered us an invaluable source of information in designing our intervention. Such rich, descriptive data could never have been obtained by means of quantitative research. In turn, we were able to integrate the knowledge we obtained concerning the audience's 'expressions to discuss sexual matters into the design of our intervention.

3. To facilitate a bottom up approach in determining the content of our intervention.
Thirdly, the interaction between the audience and the document designer facilitated a *bottom-up approach* in determining the form of our intervention. When working individually as a document designer, ideas come from a singular perspective. This perspective is biased since we were not a representative member of the audience (see Longo, 1995; Schriver, 1997). By closely collaborating with the four experts who were representative members of the audience, a synergy effect was created. The four experts and the document designer all contributed different perspectives to the discussions that subsequently generated strategies on how to effectively communicate the main objectives of the intervention. For instance, the document designer in this study initiated the discussion on how to effectively communicate the content concerning the proper use of the male condom. The ideas expressed by the document designer and the experts subsequently led to the 'Arrive Alive concept'. This concept was inspired by the well-known governmental 'Arrive Alive' campaign that aimed to reduce the deaths cause by drinking and driving among the South African population (see audience participation session 3). We believe that participatory audience analysis helps give the audience a voice in how to communicate the content of the intervention. In turn, document designers can adapt the form of their intervention to the real audience's communication preferences.

To conclude, in this study participatory audience analysis helped bridge the gap between a document designer who differed from the audience in age, cultural background and knowledge-level on the topic. This allowed the document designer to gear the presentation of our intervention to the audience's needs. Thus, we believe that participatory audience analysis has been extremely beneficial in this study for designing a more user-centred intervention, which is proposed to increase the intervention's impact. Although we are generally positive about the contribution of participatory audience analysis, we realize that there are some aspects that must be taken into account in order to ensure that incorporating participatory audience analysis in the design process will indeed result in improving the design of a text. We will discuss these aspects in section 8.2.

Conclusions on Audience's Communication Preferences
In chapter 6 we drew conclusions from the research question we had previously formulated: *'What can we learn about the audience's communication preferences by evaluating an existing Aids prevention text aimed at young South Africans of loveLife through participatory audience analysis (focus group interviews intended audience)?* (chapter 6)*'*. In chapter 7, we

illustrated how the four experts cooperated in the design process of our intervention in order to answer our research question: '*How can participatory audience analysis (collaboration four representative audience members) contribute to presenting the content of the Aids prevention text in an appealing way (e.g. language, tone of voice, and form)?'*. Now, in this section, we will finally present the product of our participatory audience research of part I and part II of this thesis: the final version of our HIV/Aids prevention brochure. First, we will present a schematic overview that summarizes the conclusions drawn in chapter 6 and 7 concerning the audience's communication preferences (table 8.1). Subsequently, we will reiterate how the audience's characteristics led to the general design decisions for our intervention. At the end of this section, a schematic overview is provided which displays the strategies we used in our intervention in communicating the content of our intervention. In this overview, each sentence of our intervention is linked to the objectives we previously defined in part I, section 5.3, for the content.

Table 8.1 *Summary Characteristics Target Audience*

	Characteristics Target Audience
Audience	African South Africans aged 12-19 who live in townships in Western Cape. Differ in sexual experience: some are already sexually active, some are not.
Language:	English: the audience is more proficient in reading English (their second language), than in reading their mother tongue Xhosa.
Knowledge:	Low level of knowledge on contraceptives.
Interests:	Mixed level of interests: the audience is put off by conventional HIV/Aids interventions, but it is highly interested in sexual matters.
Formality:	Formal language decreases the text's appeal and makes it more difficult for the audience to understand the content. Moreover, by using formal language, the perceptions of a social gap between the sender and the recipient are emphasized.

Translation of our research findings into our intervention

In this section we finally present our HIV/Aids prevention brochure that was based on a high level of participatory audience analysis. The audience's low-level of knowledge on contraceptives and the low level of interest in preventing HIV/Aids led to certain basic design decisions. To make our HIV/Aids intervention more entertaining for the audience, the following design strategies were taken into account:

- **To present the information in a visually attractive way**: we strove to use attractive visual aids that complemented the information in the text.

- **To use a comprehensible, appealing tone of voice:** we strove to avoid the use of unfamiliar terminology and communicated in the audience's everyday slang.
- **To present the information in positive way:** we strove to communicate the message in an unexpected, positive way that informs youth how to take personal responsibility for their health.

Looking at the cover of our brochure, we can see that our brochure is very colorful and contains many pictures. To evoke attention and interest among potential readers, the cover page refers to the audience's interest in sexual matters. We can see that the cover picture of the African couple is very suggestive (see figure 8.1), and that the content of the cover page deals with topics that invite the reader to study the brochure more carefully (e.g. the right age to engage in sex).

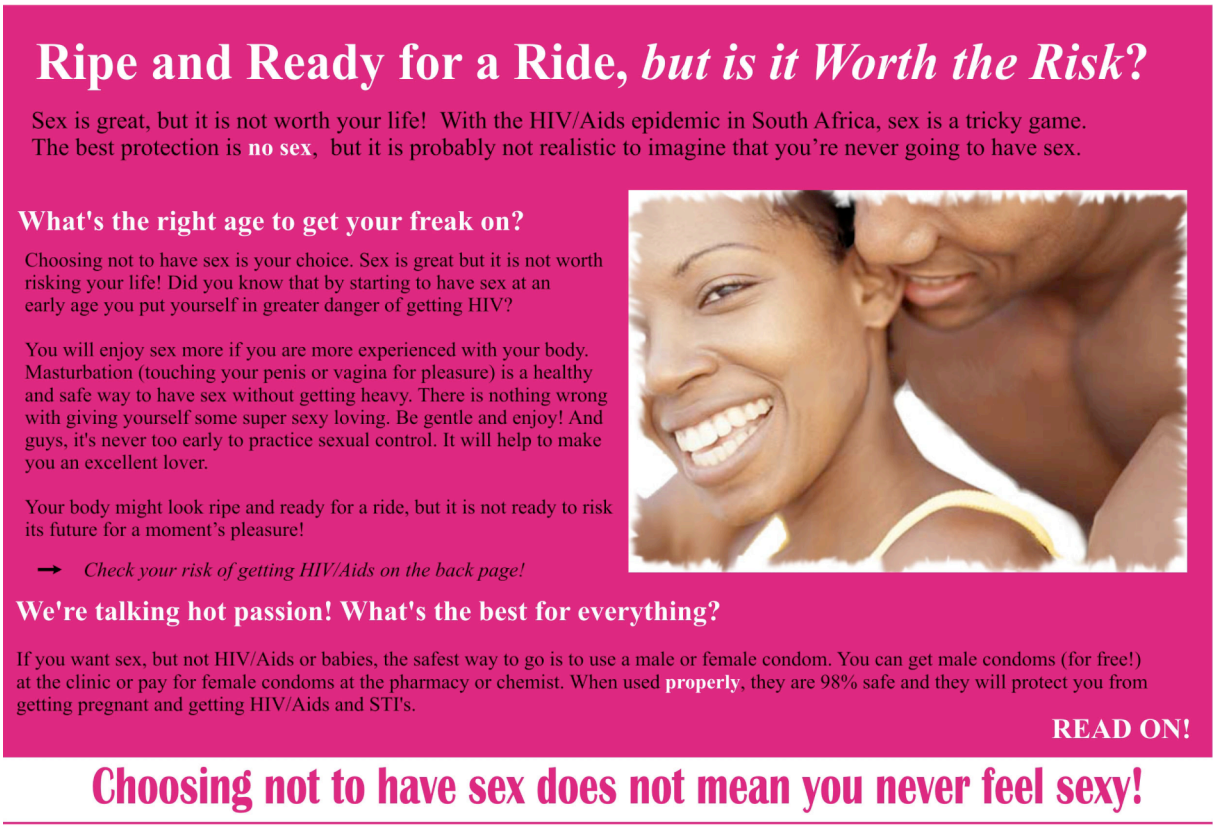


Figure 8.1 *Cover page of our Brochure*

Figure 8.2 *Center Page of our Brochure (Left)*

Figure 8.3 *Center Page of our Brochure (Right)*

The two center pages of our brochure (see figure 8.2 and figure 8.3) are entirely dedicated to informing the audience about the correct way to use a male condom. This was done since our research in part I made it clear that the audience severely lacked basic knowledge on how to use a condom correctly. It is clear that without this knowledge, members of the audience will fail to protect themselves against HIV/Aids. The six displayed visuals are proposed to complement the text and non-verbally communicate how to correctly use a condom for people who do not feel like reading the text or who suffer from illiteracy. To guide the reader's gaze through all steps of the condom demonstration, we consistently displayed all four information 'blocks' in pink and connected them with a green dotted line.

Figure 8.4 *Back page of our Brochure*

As we can see above in figure 8.4, the back page of the brochure deals with the more complicated issues of sexual decision-making. We can see that the first paragraph covers strategies for negotiating safe sex and the second paragraph focuses on what to do after having had unprotected sex. In addition, we can see that a graph is presented that summarizes the degree of HIV/Aids risks attached to a certain behavior. We perceived that these serious issues were more appropriate for a back page, because they might "turn off" potential readers.

To ensure that all of the readers will have understood and memorized the main message of our brochure, we repeated this main message under the heading “got it now?”.

To reiterate, we ended part I of our research with having selected four determinants of the audience’s contraceptive usage that we recommended to focus on in the content of our intervention (see section 5.3). These four determinants were selected by applying two sets of criteria to our conclusions of the 11 determinants of the audience’s contraceptive usage that we had previously researched (section 5.2): 1) the determinant could realistically be changed by means of an intervention (Bartholomew et al., 2001), and 2) the determinant reflected the audience’s information needs (Schriver, 1997; Moody, 1991; Bartholomew et al., 2001). For each of the four selected determinants we then set up specific objectives for communicating the content. Setting up these objectives was meant to offer us guidelines when designing our intervention.

In this part II we investigated the audience’s communication preferences in order to determine the appropriate form for communicating the defined objectives for the content. In figure 8.5, per objective, we display the creative strategies (sentences of our intervention) that we used to communicate this content in our designed intervention. It must be noted that some of the sentences found in our intervention apply to more than one objective. For instance, sentence no. 18 refers to both the first objective for ‘attitude towards the male condom’: “To encourage the audience to use condoms consistently and correctly each time they have sex”, and the second objective for ‘attitude towards the male condom’: “To reinforce that the health-related advantages of condom use outweigh the disadvantages”. A schematic overview of how we numbered all the sentences of our intervention can be found in figure 8.6.

Determinants and objectives for the content	**Sentences of our intervention that reflect this content:**
Attitude towards the male condom	
1. To encourage the audience to use condoms consistently and correctly each time they have sex.	18) If you want sex, but not HIV/Aids or babies, the safest way to go is to use a male or female condom. 42) You will enjoy having sex more when using a condom, ‘cause you can relax and won’t have to stress about HIV/Aids or pregnancy. 45) If you’re having sex, condoms are the best protection. 60) Got it now? 61) You can easily prevent HIV/Aids and pregnancy. 62) It means using a condom every time and always.

2. To reinforce that the health-related advantages of condom use outweigh the disadvantages.	18) If you want sex, but not HIV/Aids or babies, the safest way to go is to use a male or female condom. 20) When used properly, they are 98% safe and they will protect you from getting pregnant and getting HIV/Aids and STI's. 42) You will enjoy having sex more when using a condom, 'cause you can relax and won't have to stress about HIV/Aids or pregnancy. 57) Remember: Babies may look cute, but they are not worth losing your young sexy years full of life and energy. 58) It takes a lot of time and money to raise them!
3. To change negative attitudes towards male condoms: a) association of distrust b) misperception that a condom can be too small c) perception that condoms reduce sexual sensitivity	39) The reality about condoms: 40) It's crap that a condom can be too small guys! (you can easily pull a condom over your fist and down onto your arm. If you're bigger than this, it's a record!) 41) Condom's don't take away the sexy feeling (they're so thin you can even feel a tickle with a feather, try them!). 46) Using condoms shows that you care about your lover and yourself 49) If your lover doesn't want to use a condom, it could mean that he or she doesn't care for you or has something to hide. 62) It means using a condom every time and always. 63) No matter how well you know, trust and love your partner.
Attitude towards sex	
4. To acknowledge that it is not realistic to imagine that youth are never going to have sex.	4) The best protection is NO SEX, but it is probably not realistic to imagine that you're never going to have sex.
5. To encourage the audience to practice other safe sex behaviors that delay sexual intercourse such as (mutual) masturbation, kissing & hugging.	8) Did you know that by starting to have sex at an early age you put yourself in danger of getting HIV? 9) You will enjoy sex more if you are more experienced with your body. 10) Masturbation (touching your penis or vagina for pleasure) is a healthy and safe way to have sex without getting heavy. 11) There is nothing wrong with giving yourself some super sexy loving. 12) Be gentle and enjoy! 13) And guys, it's never too early to practice sexual control. 14) It will help to make you an excellent lover. 15) Your body might look ripe and ready for a ride, but it is not ready to risk its future for a moment's pleasure!
6. To reinforce the idea that engaging in sex is a personal decision.	5) What's the right age to get your freak on? 6) Choosing not to have sex is your choice. 7) Sex is great but it is not worth risking your life! 21) Choosing not to have sex does not mean you never feel sexy! 51) You are young, healthy, sexy and full of life – no reason is enough reason to throw your life away just for the sake of sex. 64) Only YOU have the power to stop HIV/Aids.
Knowledge	
7. To increase the audience's	17) We're talking hot passion! What's the best for everything? 18) If

knowledge level on correct condom usage and emergency contraception in order to make a safe, healthy, and well-informed decision.	you want sex, but not HIV/Aids or babies, the safest way to go is to use a male or female condom. 20) When used properly, they are 98% safe and they will protect you from getting pregnant and getting HIV/Aids and STI's. 22) Arrive Alive: What's the proper way to use a condom? 23) First things first: 27) Ok, I got it now. But how do I slip it on? 28) Check out the way you unroll the condom: Put the finger that you point with in it, and hold the upper part. 29) Hold the tip so there is space to collect the semen and just roll it all the way down boy! 33) Guys: never re-use a condom and always use a new condom when you're ready for some extra loving. 34) After getting heavy (and after you have come), hold the ring of the condom with your hand while you pull your penis out (otherwise the condom can slip inside your lover). 35) What to do after arriving alive: 36) Hold the ring tight with your hand so it won't get lost inside your lover and gently pull it our (avoid contact between the vagina and semen on the penis or fingers). 37) Tie a knot in the condom 38) Put it in a tissue and flush it down the toilet!
8. To inform the audience about the HIV/Aids and pregnancy risk attached to various sexual acts.	1) Ripe and ready for a ride, but is it worth the risk? 2) Sex is great, but it is not worth your life! 3) With the HIV/Aids epidemic in South Africa, sex is a tricky game. 16) Check your risk of getting HIV/Aids on the back page! 20) When used properly, they are 98% safe and they will protect you from getting pregnant and getting HIV/Aids and STI's. 52) Help, we're desperate! We had sex and did not use a condom – am I pregnant? 53) Maybe. It's best not to take any chances. 59) Risk of getting HIV/Aids.
9. To introduce information on emergency contraception as a last measure to prevent teenage pregnancies.	54) Go to the clinic within 24 hours and get the morning after pill (for free!) to prevent you from getting pregnant.
10. To change incorrect knowledge of usage and treatment of the male condom: a) using two condoms over each other b) opening package with teeth c) not checking expiry date d) keeping condoms in a warm place e) using oils as a lubricant	24) Be sure that you always have a condom on you, but do not store condoms in a place warmer than 25 ºC (you never know when you'll get some loving!). 25) Always check the expiry date [EXP.DATE]. 26) Be gently when opening the package: never use your teeth or a pair of scissors and watch out for those sexy long nails! (they will damage the condom) 30) Use some spit if you need some help sliding into your lover (no Vaseline, no baby oil & no massage oil, they can all cause the condom to break!) 31) What to do for a great, safe ride: 32) Don't use two condoms over each other (it will make them break!).
11. To promote visits to clinics	54) Go to the clinic within 24 hours and get the morning after pill (for

for emergency contraception, condoms and HIV tests.	free!) to prevent you from getting pregnant. 55) If you feel shy, ask a friend to go with you or ask him or her to pay for the pill at the pharmacy (they're 50 Rand). 56) While you're at the clinic, go for an HIV test.
12. To reiterate that male condoms are available for free at clinic and public venues, and female condoms can be purchased at chemist or pharmacy.	19) You can get male condoms (for free!) at the clinic or pay for female condoms at the pharmacy or chemist.
Sexual Negotiation	
14. To provide strategies that can be used to convince the partner to use a male condom.	44) My lover prefers flesh on flesh – how can I convince him/her to use a condom? 47) Do not play games; say clearly and calmly that you want to use condoms before you start. 48) Avoid arguing when you both feel like rolling it on!
15. To promote core values of shared responsibility, care and respect.	46) Using condoms shows that you care about your lover and yourself 49) If your lover doesn't want to use a condom, it could mean that he or she doesn't care for you or has something to hide.
16. To stress that all South African youth are personally responsible for stopping HIV/Aids by engaging in safe sex.	51) You are young, healthy, sexy and full of life – no reason is enough reason to throw your life away just for the sake of sex. 50) Did you know that 99% of the people who whine about using condoms have actually never tried them? 64) Only YOU have the power to stop HIV/Aids.

Figure 8.5 *Schematic overview sentences content*

In the below presented figure 8.6, we illustrate how we numbered all the sentences of our intervention.

Sentence Number	
	Sentences Cover Page
1)	*Title:* Ripe and ready for a ride, but is it worth the risk?
2)	*Subheading:* Sex is great, but it is not worth your life!
3)	*Subheading:* With HIV/Aids epidemic in South Africa, sex is a tricky game.
4)	*Subheading:* The best protection is NO SEX, but it is probably not realistic to imagine that you're never going to have sex.
5)	*Heading:* What's the right age to get your freak on?
6)	Choosing not to have sex is your choice.
7)	Sex is great but it is not worth risking your life!
8)	Did you know that by starting to have sex at an early age you put yourself in danger of getting HIV?
9)	You will enjoy sex more if you are more experience with your body.
10)	Masturbation (touching your penis or vagina for pleasure) is a healthy and safe way to have sex without getting heavy.

11) There is nothing wrong with giving yourself some super sexy loving.
12) Be gentle and enjoy!
13) And guys, it's never too early to practice sexual control.
14) It will help to make you an excellent lover.
15) Your body might look ripe and ready for a ride, but it is not ready to risk its future for a moment's pleasure!
16) Check your risk of getting HIV/Aids on the back page!
17) *Heading:* We're talking hot passion! What's the best for everything?
18) If you want sex, but not HIV/Aids or babies, the safest way to go is to use a male or female condom.
19) You can get male condoms (for free!) at the clinic or pay for female condoms at the pharmacy or chemist.
20) When used properly, they are 98% safe and they will protect you from getting pregnant and getting HIV/Aids and STI's.
21) *Quote:* Choosing not to have sex does not mean you never feel sexy!

Sentences Center-pages

22) *Heading center- pages:* Arrive alive: What's the proper way to use a condom?
23) *Heading text block 1:* First things first:
24) • Be sure that you always have a condom on you, but do not store condoms in a place warmer than 25 ºC (you never know when you'll get some loving!).
25) • Always check the expiry date [EXP.DATE].
26) • Be gently when opening the package: never use your teeth or a pair of scissors and watch out for those sexy long nails! (they will damage the condom).
27) *Heading text block 2:* Ok, I got it now. But how do I slip it on?
28) • Check out the way you unroll the condom: Put the finger that you point with in it, and hold the upper part.
29) • Hold the tip so there is space to collect the semen and just roll it all the way down boy!
30) • Use some spit if you need some help sliding into your lover (No vaseline, no baby oil & no massage oil, they can all cause the condom to break!).
31) *Heading text block 3:* What to do for a great, safe ride:
32) • Don't use two condoms over each other (it will make them break!).
33) • Guys: never re-use a condom and always use a new condom when you're ready for some extra loving.
34) • After getting heavy (and after you have come), hold the ring of the condom with your hand while you pull your penis out (otherwise the condom can slip inside your lover).
35) *Heading text block 4:* What to do after arriving alive:
36) • Hold the ring tight with your hand so it won't get lost inside your lover and gently pull it out (avoid contact between the vagina and semen on the penis or fingers).
37) • Tie a knot in the condom.
38) • Put it in a tissue and flush it down the toilet!
39) *Heading*: The reality about condoms:
40) • It's crap that a condom can be too small guys! (you can easily pull a condom over your fist and down onto your arm. If you're bigger than this, it's a record!).
41) • Condoms don't take away the sexy feeling (they're so thin you can even feel a tickle with a feather, try them!).
42) • You will enjoy having sex more when using a condom, 'cause you can relax and won't have to stress about HIV/Aids or pregnancy.
43) *Quote:* Sex is great, but is not worth your life!

Sentences Back–page

44) *Heading*: My lover prefers flesh on flesh – how can I convince him/her to use a condom?
45) If you're having sex, condoms are the best protection.
46) Using condoms shows that you care about your lover and yourself.
47) Do not play games; say clearly and calmly that you want to use condoms before you start.
48) Avoid arguing when you both feel like rolling it on!
49) If your lover doesn't want to use a condom, it could mean that he or she doesn't care for you or has something to hide.
50) Did you know that 99% of the people who whine about using condoms have actually never

tried them?
51) You are young, healthy, sexy and full of life – no reason is enough reason to throw your life away just for the sake of sex.
52) *Heading*: Help, we're desperate! We had sex and did not use a condom – am I pregnant?
53) Maybe. It's best not to take any chances.
54) Go to the clinic within 24 hours and get the morning after pill (for free!) to prevent you from getting pregnant.
55) If you feel shy, ask a friend to go with you or ask him or her to pay for the pill at the pharmacy (they're 50 Rand).
56) While you're at the clinic, go for an HIV test.
57) Remember: Babies may look cute, but they are not worth losing you young sexy years full of life and energy.
58) It takes a lot of time and money to raise them!
59) *Risk meter graph:* Risk of getting HIV/Aids
60) *Summary:* Got it now?
61) You can easily prevent HIV/Aids and pregnancy.
62) It means using a condom every time and always.
63) No matter how well you know, trust and lover your partner.
64) *Quote:* Only YOU have the power to stop HIV/Aids.

Figure 8.6 *Schematic overview numbered sentences*

8. 2 Discussion

In part I, we noted that in practice, many audience analysis approaches fall short when scientifically conducting audience research. As stated by Schriver (1997, p. 162): *'Up to this point, (...) there has been almost no research on how document designers move from the data they collect (e.g. usability testing) to interpretations about those observations and then to revisions that reflect those interpretations.'* Schriver (1997) warns document designers to be careful when interpreting data obtained by means of feedback driven methods (such as participatory audience analysis). According to Schriver (1997), not all remarks made by audience members are relevant, some are just "plain weird", and relying too heavily on the remarks expressed by single participants will not necessarily lead to an improvement in the text. However, in our view, integrating audience data into the design of interventions does not need to be a problem. That is, if document designers strive to meet the two main research criteria of *reliability* and *validity* when interpreting the extent to which a remark expressed by one single audience member truly represents the communication preferences of the specific audience[8] . Nevertheless, we advise document designers to be critical when interpreting data obtained by the audience, since audience members generally have not been trained to design interventions. When in doubt, the final decision regarding the design of the intervention should be based on the document designer's professional and academic expertise on designing effective documents. This section discusses the measures we took into account during our

[8] see Bergsma, 2003, for a detailed elaboration on the differences of how these two terms are used in *quantitative* and *qualitative research*.

focus groups and four audience participation sessions in order to ensure that the interpretation we made of our collected audience data would be reliable and valid.

Reliability

The reliability of the research method employed refers to the extent to which another researcher would have drawn similar conclusions if he or she had replicated this study under similar circumstances (Baarda et al., 2001, p.98). To increase the objectivity of this study, we took the following measures:

1.Conscientious registration. All of the focus group findings were conscientiously registered and described in order to ensure that conclusions could be drawn from factually expressed opinions. In a later stage, this prevented the analysis from being based on the moderator's (subjective) memory of the sessions. With regard to the audience participation sessions, notes were made immediately after the audience participation session had ended. In the later sessions, improvements of the text were indicated on the draft itself. Thus, to a certain extent, the method was standardized.

2. Triangulation. In the focus groups, we avoided subjective interpretations of the data by asking the participants for their confirmation on our interpretation of the audience's communication preferences. In the audience participation sessions, feedback was only implemented in the design of the text if at least two experts agreed to the document design decision. We believe that this enhanced the reliability of our research, and increased the extent to which the our brochure reflects the audience's needs.

3. Avoiding preconceptions and prejudices. In both the focus groups and audience participation sessions, exposing prejudices (if any) was avoided by listening closely and asking open questions.

Validity

Internal validity refers to the extent to which the research method truly measured and investigated the intended phenomenon (Baarda et al., 2001). According to Baarda et al. (2001), this is one of the strengths of qualitative research, since the method focuses on describing the situation from the perspective of the participants researched. To increase the *internal validity* several measures were taken into account.

1. Triangulation. To ensure the valid interpretation of the participants' remarks in the focus groups and audience participation sessions, the moderator probed and asked for clarification. Feedback only led to document design decisions if the remark was supported by at least one

other participant. Due to the relatively homogenous make-up of our focus groups and audience participation sessions, we believe that a representative picture of the audience's communication preferences was acquired at quite an early stage.

2. Feedback Participants. In the focus groups and audience participation sessions, we primarily took on the role of observer and listener. The interactivity of both research methods facilitated a bottom-up approach concerning the participants' communication preferences, and allowed them to pursue the discussions according to their interests. In this way, we could identify diverting opinions regarding the audience's communication preferences from group consensus. In sum, we believe that this approach substantially contributed to the validity of the audience data obtained.

The *external validity* refers to the extent to which the results of this study can be generalized (Baarda et al., 2001, p. 101). In part I, we explained which measures we took into account to prevent *elite bias*: drawing conclusions based on a sample of outspoken, well-informed participants. We stated that two principals were asked to randomly select four males and four females for the focus group to minimize our chances of selecting only extraverted participants. The principals' selection resulted in a 'young' group aged 14 to 16, and an 'older' group of which the participants' ages ranged from 16 to 19. To ensure that the introverts point of view would be taken into account, shy, introvert participants were encouraged by the moderator to contribute to the discussion by asking them specifically for their opinions. Thus, this research may be regarded as valid in the sense that the sample captured a close to representative view of our audience. However, it must be pointed out that the results might not be representative for a general population of young Africans in South Africa.

8.3 Recommendations

In this section we will give recommendations for further research and practical recommendations for planners of health campaigns.

Recommendations for further research

This research project consist of a case study that led to the design of an intervention that was based on a high level of participatory audience analysis. Although researching the audience's perspective by means of participatory audience analysis seems a sensible thing to do when designing an intervention, we cannot offer the empirical proof that our intervention is more

effective. In order to make generalizations whether the use of participatory audience does indeed contribute to designing more effective texts, we would like to offer the following suggestions for further investigation:

1. **Design a questionnaire that intends to measure effectiveness.**

To further investigate this, we would first recommend that researchers operationalize 'effectiveness'. In our case, we suggest that the effectiveness of our intervention can be determined by the degree to which our text succeeds in achieving the objectives we defined in section 5.3. For instance, the audience could be asked to indicate the degree to which the text managed to 'encourage them to practice other safe sex behaviors that delay sexual intercourse such as (mutual) masturbation, kissing & hugging' (objective measuring 'attitude towards sex'). Subsequently, the objectives of an HIV/Aids prevention text that was aimed at a similar target audience, but differed only in the degree to which the text was based on participatory audience analysis must be defined. In this way, researchers can translate these objectives into statements for using a questionnaire. In order to determine the influence of the variable 'participatory audience analysis' on a text's effectiveness, a survey can be conducted to measure to degree to which the audience evaluates both texts as being effective.

2. Compare the effectiveness of a text based on a high level of participatory audience analysis with the effectiveness of a text that has been based on a low level of participatory audience analysis among a large sample of audience members.

After having designed the research method, researchers can conduct this survey research among a large sample of participants in order to determine whether or not HIV/Aids prevention texts based on a high level of participatory audience analysis are more effective in achieving its objectives than HIV/Aids prevention texts that have been based on a low-level of participatory audience analysis. If indeed the results of a statistical analysis confirm that in a large number of studies and among a large sample of participants that the texts that have been based on a high level of participatory audience analysis are significantly evaluated by the audience as being more effective, we can then make the generalization that the use of participatory audience analysis in the design process of interventions does indeed leads to the design of more effective texts.

Practical Recommendations for planner of Health Campaigns

In this study, the author of this thesis was involved in all of the phases during the intervention's design process: 1) I took on the role of the *audience researcher* and conducted research on the audience's determinants of contraceptive usage and communication preferences 2) I acquired knowledge on the topic of preventing HIV/Aids transmission and functioned as a *subject expert* on HIV/Aids and contraceptive usage, and 3) I was involved in the actual *creative design* of the intervention. Based on our experience in this study, we would like to recommend that designers of health interventions to work in a team, and to equally divide task responsibilities in at least three of the following areas of expertise: 1) audience expert, 2) subject expert, and 3) creative expert.

The first expertise refers to the audience expert. From our experience, we note that the role of audience expert is the most demanding and time consuming in the design process. The audience expert's task is to research the audience(s) and to assure that the information about the audience(s) is effectively integrated in the design of the health campaign. We specifically state *audiences* since secondary and tertiary audiences (e.g. the NGO that provides the financial funds for the project, parents, religious institutions) must be taken into account when designing an intervention. It is waste of time, money, and energy if the final intervention that was aimed to reach the audience remains in a drawer because important stakeholders disagree with its content and/or form. By identifying these multiple audiences in an early stage of the design process, adjustments can be made to the intervention to meet their consent.

In researching the audiences, we would suggest *two researchers* to cooperate with each other in this process. For instance, a researcher with a background in Social Psychology who is familiar with models and theories of behavioral change. In addition, a researcher with a background in Document Design can be hired who is familiar with conducting research on how the audience interacts with texts. We believe that this will contribute to the quality of the obtained data and the speed with which retrieved audience data can be analysed. In turn, the researcher can translate their findings at a greater pace into communication strategies for effectively reaching the audience that can offer inspiration and guidance for the members of the team that work on the actual creative design of the intervention.

In general, we recommend audience experts to plan at least two audience visits in the design cycle. When exposed to the real audience, audience experts are advised to combine multiple things on these audience visits. For instance, seek to collect pre-production data in order to determine *what* to communicate (the audience's information needs) and production data such as *how* to communicate this content (the audience's communication preferences) by,

for instance, evaluating an existing HIV/Aids prevention text. This frequent and systematic contact with the potential receiver of the intervention will contribute to ensuring that the intervention is geared to the audience's needs.

Secondly, we believe that a more accurate and scientifically correct message can be conveyed in the intervention if a subject expert would cooperate in the design process. A subject expert refers to a person who has in-depth professional and theoretical expertise on the topic. In our case, this could be a doctor or a health nurse with knowledge on HIV/Aids transmission and the proper use of condoms. For instance, when I discussed the safety of condoms with a friend who studied Health Sciences in the Netherlands, I found that latex gloves only protect against HIV transmission for 20 minutes. Moreover, he told me that there are safer ways to unroll and open the package of a condom than is illustrated in our brochure. For instance, a person should not put his or her index finger in the condom to determine the way the condom unrolls since the person's nails can damage the condom. In stead, the tip of the condom should be held to determine the way to unroll the condom. Unfortunately, in South Africa, we based most of our information on the available HIV/Aids prevention documents.

Thirdly, it is vital to attract a creative expert in order to create an attractive HIV/Aids intervention. In this study, the author of this thesis lacked the practical skills to translate the research findings into the design of the actual intervention. Therefore, in order to effectively communicate the chosen strategies to the audience, I cooperated with a Graphic Designer who was familiar with the computer design programme *Coral.* Ideally, a substantial part of the creative team consists of members who represent the audience. The following table 8.3 provides a summary of the division of tasks:

Table 8.3. *Division of tasks Design HIV/Aids intervention*

Task	Responsibility
Audience Expert	• To establish a core strategy of the health campaign that helps ensure that all interventions consistently communicate the same message. • To hold focus-group interviews, exploratory interviews, and to pre-test draft material on the audience. • To assure audience information is effectively integrated in the design of the text. • To define an appropriate communication strategy to effectively reach the audience by means of an intervention.
Subject Expert	• To have expert knowledge on HIV/Aids transmission.

	• To have expert knowledge about the proper way to use condoms.
Creative Expert	• To design an appealing, persuasive intervention that is appropriate for mass production. • To cooperate with audience members in the design process. • To modify messages and format after pre-testing.

In this thesis we demonstrated how participatory audience analysis helped us to gain a better understanding of the audience's perspective. Especially where matters of life and death are concerned in designing HIV/Aids prevention interventions, it would only seem sensible for document designers to go beyond using an authoritarian 'top-down' approach and to investigate the information needs and communication preferences of the 'real' members of the audience. After all, it is such user-centered interventions that reflect the essence of participatory audience analysis, and that is what we believe will stand a greater chance in motivating the audience to change unsafe sexual practices.

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Appendices

In this online version of the thesis we prefer not to disclose the data in the appendices, for the privacy's sake of the participants. These data are in the possession of professor Jansen at the department of Business Communication at the Radboud University Nijmegen: c.jansen@let.ru.nl. For additional information the author of this thesis can be contacted at: sarah.vdland@gmail.com