

BRIDGE



**Exploring
Community Beliefs,
Attitudes, &
Behaviors Related
to HIV/AIDS**

*Baseline Research
from Eight
BRIDGE Districts
in Malawi*

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II. Executive Summary

In early 2004, the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), in collaboration with our partners in the Ministry of Health in Malawi, the National AIDS Commission, Save the Children, and Salephera Consulting, Ltd., conducted baseline research in eight districts in Malawi. This report is based on findings from that research.

Based on both qualitative and quantitative methods, key findings that emerged from the baseline research include the following:

- Issues disaggregated by gender:
 - Females are more vulnerable to HIV/AIDS than males. This is true not only for high-risk sexual behaviors (having multiple partners, not using condoms, etc.), but also for the behavioral predictors, including knowledge, attitude, efficacy, risk perceptions, and normative beliefs.
 - Boys (15 to 24 years old) appear to be better prepared to reduce individual risk factors, in comparison to girls, older men, and older women.
 - Girls (15 to 24 years old) are particularly vulnerable to HIV/AIDS for a number of individual-level factors (e.g., attitudes, beliefs, and behaviors), but the primary contributing factor is the lack of control they perceive in virtually every aspect of their lives, including in sexual decision making.

- Challenges:
 - Across the sample, the picture is grim. People feel a strong sense of hopelessness and lack of ability to change their future. This is manifest in feelings of abandonment – women feel abandoned with their children, the elderly feel they have to fend for themselves in the face of poverty, and many children are left as orphans.
 - Poverty and HIV/AIDS mutually reinforce each other: to meet basic needs, people encourage their children to engage in prostitution, leading to greater HIV infection, which in turn results in death and loss of earning capability. Many individuals, including girls and women, perceive little choice but to engage in prostitution in order to meet their basic needs.
 - People perceive HIV/AIDS primarily in terms of its social consequences – communities, more than individuals, are perceived to be unraveling as a direct consequence of AIDS. Causes of HIV infection and transmission are viewed through the prism of a lack of control in almost every aspect of people's lives – from poverty at the socioeconomic level, to women's input in sexual decision making at the level of interpersonal relationships, to inability to control sexual urges at the individual level. Despite this awareness of potential community consequences, perceived personal vulnerability was very low.
 - Interpersonal discussion about sex and HIV prevention was found to be low across the sample. This was particularly true within families and among males as a group.
 - Social rituals and religious ceremonies were associated with sexual initiation of children.

➤ Reasons for hope:

- People also perceive that meaningful changes can occur at the collective level – when entire communities band together to fight the disease, look after and protect members of the community, and change community norms.
- Community leaders and health professionals are held in particularly high regard – they are perceived as credible and trustworthy sources of information.

Based on these findings, the intervention to reduce HIV/AIDS in Malawi needs to focus on mobilizing the entire community around the collective theme of empowering youth, particularly young girls, in shared decision making and building on a theme of hope.

- Intended audience: Focus on empowering youth, particularly young girls
- Message strategy: Mobilization of the entire community
- Message theme: Regaining collective control
- Channels of communication: Community-based organizations
- Sources of information: Community leaders and health professionals

III. Introduction and Context of Study

III.1. Geography

Malawi is situated in southeastern Africa and is a landlocked country. It shares borders with Tanzania, Mozambique, and Zambia. The Great Rift Valley traverses the country from north to south. In this deep trough lies Lake Malawi, the third-largest lake in Africa comprising about 20% of Malawi's area.

The country is made up of 27 districts and is divided into three regions: Northern, Central, and Southern. Administratively, the districts are subdivided into Traditional Authorities (TAs), presided over by chiefs. TAs are composed of villages, which are the smallest administrative unit.

Malawi derives its name from the Maravi, a Bantu people who came from the southern Congo about 600 years ago. Migrations and tribal conflicts precluded the formation of a cohesive Malawian society until the turn of the 20th century. In more recent years, ethnic and tribal distinctions have diminished. Regional distinctions and rivalries, however, persist. Despite some clear differences, no significant friction currently exists between tribal groups, and the concept of a Malawian nationality has begun to take hold. Predominately a rural people, Malawians are generally conservative and traditionally nonviolent.

III.2. Population

Malawi is one of sub-Saharan Africa's most densely populated countries. The population of Lilongwe – Malawi's capital since 1971 – exceeds 400,000. The 1998 Population and Housing Census enumerated a total population of 9.9 million; today, it has grown to over 11 million people. The population of Malawi is growing at a rate of approximately 2.0 percent per year and has been accompanied by increasing population density, from approximately 85 persons per square kilometer in the late 1980s to over 100 persons per square kilometer to date. To address the problems associated with rapid population growth, the Malawi government adopted a National Population Policy in 1994. The policy objectives include the following:

- To improve family planning and health care programs;
- To increase school enrollment with an emphasis on raising the proportion of females students to 50% of total enrollment; and
- To increase employment opportunities – particularly in the private sector.

III.3. Economy and Political Structure

The Gross Domestic Product of Malawi is estimated at \$1,778,000,000 and the per capita income at \$180. Approximately 65% of the population is estimated to live in poverty, and a vast majority of the population, approximately 85%, lives in rural areas.

In 1994, the country adopted a strategy to eradicate poverty. Since then, free primary school education, a free market economy, and a democratic, multiparty state and parliament have been

introduced. With these changes came a considerable increase of migrants from rural to urban areas.

Malawi has a predominantly agricultural economy. Agricultural produce accounts for over 60% of Malawi's exports.

Malawi's government ministries and the Parliament are located in Lilongwe. Blantyre remains Malawi's major commercial center and largest city.

III.4. Health

Malawi's National Health Plan for 1999 to 2004 identifies four priority health problems:

- High HIV seroprevalence and deaths due to HIV/AIDS related illnesses;
- High maternal mortality and morbidity;
- High child mortality and morbidity; and
- High morbidity and mortality in the general population due to infectious diseases.

Cutting across these major health issues are two important factors affecting health levels in Malawian society: the continuing high fertility rate and HIV/AIDS. Considerable progress has been made over the last decade in reducing total fertility from 6.7 in 1992 to 6.3 in 2000, but the HIV/AIDS epidemic still looms over rural and urban populations alike.

All four health challenges – but particularly the HIV/AIDS epidemic – are decimating Malawian society's productive capacity and sector, hence negating poverty-reduction efforts, and hindering efforts to achieve economic growth and to establish a stable and vibrant civil society. The active labor force is becoming too small to support the needs of the young, the old, and those chronically ill with such diseases as AIDS, tuberculosis, and malaria. The problem is likely to become worse, given that the current generation of young adults (particularly those in the 25-30 age group) is amongst the hardest hit by the epidemic. Many will die at a young age from AIDS, maternal complications, or infectious diseases. Life expectancy has dropped to 39 years over the last decade and 23% of all Malawian children die before reaching five years of age.

Of the four priority health problems identified by the Government of Malawi, the HIV/AIDS epidemic is the most devastating, with Malawi rated as one of the ten countries worldwide most affected by AIDS. It is estimated that 800,000 Malawians are now living with HIV. Approximately 15% of adults aged 15-49 are infected, translating into a 50% lifetime risk of contracting the virus. As a result, AIDS is now the leading cause of death in adults. More than 80,000 die annually – double what the number would be without AIDS. This figure is projected to rise to over 100,000 adult deaths annually by 2005. The National AIDS Commission estimates that there are approximately 70,000 new cases of AIDS each year in Malawi.

It is estimated that over 300,000 Malawian children have lost parents to AIDS – a number that is projected to increase to over half a million by the year 2005.

HIV/AIDS is also overwhelming Malawi's weak public sector health system. Presently over 70% of medical ward beds are occupied by patients with HIV/AIDS-related conditions. The

health care system does not have the capacity or supplies to care for such a high number of patients with serious and often terminal medical problems. In other settings, many of these patients would be referred to hospice care. In Malawi, there are no such institutional options.

As an additional complication, stigma continues to have a subtle but pervasive negative impact on both communities' and organizations' ability to provide a full range of services to those who might need them. Health care providers and outreach workers often witness the difficulty HIV+ individuals have in discussing their status with family members. Support groups hesitate to meet openly for fear of negative community response. As a result, only a limited number of individuals admit to being HIV+ and many are not interested in knowing their HIV status.

A lack of quality supportive services, which are essential for risk reduction, making informed decisions, protecting partners and otherwise engaging in "safe" sexual behaviors, constrains Malawians' ability to maintain or change behavior. Services such as condom distribution, diagnosis and effective treatment of sexually transmitted infections, prevention of mother-to-child transmission, counseling, identification and treatment of opportunistic infections, particularly tuberculosis, family planning, and basic reproductive health services are both of poor quality and not widely available to the average Malawian.

III.5. Malawi BRIDGE Program Description

The Malawi BRIDGE program is a new cooperative agreement awarded to the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP) in collaboration with Save the Children. The project began on July 1, 2003. It is a two-year project with two possible one-year extensions.

The BRIDGE project is informed by the country's National Behavior Change Interventions Strategy for HIV/AIDS and Sexual Reproductive Health. The program aims to change the way Malawians think and speak about HIV/AIDS, and most importantly helps them adopt behaviors that prevent HIV transmission. Its approach reflects innovative behavior change models and lessons learned from the Africa region. Informing these important outcomes are the proposed BRIDGE principles and values, which will guide all interventions:

Belief in a better future (Hope)

Risk is shared by everyone (Personalized Risk)

I can STOP AIDS (Personal responsibility, action, self-efficacy)

Discussion about HIV/AIDS (Openness, destigmatization)

Gender equity (Girls' empowerment and changed men's behavior)

Emphasis on the positive (Action oriented, community-assets, positive-deviant role modeling)

Malawi BRIDGE will engage Malawians to move from knowledge to preventive action and assist stakeholders to move from strategy to coordinated implementation. By the end of the program, Malawians will openly discuss HIV/AIDS with their partners, children and peers; have a sense of hope and efficacy; and have the skills to act. Underpinning this change will be increased technical capacity among Malawians to design, implement, and monitor effective behavior change strategies and interventions (BCI).

To achieve this vision, the BRIDGE team will assist Malawian stakeholders to implement evidence-based interventions at national, district/community and individual levels. Unifying themes will help focus efforts and foster synergy across these three levels of intervention:

- At the *national* level, an enabling environment will be created through the harmonization of action plans, unifying themes such as “openness and hope,” and BCI to support local mobilization.
- At the *district/community* level, social systems will be mobilized through a grants program, participatory BCI, and supporting change agents to play a more powerful and persuasive role.
- At the *individual* level, youth, men, and women will be reached through a range of approaches including radio drama, sports interventions, youth events, and community-mobilization efforts.

Specifically, Malawi BRIDGE aims to:

- Increase the median age at first sex;
- Decrease unmarried youth 15 – 24 having sex in last 12 months;
- Decrease the number of men reporting more than one sexual partner during the last 12 months;
- Increase condom use at last sex by unmarried youth; and
- Increase condom use by adults with non-regular partner.

Malawi BRIDGE will operate in the following 8 districts: Balaka, Chikwawa, Kasungu, Mangochi, Mulanje, Mzimba, Ntcheu, and Salima.

IV. Rationale for the Study

This report is based on findings from a baseline assessment that was conducted in December 2003, and January 2004, in eight districts in Malawi. Two sets of studies were conducted simultaneously: a qualitative study, comprising focus group discussions, and a quantitative study, comprising surveys of household members.

IV.1. Qualitative Study

The qualitative study was based on focus group discussions (FGDs) with the aim of investigating and describing perceptions, beliefs, norms and practices regarding HIV/AIDS prevention and reproductive health among different age groups in rural areas of Malawi. Taking the stance that a deep understanding of behavior must include the meaning that social actors give to what they and others do (Weber, 1962), the focus-group discussions sought to explore and validate the participants' opinions and worldview in a non-directive, participatory way. The use of self-projection images and games generated open discussions on several topics, including participants' perceptions about risks, sense of self-efficacy and control, beliefs, collective values, and prevailing social norms regarding HIV/AIDS, sexuality, and reproductive health. The group dynamics as well as the non-judgmental atmosphere in which the FGDs took place allowed us to collect information on sensitive topics such as sexual practices and cultural traditions. Likewise, the participatory approach used during the FGDs helped unveil individual, social, and structural factors that influence HIV/AIDS from participants' own point of view. We were able to identify prevalent intergenerational and gender-based patterns of interaction as well as credible sources and channels of information on HIV/AIDS from the participants' point of view. In some instances, data gathered during the FGDs helped confirm or contrast data collected through the survey. In other instances, qualitative data complemented the survey with new information that was elicited as a result of the group dynamics and that would have been impossible to collect through the use of quantitative survey instruments alone.

IV.2. Quantitative Study

Based on the behavior change literature, we focused on a number of factors: risk perceptions, efficacy beliefs, perceived norms, and other ideational variables, including salient beliefs, values, and communication patterns. These variables have been widely used to study a range of behaviors, including those pertaining to HIV/AIDS prevention. The central assumption underlying this approach is that, to the extent that interventions can make an impact on the behavioral predictors, behavior change can occur. In order to assess the intervention's impact on these behavioral predictors, it was necessary to obtain baseline measures on these variables. We thus conducted surveys among a randomly selected group of residents in the eight focal districts in Malawi. These surveys served three objectives:

- to gauge pre-intervention levels of key behavioral predictors,
- to determine whether these predictors were associated with key indicators of HIV/AIDS-related behaviors, and
- to understand the communication behaviors of the intended audience.

IV.3. Theoretical Basis for the Project

The theoretical models used as a basis for the BRIDGE intervention are multi-dimensional, implemented at multiple levels and are guided by structural-environmental theories. These theories include the social-ecological model for health promotion and the theory for individual and social change (empowerment model). The project is thus based on the design and implementation of coordinated activities at the individual, community, and organizational level. Activities at the three levels (national, community, and individual) reinforce one another with positive synergistic consequences for individual and social change.

The central issue in the prevention of HIV/AIDS is behavior change. In order to reduce the prevalence of HIV/AIDS, individuals must be able and willing to take preventive actions. Our baseline research was based on a number of conceptual models of behavior change, including social cognitive theory (Bandura, 1977, 1986), extended parallel process model (Witte, 1992), the risk perception attitude framework (Rimal & Real, 2003), and ideation theory (Kincaid, 2000). In order to choose the appropriate theory, this research was guided by answering the central question: Despite widespread knowledge about HIV/AIDS, as has been widely reported, why are individuals not taking appropriate preventive action against the disease? To answer this question, we sought to determine the important facilitators of and barriers to behavior change.

In order to identify key behavioral facilitators and barriers, two interrelated factors were considered: key concepts from the literature on behavior change and how they manifest in the Malawi context. Thus, we deemed it important to be guided by the prevailing literature in selecting our focal concepts, but we also operated under the assumption that it was essential to gain an in-depth understanding about how these concepts operate in our intended audience's social context.

IV.4. Conceptual Background

IV.4.1. Perceived Risk and Efficacy Beliefs

Perceived risk, the belief that one is vulnerable to a disease, is thought to be a significant predictor of self-protective behavior. In the health belief model (Janz & Becker, 1984) and protective motivation theory (Rogers, 1975, 1983), for example, perceived susceptibility (together with other concepts, such as perceived severity, perceived benefits, and perceived barriers) plays a significant role in predicting individuals' likelihood of taking preventive action. In the health campaigns literature, perceived risk of a disease is thought to be a motivator of change (Chaffee & Roser, 1986; Rimal, Flora, & Schooler, 1999). Yet, researchers who theorize a causal relation between perceived risk and behavioral action have been puzzled by contrary findings. Whereas some studies do find the hypothesized link (Dolinski, Gromski, & Zawisza, 1987; Larwood, 1978; Weinstein, 1982, 1983; Weinstein, Sandman, & Roberts, 1990), others do not (Joseph et al., 1987; Robertson, 1977; Svenson, Fischhoff, & MacGregor, 1985), and still others show a negative correlation (Svenson et al., 1985; van der Velde, Hooijkaas, & Pligt, 1991; Weinstein, Grubb, & Vautier, 1986).

A number of explanations have been advanced to account for these contradictory findings, two of which are addressed in this report. Chaffee and Roser (1986) note that heightened risk perception may inhibit action because of the risk-induced excessive fear. If this explanation is

correct, then high-risk individuals who also possess high efficacy beliefs in dealing with the threat should differ significantly in their risk-ameliorating behaviors from high-risk individuals lacking in efficacy. Specifically, to the extent that perceived risk acts as a motivational factor, those with high perceived risk and strong efficacy beliefs can be expected to engage in more extensive preventive behaviors than those with high perceived risk and low efficacy beliefs, as well as those with low perceived risk (regardless of efficacy beliefs). This is, in fact, analogous to the prediction of Witte's (1992, 1994) extended parallel process model (EPPM). The EPPM predicts that the most healthy response will occur among individuals who have both high risk perceptions and high efficacy beliefs.

The Risk Perception Attitude (RPA) framework (Rimal & Real, 2003), which is derived from the predictions of the EPPM, also makes similar predictions between risk perception and efficacy beliefs, on the one hand, and behavioral change, on the other. The RPA framework hypothesizes that the effect of perceived risk on people's self-protective motivations and behaviors will be moderated by their efficacy beliefs. A similar prediction can also be derived from social cognitive theory (Bandura, 1977). According to the theory, those who feel efficacious are likely to construe potential risks as challenges to be overcome, whereas those lacking in efficacy typically interpret their vulnerability in a fatalistic manner (Maibach & Murphy, 1995; Rimal, 2000).

Based on individuals' risk perceptions and efficacy beliefs, the RPA framework identifies four attitudinal groups.

First, those with high perceived risk who also possess high efficacy beliefs are characterized by a *responsive attitude*. These individuals, being aware of their risk status and believing they have the requisite skills to avert the threat of the disease, are expected to be most motivated in enacting self-protective behavior.

Second, people with high risk perceptions and low efficacy beliefs are characterized by an *avoidance attitude*. These individuals are likely to experience conflicting motivations. On the one hand, their high risk perception likely makes them concerned about their health status, but on the other, their low efficacy beliefs are likely to dampen their motivations. Hence, this group is likely to be less motivated than the responsive group.

Third, individuals with low risk perceptions but high efficacy beliefs are characterized by a *proactive attitude*. They are not motivated by their perceived risk status, but rather by their desire to remain disease free.

Finally, those with low perceived risk and low efficacy beliefs are likely to be the least motivated. They believe they are not vulnerable and, even if they were, they do not believe in their ability to avert the threat. They are characterized by an *indifference attitude*. The four-group format is shown in Table IV.1.

Table IV.1. The Risk Perception Attitude (RPA) Framework

Risk Perception	Efficacy Beliefs	
	High	Low
High	Responsive	Avoidance
Low	Proactive	Indifference

IV.4.2. Perceived Norms

Health behaviors are guided not only by individuals’ efficacy beliefs (Bandura, 1977, 1986), barriers (Janz & Becker, 1984; Rogers, 1975), and risk perceptions (Weinstein, 1989; Weinstein & Nicolich, 1993), but also by their perceptions about *others’* beliefs (Ajzen & Fishbein, 1980) and behaviors (Asch, 1951; Deutsch & Gerard, 1955). The latter concept is commonly referred to as subjective norms (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975), social norms (Perkins & Berkowitz, 1986; Perkins, Meilman, Leichliter, Cashin, & Presley, 1999), normative influences (Cialdini, Reno, & Kallgren, 1990; Deutsch & Gerard, 1955), social influences (Rice, 1993), or simply norms (Bendor & Swistak, 2001). This preponderance of different terms used to describe the same phenomenon, we believe, stems from the failure to make a distinction between two interrelated but distinct terms – descriptive norms and injunctive norms.

In the broadest sense, norms are codes of conduct that either prescribe or proscribe behaviors that members of a group can enact. This definition comprises four important features. First, norms are thought to exist “if any departure of real behavior from the norm is followed by some punishment” (Homans, 1950, p. 123). Indeed, it is meaningless to talk about norms unless their violation triggers some form of sanction (Bendor & Swistak, 2001). Second, norms are different from laws in that laws are explicitly codified, whereas norms are understood through social interaction. This “social interaction” component is an important consideration because sanctions for the transgression of norms need not be imposed exclusively by the aggrieved party; indeed, it is often imposed by a third party (Bendor & Swistak, 2002). In this sense, norms comprise modes of conduct larger than those agreed to by individuals in a dyadic relationship, which has been called a norm of reciprocity or reciprocal norms (Axelrod, 1984; Bicchieri, 1993). Third, implicit in this argument is the idea that norms do not exist independent of individuals’ group identity, their sense of belonging or “oneness” with the group (Tajfel & Turner, 1986). Finally, because social interaction can occur only through communication, norms cannot exist in the absence of communication among members of the group. Put another way, norms are constructed, understood, and disseminated among group members through communication. Given these characteristics, we can redefine norms as group identity-based codes of conduct that are understood and disseminated through social interaction. Descriptive norms provide information about, while injunctive norms provide sanctions for, group members’ noncompliance. In this report, we draw a distinction between these two norms and we develop a model that includes the influences of communication behaviors and group identity.

Descriptive norms refer to individuals' beliefs about how widespread a particular behavior is among their referent others. They provide information about the strength of the norm. The greater the perceived prevalence of a behavior, the greater the likelihood that individuals will believe that engaging in the behavior is normative, i.e., within the prevailing norms of conduct.

Thus, whereas descriptive norms describe the prevalence of a behavior, injunctive norms refer to the extent to which individuals feel pressured into engaging in a behavior. In this conceptualization, pressure can occur because of perceived threats (e.g., losing friendships or being unable to cultivate them) to either oneself or to one's social network.

IV.4.3. Other Theoretical Frameworks

In order to uncover the implicit and explicit ideational factors present in participants' discourse, we combined the inductive techniques described by Patton (1990) and Strauss (1987) with the methods for data display proposed by Miles and Huberman (1994). Several methods and tools for content analysis provided by contemporary theories of semiotics were used to unveil the denotative and connotative meanings of words, syntagms, and paradigms (Eco, 1988; Greimas, 1990 and 1979; Hall, 1980). We used the tools developed by Cohen Émerique (1998) to uncover implicit social representations of the subject that influence the perceived costs of the HIV/AIDS epidemic, the prevailing values, and social norms in the communities.

IV.5. Summary

In summary, in order to gain an in-depth understanding about the ideational factors that influence HIV/AIDS preventive behavior as well as the socio-cultural and normative issues surrounding HIV/AIDS, a series of focus group discussions were held in two of the eight focal districts in Malawi.

In order to identify the relationship between risk perceptions, efficacy beliefs, normative perceptions, and ideational factors on the one hand, and HIV/AIDS-related behaviors, on the other, surveys were conducted in the eight focal districts in Malawi.

Finally, this baseline research also sought to understand various contextual factors in order to develop effective messages that could persuade people to engage in self-protective behaviors in the fight against HIV/AIDS.

V. Research Methods

One set of qualitative and one set of quantitative survey techniques were adopted. Qualitative methods comprised focus group discussions (FGD), whereas quantitative approaches comprised a representative survey (RS). FGDs were conducted in two of the eight focal districts, Mzimba and Mangochi, whereas the RSs were conducted in all eight districts: Mzimba, Mangochi, Ntcheu, Salima, Chikwawa, Balaka, Mulanje, and Kasungu.

V.1. Objectives

The primary objectives of the RS and FGD were:

- To provide a baseline reference in order to evaluate the overall effectiveness of the BRIDGE project
- To provide meaningful input to intervention efforts in order to enhance the effectiveness of program implementation

V.2. Qualitative Study

Focus group discussions (FGD) were designed to gain an in-depth understanding about the various determinants of HIV/AIDS-related behaviors. It was important to understand why people engage in high-risk behaviors; what barriers they face in changing those behaviors; what people's relevant attitudes and beliefs are; what levels of knowledge exist; what environmental factors facilitate or hinder behavior change; and what program planners can do to facilitate behavior change.

V.2.1. Sampling

Ten FGD were conducted in two of the eight districts (five in each), as shown in Table V.1.

Table V.1. Focus Group Discussion Sessions

<u>Participants</u>	<u>Mangochi</u>	<u>Mzimba</u>	<u>Total</u>
Boys	1	1	2
Girls	1	1	2
Men	1	1	2
Women	1	1	2
Village elderly	1	1	2
<u>Total</u>	5	5	10

Each group, except the two groups with elders, consisted of 8 to 10 participants. Each of the two groups with elders consisted of 4 to 5 individuals. Attempts were made to compile groups that comprised individuals with a wide range of backgrounds. For example, the group of boys (or girls) included some who were in school and others who were not; similarly, the group consisted of some who were married and others who were not.

V.2.2. Topic Areas

Specific topic areas covered during the FGD pertained to the following:

- HIV/AIDS-related behaviors
- Efficacy beliefs
- Risk perceptions
- Discussion patterns surrounding sexuality
- Perceived barriers
- Perceived sexual norms
- Perceived stigma
- Knowledge about HIV/AIDS
- Prior exposure to HIV campaigns
- Anxiety surrounding HIV/AIDS
- Exposure to and first-hand experience with PLWHA.
- Radio listening patterns
- Beliefs about the credibility of various sources of HIV/AIDS information

V.2.3. Procedures

Each focus group was conducted by two enumerators – one moderator and one note taker. The moderator was in charge of conducting the focus group and he or she led the discussion and asked questions. Focus groups comprising male participants were conducted by a male moderator (and the note taker was also male), whereas focus groups comprising female participants were conducted by a female moderator (and the note taker was also female). The role of the note taker was to record discussion topics and provide overall observations. Each focus group lasted approximately 90 minutes.

V.2.4. Recording Equipment

All FGDs were audio taped on cassette tape recorders through the use of microphones. Cassette tapes were subsequently transcribed and translated verbatim into English.

V.3. Quantitative Study

V.3.1. Principles

Representative surveys (RS), which comprised the quantitative component of the assessment, were designed to collect information that could be generalized to the larger population. A sample representative of the 8 demonstration districts was drawn by randomly selecting households within each district and selecting no more than one individual per household. Survey

data were collected from 891 participants – more than 100 each from Mzimba, Mangochi, Ntcheu, Salima, Chikwawa, Balaka, Mulanje, and Kasungu, as shown in Table V.2.

Table V.2. Survey Research Participants

<u>District</u>	<u>Male</u>	<u>Female</u>	<u>Total</u>
Balaka	37	68	105
Chikwawa	54	50	104
Kasungu	52	51	103
Mangochi	54	62	116
Mulanje	53	79	132
Mzimba	55	50	105
Ntcheu	53	50	103
Salima	47	72	119
<u>Total</u>	405	482	887 ^a

^aDue to missing values, total in this table is less than overall total (891) in the sample.

V.3.2. Procedures

All households within the specified district had equal chance of being included in the RS. Enumerators selected a male adolescent from the first household that they visited, a female adolescent from the second household, a male adult from the third household, and a female adult from the fourth household. This pattern was repeated whenever possible, although household configuration often dictated skipping members from one age group in order to secure someone else from the selected household.

V.3.3. Topic Areas

Topic areas were the same as those noted under the Qualitative Section (above). In addition, participants were also asked about their socioeconomic status (in the case of adolescents, the socioeconomic status of their parents) and demographic particulars (e.g., age, sex).

V.4. Pre-testing and Training for Quantitative and Qualitative Studies

Based on previous surveys conducted by the CCP research team, the BRIDGE staff developed the draft survey instrument in English. The questionnaire included socio-demographic, psychosocial, communication, and behavioral questions.

Questions were translated into Chichewa and Tumbuka, and then back translated for accuracy, and all members of the data collection team were invited to attend a weeklong workshop in Lilongwe. This workshop provided training in interview techniques, administration of focus group discussion, and other research methods skills. Each question item was discussed among workshop participants in order to ascertain clarity, facilitate its administration, and make it suitable for the local vernacular. Participants provided feedback, which was used to modify question items as needed.

The modified questionnaire was then field tested among Lilongwe residents. Field testing was done by conducting focus groups and surveys. Results from this field test were incorporated in further refinement of the focus group protocol and survey instrument.

All data for the FGDs and RSs were collected by members of Salephera Consulting, Ltd., Malawi. They translated the FGD transcripts into English, entered all the data from the RSs, and checked the entered data for accuracy.

VI. Results

VI.1. Qualitative Research Findings

Findings from the qualitative research are presented around the main themes that emerged during the focus group discussions and that reflect, in turn, the conceptual issues that guided this research. In particular, we focus on the following topics: the ideational factors that influence the adoption of HIV/AIDS preventive behaviors (e.g. perceived costs and risks associated to HIV/AIDS, perceived control, sense of self-efficacy, beliefs, norms, etc.); the social, cultural, and economic factors surrounding HIV/AIDS; and the prevailing attitudes towards HIV/AIDS testing and treatment. In addition, we also report on the preferred communication channels and information sources regarding HIV/AIDS from the point of view of participants.

Results are presented following the emerging themes in the participants' discourse. We first present the overall problems surrounding HIV/AIDS in the communities, which leads us to elaborate on the underlying value system that influences the perceived risks and costs associated with HIV/AIDS. We then tackle the issues of perceived control and self-efficacy, taking into account the socioeconomic, family and interpersonal intervening factors that participants pointed out during the focus group discussions. The section on whether HIV/AIDS is a punishment from God leads us to discuss two different tendencies among the participants who either adopt a fatalistic attitude and express feelings of powerlessness vis-à-vis HIV/AIDS infection, or stress a sense of control and responsibility in the prevention of the disease. Participants' attitudes, beliefs, and practices concerning the use of condoms and HIV testing are then explored. Certain sexual practices rooted in cultural tradition as well as the perceived descriptive norms surrounding those practices are described. Finally, we devote the last section to the description of intergenerational and gender-based communication patterns, channels, and sources of information on reproductive health and HIV/AIDS.

VI.1.1. Risks and Costs Associated with HIV/AIDS

The most recurrent problems related to HIV/AIDS explicitly mentioned by participants were poverty and orphanage. These social problems were regarded by participants as both cause and consequence of the HIV/AIDS epidemic, both contributed to perpetuating the epidemic.

Young productive people die leaving behind their spouses, their children, and the elderly. A recurrent theme in the discussions was the feeling of being abandoned: women are abandoned with their children, the elderly have to fend for themselves, and orphans are not well taken care of and end up being "out of control" because of the lack of parental supervision. A particularly common issue was orphanage and the social problems that it brings about. When participants talked about the orphans who are "out of control," they made reference to the absence of an authority figure capable of setting limits on their behavior. The elderly cannot take care of the orphans: They don't have the (material) means to support them, and they "don't manage to control the youth."

Women and children suffer from the absence of the husband/father or of both parents, and don't have any other alternative but to have sex in exchange for money. Some participants explained

that women send their children to have sex for money to be able to pay for basic necessities. Others talked about grandparents doing the same with their orphaned grandchildren. Women have sex outside marriage to be able to satisfy the family's basic needs. Although it was a rare sentiment, one participant (in this case an elderly person) stated that these women are promiscuous because they "like money;" the majority of women and girls explained that they did not have any other alternative. As a result, participants explained, more people get infected and die.

I support and agree with the orphan issue being discussed here. We worry because you have lost your child who was the sole support of the family and the children are left with the grandparents who were also relying on the one/ones who have died. *It becomes a hopeless situation.* The government should seriously consider and do something to help the orphans. (Mzimba women, p.3, emphasis added)

HIV/AIDS is destroying the social fabric of the community and people are aware of this: the elderly are left alone to struggle by themselves, orphans are out of control and have sex for money to survive, and parents or grandparents send their children to have sex for money because they need to cover basic needs (or because "they love money").

HIV/AIDS was explicitly mentioned as one of the main community problems by girls in Mangochi, and by women in Mzimba and Mangochi. The girls from Mangochi explained that they were particularly concerned about HIV/AIDS and other STIs, such as syphilis, because "we get the diseases while young and these diseases *have no cure.*" (Mangochi girls, emphasis added).

Like the other participants, girls and women in both communities considered that poverty and orphanage were, at the same time, cause and consequence of the HIV/AIDS epidemic. For instance, women in Mzimba said, at the beginning of the FGD, that "Here, in [our village], our problem is poverty" and explained that the unaffordable cost of fertilizers does not "enable us to produce or harvest enough food." Later on in that same group, a participant asserted that women got infected with HIV/AIDS because "we desire to have sex with ... the vegetable seller because of the way we toil to get things like fertilizers." The girls and women in that community also mentioned among the main community problems the increase in prostitution. Women from Mzimba said that "the source of concern [as related to HIV/AIDS] is promiscuity because that is the behavior that has spread the disease." Girls from that same community expressed their concern for the increasing number of orphans: "A lot of parents are dying of HIV/AIDS," they said.

Apart from HIV/AIDS and the social problems that the epidemic accentuates, girls from both communities mentioned that one of their main sources of concern was adolescent pregnancy. One participant from Mzimba explained that there was "*a bleak future for girls*" because they get pregnant before they completed their education (emphasis added). Meanwhile, a girl from Mangochi explained that "the man responsible for the pregnancy does not give us the support we need [and], as a result, we ... [become] a burden [to] our parents."

VI.1.2. Reasons for Concern

One of the reasons for concern regarding HIV/AIDS, from the participants' perspective, is that it has no cure. Statements such as the following appear in the discourse of participants from both communities:

We get concerned because when we get AIDS we cannot be healed. (Mzimba girls)

... here at Chowe [Mangochi] people are concerned with HIV/AIDS because it has no cure. (Mangochi boys)

Once a person is infected, participants implied, there is nothing to do. No one can control or stop the inevitable progression of the disease. Participants were concerned about the disease because

- HIV/AIDS has no cure
- It takes long for an AIDS patient to die (i.e. it is a long disease)

The last statement lends itself to different interpretations. When the participant (a girl from Mzimba) said that: "People worry because it takes so long for an AIDS patient to die," she might have been thinking about the long suffering of the sick person. However, in the context of the FGD, it appears as intrinsically related to the fact that the sick person could no longer fulfill his or her customary (productive) role and thus becomes a burden for the family and the community.

In the same vein, when participants explained why or to what extent they were worried about HIV/AIDS, the reasons they gave were more related to the collective well-being of the community than to personal, individual health. Participants – female and male youth, adults and elderly alike – were concerned about HIV/AIDS, first and foremost, due to its social consequences, which include the following:

- Many people die
- Productive people die
- The elderly are left alone to fend for themselves
- Children become orphans
- Orphans are not well taken care of or supervised

There is no doubt that seeing someone get sick and die due to HIV/AIDS may affect people individually. For instance, a boy from Mangochi said that when he saw a person increasingly get ill and eventually die of an infection related to AIDS, he decided to use condoms. At the same time, several participants in both communities showed an attitude towards PLWHA that revealed a sense of communal solidarity:

If someone gets sick from HIV/Aids *in our village we become unhappy; we get psychologically disturbed/troubled because we see how the disease is affecting the person.* (Mzimba women, emphasis added)

Note that the participant used the first person plural. He said "*we become unhappy; we get psychologically disturbed/troubled,*" implying that the illness of one individual affected the

community (we) at large. Likewise, when participants worried that productive people died leaving behind the elderly and orphans to fend for themselves, they were implicitly expressing their concern for what constitutes the breakdown of the very foundations of the community.

VI.1.3. Personal Risks and Social Costs

Analysis of the participants' discourse regarding the main problems and concerns associated with HIV/AIDS unveiled a predominantly collectivist notion of self and social relations. Cohen Émerique (1998) explains that in a collectivist model of self "... il n'y a jamais de coupure du milieu familial d'origine et du groupe d'appartenance; c'est le sentiment du "nous" qui prédomine et non celui du moi¹." Solidarity and group cohesion are fundamental values within a collectivist orientation towards self and social relations: "La solidarité est un impératif auquel on ne peut se soustraire; on y fait appel pour la maladie, le deuil ou pour pallier à une carence de parents dans l'éducation de leurs enfants.²" As we have seen, the main concerns expressed by participants in relation to HIV/AIDS were related more to the collective well being of the community than to personal, individual health. They tend to talk and worry about "us" as a community; the illness of one individual member affects the community at large both emotionally and in concrete, material terms.

The predominance of a collectivist orientation towards self and social relations in the participants' discourse does not preclude, however, the expression of values that reflect and are inherent to an individualist orientation towards the subject. As Cohen Émerique (1998) demonstrates, both orientations can co-exist in the same society and the same individual, with variations depending on the societies and contexts. Thus, in the present case, some of the participants' (legitimate) concerns were related to their awareness of the individual risk of contracting an incurable and long disease, and the consequences that it may have in the development or self-realization of the individual: if a person is found HIV positive, a participant said, all his projects come to a halt, and there is no possibility of personal progress anymore. Self-realization and self-development are among the fundamental values of an individualist orientation. Likewise, at another level, the Judeo-Christian notion of "sin," which also corresponds to an individualist notion of self is recurrent in the participants' discourse. However, the majority of problems and concerns that participants in the different FGDs associate with HIV/AIDS correspond to the social costs of the pandemic and refer us to values of interdependency and social cohesion, characteristic of a collectivist representation of self and social relations. Those social problems, which are perceived at the same time as cause and consequence of the disease and greatly concern participants, correspond to key social and economic costs associated with HIV/AIDS and sexual activity:

- Being left alone or orphaned
- Elderly to shoulder the burden
- Loss of productive individuals

¹ *There is never a distinction between the family of birth and the broader group to which one belongs; it is a sense of "us" that prevails, and not one of "me."*

² *Solidarity is an imperative, without which one could not support oneself; you call upon it in times of illness, mourning, or to compensate for where parents lack in the education of their children.*

From this perspective, the HIV/AIDS pandemic not only represents a personal health risk (i.e. contracting an incurable disease) but also, and most importantly, enormous social and economic costs for the community as a whole. From the participants' point of view, the greatest (albeit never mentioned) social risk associated with the HIV/AIDS pandemic would ultimately be the disappearance of the community. Concomitantly, the fight against HIV/AIDS may find its full sense if it is translated into action that, while acknowledging the importance of individual self-preservation, stresses the vital importance of the community's survival.

During the focus group discussions, in which participants were encouraged to freely express their problems and concerns regarding HIV/AIDS, they emphasized the social consequences of the disease. The participants' perceived individual risks related to health, which were also present (although to a lesser degree) in the participants' discourse during the FGDs, were further investigated in the survey and are discussed in the part of the report devoted to the quantitative research findings.

VI.1.4. The Issue of Control

Persuasion scholars have noted that understanding the nature of counterarguments generated by people when exposed to persuasive messages provides important clues about their source of resistance to such messages. Counterarguments to a persuasive message also reveal the perceived barriers to change as advocated in a particular message. In order to elicit relevant counterarguments generated by our intended audience in response to commonly used HIV prevention themes, we played a "game" by asking participants to complete the sentence, "Yes, but...", in response to a prescriptive message about HIV prevention. For example, the prescriptive message would mention, "Always use a condom," and audience members were then asked to complete the sentence, "Yes, but..." In this context, when participants talked about the reasons that prevented them or others from following certain prescriptions to avoid getting infected with HIV (e.g. having one partner, being faithful, using condoms, protecting oneself from HIV/AIDS etc.), the issue of control was prominent in their discourse.

VI.1.4.1. Lack of External Control

Participants expressed a feeling of lack of external control at different levels:

Socioeconomic level

Participants stressed their lack of control over poverty.

It is worth noting that many of the girls from both communities completed the following phrases:

"Protect yourself against HIV/AIDS..." and

"HIV AIDS is a deadly disease and nothing is more important than remaining free from this disease..."

with sentences that were related to their poverty. For example, in response to the phrase “HIV/AIDS is a deadly disease and nothing is more important than remaining free from this disease,” a girl from Mzimba stated:

OK, but the problem would be that one may not contract it, but *because of poverty one may be enticed to sleep with the man who has offered her money*. That’s how one may contract the disease. (Mzimba girls, emphasis added).

Similarly, a girl from Mangochi completed the phrase “Protect yourself against HIV/AIDS” as follows:

OK, but as said earlier, on that we lack assistance from parents and think, “since this one has given me these clothes, then I will sleep with him.” In the end one gets HIV/AIDS.

Girls and women from both communities completed the phrase “Don’t sell your body for money” with sentences such as the following:

Sometimes you find that both parents passed away, and then you are alone without a shepherd, you lack the daily basic needs. And then you do prostitution as the last option. (Mangochi girls)

But my daily needs are just too many. (Mzimba girls)

Family level

Women and girls in particular perceived a lack of control over their lives. Parents and/or partners either imposed orders on them or made decisions that directly affected their lives. For instance, parents want their daughters to get married young, even though the latter are afraid of getting married for fear of being infected with HIV by their partners. Parents or grandparents may send their children to have sex for money – situation that participants regarded as a problem related to poverty and rarely to greed. According to participants, orphaned children were not well taken care of and lacked parental supervision. Most of the time, when participants talked about children’s prostitution, they were implicitly or explicitly talking about girls and not boys.

Men also felt that they lacked control over certain situations and did not have the power to intervene in order to change them. For instance, even though they can decide whether or not to use a condom with a sex worker, they felt powerless when it came to preventing child prostitution or discussing the use of a condom with a woman who refuses to use it. Some men lamented that when women send their children to have sex for money, men/husbands feel unable to intervene or give advice.

Interpersonal level

Women and girls perceived that they did not have control over what their partner does:

- Husbands, friends, lovers, or men in general decide whether or not to use condoms.
- Some men are “cruel”: they remove the condom without the woman’s consent.

- Condom use is not in the woman’s hands: she’s not the one who wears it.
- Even if they are faithful, married women may get infected by unfaithful husbands.
- Women may not feel entitled to know their partner’s HIV status. A girl from Mzimba said: “I wouldn’t know if my partner is negative; I can just sleep with him.” This could imply that women are not supposed to ask their partners for their HIV status. It could also be related to the lack of access to HIV/AIDS testing: since the test is not available, it is not possible for women (and men) to know their partner’s HIV status.

VI.1.4.2. Lack of Internal Control

The sense of lack of internal control was also recurrent in participants’ discourse (male and female youth, adults, and elderly). The expressions related to lack of internal control ranged from people’s inability to resist Satan’s temptation that an elderly person pointed out, to the expression of some typical adolescent feelings regarding their sexuality and their felt inability to control their sexual impulses. Thus, girls from Mzimba talked about their “uncontrollable sexual desires,” while boys from Mangochi pointed out the difficulty for the youth “to refrain” or practice abstinence. In several occasions, Mzimba girls made reference to the (uncontrollable) “sexual desires” or “sexual feelings” that may prevent them from following HIV/AIDS prevention advice:

Prescription/Advice: Protect yourself against HIV/AIDS
 Yes, but we are enticed by our sexual desires. (Mzimba girls)

Prescription/Advice: Be faithful
 Yes, but sometimes I have uncontrollable sexual feelings. (Mzimba girls)

In the Malawian context, these typical adolescent feelings helped reinforce an overall sentiment of lack of control regarding sexual behavior among sexually active people in general and youth in particular.

VI.1.4.3. Self-efficacy

Certain explanations of inability to perform preventive behaviors reveal key factors related to girls’ sense of self-efficacy. The following excerpts illustrate the type of statement we are referring to:

R *Prescription/Advice: Don’t have more than one sexual partner...*
 [Yes,] But *I’m used to* having more than one sexual partner. (Mzimba girls, emphasis added)

R *Prescription/Advice: Be faithful*
 [Yes, but] *It’s a habit* not to be faithful. (Mangochi girls, emphasis added)

R *Prescription/Advice: Protect yourself against HIV/AIDS*
 [Yes,] But it’s because *we are used to* go out with boys. (Mzimba girls, emphasis added)

[Yes,] But *we're still young and are still searching* for the right partner...*we don't know how to find out properly the virus-free partner.* (Mzimba girls, emphasis added)

Two main axes were found in participants' discourse: the difficulty to break a "habit" and the girls' "inexperience." Girls used phrases that denote a perceived inability to break a deep-rooted habit, namely: having more than one sexual partner, not being faithful, going out with boys. Likewise, when a participant from Mzimba said, "we are still young and are still searching for the right partner... *we don't know how to find out properly the virus-free partner,*" she was implicitly stating that girls ("we") are in a period of searching and exploration (to find the right partner), and do not yet have the necessary "skills" to choose their partner. That this participant mentioned "we don't know how to find out properly the *virus-free partner*" may also point to the fact that, because the HIV test is not available, girls cannot know whether their partner is "virus-free." However, in the context of the discussion, the phrase would seem to be related to the girl's felt inexperience: she said, "... we are still young and still searching," implying that time (and experience) would give her the tools to "find out" the "virus-free partner." Finding the "proper virus-free partner" could also imply, in this context, starting a more steady relationship (with "the" right person) instead of going out with several boys at a time.

VI.1.5. Punishment from God: Fate or Fault?

In most groups from both communities, the majority of participants believed that HIV/AIDS was not a punishment from God. Participants' discourse revolved around several ideational factors, such as: beliefs, perceived control, and knowledge. Although the same categories tended to appear in the discourse of both groups, the predominance of some of them varied according to whether people believed that HIV/AIDS was a punishment from God.

The main category in the discourse of those who believed that HIV/AIDS was a punishment from God corresponded to "beliefs," while the most predominant category in the discourse among those who believed that HIV/AIDS was not a punishment from God was "perceived control."

VI.1.5.1. It is a Punishment

Participants explained that HIV/AIDS was a punishment from God because people have disobeyed God's commandments. From the perspective of participants who held this belief, one of the proofs that HIV/AIDS was a punishment from God would be that only those who commit sins (e.g. adultery) get sick. In the FGD with girls from Mzimba, HIV/AIDS appeared as the crystallization of a religious prophecy. God has sent this illness all of a sudden, some participants say, and that HIV/AIDS did not exist in the past. In addition, participants who believed that HIV/AIDS was a punishment based their conclusion on the absolute power of God: every sickness comes from God and HIV/AIDS could only be ended through the Almighty Power of God.

Participants who believed that HIV/AIDS was a punishment from God used arguments that were directly related to a sense of lack of control. HIV/AIDS, they said, has no treatment, and even if people took medications, they could not be cured. Whether the person was rich and “has everything” or s/he was poor and “would like not to have needs,” s/he was equally at risk of contracting HIV/AIDS. Only God can decide whether a person gets sick or not with HIV/AIDS, and only He “could decide to end the pandemic today.” The only thing people can do is to “pray to God because He is the only one who can help us with our sickness.” We notice that participants’ beliefs, their perceived lack of control, and their lack of self-efficacy become intermingled in their discourse. Since only God can decide who gets sick or whether the pandemic ends or continues, human beings end up being dispossessed of their ability to effect change or produce the desired outcome (i.e. reduction of cases of HIV/AIDS or its eradication). Becoming infected with HIV/AIDS would be, in this case, a deserved punishment inflicted on human beings, and part of people’s fate.

VI.1.5.2. It is not a Punishment

Participants who stated that HIV/AIDS was not a punishment from God contended that if it came from God, “everyone would be infected.” They express the belief that “God loves everyone, whether s/he has AIDS or not.” They also asserted that only if one does not follow God’s will (i.e. abstinence, faithfulness), “then the punishment is inflicted.”

Participants emphasized that people contracted HIV/AIDS “out of their own will,” and in saying so, they stressed that people do have control of whether they get infected or not and are, consequently, capable of performing the required behaviors to prevent the disease (sense of self-efficacy). Instead of focusing on God’s almighty powers, these participants acknowledged human beings’ responsibility in the spread of the disease. They stated, for instance, that people (including themselves) get infected because:

- They want to please themselves
- Even though they can distinguish good from bad, they have “insatiable desires” and want to get money to buy things or get fertilizers
- They go against God’s wishes and commit sins

They also stressed that HIV/AIDS was preventable. They mentioned the following preventive behaviors: not having multiple partners, having sex only with one’s spouse, being faithful to one’s partner, and practicing abstinence. In addition, they pointed out that those who obeyed their parents did not get infected. Girls from Mangochi stressed that “we get infected because we’re not satisfied with one partner,” “we are not faithful,” “we contract HIV/AIDS because of our prostitution.” An elderly person from that same community concluded that HIV/AIDS “comes from people’s lack of self-control [i.e.] running after money.” This participant questioned the current state of affairs in which money is at the center of people’s lives:

It comes from (a mentality) of ‘let me run and therefore get money, let me run after Tambalas’ (money). (Mangochi elderly)

Figures VI.1 and VI.2 summarize participants' discourse about HIV/AIDS and God's punishment. People who believed that HIV/AIDS was a punishment from God had a fatalistic attitude and felt that the epidemic was the result of God's will and a deserved punishment because of human beings' sins and disobedience. Those who did not believe that HIV/AIDS was a punishment from God attributed the disease to people's decision not to adopt preventive behaviors and/or follow God's wishes or parents' orders.

Figure VI.1. HIV/AIDS IS A PUNISHMENT FROM GOD

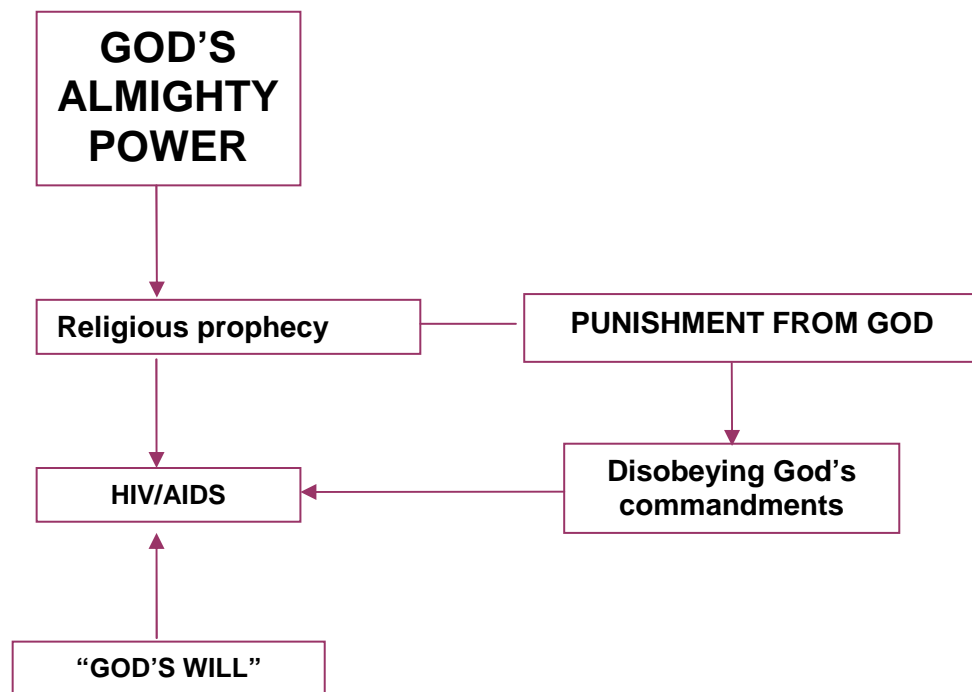
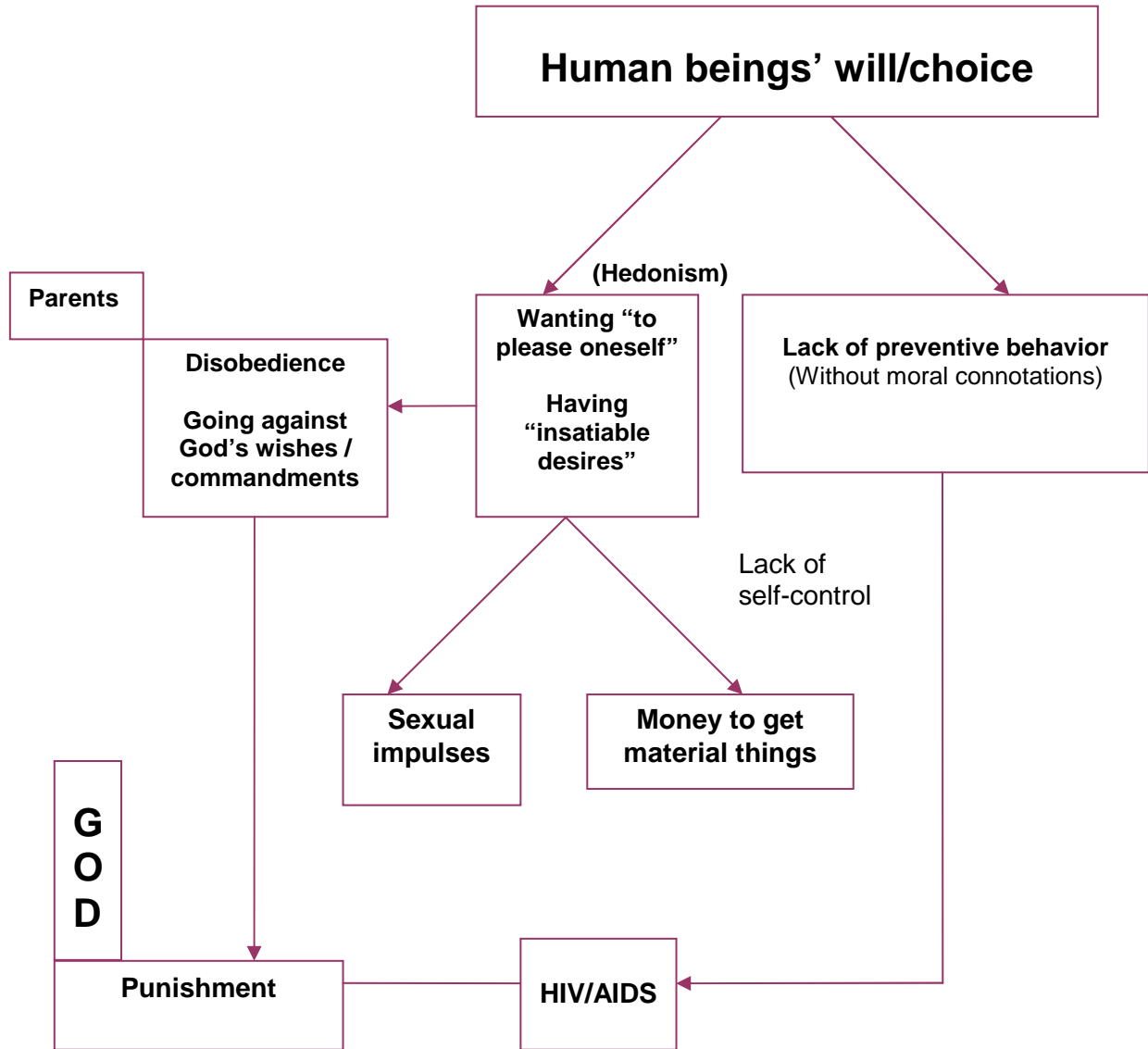


Figure VI.2. HIV/AIDS IS NOT A PUNISHMENT FROM GOD



The element that we found in common in both cases was that disobeying God’s will and commandments (or parents’ advice/orders) leads to punishment, meaning contracting the disease. In both cases there was an authority figure (God or God/parents) that participants disobey. Those who thought that HIV/AIDS was not a punishment from God stated that people got infected because they disobeyed God and their parents. People disobeyed God/their parents because their actions were guided by “desires.” People’s search for pleasure (i.e. sex and material things) was thus implicitly condemned. Pleasure was considered a sin and thus implicitly and intrinsically related to feelings of guilt. The other recurrent and complementary category in the discourse of those who considered that HIV/AIDS was not a punishment from God was the lack of preventive behavior without religious or moral connotations.

VI.1.6. HIV/AIDS Prevention, Testing and Treatment

VI.1.6.1. Condom Use

People mentioned more reasons not to use condoms than reasons to use them. Table VI.1 summarizes the main reasons to use and not to use condoms that participants mentioned.

<i>Table VI.1. Reasons to Use and Not to Use Condoms Mentioned by Participants</i>	
<u>Reasons to Use</u>	<u>Reasons Not to Use</u>
Preventing pregnancy Protection from HIV/AIDS Self-preservation Everyone can follow the the advice	The product: they are useless, they burst/have holes/are damaged, and are not 100% reliable The risk of infection goes beyond sexual intercourse: there are multiple ways of transmission apart from intercourse Decision-making process: girls refuse, men make the decisions Hedonism: decrease pleasure Fears: health hazard, prevents conception, diminishes pleasure Personal (conscious) choices: no need if there is trust, better to be faithful, better to abstain Religious connotation: encourages promiscuity, it is a sin Lack of preventive mentality: not preventive thinking, a lot of people choose not to follow the advice Other reasons Time: being in a hurry Harmful intent: wanting to harm others intentionally Lack of knowledge (among the elderly) on proper use Idealized vision of the past: people did not use anything in past

Apart from the mistrust of the product (condoms), other key ideational factors that may prevent the use of condoms fell under the following categories: emotional response (pleasure and love), control (lack of external/internal control), and social interaction.

Girls from both communities, as well as participants from other FGDs in Mangochi (women, men and the elderly), argued that “one doesn’t get satisfied when using condoms” (Mzimba girls). If the condom is expired and bursts, “it is difficult to start all over again when you’re already heated up” (Mangochi men). Two girls from Mzimba explained that when a woman is in love “it is impossible [for her] to refuse” sex, even if her partner does not want to use a condom. Likewise, a girl from Mangochi stated that she could not refuse having sex with a man, even if he did not want to use a condom, because she wants “to get material things.” In addition, girls and women stated that they have no control over the use of condom because men decide whether or not to use a condom. Men may also deliberately use a “broken condom,” remove it without the woman’s consent, or force her to have sex (in which case “a condom is not remembered”). Lack of control tended to be much less present in the male participants’ discourse. One of them stated that “sometimes the situation may not allow you to use a condom” (Mangochi men). In this case, the participant attributed the problem to the “situation” or circumstances.

The analysis of the participants’ discourse revealed a predominant asymmetrical pattern of interaction between women and men in which the former tended to depend emotionally and financially on the latter. If the girl refuses to have sex without a condom, “your partner can terminate the relationship” or “can tell you that he is not going to give you the money” (Mangochi girls, two different participants). In addition, women were sometimes forced to have sex and, “[s]ome men already know their status and they bring with them condoms with holes, and you have sex with them not knowing [that] the condoms are not good and get the disease eventually” (Mzimba women). Women cannot refuse to have sex without a condom with their husbands. Doing so would be not only unacceptable from their husbands’ point of view, but also harshly criticized by their parents:

... and you cannot report the matter outside your home because parents will say you are denying your partner sex. The result is you gradually become thin, you eventually have the disease. (Mzimba women)

Although to a lesser extent than among female participants, expressions of fear of loss and emotional dependency were also present in male participants’ discourse. Thus, for instance, an elderly man stated that “if you refuse, the partner may say that you do not love him or her and this will be the end of the friendship” (Mzimba elderly). Likewise, men also mentioned the difficulty of using condoms when the person has “strong feelings” for his partner. A male participant asserted, for instance, that “I can sleep with her even though she refuses a condom *especially when I have strong feelings for her*” (emphasis added, Mzimba men).

VI.1.6.2. HIV/AIDS Test and Treatment

The first question that came to mind when analyzing the participants’ discourse about HIV/AIDS testing was: How do Malawians feel about testing and treatments for HIV/AIDS?

There was a deep sense of hopelessness and helplessness in the participants’ discourse about HIV/AIDS testing when they were prompted to complete the sentence “Get tested for HIV/AIDS.” According to participants in the various FGDs, learning that one is positive leads to depression and may ultimately lead to suicide. It is a death sentence. Some people believed that

they would die faster if they knew that they were HIV positive because the anxiety would kill them. In addition, they questioned the usefulness of being tested when they don't know whether their partner is faithful to them.

Other reasons not to be tested were related to the stigma surrounding PLWHA:

But when you find out that you are positive, *you feel like you are already dead because of the insults that you receive.* (Mangochi boys, emphasis added)

... but if other [people] know that you have the disease, they laugh at you, they start to stigmatize you. They may want you to eat separately, use a separate bath and may not want to chat or spend time with you for fear of getting infected. These may create fear or anxiety and [people who have the disease] may commit suicide. (Mzimba elderly)

Boys from Mangochi stated that if they got tested, their friends would laugh at them or bother them:

But our friends will laugh at us. (Mangochi boys)

But your friends will bother you so much when they find out that you are positive. (Mangochi boys)

Unfortunately, this topic was not further explored. It is not clear what would lead people to laugh or bother kids or other persons who are found to be HIV positive.

It is important to note that when people talked spontaneously about HIV testing their attitude towards it seems to be more positive. For instance, one of the reasons why participants would see a health professional if they needed information about HIV/AIDS was that the latter could tell them “the truth,” meaning that they could get tested and find out whether or not they are HIV positive.

VI.1.7. Social and Cultural Dimensions of Certain Sexual Practices

VI.1.7.1. Early Initiation to Sex

In most FGDs participants asserted that both girls and boys started “having sex” at an early age. The following are some of the age ranges for sexual initiation that participants mentioned in the FGDs:

<i>Table VI.2. Age of First Sexual Experience According to Participants</i>			
Group	Community	Girls' Age	Boys' Age
Girls	Mangochi	10 to 16	8 to 15
	Mzimba	(Not covered)	5, 12
Women	Mangochi	12, 15	7, 12
	Mzimba	8	9, 10; "very young"
Boys	Mangochi	4 to 14	5 to 13
	Mzimba	14, 15	12, 14, 17
Men	Mangochi	12, 16	10 to 20
	Mzimba	15, 18	< 20, 15
Elderly	Mangochi	4, 8	2, 4; 12-25
	Mzimba	12-14, Similar to the boy: 6 -12	6 – 12

Elderly from Mangochi mentioned the youngest ages: 4 for girls and 2 for boys, while men and elderly from Mzimba and Mangochi mentioned the oldest: 18 for girls and 25 for boys respectively. Varied, implicit definitions of "having sex" were found in the participants' discourse. These definitions included the following: 2 and 3 year olds playing and imitating adults, older kids exploring sex with each other; "throwing ashes or dust" during initiation ceremonies (i.e. female and male circumcision), having sex for money, forced sex (rape), and first-sex experience with a partner. Since participants had different conceptions of what "having sex" meant, inferring the actual ages at which kids start having sex on the basis of this data would be inaccurate.

The reasons for an early initiation to sex provided by participants were also varied and include the following:

- a) Initiation ceremonies: In several groups, participants described initiation ceremonies in which young kids were encouraged to have sexual intercourse with one another. According

to participants, kids were told to “throw away dust or ashes,”³ meaning having sex, after the female and male circumcision ceremonies. The following two excerpts illustrate the descriptions provided by the participants:

Part 5: He was *seven years old*.

Facilitator: Why [did he have sex at that age]?

Part 5: Because when he is leaving the initiation place, *he is told that once he has left the initiation place, he must throw away the ashes (i.e. have sex)*. Also when leaving the initiation place, they have those thoughts that “once I get out of this place and get there, I will deal with that girl.” (I will have sex with her). Also in the evening after eating nsima (staple food in Malawi) they go to the ground to play. *They play “touch me” and “hide and seek” and that’s where they start having sex.* (Mangochi women, emphasis added)

[Question: With whom does the boy have sex?]

Participant 8: His young female friends. Females who have also just come from Msondo (girls’ circumcision ceremony), they too throw away dust by sleeping with boys who have just come from Jando.

Facilitator: What does Kutaya Fumbi mean (what does throwing away dust mean)?

Participant 8: Having sex.

(Mangochi girls)

- b) Kids share rooms with older people, watch them making love, and want to imitate them: According to participants, since kids share the rooms with parents, grandparents and older siblings, they see them making love and they imitate them with their peers.
- c) On several occasions, participants made reference to incest: brother, sister, uncle, and grandparent. However, no one used the word “incest” or implied any value judgment about the practice. They just mentioned/described it.
- d) In the FGD with women in Mangochi, one participant pointed out that older men abuse and rape children. They take advantage of them, for instance, when they are taking a bath:

Part 8: Sometimes some [of] these men (older) say, let’s go chat over there? Or when he is taking a bath inside the fence, you would hear, “Children, come here, get that pair of trousers [off] and [leave] it here with the fence;” the child fails to say no. Then takes the trousers (to him) “Sir here is the trousers” and the next thing is he rapes the child.

(Mangochi women)

³ The same expression was used in at least two groups, but with a small semantic difference: In some cases people talked about throwing away “dust,” while in other cases, they used the word “ashes.” If this image were to be used during the development of community activities or the mass-media campaign, it would be good to verify if the same word in Chichewa has these two meanings or if one of the translations is more accurate than the other.

- e) In the FGD with boys from Mangochi, participants mentioned that boys start having sex because they have sexual desires and sometimes are “provoked” (i.e. seduced) by girls (e.g. when parents let their daughters play outside without underwear).

In summary, boys and girls seemed to start being sexually active at an early age for different reasons, but the qualitative data did not provide a clear idea about the average age of kids’ initiation to sexual activity. The quantitative research did indicate that twice as many boys (32.5 percent) than girls (17.8 percent) had their sexual debut at an age earlier than 15 years (see Table VI.17). However, the qualitative data provided information about traditional practices, such as the initiation ceremonies, that although perhaps “marginal” at the present time in the country are still entrenched in the local culture. Data gathered by Angela Melchiorre in the framework of the Right to Education Project confirms that

In practice, it is common in the rural areas of Southern and Central Regions for girls of age 15 years and below to enter into marriage. This is mainly due to the cultural practices prevailing in these two regions. For example, during initiation rites girls as young as 10 years are prepared for possible marriages. It is difficult to stop this practice, partly because the law does not expressly prohibit marriages of children below 15 years old. The Constitution merely states that the State should discourage such marriages. (Melchiorre, 2004)

Those who spoke about the initiation ceremonies during the FGDs did so without implying any value judgments; they implicitly approved it or considered it as a “normal” practice in the community. Sex did not seem to be a taboo subject in the communities, people talked about it openly.

VI.1.7.2. Prostitution or Having Sex for Money?

In some cases, participants talked about people who “have sex with multiple partners” as a “business.” It would seem that the facilitators had the tendency to immediately label the female or male (fictitious) character that had several partners as a “prostitute.” In other cases, participants chose names for those fictitious characters that denoted “a person who has sex in exchange of money for a living” or “who has sex with anyone.”

Participants gave different names to the female and male fictitious characters that had multiple partners:

- Apallowaina, meaning “a lady who sleeps with many men” (Mangochi girls)
- “Chilera Walanda” since she assists or has sex with anyone who asks her to. Chilera Walanda means “one who takes care of orphans.” (Mangochi women)
- ... Unfaithful woman is called “Chilera Walanda” or “Chisime Cha Wali Yose,” she becomes a woman without respect. (Mangochi women)

- Bwex: It means the person who makes no choice whom to sleep with. He just picks anyone. (A male prostitute⁴)” (Mzimba boys)
- “Ntchontchi (one who likes sex or one who likes sleeping with ladies) (Everybody laughed when one participant said the name of the boy should be Ntchontchi) (...) Ntchontchi also means a boy who likes sleeping with girls.” (Mzimba boys)

It is hard to judge whether the names assigned to the fictitious characters had an implicit negative connotation. For instance, when boys talked about “Ntchontchi” a participant explained that the word means “...a boy who likes sleeping with girls,” which may or may not have negative connotations. When women used the words “Chilera Walanda” to talk about the woman who had multiple partners, one participant explained that “Chilera Walanda means one *who takes care of orphans*” while another one explained that “she *assists* or has sex with anyone who asks her to” (emphasis added). In this case, the phrases “taking care of orphans” or “assisting” others would not have negative connotations unless they were used in an ironic or sarcastic way.

In the imaginary situation that the participants were presented with (question number 6), a girl advised the woman who sleeps with many men to use condoms so as to make sure that her “business goes well”:

I would tell her ... my friend Tayifa, in order for your business of prostitution to go well you must be using condoms because you don't know what kind of sperms you come in contact with. So you should be using condoms to protect your life. (Mzimba girls)

Note that the participant did not judge or questioned the type of business that this person does, neither did she try to persuade her to do something else. Tayifa (a fictitious character) may be considered a “friend.” Some participants asserted that they would not insist too much on trying to convince Tayifa to use condoms for fear that she might think that they are jealous of her.

In other instances, it became clear that having sex for money was regarded as a legitimate way of getting the needed money to satisfy basic needs. Receiving money in exchange for sex could happen between boyfriend and girlfriend. For instance, when parents saw that “commodities [or money] go missing” in their house, they realized that their son had started having sex. They knew that their son was stealing the money to give it to his girlfriend:

Part 5: When the boy [is] having sex, commodities go missing from the house, whenever parents put a K10.00 on the table, they don't find it (again) ... when you ask “where is that K10.00?” he just answers something else, while he is thinking, “I'll give it to my girlfriend.” (Mangochi women)

It is important to keep in mind during program development and implementation that people's conceptions of sex are culturally bound. For example, providing sex favors in exchange for money or a gift is a common practice across much of Africa; this is true in Malawi too. In this case, women may accept or actively seek money in exchange for sex or “sex favors.” This could apparently happen even among women who were not considered sex workers (or “prostitutes”).

⁴ This comment seems to have been added by the note taker or the person who transcribed the FGDs

Note that the money received in exchange for sex may be considered a “gift,” which has positive connotations (and could even be flattering). At the same time, the fact of receiving money in exchange for sex places women in a situation of submission and dependency in relation to men.

VI.1.8. Communication and Information about HIV/AIDS

VI.1.8.1. Parents – Youth Interaction

In the same way that people tended to have an internalized image of God as an authority figure that punishes those who don’t follow His commandments, participants from both communities tended to regard parents as punitive authority figures whose central role is to punish and reprimand their children when they disobey them. The predominant type of interaction between parents and their children reflected in the participants’ discourse was characterized by “*epitactic* communication,” in this case, orders, reprimands, warnings, and punishment (Pasquali, 1980).⁵ When participants were asked about what parents should do if/ when they learnt that their sons or daughters were active sexually, the most common responses fell under the following categories:

- “Advice,” which may include implicit orders, such as, “stop having sex”
- Reprimand
- “Warning,” which may include the warning that they will beat their daughters if they continue having sex
- Punishment, which is usually physical (e.g. whipping, beating)

The accepted social norm seemed to be to give advice to kids and to reprimand them. Physical punishment was much more common when participants talked about a daughter who was having sex than when they talked about a son who was having sex. To whip or beat a girl (or, in some cases, a boy) who was not behaving properly seemed to be socially accepted. It was a measure that participants in different groups from both communities recommended:

Rather tell him to stop having sex or punish him; tell him to stop and beat him up
(Mzimba women)

When participants were asked to complete the phrase “Talk to your family about HIV/AIDS,” most of the responses in both communities revealed that parents and kids do not usually talk to each other about sex. Communication between parents and children about sexual issues was not viewed as a social norm:

But *according to our culture, it’s difficult to discuss sexual issues with our parents.*
(Mzimba girls, emphasis added)

⁵ Antonio Pasquali (1980) defines “epitactic communication” as follows: “We propose to call the informative and causative message epitactic, to encompass in only one term all its genres and species. In the word epitaxis or “prescription” the preposition *epi* expresses universally the **on top**, the **against**, the **up**, while the verb *tássso* covers without specific value connotations all the range of to order, to prescribe, to establish, to determine, to impose, to entrust, to assign and of other analogous verbs.” (Emphasis in the original).

Talking to family members about sex or sexuality seemed to fall outside the norm, especially when the children were not married:

But how can we talk to our family members since we are not married? (Mangochi boys)

In addition, boys from Mangochi acknowledged that they would not know how to address the issue with their parents:

But how should we talk to them? (Mangochi boys)

But how can we address the topic? (Mangochi boys)

These statements pointed to the lack of sense of self-efficacy among boys when it came to talking about sex with their parents. In the same way, men from Mangochi recognized their own inability to talk about sex with their kids:

But as a parent you become tongue-tied to talk about condoms with the children.
(Mangochi men)

Several of the participants' responses in this part of the discussion revealed that establishing dialogue between parents and children about HIV/AIDS or sexual behavior in general may be difficult if not impossible. Kids may not feel free to ask their parents questions, and parents, in turn, may not feel free to talk about sex with their children:

But the children are not free to ask questions. (Mangochi boys)

But the problem is that we are not free with our children (Mangochi men)
But as a parent you become tongue-tied to talk about condoms with the children.
(Mangochi men)

Parents may consider that if the child is young (they did not specify the age), s/he will not understand. Kids will start to understand "when they are old enough." Women from Mangochi pointed out that, even if parents "teach" their children, they cannot control what they do: "You can teach them, but you are not with them wherever they go." Some children may become insolent when their parents raise the issue of HIV/AIDS prevention:

OK, you can talk to the young ones but they do not listen and girls will talk back to you and say, "I will not be the first to die." (Mangochi women)

Mothers might even be afraid that their sons would physically harm (i.e. "beat") them if they told them what to do or not to do. Only a few kids will listen to their parents, participants said. Girls from Mzimba recognized that

... some of us undermine our parents' advice. (Mzimba girls)

A woman from Mangochi explained that

You can talk to them, but, as already said by others, they do not listen to you. Sometimes when they see that at home the parents have no soap just for a day [and] it will be an advantage for them to go to 'bwandilo' (go out) to look for soap and other things. (Mangochi women)

In the same vein, when participants were asked whether parents should talk to their children about the use of condoms, the most frequent answer was “No” regardless of the kid’s sex. The main reasons given for not talking to boys about condoms were the following:

It would be like giving them a “green light” to do whatever they want. (Mangochi and Mzimba girls, Mangochi and Mzimba women, Mangochi men)

He is just a kid; parents should wait until he reaches certain age (Mangochi girls and elderly)

He would not understand (Mangochi elderly)

Only as a second recourse, if he cannot abstain (Mangochi boys)

Parents would feel uncomfortable talking to their son about sex (Mzimba girls)

The reasons for not talking to girls about condom use included the following:

Some women don’t have the time (Mangochi girls)⁶

They already know that they should use a condom and that they should not wait for the man to decide (Mangochi women)

Only as a second recourse, if abstinence does not work (Mangochi men)

It would be useless; they would not listen to them (Mangochi elderly)

Only few participants thought that parents could and should talk to their children about condoms. In the case of a boy who has become sexually active, some men from Mangochi pointed out that parents should be realistic: Once the boy starts having sex, it will be difficult for him to abstain, and therefore, his parents should tell him to use condoms. In the FGD with boys from Mzimba, a participant asserted that the girl’s mother could talk to her about condoms. Women from Mangochi pointed out that a girl could receive advice on the use of condoms from her mother or the first-born child closer to her age. It would be inadequate for her father to talk to her “because of the age difference.” Mzimba boys thought that the girl’s mother, mother-in-law, or grandparents could talk to her about the use of condoms. However, neither the girls from Mzimba nor those from Mangochi explicitly talked about the possibility of having close relatives talk to girls about the use of condoms.

⁶ It is implicit in the text that it would be the mother’s duty or role to talk to her daughter

The most current pattern of interaction between parents and their children when the former “teach” or “educate” the latter (i.e. on sexual matters) seemed to be predominantly top-down and punitive. Parents did not appear to be the preferred source of information and advice on sexual matters or behavior for both male and female youth. At the same time, parents did not necessarily feel comfortable and/or equipped to talk to their children about sex.

VI.2. Quantitative Research Findings

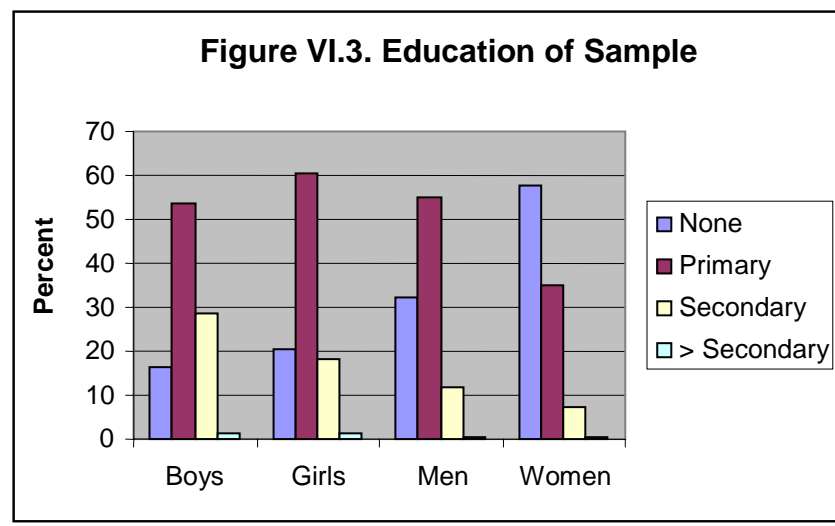
Findings from the quantitative research are presented around the conceptual issues guiding this project. In particular, we focus on four primary issues: risk perceptions, efficacy beliefs, normative perceptions, and behaviors surrounding HIV/AIDS. In addition, we also report on the ideational variables that have been found to be associated with health behaviors. These variables include awareness, knowledge, attitudes, and stigma surrounding HIV/AIDS.

Results are presented in two parts. First, we provide a descriptive analysis of the variables of interest, segmented and discussed according to the four population groups of interest: boys, girls, men, and women (boys and girls are defined as being between 15 and 24 years of age). Second, we investigate the multivariate relationships between the four primary concepts of interest (risk perception, efficacy beliefs, normative perceptions, and ideational variables), on the one hand, and behavioral intentions, on the other.

VI.2.1. Descriptive Analyses

VI.2.1.1. Education

As shown in Figure VI.3, formal education of the entire sample was fairly low. A majority of the sample had some primary education, and a majority of the women (58%) had none. The younger generation was better educated than the older generation, but within each generation males were better educated than females.



VI.2.1.2. Awareness and Knowledge about HIV/AIDS

As other studies have shown, degree of awareness of HIV/AIDS among the population was moderately high. Responses to the questions, “Have you ever heard of a disease called AIDS?” and, “Is there anything a person can do to avoid getting AIDS or the virus that causes AIDS?” are shown in Table VI.3. Awareness of AIDS was uniformly high: More than 9 in 10 individuals expressed that they were aware of the disease, although girls and women scored lower than boys and men. Responses to both questions indicate, however, that older women were less aware of AIDS than the other three groups. Most participants recognized that AIDS was preventable.

Table VI.3. Awareness of AIDS and AIDS Prevention

	Heard about AIDS		Can Prevent AIDS		
	No (%)	Yes (%)	No (%)	Yes (%)	DK (%)
Boys	0.7	99.3	0.0	97.1	2.9
Girls	7.8	92.2	5.8	92.2	1.9
Men	3.1	96.9	1.6	94.0	4.4
Women	7.8	92.2	3.9	89.0	7.1

Participants’ knowledge about AIDS was assessed through 13 questions, shown below. The percentage answering correctly is shown in parentheses.

Items Assessing HIV/AIDS Knowledge

1. HIV and AIDS are the same thing (22%)
2. A person can get AIDS from mosquito bites (58)
3. A person can get AIDS from sharing dishes and food with people infected with the HIV virus (72)
4. It is possible for a healthy-looking person to have the virus that causes AIDS (79)
5. If a person abstains from sex entirely he or she can be protected from the AIDS virus (72)
6. You cannot get HIV if you have sex with only one person (29)
7. People can protect themselves from the HIV virus even if they have multiple partners by using condoms every time they have sex (52)
8. The probability of a person getting AIDS depends mostly on the choices he or she makes in life (66)
9. Some traditional healers have the power to give special protection so that one will not get the HIV virus no matter how many sex partners one has (79)

- 10. Some traditional healers have the power to cure AIDS (80)
- 11. If getting AIDS is in a person's destiny, there is little that he or she can do to avoid it (45)
- 12. A pregnant woman can transmit the AIDS virus to her unborn child (84)
- 13. A woman can transmit the AIDS virus to her child through her breast milk (83)

A majority of the people did not make the distinction between HIV and AIDS: Only 22 percent of the sample did so, suggesting perhaps that individuals perceived the inevitability of developing AIDS if one is HIV positive. It could also reflect the fact that both terms are seen in their social, not medical, context. Another issue that warrants our attention is response to Q.6: Almost a third of the sample believed that limiting sex to just one partner will protect them from HIV. It appears that individuals did not make allowance for the possibility that their partner may have multiple sexual partners. Hence, it appears that many participants did not make the distinction between “being faithful” and “being mutually faithful.” In response to Q.11, more than half the respondents believed that having AIDS in one's destiny meant there was little one could do to protect oneself. The majority of participants in the FGDs considered that HIV/AIDS was not a punishment from God or an inevitable fate. Those who said it was a punishment from God based their assessment on religious beliefs. Those who considered that HIV/AIDS was not a punishment from God tended to recognize people's responsibility in the spread of the disease; their discourse revolved around perceived control.

More than 80 percent of the sample was knowledgeable about mother-to-child transmission of AIDS (Q.12 and Q.13). Respondents were also knowledgeable about the powers (limitations) of traditional healers (Q.9 and Q.10) and most people knew that healthy-looking people could be carriers of HIV. Overall knowledge about AIDS across the 13 items is shown in Table VI.4.

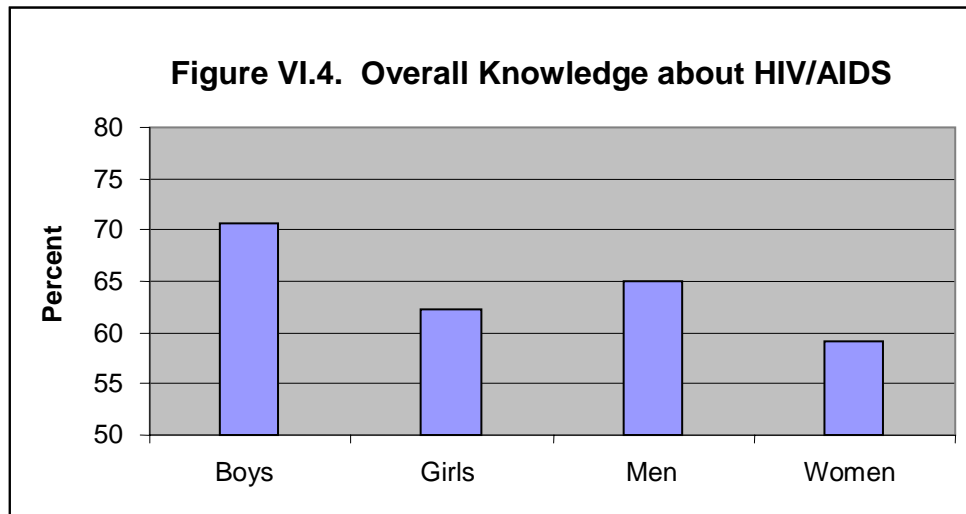
Table VI.4. Knowledge about HIV/AIDS (Overall Knowledge Score)

	<u>Raw Score</u>	<u>Score adjusted for education</u>
Boys	70.6	67.3
Girls	62.2	60.3
Men	65.0	64.9
Women	59.2	61.9

Also shown in Table VI.4 are scores adjusted for education level of the respondent. The wider range of the raw scores (59.2 to 70.6), relative to the range of the scores adjusted for education

(60.9 to 67.3), indicates that much of the variance in AIDS knowledge can be attributed to the respondents' formal education level. Adjusting for education narrows the knowledge gap between the most and least knowledgeable segments of the population. After adjusting for education, young girls are seen to be least knowledgeable about AIDS.

Responses across the four groups are shown in Figure VI.4. Knowledge about the transmission of the disease, as well as protective and risk factors associated with the disease are significant, although differences were found among various population segments. Whereas boys were most knowledgeable about the disease, women were least knowledgeable. It does appear, however, that knowledge about HIV/AIDS has not reached a saturation point; considerable misconceptions are still prevalent in the population.



VI.2.1.3. Attitudes and Beliefs about HIV/AIDS

VI.2.1.3.1 HIV Testing

Testing for HIV was assessed by asking respondents whether they desired to know their HIV status, whether they desired to get tested, whether they had been tested in the past, whether they knew where they could get tested, and whether they believed they could afford the financial cost associated with testing. Results are shown in Table VI.5.

Table VI.5. HIV Testing Preferences, Barriers, and Behaviors (Percent Responding Affirmatively)

	<u>Desire to know status</u>	<u>Want to be tested</u>	<u>Tested in the past</u>	<u>Know location for testing</u>	<u>Afford the test financially</u>
Boys	87.9	72.9	15.7	55.7	60.2
Girls	74.9	63.5	12.6	50.9	55.6
Men	70.7	64.5	13.9	57.9	49.2
Women	69.9	56.5	12.7	43.1	46.5

There appears to be a great need for HIV testing. Most individuals expressed a desire to know their HIV status and most wanted to get tested. Some of the barriers to testing included perceived financial costs and knowing a location for testing. Yet, only 15 percent of the sample had been tested in the past. This finding, however, is at odds with what we found in the qualitative discussions. On the one hand, participants said they trusted doctors, health professionals or organizations that “can tell them the truth,” namely read the results of the HIV test and tell them their HIV status. On the other hand, during the counterarguments exercise, many expressed fear of being tested. Furthermore, the cost of the test was not frequently cited as a barrier in the participants’ discourse.

Members of the younger generation, both boys and girls, expressed a desire to know their HIV status, but a vast majority of individuals have not been tested, despite strong desires to know their serostatus. Some of this can be attributed to perceived costs. More than 50% of men and women, for example, believe that they could not afford to get tested.

VI.2.1.3.2 Fatalism

Overall fatalism was operationalized through three questions: Respondents were asked to express how true it was that they could (a) manage to solve difficult problems if they tried hard enough, (b) deal with unexpected situations, and (c) find several solutions to deal with a difficult problem. Responses were scored on a four-point scale (0 = not at all true, 1 = don’t know/not sure, 2 = somewhat true, 3 = exactly true). Responses are shown in Table VI.6.

Table VI.6. Overall Fatalism (Lower Scores Reflect Greater Fatalism)

	<u>Manage to solve difficult problems</u>	<u>Deal with unexpected situations</u>	<u>Find several solutions</u>	<u>Overall score</u>
Boys	1.60	1.50	1.93	1.68
Girls	1.41	1.33	1.60	1.45
Men	1.67	1.49	1.82	1.66
Women	1.37	1.39	1.65	1.47
	<i>p</i> < .05	<i>p</i> > .05	<i>p</i> < .05	<i>p</i> < .07

Also shown in Table VI.6 are the statistical differences across the four groups. The four groups did not differ from each other on perceived ability to deal with unexpected situations, but they did differ from each other on perceived ability to manage difficult problems and find several solutions. The overall fatalism score was marginally different across the four groups.

In general, males perceived greater ability in solving every-day problems and finding solutions, in comparison to females. This perhaps reflects the greater decision-making role enjoyed by males, as was also revealed through the qualitative research.

Overall, about a third of all participants held fatalistic attitudes with regard to overcoming every-day problems. This sense of being overwhelmed seems particularly strong among females, both girls and women.

VI.2.1.3.3. Stigma

Issues of stigma surrounding HIV/AIDS has proved to be a difficult construct to measure directly. We measured it indirectly through multiple questions, including (a) whether AIDS should be disclosed, (b) whether people are willing to take care of someone with AIDS, and (c) how people should interact with someone with AIDS.

As shown in Table VI.7, women were more likely to want to keep positive AIDS status private and people were less willing to disclose the positive AIDS status of a close friend or relative (compared to that of people in general or of a family member).

As a second measure of stigma, we asked people whether they would be willing to personally take care of a family member who was sick with AIDS. Virtually everyone (95.8 percent) said they would. This coincides with participants' expressions of solidarity during the focus group: They noted that the suffering of a PLWHA affected everyone in the community ("us") and the community as a whole.

Table VI.7. Disclosure of AIDS status

	<u>Boys</u>	<u>Girls</u>	<u>Men</u>	<u>Women</u>
If a person (in general) had AIDS,				
Should keep positive AIDS status private (%)	10.9	20.1	12.8	23.1
Should tell others about positive AIDS status	87.6	76.2	85.6	71.3
DK/Not sure	1.5	3.7	1.6	5.6
If a friend or close relative had AIDS,				
Should keep positive AIDS status private (%)	14.4	20.6	20.5	26.2
Should tell others about positive AIDS status	79.9	75.2	77.6	67.4
DK/Not sure	5.8	4.2	1.9	6.3
If someone in your family had AIDS,				
Should keep positive AIDS status private (%)	8.0	14.6	10.9	18.6
Should tell others about positive AIDS status	91.3	83.5	86.8	76.7
DK/Not sure	.7	1.8	2.3	4.7

We also asked respondents whether they agreed or disagreed with statements pertaining to people living with AIDS. Responses are shown in Table VI.8.

Table VI.8. Percent Agreeing with Statements about the Treatment of People Living with AIDS

	<u>Boys</u>	<u>Girls</u>	<u>Men</u>	<u>Women</u>
Teachers with AIDS should <u>not</u> be allowed to teach in school	31.7	31.1	34.7	37.1
Students with AIDS should <u>not</u> be allowed to attend school	15.8	30.1	30.9	35.8
People with AIDS should be <u>isolated</u> from healthy people	21.0	30.1	29.8	33.1
People with AIDS should be left to <u> fend for themselves</u>	21.6	28.2	24.8	28.9
Most families would <u>reject</u> relative ill with AIDS	42.8	49.7	53.5	56.5
For safety, better to <u>stay away</u> from a person with AIDS	10.2	26.5	29.1	31.9
People with AIDS should be entitled to <u>better</u> medical care	79.9	84.0	88.4	83.4
People with AIDS should get the <u>best</u> medical care available	82.7	84.7	86.5	84.0
Most families in community <u>would</u> take care of AIDS patient	82.6	77.2	82.2	81.0

From Table VI.8, it appears that negative attitudes toward people with AIDS were considerably high – about a third of the sample believed in some form of isolation for those living with AIDS. There was, however, a great deal of support for better medical care for people living with AIDS.

VI.2.1.4. Efficacy Beliefs

Efficacy beliefs were operationalized in terms of the two constituent components: self-efficacy, which refers to people’s confidence to enact specific behaviors, and outcome expectations, which refer to people’s beliefs that enacting a particular behavior will result in the changes they seek.

Eight questions were asked to assess self-efficacy: Respondents were asked how strongly they agreed or disagreed (on a five-point scale) with the following statements:

Items Assessing Self-efficacy

1. I am confident that I can use a condom every time that I have sex
2. If my partner does not want to use a condom, I can insist that I will not have sex without a condom.
3. I am confident that I can talk a bout using a condom with the person with whom I’m going to have sex.
4. If my sexual partner does not talk about condoms, I feel confident that I can bring up the topic with him or her.
5. I am confident that I can plan ahead to have a condom available at all times.
6. I am confident that I can remain faithful to my partner (that is, not have sex with anyone else).
7. If I am not in a long-term relationship with someone, I am confident that I can remain abstinent
8. I am confident that I can have sex only with someone I love and trust and not have sex with anyone else

Responses across the four groups are shown in Table VI.9. Self-efficacy differed significantly across the four groups. Overall, the younger generation (both boys and girls) perceived greater efficacy than the older generation; within age groups, males perceived greater efficacy than females. Table VI.9 also shows that the two items with the highest scores were the ability to remain faithful to a partner, and the ability to have sex with only a loved one. Perceived ability to use condom during each sexual act received the lowest score. It appears that, in terms of the “ABC of prevention,” respondents perceived greater efficacy for abstinence and being faithful and lower efficacy for the use of condoms.

During the FGDs, however, participants expressed low perceived self-efficacy for abstinence or faithfulness. Young boys noted, for example, that it was difficult to abstain and men noted that it was unrealistic to expect boys to abstain once they have started having sex. Similarly, girls noted that “it is a habit not to be faithful”; “we are used to going out with boys”; etc. Thus, even though participants rated their efficacy to remain abstinent or be faithful relatively higher than their efficacy to use condoms, it appears that there is considerable room for improvement on all counts.

Table VI.9. Self-efficacy to Enact Various Behaviors (5-point scale, higher numbers = greater efficacy)

	<u>Use condom every time</u>	<u>Insist partner use condom</u>	<u>Talk w/partn re: condom</u>	<u>Bring up topic w/ part. re: condoms</u>
Boys	3.59	3.76	4.09	3.88
Girls	3.42	3.52	3.51	3.44
Men	2.85	3.18	3.33	3.22
Women	2.68	2.93	3.01	2.99
Overall	3.02	3.25	3.37	3.29
	<u>Plan ahead cond avail</u>	<u>Faithful to partner</u>	<u>Abstinent if in relatshp</u>	<u>Sex only with love and trust</u>
Boys	4.01	4.10	3.84	4.01
Girls	3.36	3.93	3.92	3.93
Men	3.22	3.80	3.71	3.77
Women	2.88	3.60	3.71	3.67
Overall	3.25	3.80	3.77	3.81

(Note: On seven of the eight efficacy items, the four groups are statistically different; efficacy to remain abstinent if in a relationship is not different across the four groups)

Table VI.10. Correlations between Self-efficacy and Overall Fatalism

Group	<i>r</i>
Boys	.00
Girls	-.17 (<i>p</i> < .05)
Men	-.18 (<i>p</i> < .01)
Women	-.13 (<i>p</i> < .05)
Overall	-.14 (<i>p</i> < .001)

In order to determine the extent to which self-efficacy was specific to HIV/AIDS-related behaviors, it was also evaluated in terms of respondents' overall fatalism. Correlations between overall self-efficacy (across the eight items) and overall fatalism score are shown in Table VI.10.

The correlation between self-efficacy and overall fatalism, for the entire sample, was $r = -.14$ ($p < .001$). Though statistically significant, this low correlation reveals that the two constructs appear to be independent of each other, suggesting that it is possible to enhance HIV/AIDS-related efficacy even if overall fatalism remains unchanged. It is also interesting to note that the correlation between these variables was non-existent for boys, suggesting that boys make a sharper distinction between their ability to enact specific HIV-related behaviors and their ability to tackle general life-problems that they face.

Overall, efficacy to enact HIV prevention behaviors was moderate in strength, and women in particular felt powerless. They scored lowest on ability to engage in discussions about use of condoms, in planning ahead to acquire condoms, and in remaining faithful to their partners. This is similar to findings from the FGDs, which revealed, for example, that the use of condoms was mostly up to men. Interestingly, men did not perceive greatest efficacy to enact the same behaviors. Rather, young boys seemed to feel efficacious. Furthermore, efficacy beliefs pertaining to condom use, discussion, and sexual behavior were only minimally correlated with overall fatalism, indicating that it may be possible to enhance HIV-related efficacy beliefs despite high fatalistic attitudes.

Principal component factor analyses with varimax rotation revealed two dimensions of self-efficacy – one pertaining to condom use and the other pertaining to limiting the number of sexual partners. To reflect these underlying dimensions, two separate self-efficacy indexes were then computed. These two indexes were internally consistent: self-efficacy to use condoms, $\alpha = .91$ and self-efficacy to limit sexual partners, $\alpha = .89$.

Table VI.11 shows the distribution of these two self-efficacy indexes across the four groups. Self-efficacy to use condoms was significantly different across the four groups. Boys felt most efficacious, followed by girls, men, and women, respectively. Differences across the four groups on the second self-efficacy item, self-efficacy to limit sexual partners, were weaker. On this variable, women felt least efficacious, but the other three groups were not significantly different from each other. Thus, across both self-efficacy indexes, women scored the lowest and boys scored the highest.

Table VI.11. *Self-efficacy to Use Condoms and to Limit Sexual Partners*

	Self-efficacy			
	To Use Condoms		To Limit Sexual Partners	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Boys	3.86 _d	.96	3.99 _b	.92
Girls	3.45 _c	1.12	3.92 _b	1.12
Men	3.16 _b	1.27	3.76 _{ab}	1.23
Women	2.90 _a	1.33	3.66 _a	1.18

Measured on a five-point scale, higher numbers indicate greater self-efficacy. Cell entries not sharing the same subscript are significantly different from each other at $p < .05$. In all tables, *M* refers to the mean and *SD* the standard deviation.

Outcome expectations were operationalized as the benefits that respondents perceived from enacting various behaviors. They were measured through six questions, each assessed on five-point scales ranging from 1=disagree very strongly to 5=agree very strongly:

Items Assessing Outcome Expectations

1. If I use a condom every time I have sex, I can protect myself from HIV/AIDS.
2. Talking about using a condom with my partner will help us reach an agreement about using it.
3. Talking with your sexual partner about using condoms is an effective way to protect yourself from HIV/AIDS.
4. If I plan ahead to have a condom available, I will be more likely to use it when I have sex.
5. If I reduce the number of people with whom I have sex, I will reduce my chances of getting HIV/AIDS.
6. If I have sex only with the person that I'm in a relationship with, I will reduce my chances of getting HIV/AIDS.

Responses to these questions across the four groups are shown in Table VI.12. Older females perceived the least, and boys the most, benefits in enacting various behaviors.

Table VI.12. Outcome Expectations (5-point scale, higher numbers = greater benefits)

	<u>Condoms protect</u>	<u>Talk, cond agreement</u>	<u>Talk, cond protection</u>	<u>Plan ahead then will use cond</u>
Boys	3.71	3.90	3.98	4.09
Girls	3.51	3.62	3.71	3.50
Men	3.43	3.57	3.64	3.52
Women	3.20	3.30	3.29	3.27
Overall	3.41	3.54	3.58	3.52
	<u>Reduce partners= reduce HIV chance</u>	<u>Only 1 partner will reduce HIV chance</u>		
Boys	3.95	3.83		
Girls	3.75	3.73		
Men	3.68	3.75		
Women	3.49	3.59		
Overall	3.67	3.70		

(Note: The four groups differ significantly across five of the six variables; “only 1 partner will reduce HIV chance” did not differ statistically across the four groups.)

Analogous to the self-efficacy indexes, we also created two indexes for outcome expectations – those pertaining to the use of condoms ($\alpha = .85$) and those pertaining to limiting one’s sexual partners ($\alpha = .75$). Distribution of these indexes across the four groups is shown in Table VI.13. Patterns across the two outcome expectation indexes are similar in that boys were associated with the greatest levels of outcome expectations, followed by girls, men, and women, in that order.

Table VI.13. Outcome Expectations to Use Condoms and to Limit Sexual Partners

	<u>Outcome Expectations From</u>			
	<u>Using Condoms</u>		<u>Limiting Sexual Partners</u>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Boys	3.71 _c	.85	3.89 _b	.99
Girls	3.49 _{bc}	1.00	3.75 _{ab}	1.16
Men	3.42 _b	1.15	3.72 _{ab}	1.18
Women	3.20 _a	1.22	3.54 _b	1.31

Measured on a five-point scale, higher numbers indicate greater outcome expectations. Cell entries not sharing the same subscript are significantly different from each other at $p < .05$.

VI.2.1.5. Risk Perception

Risk perception was operationalized in terms of two underlying constructs: perceived susceptibility, which refers to the strength of one's beliefs that one could become HIV positive, and perceived severity, which refers to the extent to which HIV/AIDS is perceived as a severe or life-threatening disease.

Perceived susceptibility was measured through five questions by asking participants whether they believed that they could become HIV positive in the next six months, year, two years, five years, and 10 years (each response coded on a three-point scale). Responses were averaged into an index ($\alpha = .95$). Table VI.14 shows levels of perceived susceptibility across the four groups.

Table VI.14. *Perceived Susceptibility and Severity*

	<u>Susceptibility^a</u>		<u>Severity^b</u>	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Boys	.95	.60	3.85	.62
Girls	.84	.61	3.87	.54
Men	.85	.64	3.88	.49
Women	.95	.62	3.87	.56

^aMeasured on a three-point scale: 0=could not happen, 1=don't know if it could happen, 2=could happen. The four groups are not statistically different from each other. ^bMeasured on a four-point scale: 1=strongly disagree to 4=strongly agree that AIDS is a severe disease. The four groups are not statistically different from each other.

Overall, most participants believed in a moderate level of susceptibility, and the four groups were not significantly different from each other in their susceptibility perceptions.

Perceived severity was operationalized through four questions. We asked participants how strongly they agreed or disagreed with the statements: (1) AIDS is a severe disease that can kill; (2) When someone has AIDS, they will die from the disease; (3) AIDS is one of the most serious diseases; and (4) AIDS is more deadly than any other disease. Responses to each item were coded on a 4-point scale, ranging from 1 = strongly disagree to 4 = strongly agree. An overall index of perceived severity was computed as the average of the four responses ($\alpha = .97$). Table 14 also shows the responses across the four groups.

AIDS was perceived with a great deal of severity. On a four-point scale, responses were above 3.85 across the board, and the four groups were uniformly high in their perceived severity. This conforms with the FGD findings in which participants noted that HIV had no cure and that having HIV was similar to receiving a death sentence.

Thus, most participants perceived that they were moderately vulnerable to AIDS, but the disease itself was uniformly perceived to be very severe.

Predictors of perceived risk (for both susceptibility and severity) as well as the relationship between perceived risk and behavioral intentions are provided in the second part of the quantitative analysis section.

VI.2.1.6. Normative Beliefs

Normative beliefs were evaluated in terms of descriptive norms and injunctive norms. Descriptive norms refer to the extent to which participants believe particular behaviors are widespread, and injunctive norms refer to the pressures people perceive to comply with others' beliefs.

We computed descriptive norms along two dimensions – perceived prevalence of condom use (the extent to which people believed that most others used condoms) and perceived prevalence of having sex with multiple sexual partners (the extent to which people believed that most others engaged in sexual activity with multiple people).

Perceived prevalence of condom use was measured through three items: the extent to which people agreed with the statements: (a) most people my age, (b) most of my friends, and (c) most people in my village use condoms whenever they have sex. Responses, each scored on a four-point scale (1=strongly disagree, 4=strongly agree), were averaged into an index ($\alpha = .90$).

Perceived prevalence of sex with multiple partners was measured through three items: the extent to which people agreed with the statements: (a) most people my age, (b) most of my friends, and (c) most people in my village have more than one sexual partner. Responses, each scored on a four-point scale (1=strongly disagree, 4=strongly agree), were averaged into an index ($\alpha = .91$).

Thus, one of the two descriptive norms represents the perceived prevalence of a positive behavior (using condoms) and the other represents the perceived prevalence of a negative behavior (having multiple partners).

Table VI.15 shows the distribution of the two descriptive norms across the four groups. Descriptive norms surrounding the use of condoms did not vary across the four groups – that is, boys, girls, men, and women all seemed to hold similar beliefs about the prevalence of condom use in their social midst. The perceived prevalence of having multiple sexual partners, however, was statistically significant across the four groups. In particular, girls and women perceived more strongly that others had multiple sexual partners, as compared to boys and men.

Injunctive norms were operationalized as the importance of complying with others' beliefs. This variable was measured through three items: It is important for me to do what (a) other people my age, (b) my friends, and (c) most of the people in my village are doing. Responses to each item were recorded on four-point scales, ranging from strongly disagree (1) to strongly agree (4). These three items were internally consistent ($\alpha = .94$) and were averaged into an index. Table VI.15 also shows the distribution of this index across the four groups. As shown in the table, the four groups did not differ from each other on injunctive norms, and these norms were generally weak across the sample, reflecting a strong possibility of floor effects. It thus appears that our measure of injunctive norms were not sensitive enough to capture underlying differences.

Table VI.15. Normative Beliefs

	Use of Condoms		Descriptive Norms		Injunctive Norms	
			Multiple Sexual Partners		Importance of Others' Beliefs	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Boys	2.68 _a	1.19	2.83 _b	1.12	1.80	1.05
Girls	2.87 _a	1.10	3.13 _c	1.05	1.90	1.20
Men	2.66 _a	1.18	2.87 _b	1.15	1.65	1.01
Women	2.81 _a	1.17	3.06 _c	1.05	1.74	1.08

Measured on a four-point scale, higher numbers indicating higher norms. Cell entries not sharing the same subscript are significantly different from each other at $p < .05$.

VI.2.1.7. Behaviors and Behavioral Intentions

VI.2.1.7.1. Sexual Behaviors

Respondents were asked whether, in the last 12 months, they had had sex with someone who may have been HIV positive. Responses are shown in Table VI.16. Overall, approximately 5 percent of the respondents reported being abstinent in the last 12 months. It is striking that close to 8 percent of boys, 6 percent of girls, 7 percent of men, and 5 percent of women reported that they may have had sex with an HIV-positive person in the last six months.

Table VI. 16. Sex in the Last 12 months with Someone who May Have Been HIV positive

	<u>No</u>	<u>Yes</u>	<u>No sex</u>	<u>DK/Not sure</u>
Boys	68.6%	7.9	5.0	18.6
Girls	68.3	6.0	3.6	22.2
Men	66.8	6.6	5.0	21.6
Women	70.3	4.9	5.6	19.3

Age of sexual debut is shown in Table VI.17. Twice as many boys (32.5 percent) than girls (17.8 percent) reported their sexual debut at an age earlier than 15 years. As noted in the qualitative section, however, there is a great deal of ambiguity surrounding the meaning of sexual debut. Participation in certain rituals, which can occur at pre-puberty, for example, is also construed by some participants as constituting sexual acts.

Table VI.17. Age of First Sex

	<u><15 yrs</u>	<u>15-24 yrs</u>	<u>≥ 25 yrs</u>	<u>Never</u>	<u>When married</u>
Boys	32.5%	48.8	--	17.1	1.6
Girls	17.8	54.1	--	21.2	6.8
Men	17.3	58.7	9.7	4.1	10.2
Women	14.6	59.7	1.0	3.4	21.4

As shown in Table VI.18, most participants reported that their last sex occurred with their regular partner. Boys and girls (compared to men and women) were more likely to report that their last sex occurred with someone beside their regular partner.

Table VI.18. Person with Whom Last Sex Occurred

	<u>Regular partner</u>	<u>Someone else</u>	<u>Refused to say</u>
Boys	95.7 %	4.3	0.0
Girls	92.0	4.5	3.4
Men	96.4	1.8	1.8
Women	98.7	0.6	0.6

VI.2.1.7.2. Condom Use

Use of condoms during last sex was reported by approximately 30 percent of sexually active boys and by 20 percent of sexually active girls. As shown in Table VI.19, use of condoms was much lower among men and women (as compared to between boys and girls), probably reflecting their stable relationships.

Table VI.19. Use of Condom during Last Sex

	<u>Didn't use anything</u>	<u>Used male condom</u>	<u>Used female condom</u>
Boys	68.1	30.6	1.4
Girls	79.8	20.2	0.0
Men	91.8	7.7	0.5
Women	95.4	4.6	0.0

Participants who reported using condoms were also asked who made that decision. As shown in Table VI.20, boys, girls, and men were more likely to attribute this decision to themselves, whereas women were more likely to attribute it to someone else or report that they did not know who made the decision.

Table VI.20. Who Decided to Use Condom during Last Sex

	<u>Respondent</u>	<u>Partner</u>	<u>Jointly</u>	<u>DK</u>
Boys	79.2	8.3	8.3	4.2
Girls	60.0	25.0	10.0	5.0
Men	93.3	0.0	6.7	0.0
Women	38.5	23.1	15.4	23.1

Reasons that participants provided for using a condom are shown in Table VI.21. Women and boys' primary motivation for the use of condoms was to prevent diseases. Girls and men were more likely to use condoms for dual purpose – to prevent disease and prevent pregnancy.

Table VI.21. Why Used Condom during Last Sex

	<u>Avoid pregnancy</u>	<u>Prevent disease</u>	<u>Prevent preg & disease</u>	<u>DK</u>
Boys	8.7	43.5	39.1	8.7
Girls	15.0	30.0	50.0	5.0
Men	25.0	25.0	43.8	6.3
Women	33.3	50.0	8.3	8.3

VI.2.2. Multivariate Analyses

In this section, we investigate multivariate relationships among the concepts of particular interest: risk perceptions, efficacy beliefs, and normative perceptions, on the one hand, and behaviors, on the other. This portion of the report is presented in two parts. In the first part, following the risk perception attitude (RPA) framework, we focus on factors, including normative perceptions, that are associated with membership into one of the four groups determined on the basis of risk perception and efficacy beliefs: responsive (high risk, high efficacy), avoidance (high risk, low efficacy), proactive (low risk, high efficacy), and indifference (low risk, low efficacy). In the second part, we use the RPA framework to predict behavioral intentions.

VI.2.2.1. Understanding Risk Perceptions and Efficacy Beliefs

Using the RPA framework as a guide, we first sought to determine which variables best predicted individuals' risk perceptions and efficacy beliefs. In other words, the question raised here was: If risk perceptions and efficacy beliefs are sound predictors of individuals' behaviors, what variables affect risk perceptions and efficacy beliefs?

To answer this question, we conducted a series of discriminant analyses, using the four-group RPA framework as the classification category.

VI.2.2.1.1. Procedure

Based on individuals' risk perceptions (combined scores on susceptibility and severity), we created two groups – those who scored either above or below the median. Similarly, individuals' efficacy beliefs (combined scores on self-efficacy and outcome expectations) were used to create two groups – those who scored either above or below the median. Based on these median splits, four groups were created, as shown in Table VI.22.

We then used various predictors in a discriminant analysis model to determine which variables were most strongly associated with membership in the RPA groups. Predictors, derived from ideational theory, included the following:

- socio-demographic indicators – sex, age, education, marital status, religiosity
- psychosocial variables – knowledge about HIV/AIDS, desire to learn about one's HIV status, locus of control, self-perception, perceived stigma, awareness about HIV/AIDS
- normative beliefs

Table VI.22. Formulation of the Risk Perception Attitude (RPA) Framework Groups

Risk Perceptions	Efficacy Beliefs	
	Low	High
Low	Indifference	Proactive
High	Avoidance	Responsive

Significant predictors were then retained and a subsequent discriminant analysis model was run with only the significant predictors in the model.

VI.2.2.1.2. Results

Discriminant analyses look for factors that produce the greatest distinction between pre-specified groups. In our analyses, there were four pre-specified groups (i.e., $k = 4$) – indifference, proactive, avoidance, and responsive. These factors are known as discriminant functions. In discriminant analyses, the number of possible discriminant functions is always one fewer than the total number of pre-specified groups. Hence, because we have four groups, three discriminant functions are possible. Two of these functions were statistically significant: Function 1, chi-square = 117.4, $d.f. = 21$, $p < .001$ and Function 2, chi-square = 41.5, $d.f. = 12$,

$p < .001$. The third discriminant function was marginally significant: chi-square = 9.24, $d.f. = 5$, $p = .10$. The discriminant function structure matrix is shown in Table VI.23.

Table VI.23. Discriminant Function Structure Matrix

Predictors	Function 1	Function 2	Function 3
Internal locus of control	.74	-.17	.18
Desire to know HIV status	.46	-.13	.38
Age	-.41	-.29	.34
Education	.28	.76	-.38
Knowledge about HIV/AIDS	.31	.41	.23
Perceived ability to solve problems	.20	.36	.40
Age of sexual debut	.39	-.42	-.53

Bold face entries refer to the functions relevant for each item.

Function 1 thus comprises individuals characterized by an internal locus of control, desiring to know about their HIV status, and younger in age.

Function 2 comprises individuals who are better educated and knowledgeable about HIV/AIDS.

Function 3 comprises individuals who perceive having a greater ability to solve life's everyday problems and those whose sexual debut occurred earlier in life.

Table VI.24. Functions at Group Centroids

RPA Groups	Function 1	Function 2	Function 3
Indifference: Low risk, low efficacy	-.51	.24	-.12
Proactive: Low risk, high efficacy	.32	.34	.15
Avoidance: High risk, low efficacy	-.27	-.23	.12
Responsive: High risk, high efficacy	.33	-.12	-.10

Bold face entries refer to the functional loading for each group.

Table VI.24 shows the association between the three discriminant functions and the four RPA groups. Thus, Function 1 differentiates the responsive group from the indifference group; Function 2 differentiates the proactive group from the avoidance group; and Function 3 differentiates the proactive group from the indifference group.

VI.2.2.1.3. Conclusion

Based on Tables 23 and 24, the following conclusions can be drawn:

- The two diagonally opposite groups (those with high risk perceptions and high efficacy beliefs versus those with low risk perceptions and low efficacy beliefs) are differentiated primarily by their locus of control, their desire to know about their HIV status, and their age. In particular, those with high risk perceptions and strong efficacy beliefs have an internal locus of control, they desire to know their HIV status, and they tend to be older in age. The opposite is true of those with low risk perceptions and low efficacy beliefs.
- The two intermediate groups (low risk/high efficacy and high risk/low efficacy) are differentiated by their education and knowledge. In particular, those with low risk perceptions and strong efficacy beliefs are better educated and more knowledgeable than those with high risk perceptions and low efficacy beliefs.
- The two groups with low risk perceptions are differentiated by their perceived ability to solve problems and age of sexual debut. In particular, when risk perceptions are low, those who believe in their own ability to solve problems and those who initiated their sexual activity earlier in life tend to be more efficacious in their HIV-related behaviors.

VI.2.2.2.1. Behavioral Intentions

Our final analysis investigates the relationship between the RPA framework and behavioral intentions. Behavioral intentions were conceptualized along two dimensions – individuals’ intentions to use condoms and their intentions to limit their number of sexual partners.

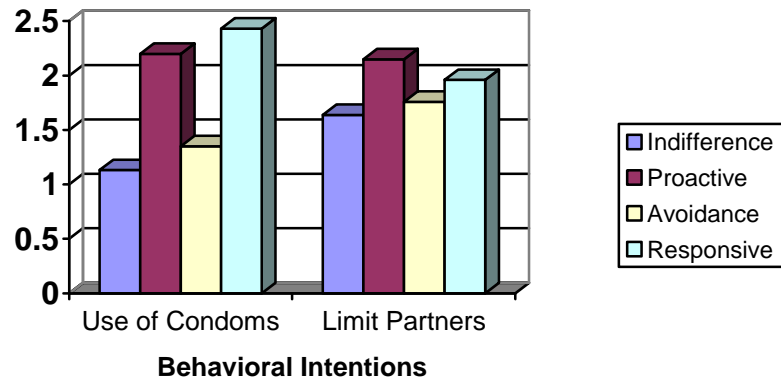
With intentions to use condoms as the dependent variable and membership in the RPA group as the independent variable, an analysis of variance (ANOVA) test was conducted. The overall model was significant, $F(3, 868) = 78.76, p < .001$. Similarly, a second ANOVA model with intention to limit the number of sexual partners as the dependent variable was also significant, $F(3, 868) = 19.66, p < .001$. Mean values on these variables are shown in Table VI.26 and they are graphically displayed in Figure VI.5.

Table VI.26. Behavioral Intentions as a Function of the RPA Framework

RPA Group Membership	Intention to			
	Use condoms		Limit Partners	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Indifference	1.13 _a	1.18	1.64 _a	1.17
Proactive	2.20 _c	.99	2.15 _b	.94
Avoidance	1.35 _b	1.26	1.76 _a	1.10
Responsive	2.43 _d	.79	1.96 _b	1.04

Dependent variables measured on a scale from 0 to 4, higher values signifying a positive behavioral intention. Cell entries sharing the same subscript are not different at $p < .05$.

Figure VI.5. Behavioral Intentions of the Four RPA Groups



VI.2.2.3 Summary

The RPA framework successfully predicted both behavioral intentions. Specifically, use of condoms was characteristic of those in the responsive group (those with high risk perceptions and strong efficacy beliefs). Those in the indifference group (low risk perceptions and low efficacy beliefs) were associated with the weakest intentions to both use condoms and to limit their number of sexual partners. Those in the proactive group (low risk perceptions and strong efficacy beliefs) were most likely to limit their number of sexual partners. It thus appears that the RPA framework provides a convenient classification scheme with which to understand HIV/AIDS-related behaviors.

Table VI.27 consolidates the findings observed in the discriminant analyses. Based on our analyses, HIV-protective behavioral intentions were the lowest among the indifference group, and this group’s members were characterized by an external locus of control, desiring not to know about their HIV status, being older, having lower problem-solving abilities, and having sexual debut later in life. On the other extreme, condom use intentions were greatest among the proactive group members, and they were characterized by their higher level of education, greater knowledge, greater problem-solving abilities, and having sexual debut earlier in life. Having an internal locus of control, desiring to know one’s HIV status, and being younger were characteristics of those in the responsive group, and members of this group had the most positive intentions with regard to limiting the number of sexual partners.

What this analysis reveals is that the effects of background variables (e.g., education, desire to know about HIV status, etc.) on behavioral intentions are moderated by individuals’ risk perceptions and efficacy beliefs. Table VI.27 shows, for example, that the effects of having an external locus of control are most pronounced among those with low risk and low efficacy beliefs and that the effects of having an internal locus of control are most pronounced among those with high risk and high efficacy beliefs.

Table VI.27. Characteristics of the Four RPA Groups on Behavioral Predictors and Behavioral Intentions

RPA Group Membership	Behavioral Predictors	Rank ^a on Behavioral Intentions to	
		Use Condoms	Limit Partners
Indifference			
Low risk/low efficacy	External locus of control Desire not to know HIV status Older Lower problem-solving ability Older age of sexual debut	4	4
Proactive			
Low risk/high efficacy	Better educated More knowledgeable Greater problem-solving ability Younger sexual debut	2	1
Avoidance			
High risk/low efficacy	Less educated Less knowledgeable	3	4
Responsive			
High risk/high efficacy	Internal locus of control Desire to know HIV status Younger	1	1

^aRanks are based on findings from analysis of variance. Rank 1 signifies most positive intentions among the four groups and Rank 4 the most negative intentions. For intention to limit number of sexual partners, only two statistically different groups emerged (see Table 25), and hence only two rank orders are shown.

It is also interesting to note that the proactive and responsive groups did not differ from each other in their intentions to limit the number of sexual partners. This implies that this behavior is guided more by efficacy beliefs than by risk perceptions because, as long as efficacy beliefs were strong, risk perceptions seem not to have mattered.

Finally, we note that normative perceptions (descriptive norms or injunctive norms) were associated neither with the RPA framework nor with behavioral intentions.

VII. Conclusions

A number of important themes emerged from the focus group discussions, conducted in two of the eight focal districts, and the quantitative surveys, conducted in all eight districts. Before discussing the overall research findings, we should first make some observations about the correspondence between outcomes from the qualitative and quantitative methods. Although many of the findings observed through one method were concordant with those observed from the other, there were some important differences as well, and we have pointed out similarities and differences throughout this text.

VII.1. Important Caveats

It is our view that, when findings are contrary to each other, it would be incorrect to conclude that one method provides more valid data than the other. After all, both methods are based on a number of assumptions that may be more or less valid, depending on the context, the individual, the interviewer, etc. For example, one of the assumptions made in qualitative research is that individuals will rise above group pressures to reveal their true beliefs, attitudes, and perceptions, even when the topic under discussion is sensitive in nature or when social desirability biases are strong. This may or may not be a valid assumption. Similarly, quantitative methods assume that individuals' actual responses are captured by one of the answer choices given to them at the end of each question. This, too, may or may not be a valid assumption. Instead of judging the relative superiority, findings from the two methods should be interpreted bearing in mind the constraints that each one presents. Furthermore, the purpose of each method is different. Qualitative methods seek to strive for depth; the concern here is to understand the issues as participants themselves understand them, recognizing that the derivation of meaning, on the part of the participant as well as the observer, is an inherently subjective experience. Qualitative methods do not lend themselves, nor is there any pretense of, generalizability. Quantitative methods, on the other hand, strive for breadth and scope, and findings are projected onto a larger population. They lend themselves to revealing broad trends and relationships among constructs; they are not particularly suitable for understanding participants' subjective experiences.

With these important caveats in mind, we next summarize findings that emerged from our baseline research. We focus on our theoretically driven concepts of interest – risk perceptions, efficacy beliefs, and normative perceptions – that drove this research process. In conducting the research, however, we also uncovered other issues that emerged inductively through the qualitative methods that we employed. Our findings reinforce the notion that HIV/AIDS cannot be investigated solely in terms of the underlying health dimension. Health is only one, albeit important, dimension that defines HIV/AIDS. AIDS is not only a disease, it is also an embodiment of many underlying problems being faced by contemporary Malawians. It brings up issues of morality, religion, poverty, hopelessness, communicative barriers, gender relations, interpersonal power, and the decay of the social, interpersonal, and familial relationships.

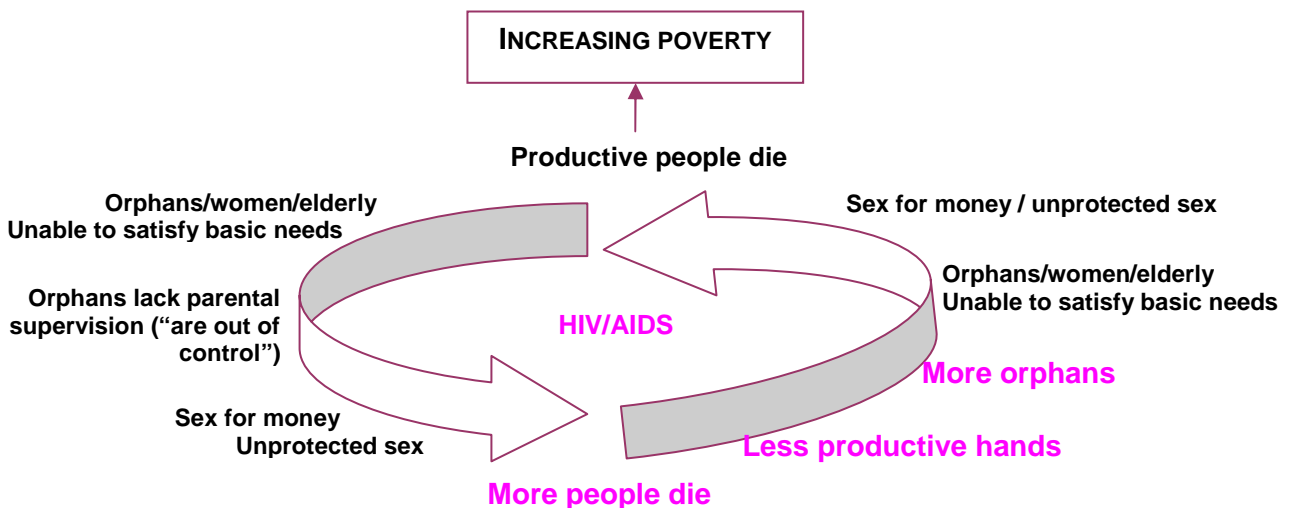
VII.2. The Social Dimensions of HIV/AIDS

We use the term “social” in a broad context, to capture the underlying moral, religious, and interpersonal dimensions. Our research found that issues surrounding HIV/AIDS in Malawi have to be investigated in the context of poverty and people’s perceptions about a lack of control in their daily lives.

VII.2.1. A Vicious Circle

According to participants, the need to fulfill basic needs leads people, women, and girls in particular, to have (unprotected) sex in exchange for money. In some cases, parents or grandparents send children to have unprotected sex in exchange for money to be able to cover basic needs. As a result, participants explained, people get infected with HIV, which leads to increasing suffering and difficulty to satisfy basic needs. The economic problems lead parents or grandparents to encourage their children or orphaned grandchildren to engage in unprotected sex to satisfy basic needs. Engagement in such behaviors has tremendous consequences for HIV/AIDS in Malawi. Poverty is driving many individuals to engage in unsafe sexual practices, leading to higher infections, loss of productivity, and further pressures on survivors to engage in sex for money. The vicious circle thus gets reinforced, as depicted in Figure VII.1.

Figure VII.1 Participants’ view: The vicious circle of poverty, infection and death



VII.2.2. Lack of Control and Efficacy

The analysis of the participants' discourse showed that when they talked about the "future," rarely did they use optimistic or hopeful terms. Rather, they tended to imagine or qualify discussions about their future using negative terms. This hopelessness about the future was manifest most strikingly in their discussions that centered around a generalized lack of control in virtually every aspect of their lives.

Participants expressed a lack of external control in broader social terms, including poverty, loss of assistance from family members because of death, and loss of productive members from the community. Parents perceived that they could exercise little control over their children, and children perceived that their parents imposed discipline on them and made decisions that directly impacted their lives. Similarly, women perceived little personal control in being able to make decisions about their own sexuality, particularly in the use of condoms – a domain in which men were found to exercise almost total control.

Lack of control was also internal. Many young participants noted, for example, that they were unable to control their physical urge to engage in sex, and the elder participants referred to young people's inability to "resist Satan's temptations." Similarly, girls noted that they were "used to" having more than one partner, and that it was a "habit."

Lack of control speaks directly to notions of efficacy beliefs that health communication researchers have isolated as one of the most important predictors of human behavior. Indeed, from the quantitative data, it is clear that there are significant discrepancies in efficacy beliefs surrounding the enactment of self-protective behaviors among various segments of the population. In particular, the older (relative to the younger) generation's efficacy beliefs were significantly lower. Furthermore, within each generation, efficacy beliefs of women, relative to men, were significantly lower.

This finding has clear implications for the intervention. Efforts have to be made to enhance individuals' efficacy beliefs with regard to all aspects of HIV/AIDS-related behaviors, including decision-making with regard to condom use and limiting the number of sexual partners.

Social cognitive theory (Bandura, 1976) points out that there are four primary sources of efficacy beliefs: performance accomplishment (using one's own prior behaviors to enhance one's confidence), vicarious reinforcement (use of appropriate role models), physiological arousal (reflecting upon the positive affect that results from enhanced confidence), and verbal persuasion (use of empowering messages to boost confidence). Use of these strategies should be an integral part of the campaign effort.

VII.2.3. Theory of Dialectics

According to Baxter and Montgomery (1998), communication parties experience internal and external conflicting pulls causing relationships to be in a constant state of flux. This constant flux is known as "dialectical tension." The pressures of these tensions occur in a wavelike or cyclical fashion over time. The theory of dialectics stresses that "contradictions are inherent in social life and are the basic 'drivers' of change and vitality in any social system." In this context,

contradiction signifies the interplay between unified, interdependent opposites. The existence of a “dialectical tension” between interdependent opposites in interpersonal relations was manifest among a number of different dimensions in our research.

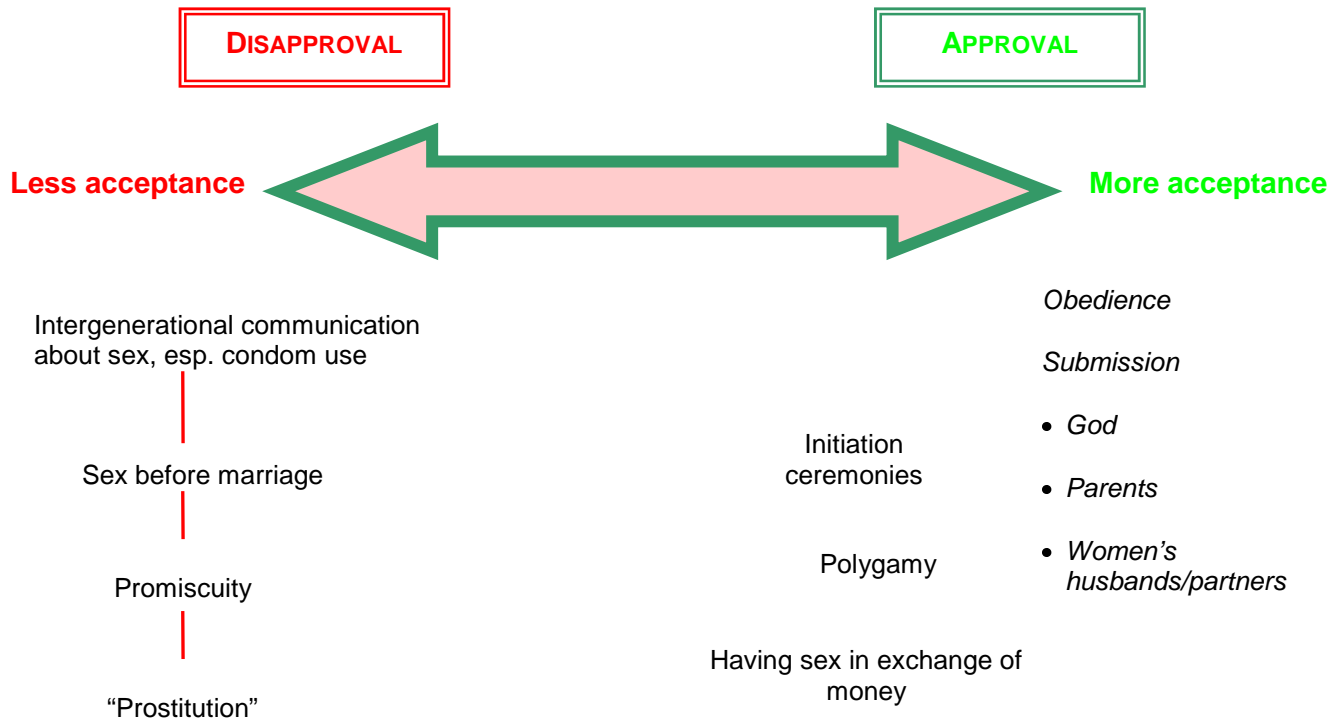
VII.2.3.1. The Dialectic Tension in Norms

There was considerable dialectic tension in both injunctive and descriptive norms as perceived by our participants. Injunctive norms provide sanctions for group members’ noncompliance and refer to the extent to which individuals feel pressured into engaging in a behavior. Descriptive norms, on the other hand, refer to individuals’ beliefs about how widespread a particular behavior is among their referent others. Some of the relevant injunctive norms among our participants carry important social sanctions in the form of either approval or disapproval. Figure VII.2 depicts the dialectical tension between two sets of norms found in the participants’ discourse. At one end (left-hand side of the figure), we find behaviors that are socially disapproved of and that correspond to injunctive norms of the type “One should not...” One of those injunctive norms is “Don’t be promiscuous.” The sanction for noncompliance would be social condemnation. Thus, those persons who are “promiscuous” and have multiple partners are considered “prostitutes” and lose people’s respect. Another injunctive norm, according to the participants’ discourse, is that kids should not have sex outside marriage. We have seen that failing to follow that code of conduct may lead to physical punishment which, in turn, is an accepted norm in the community. At the other end of the continuum, we find an accepted, internalized central norm in the community: “People should obey God and their parents,” “Women should obey their husbands.” God, parents, husbands are internalized authority figures. These strongly hierarchical relations – characterized by respect to the authority, but yet impregnated with affection – are the basis of the collectivist worldview that gives sense to the participants’ existence (Émerique, 1998).

Other implicit norms correspond to “more accepted behaviors” in the continuum (right-hand side of the figure). Although participants did not provide any information about how widespread these practices actually were, we could infer that children’s initiation to sex during circumcision ceremonies and receiving money in exchange for sex are (at least were perceived to be) common behaviors in their communities. These practices correspond to descriptive norms: “many people are doing it,” participants implicitly told us. Participants did not approve or condemn these practices; they simply described them – which is an implicit way of portraying them as acceptable behaviors. Likewise, although participants did not use the word “polygamy,” statements such as the following were made by male and female participants from both communities: (a) having just one partner may not satisfy men; (b) in monogamous relations, women may become “proud of themselves” or hard to control. Even though the topic was not openly discussed during the FGDs, polygamy seems to be an accepted practice in the communities, and one that would ensure that women obeyed their husbands.

The injunctive norms that proscribe promiscuity and sex outside marriage or without parental consent and the norm prescribing obedience towards authority figures are complementary. However, we identified several “contradictions” (i.e. interplay between unified and

Figure VII.2 Norms in a Dialectic Tension



interdependent opposites) in our research. First, children were supposed to obey parents and not have sex before marriage. However, during the initiation ceremonies, which are carried out with parents' consent, children were induced to having sex at a very early age, seemingly before marriage. Second, promiscuity was proscribed but people had the impression that others have several partners – which may be justified due to the problems that having only one woman could bring about for men (i.e. women difficult to control or proud of themselves). Third, sex work was proscribed, but, at the same time, receiving money in exchange of sex was considered “normal.” It is, in fact, a widespread practice in Africa. It is hard to grasp the subtle difference that participants may make between receiving money from a “friend” or “lover” and from a “client.” Yet, this implicit social norm co-exists in a functional opposition with the explicit proscription of promiscuity and “prostitution.”

We found another significant contradiction in participants' discourse when they talked about (a) parents' punishing kids who have sex outside marriage and (b) parents or grandparents seemingly “sending their children or orphaned grandchildren to have sex for money.” It is possible that grand/parents tell their girls to “go out and earn money” and never talk explicitly about how the girls earned the money. The girls are supposed to help support the family and be productive (which also corresponds to an accepted social norm), and may opt for sex work because it is the only alternative they perceive to have. In that context, the girls would be just “obeying” their grand/parents (the explicit order being: “go earn money”). They would also be fulfilling their role within the family without having to explicitly talk about how they do it and the risk of HIV infection that they take in order to “earn money” for the family. In this context, girls would be complying with injunctive norms at different levels: They would be fulfilling the productive role they are supposed to within the family and community and, at the same time, they would be obeying their grand/parents' orders. In addition, having sex for money could be regarded by the girls as a widespread practice in the community (descriptive norm) and, therefore, be acceptable from their point of view.

It is important to note that some of the practices described by participants probably correspond to normative beliefs that do not find a correlate in reality. For instance, it is possible that participants believed that parents' “sending their children to have sex money” was more widespread a practice than it actually was. It is worth stressing that, during the FGDs, adult and elderly participants talked about “other” parents and grandparents sending their children to have sex for money. They never said that they themselves did it. More often than not they disapproved of that practice, which, nonetheless, they seemed to regard as “common” in the communities. There is reason to believe that most parents whose children are forced to engage in sex for survival are not happy about that choice and may see it as a last alternative; their ideal may in fact be that their children are not sexually active. Although there are many young women having sex for survival, it is possible that the phenomenon of parents (implicitly) encouraging their children is not as widespread as the participants seem to believe.

How widespread is the practice of subjugating one's children to prostitution in Malawi? Our research was not designed to, and hence cannot, answer that question. However, it is clear that many individuals believe that many *others* engage in this behavior, and thus it is likely that people harbor an exaggerated perception about the prevalence of this practice. If so, this has

direct implications for the BRIDGE project, as it suggests that correcting this normative belief is an important step to undertake.

Baxter and Montgomery's (1998) dialectic theory leads us to recognize that social reality and human interactions are complex and multifaceted: Totality, as they put it, can only be understood in the context of other phenomena, as a process of relations or interdependencies. Unveiling the dialectic tension between and among social norms can help inform the development of the BRIDGE Project communication strategy at different levels. At one level, key internalized social norms that tend to increase the risk of HIV/AIDS infection and that have been identified through the analyses could become a focus of media messages and community-based activities. At another level, fostering an open dialogue about the opposing norms that seem to co-exist in the communities would not only help increase people's awareness of those underlying, latent contradictions, but also demystify perceived normative behaviors that do not correspond to reality. The dialectic tension and contradictions that underlie social interaction could then become "basic 'drivers' of change and vitality" in the communities.

VII.2.3.2. The Dialectic Tension between Pleasure and Suffering

Throughout participants' discourse, we observed a tension between two poles that are part of the same continuum (see Figure VII.3). On the one hand, as participants put it, "sexual desires" lead people to have (unprotected) sex. The drive to satisfy basic needs is also related to survival and life. On the other hand, the pleasure and desire to live (and satisfy basic needs) lead to suffering and death. At the center of the participants' discourse, we find an important recurrent factor, poverty, which leads them to take risks. The risks that people take are the following:

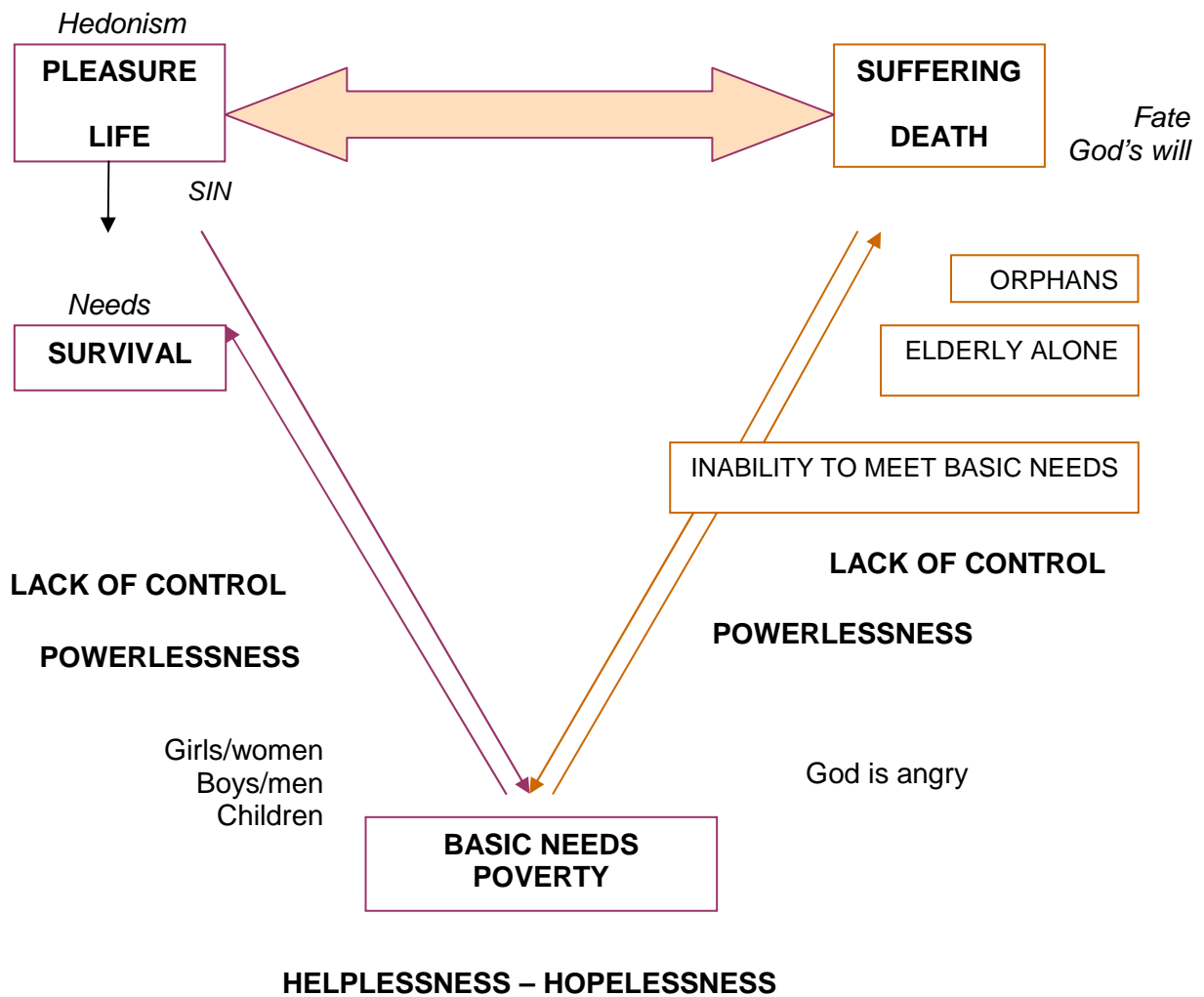
- having several partners
- being unfaithful
- being promiscuous
- having sex for money

On both extremes of the continuum, people feel out of control. On the left-hand side – which corresponds to pleasure and life – people feel inclined to commit sins because of their sexual drives (hedonism) or their survival needs. On the right-hand side – which corresponds to suffering and death – people feel unable to control God's will/punishment, or their Fate. Both extremes converge into feelings of powerlessness and hopelessness. The feeling of hopelessness is intrinsically related to the vicious circle of poverty, infection, and death. The feelings of hopelessness and helplessness go hand in hand.

The analysis of participants' discourse directs our attention to the imperative of transforming hopelessness into hope, and powerlessness and helplessness into concrete actions. Concomitantly, it leads us to propose a holistic and integrated approach to HIV/AIDS prevention in Malawi. That approach requires the concerted work of a variety of partners to develop an encompassing communication strategy while, at the same time, offering people concrete opportunities to develop their sense of internal and external control and self-efficacy. With that perspective, the development of a participatory communication strategy that includes work at the ideational level as well as the consolidation of partnerships with key organizations for work at

that and other levels (i.e. sociopolitical, economic) seems to be an adequate alternative. As we have seen, from the participants' point of view, the central issue at stake in the fight against the AIDS pandemic is the survival of the community as a whole. Any effort to support the communities in their fight against HIV/AIDS should take that perspective into account.

Figure VII.3 Two Extremes of the Same Continuum



VII.2.4. Gender Differences in Reaction to HIV/AIDS Messages

Male and female participants differed significantly in how they reacted to information about HIV/AIDS. Boys and men asserted that they went to the hospital for blood tests, abandoned past “immoral behavior,” and started carrying condoms wherever they went. Girls and women (including elderly women), on the other hand, said that they shared information with others (e.g. friends, mother, children), and planned to form a club. Note that while the female participants focused on communication with others (at home or in a club), men focused on action (i.e. individual and personal behavior change). This difference may be attributed to two sets of factors. First, it may be related to the feeling of powerlessness that is particularly present in the female participants’ discourse: Women could feel more at ease and capable of communicating with others than making decisions to produce changes in their lives. Second, it may be due to differing, gender-based communication styles. Linguists and anthropologists have studied and demonstrated the significance of gender- and culture-based differences in patterns of interaction and communication. Although gender-based differences in communication patterns should not be taken as absolute, immutable generalizations, studies carried out by linguists demonstrate a basic difference that is confirmed by the data collected in this study: while women’s interaction styles were centered on verbal communication, men tended to develop their relations with the world and others primarily through action. This would explain why women participants focused on the links with others through communication while men seem to prefer action.

It would be important, during the development of activities, to take into account the difference in perspective between female and male participants when it comes to “taking action” to prevent HIV/AIDS. Girls and women tended to share information and communicate with others, while boys and men seemed to be more focused on actions that imply individual behavior change. In that sense, the activities that interest girls may not be the same as those that interest boys and vice-versa. These two orientations (communication and individual action) complement each other and could be used to develop a comprehensive program that takes into account subtle (and sometimes obvious) gender differences. Likewise, gender-based differences that reinforce unequal patterns of interaction between men and women could be tackled through specific activities geared towards the development of women’s decision-making and negotiation skills.

VII.2.5. The Issue of Time

In several focus groups, participants stated that they did not have time to use a condom. One would think that people living in rural areas and traditional societies have “more time” than those living in Westernized, modern urban areas. Why then are participants apparently in a hurry when they have sex? They gave several implicit and explicit explanations for this. Explicitly, some participants explained that the use of condom “delays the whole deal” (i.e. delays ejaculation), which is not convenient for the person who is having sex for money (e.g. sex worker).

Implicitly, people have sex in a rush because they are doing it on their way to school, in the bush, and/or in hiding from others (parents, husbands, etc.). Also implicit in the participants’ discourse about time was a sense of lack of control in the present, let alone the future. This sense of lack of time may also be related to an implicit predominant focus on the immediate versus the long term, or on the “urgent” versus what would be (rationally) “important.” Working on the notion of time at an ideational level by emphasizing people’s ability to grasp and develop control over

the present and to build a common projection towards the future would help enable the emergence of feelings of control and self-efficacy.

VII.3. The Health Dimensions of HIV/AIDS

Although determinants of behaviors operate at interpersonal, communal, environmental, and societal levels, HIV infection occurs because of what individuals, as individuals, do. Hence, from a public health perspective, reduction of HIV prevalence has to take into account individuals' behaviors. Toward that end, we focused on the primary determinants of health behavior change, including risk perceptions, efficacy beliefs, normative perceptions, and ideational variables, such as attitudes, knowledge, stigma, education, and cultural beliefs. We next summarize some of the key findings in this regard.

VII.3.1. Awareness and Knowledge about HIV/AIDS

Awareness of HIV/AIDS as an issue was uniformly high across the sample, and knowledge about modes of transmission was moderately high. We did find, however, that there is confusion among participants about the difference between HIV and AIDS. In the absence of cure for AIDS, it is not surprising that many participants equated HIV infection with contracting AIDS. After all, even this report refers collectively to "HIV/AIDS." Both were likely perceived as a death sentence and hence there was little need to make the distinction. Given increasing levels of investment in Africa in recent years toward ARVs, this is likely to become an important issue for the BRIDGE campaign to address. In fact, stressing that ARVs can assist people manage the disease may be one way of engendering hope amidst a great deal of hopelessness that currently exists.

Other misperceptions were also widespread, including the belief held by roughly 60 percent of the population that one can acquire AIDS from mosquito bites, and the belief held by 71 percent that having sex with only one person guards one from AIDS. Only 50 percent of participants believed that condoms could protect them from AIDS even if they have sex with multiple partners. The issue of hopelessness noted earlier was also apparent in participants' beliefs that having AIDS in one's destiny precluded the efficacy of any preventive action that they could take. Thus, even though overall knowledge about AIDS was fairly high, it is clear that there are pockets of misperception that still exist. Given this finding, it would be counterproductive to dismiss the enhancement of knowledge as one of the BRIDGE campaign themes.

VII.3.2. Attitudes and Salient Beliefs

When asked explicitly about HIV testing, a vast majority of participants expressed a desire to know their HIV status, and many noted significant barriers in doing so. Yet, this was not an issue that participants brought up on their own during the focus group discussions. In fact, because AIDS was perceived as a death sentence, many expressed a desire not to know.

Perhaps individuals can be persuaded to learn about their HIV status if they perceive that (a) they will not be stigmatized should they test positive and (b) ARVs are readily available to them. Considerable challenges exist, however, to bring about this level of change in Malawi. This

research found, for example, that stigma toward people living with HIV/AIDS was considerably high. A third of the participants believed that people with AIDS should be isolated from others, and a fifth believed that they should fend for themselves. Whereas most people stated that they would not harbor negative attitudes toward people living with HIV/AIDS, many believed that most others would. It thus appears that a campaign geared toward the reduction of stigma would confer dual benefits: not only would it ease the suffering of people living with HIV/AIDS, but it could also encourage testing among the population if they believed that they themselves would not be subjected to stigma.

VII.3.3. Efficacy Beliefs

There was considerable variation in efficacy beliefs across the population. In particular, women were associated with lower levels of efficacy beliefs across the various measures of this concept. Furthermore, overall efficacy beliefs were only moderate in strength, implying that there is considerable room for improvement. Given the strong association between efficacy and behavioral action that has been found in many studies (including this one), there is little doubt that the BRIDGE campaign needs to focus on enhancing people's confidence in their ability to take various preventive actions.

We found that efficacy beliefs also varied by the particular behavior under consideration. For example, in the quantitative surveys, participants reported higher levels of efficacy in remaining abstinent and limiting their number of sexual partners, as compared to using condoms consistently. Even though the focus group discussions revealed that young people were particularly lacking in their ability to be abstinent or to limit their number of sexual partners, individuals' perceived abilities in both domains were only moderate in strength.

Another component of efficacy pertains to outcome expectations, the belief that enacting specific behaviors will confer benefits that people seek. We found that outcome expectations regarding condom use were moderate in strength. As was also found in the focus group discussions, many individuals seemed to believe that condoms are ineffective in preventing HIV/AIDS; others expressed various negative attitudes toward condoms. Use of condoms is strongly associated with gender roles. Many women, for example, expressed a sense of powerlessness in making decisions about using condoms and in persuading their partners to do so. Others noted that their partners did not believe in using condoms.

Thus, building skills to enhance efficacy beliefs needs to be a central strategy for the BRIDGE campaign. As noted previously, social cognitive theory provides specific guidelines for doing so. It should also be noted that individuals' efficacy beliefs were not correlated strongly with their perceptions of fatalism. This implies that participants make distinctions between their ability to enact specific HIV-preventive behaviors, on the one hand, and their overall outlook on life, on the other.

VII.3.4. Risk Perceptions

Risk perceptions comprise two dimensions: perceived susceptibility to a disease and perceived severity of the disease. In this research, we found low levels of susceptibility to HIV/AIDS

among the participants with little variation across the four groups (boys, girls, men, and women). Furthermore, levels of perceived severity were high across the board.

Research shows that individuals are optimistically biased in their assessments of personal vulnerability: they tend to believe that others are generally more vulnerable than themselves. This could explain the low levels of personal vulnerability to HIV/AIDS that individuals perceived. Research also shows that moderate levels of susceptibility are required to motivate individuals to take preventive action. Hence, it appears that increasing people's perceptions about personal vulnerability to AIDS needs to be an integral strategy for the BRIDGE campaign. Focusing on the severity of the disease, however, is less of a concern as it is already high among participants.

VII.3.5. Joint Influences of Risk Perception and Efficacy Beliefs

According to the extended parallel process model (Witte, 1992) and the risk perception attitude framework (Rimal & Real, 2003), motivating individuals to take preventive action has to incorporate both risk perceptions and efficacy beliefs. Increasing people's perceived risk to a disease without also enhancing their coping skills is likely to result in negative outcomes, including generating fear responses and avoidance behaviors. In this research, we found considerable support for this hypothesis. Individuals with high levels of risk perceptions and efficacy beliefs were associated with significantly more positive behaviors, as compared to those whose efficacy beliefs did not match their heightened risk perceptions.

Our multivariate analyses revealed that variables important in individuals' dual assessment of risk and efficacy included locus of control, desire to know one's HIV status, age, education, knowledge about HIV/AIDS, perceived ability to solve problems, and age of sexual debut. These variables were also associated with intentions to take preventive action.

VII.3.6. Sexual Behaviors

Many of the behaviors reported by our participants are troubling.

Between 5 to 8 percent of our participants reported that they may have had sex in the previous 12 months with someone who was HIV positive. This figure is strikingly high, and it makes us wonder whether the actual figures are even higher, given the social desirability biases likely at play in answering this question.

A third of the boys in our sample reported that they were younger than 15 years old at the time of their sexual debut; the corresponding figure for girls was 18 percent. As noted in the qualitative findings, one has to interpret this figure with caution, as it is not clear what participants actually mean by engaging in their first sexual activity. Some of the religious rituals and initiation ceremonies, for example, may not constitute sex, but it appears that many individuals construe it as such.

A vast majority (as high as 95 percent among women) of those who were sexually active reported not using a condom during their last sexual episode. While this may reflect trends

among those in stable (or married) relationships, it is troubling that only 20 percent of girls and 30 percent of boys reported using a condom during their last sexual episode. When a condom was used, this decision was most often made by the male partner. This finding corresponds with those from the focus group discussions in which girls and women expressed their powerlessness in making decisions about using condoms. Thus, the BRIDGE campaign should also focus on empowering women and girls to participate in such decisions.

VII.3.7. Normative Beliefs

We measured normative beliefs in terms of both descriptive norms (the perceived prevalence of a behavior) and injunctive norms (pressures individuals perceive to engage in a behavior). Findings indicated that neither measure of normative beliefs were associated with risk perceptions, efficacy beliefs, or behavioral intentions. Findings also revealed that our measure of injunctive norms were not precise enough to capture meaningful variance among the population. Hence, it is difficult to tell whether the norms-related non-significant findings are due to measurement problems or something else. From the qualitative data, it does appear that community norms, particularly those surrounding gender issues and issues of power in interpersonal relations, are fairly strong. It may well be that such norms were uniformly high across the sample. This issue, however, cannot be resolved through the current research.

VII.3.8. Channels and Media of Communication and Information

VII.3.8.1 Privileged Sources of Information

When participants are asked whom they would contact to get information on HIV/AIDS, the most frequent response in every group, regardless of their age or sex, is “health personnel.” This category includes the following health providers: health surveillance assistant, doctor, nurse, health advisor or counselor, health supervisor, clinical officer, and health workers or health personnel in general. Three out of the five groups (girls, women and men) in Mangochi would also go to Banja la Mtsogolo (BLM), an NGO specializing in Health and Family Planning. Other potential sources of information are much less recurrent in the participants’ discourse: friends (Mzimba girls); theatre group (Mangochi girls); radio (Mzimba girls); religious authorities (Mzimba women); and youth clubs (Mangochi men).

Participants would prefer to seek out HIV/AIDS-related information from health personnel at the hospital, staff from BLM, and religious leaders because these persons/organizations are “knowledgeable.” For instance, participants say that health personnel do “have a good knowledge of HIV/AIDS,” “are knowledgeable about everything,” and/or “capable of providing us with the right information of AIDS and anything that has to do with our body system.” In addition to being knowledgeable, doctors and organizations such as BLM or MACRO can tell people “the truth,” which means that they can read the results of the blood tests and tell patients/clients their HIV status. It is interesting to notice that, in this part of the discussion, some people (in FGDs with Mzimba and Mangochi women, and Mangochi men) express their interest in having their “blood tested” and being told “the real truth.” However, as we have seen above, when participants in the different groups in both communities are asked to complete the phrase “Get your blood tested so that you may know if you have the virus that causes HIV/AIDS or not,” most participants express fear of being tested.

VII.3.8.2. Current Media and Channels of Information on HIV/AIDS

Radio is mentioned in all the groups among the current media and channels of communication that convey HIV/AIDS messages. However, not everyone has a radio and those who have one do not always have access to batteries. Other media that are mentioned in several groups include the following: drama and songs, church and mosques, women's groups affiliated with the church, Village and Toto Clubs. "Toto AIDS Club" means "No Aids Club." Toto Clubs are anti-AIDS groups formed by youth in the communities. The members of these clubs are encouraged to write and perform poems, plays and songs designed to educate a variety of young people about the impact of AIDS on communities, families and individuals.

It is worth noting that church and mosques are not mentioned in the FGDs with girls (Mzimba and Mangochi). Girls mention the following media and channels: AIDS Toto Club and village clubs (Mangochi and Mzimba respectively); Banja la Mtsogolo (NGO) (Mangochi); and friends in town and street workers (Mangochi). Street workers, who fulfill the role of informal educators, are considered "friends" by girls from Mangochi. Girls and boys from Mangochi also talk about films: "We can also get HIV/AIDS messages through the cinemas which the Population Service International (PSI) people show to us." PSI screenings are probably designed to reach the youth at large in that community.

When participants talk about how they would reach people if they wanted to transmit HIV/AIDS prevention messages, they opt, first and foremost, for group and communal activities. In order of frequency across the FGDs, some examples are, youth/women drama groups; groups formed by traditional leaders; group discussions; enter-education activities (groups that would go from village to village with "humorous articles, jokes and other interesting comedies"); and meetings called by the village chief. Among those activities, the ones that are mentioned in the FGDs with girls are the following: youth and drama groups (Mzimba girls), group formed by traditional leaders and meeting called by the village Chief (Mangochi girls). The girls from Mangochi also suggest informal, face-to-face communication as a way of sharing information on HIV/AIDS. They say, for instance, that during antenatal visits, "we are all seated and we can be advising each other." They also point out that, "I can just go to school and advise my friends." In contrast to this informal type of interaction at school, some participants suggest that students could get information from their teachers in a (formal) classroom, where the teacher would stand in front of them and talk about HIV/AIDS. "I have chosen the school," this participant said, "because there are many people there." (Mangochi girls)

The most frequently mentioned type of message that participants would like to convey to others is the "warning of dangers of HIV/AIDS." The dangers of HIV/AIDS include the fact that it has no treatment or cure, as well as general statements such as: "it is 'dangerous' and 'bad.'" The girls from Mzimba, who talk about a Club that they would like to establish at school, state that they would need condoms for the club "because sometimes we will need to show people how to use them" (i.e. product use demonstrations). Finally, other comments by Mangochi girls include encouraging abstinence to prevent HIV/AIDS: "... We would advise them that AIDS is dangerous, let us abstain."

VIII. Recommendations

Based on qualitative and quantitative results, recommendations for campaign strategy and message design include the following:

VIII.1. Intended Audience

Focus on young girls as the primary intended audience, but elicit the participation of boys and other members of the community (including adult males and females) in collective decision making.

- There is need to enhance knowledge, change attitudes, increase self-efficacy, and empower young girls to become more proactive in decision-making and self-protective behaviors.
- This research found that women and girls are particularly vulnerable to the rising epidemic because of their lack of power in decision making, lower levels of efficacy, and lower levels of knowledge. Given that girls (compared to older women) have many more years of sexual activity ahead of them, addressing their concerns and empowering them to take self-protective steps should be an integral strategy for the BRIDGE campaign.

VIII.2. Primary Message Themes

- **Message of Hope:** Inculcating a sense of hope seems to be of utmost importance. Hopelessness, primarily around issues of poverty and lack of decision-making powers in sexual acts, is high among young girls, who also hold fatalistic attitudes. They appear to be burdened by lack of control and low efficacy. Concomitantly, lack of control and self-efficacy, and the fatalistic attitudes that accompany them, stem from entrenched religious beliefs in which God appears as a punitive authority figure. Moving away from feelings of guilt and closer to individual and collective (positive) action, responsibility, and self-efficacy seems to be essential for the development of a sense of hope. Likewise, emphasizing people's ability to grasp and develop control over the present and to build a common vision for the future appear to be essential elements to enable the emergence of feelings of control and self-efficacy, all of which is intrinsically related to messages of hope.
- **Discussion about Sexuality:** There is a lack of open communication about HIV/AIDS. Furthermore, strong barriers exist that impede people from initiating discussions about sex – a pattern found in the entire sample. Parents believe that they cannot discuss sex and that they cannot influence their children to adopt safer behaviors. By the same token, children do not seek information about safer behaviors. Creating opportunities for the discussion of HIV/AIDS in community settings and bringing the topic to the public arena would increase the possibilities of having open discussions within and outside the family and help improve intergenerational communication on a sensitive topic such as sexual behavior.

- **HIV Risks:** Perceived vulnerability to HIV/AIDS appears relatively low, given the explosion in HIV infections among the younger generation.
- **Efficacy Beliefs:** Across most behaviors, girls' efficacy beliefs need to be enhanced. They feel powerless to persuade their partners to use condoms, acquire condoms for themselves, or engage in discussions about condoms with their partners.

VIII.3. Role of Community

Community leaders, health workers, and NGOs are held in particularly high esteem and they are perceived as credible sources of information. Thus, the overall effort needs to capitalize on the use of community organizations and community leaders in disseminating information about HIV/AIDS, providing access to services, and providing a venue for discussions about HIV prevention.

VIII.4. Cultural Specificities

Taking into account cultural specificities and local worldviews seems to be essential.

- In the Malawian context, sex is conceived of in a way that may greatly differ from Western notions. Receiving money in exchange for sex may not always have the negative connotations that it has in Western societies. At the same time, that practice often places girls and women in a position of submission and dependency in relation to men and makes them particularly vulnerable to HIV infection. It would be important to integrate into the program a gender approach that takes into account these cultural specificities.
- Likewise, ceremonies of early sexual initiation may influence the development of patterns of sexual interaction (e.g. sex as a child's game, having multiple partners) that may increase the chances of infection. More investigation is needed in this regard.
- Finally, the results of the study clearly show a predominant collective orientation towards self and social relations in the communities, which differs from the predominant Western views centered on individual autonomy and self-realization. People's conception of the costs and consequences of the AIDS pandemic as related to the community as a whole, and beyond each of its individual members, is part of that collective-oriented worldview. Similarly, their preference for group and communal activities also reflects that type of orientation. Any effort to support the communities in their fight against HIV/AIDS should build on that collective notion of self and social relations and help develop or strengthen values of solidarity and interdependence. This does not preclude individual behavior change, but helps insert it into the broader social and cultural context where it takes place. From this perspective, community authority figures, who are perceived as credible sources of information, could be called upon to play key roles in the development of new social norms regarding sexual behavior and RH and the strengthening of social cohesion.

VIII.5. Participatory Communication Strategy

The development of an encompassing participatory strategy seems to be viable and appropriate. Specific information, education and communication activities, as well as the media campaign, should be built around and stem from that overall strategy. This encompassing participatory communication strategy should include the development of effective messages and activities as well as the consolidation of partnerships with key organizations. Ideally, work at the ideational level should be complemented with the participation of institutional and community partners in local, national and international coalitions to influence the sociopolitical environment and facilitate bottom-up communication about HIV/AIDS-related issues from the communities to decision-makers.

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