

## **CHAPTER TWO**

### *PSYCHOSOCIAL CAUSES OF UNSAFE HEALTH BEHAVIOUR OF SOUTH AFRICAN CHILDREN AND ADOLESCENTS*

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#### **2.1 Introduction**

According to the World Health Organisation (WHO), the term ‘health’ is defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 2001). To build up on the WHO’s theoretical concept of health this study follows health promotion approaches (see also Hurrelmann et al., 2004), that understand health-related behaviours as being always formed by risk and protective factors which are based on three domains: physical, psychological and social. Thus, the foci of interest in chapter 2 is the presentation of an extensive literature review of different studies, especially from South Africa, in an attempt to explain the diverse psychosocial factors that go with the development of mental and physical health among children and young people<sup>1</sup> that make them vulnerable to HIV infection. The first part of this chapter, therefore, explains how health-related behaviour develops from childhood to adolescence, and presents specific psychosocial risks and resources effecting the development of health behaviour among children and adolescents in South Africa.

The second part of the chapter describes foremost the theoretical basis and the designed model for this thesis. The social cognitive theory (SCT) by Bandura (1986) forms the theoretical basis for the evaluation of the acquisition of cognitive and social competencies or rather learning processes of children participating in a specific primary preventive approach, that is, a life skills programme on AIDS and sex education. Due to an absence of research findings on pre-adolescents, the research model used and the relevance of the examined variables are explained by describing results from studies on (unsafe) sexual behaviour among South African adolescents.

#### **2.2 HIV/AIDS Epidemic and its Impacts on the South African Society**

According to the United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organisation 40.3 million people currently live with HIV worldwide. Almost five million

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<sup>1</sup> In this study the terms ‘youth’ and ‘young people’ also refer to the stage of adolescence.

people were newly infected with HIV and 3.1 million died of AIDS in 2005. The sub-Saharan region has the highest number of HIV infection with 25.8 million people. This means, approximately 65% of all people infected with HIV live in this region and 77% of all infected human beings are African women (UNAIDS/WHO, 2005a). UNAIDS stated in its last report on the situation of the global AIDS epidemic that the total number of people living with HIV reached its highest level in 2005 with increasing prevalence on other continents. It concluded that a reduction of the AIDS pandemic is not foreseeable (UNAIDS/WHO, 2005a).

According to UNAIDS (2002), the youth are at the centre of the global HIV/AIDS pandemic as the next generation who has to face a cumulative impact in the forthcoming years. The predictions are that a large part of the young generation, as the most infected, will be unable to raise and educate their children. The current number of 14 million AIDS orphans and terminally ill people (UNAIDS, 2002) is on the increase worldwide and without adequate treatment and care, most of them will not survive the next decade (UNAIDS/WHO, 2001). To make matters worse, most of these infected people are unaware of carrying the virus, many millions more know nothing or far too little about HIV and how to protect themselves against it (UNAIDS/WHO, 2001). Regarding taboo issues such as sex, death and illness, stigmatisation of HIV-positive people is high. Therefore, many infected people decide not to disclose their status to relatives or neighbours because they are afraid of becoming social outcasts (Campbell, 2003). Because the HIV epidemic affects mainly low- and middle-income countries, it has tremendous impacts on the stability of societies putting an additional burden on their economic, political and health systems.

South Africa has one of the highest numbers of people living with HIV worldwide. According to the National Department of Health (2004a) it is estimated that between 5.7 and 6.2 million South Africans are currently living with the virus and 1 700 more people are infected with this virus every day. The statistics on HIV prevalence in South Africa, however, consistently vary as do all statistics in this field. In the knowledge of the worldwide methodological discussion on the reliability of HIV/AIDS statistics, one resource which tends to be most valid and widely distributed is the South African National HIV prevalence, HIV incidence, behaviour and communication survey (2005). This survey was conducted in cooperation with the Human Sciences Research Council (HSRC), the Centre for AIDS Development Research and Evaluation (CADRE), and the Medical Research Council (MRC) (HSRC, 2005) and gathered its data from a cross-sectional multistage disproportionate, stratified sampling procedure. Data were obtained by collecting blood specimens. The overall national HIV prevalence is estimated at 10.8% (2 to 50 years and older). The highest HIV

prevalence can be found in the age groups 20 to 24 (15.2%), 24 to 29 (23.2%), and 30 to 34 (24.9%). Figure 2.1 shows the HIV prevalence rates clustered in age ranges and gender distribution. Statistics of the survey illustrate women in the age group 20 to 39 years are the most infected, with the most infected age group the 25- to 29-year-old group (33.3%). The survey also revealed that the highest HIV prevalence range is among African females (24.4%) and among adults, age 15 to 49 years (25.8%) living in urban informal areas (HSRC, 2005).

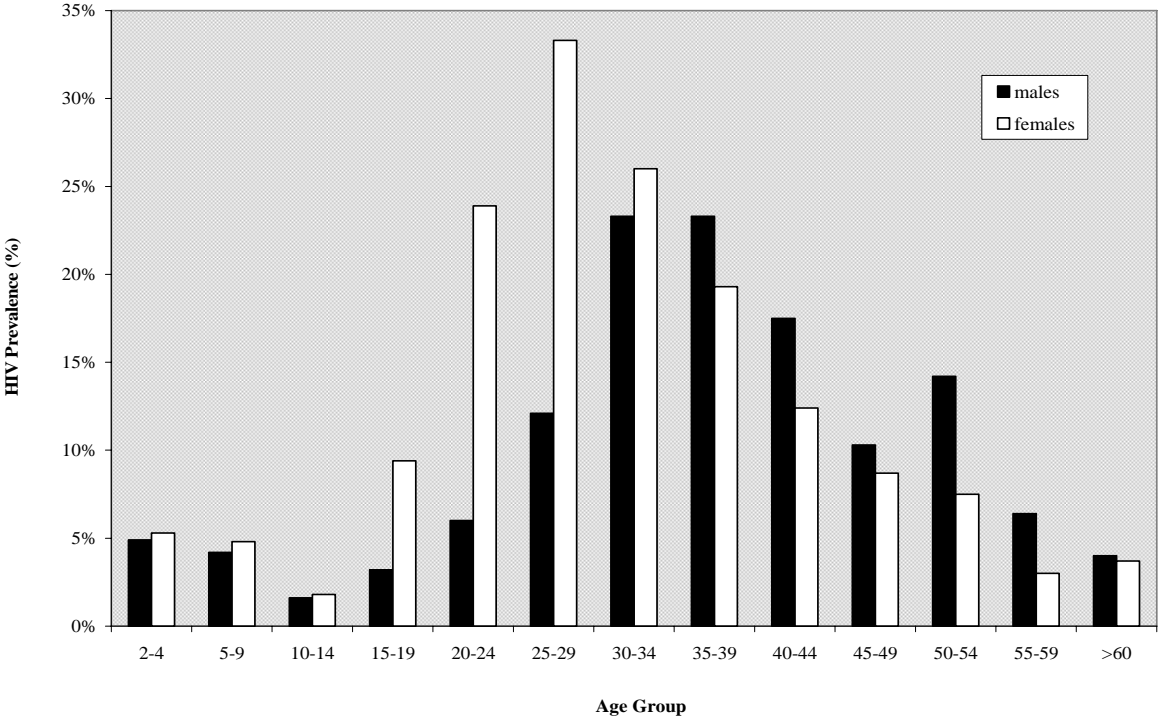


Figure 2.1. HIV Prevalence among Respondents aged two Years and older by Sex and Age Group, South Africa 2005 (HSRC, 2005).

The data gathered on children at the age of 2 to 14 were confusing. The HIV prevalence within this group was 3.3% in 2005. Compared to the survey of 2002, where 5.6% children were tested HIV positive (HSRC, 2002), the HIV prevalence decreased over the years in a confusing way (HSRC, 2005). However, the breakdown of ages makes it clear that a high number of 5- to 9-year-old boys (4.2%) and girls (4.8%) were already HIV positive. The National Household Survey of HIV Prevalence and Risk Survey of South African Children of 2004 discovered that the highest HIV prevalence was found among children living in informal urban areas (6.4%) (Brooks, Shisana, & Richter, 2004). Nonetheless, this result is alarmingly high in an age group that should show a smaller birth-related infection rate due to an absence of unsafe health behaviour (e.g. unprotected sex), which normally contributes to sexually transmitted diseases such as HIV. These findings lead to a closer contemplation of the

national discussion on the distribution of sexual abuse among children in South Africa (see par. 2.3.3).

The forecasts for South Africa are frightening. By the year 2010 South Africa will experience an overall prevalence of 25% of HIV infections. Life expectancy is predicted to drop from 65 years to 48 years due to the impact of HIV (H.J. Kaiser Foundation, 1999). A recent study on death registration has shown that deaths among people 15 years of age and older increased by 62% between 1997 and 2002, with deaths among people aged 25 to 44 more than doubling in South Africa (Statistics South Africa, 2005a). It is assumed that roughly 39% of the child population will be affected by adult morbidity and mortality (Dorrington, Bradshaw, Johnson, & Budlender, 2004).

The country South Africa experiences, besides one of the highest rates of HIV infection in the world, a non-foreseeable increase in new HIV infections among the youngest groups of society. It is also expected that the heaviest toll of this tremendous national crisis will be borne by South African children and young people because most of the people dying of AIDS will be the biologically and economically viable parts of the country. It is estimated that they will leave behind three million orphans (Gow & Desmond, 2002).

Apart from these discouraging prospects, there is still a chance to turn the tide or at least, to alleviate the heaviest burden for the human beings living in this epidemic situation. As the vast majority of children and youth under 15 years of age are not HIV-positive, they form a promising target group for prevention efforts that provide them with tools to cope with this extensive life crisis and to protect themselves against an HIV infection later in life.

## **2.3 Factors Contributing to the Transmission of HIV among Children and Adolescents in South Africa**

The statistics mentioned above provide evidence that especially the youngest sections of South African society are exposed to specific risk factors leading to the acquisition of unhealthy (sexual) behaviour or conditions, which might make them vulnerable, for instance, to becoming infected with HIV. The following paragraphs discuss from a broader perspective what psychosocial factors influence children and youth in South Africa in their development of physical and mental health while simultaneously being influenced by the social context. These factors are considered strongly interconnected and determining in the practise of health behaviour among individuals. The following section describes specifically existing risk factors which have a great impact on the growing up of children and young adults in South Africa. The discussion is based on scientific knowledge on common psychosocial risk and

protective elements effecting the development of health behaviour from childhood to adolescence as the two main developmental phases described in this study.

### **2.3.1 Psychosocial Risk Factors Effecting the Development of Health Behaviour – The Starting Point**

There is a conviction in the public health field that every developmental step in a human being's life from before birth until late adulthood bears specific protective or risk factors that either draw the individual towards positive outcomes or push the individual towards negative (or risky) outcomes (Richter, 2001). In other words, when trying to prevent disease and encourage the development of competences to maintain an individual's health, the best would be to encourage health even before birth or in early *childhood* (0 – 6 years). As Hosman and Llopis (2005) state, there is not only more development in mental, social and physical functioning during the early stages of life than in any other period, but this phase also determines a child's functioning in school later on and in the broader society, as well as relationships – with peers as well as intimate relations. However, when trying to influence health behaviour to enhance a positive quality of health, or rather to reduce negative outcomes of health effects, the developmental phase of late childhood and adolescence is regarded as a good temporary gate for health-promoting interventions, especially when preventive attempts are undertaken in cooperation with the main forms of social support, namely the family and the school.

*Childhood* (6 – 13 years) is that phase in life when body, soul and mind, together with social relationships and skills, develop within a short period of time and are subject to big changes. During this time biological disposition, learning processes and influences from the immediate environment (the family and school) interact (Bergmann & Bergmann, 2004), resulting in the creation of a personality with its individual properties, skills and behaviour (Keller, 1998; Markefka & Nauck, 1993; Bergmann & Bergmann, 2004). This process includes the completion of perception and articulation abilities, the broadening of an individual's horizon, the expansion of a role repertoire that can be used outside the family, and the development of the first signs of a social identity (Schnabel, 2004). On the basis of these developmental processes the deduction can be made that the health behaviour that is practised in childhood is very often sustained throughout life (Oerter, 1995a; Knäuper, 2002). With reference to the prevention of disease and the development of competencies that will help to maintain health, childhood is probably the most important stage in life, as most children are born healthy,

meaning that the metabolism and immune system of children are sustainable and their health behaviour (or risky behaviour) has not yet been established (Bergmann & Bergmann, 2004).

The stage of *adolescence* (13 – 18 years), the passage from childhood to adulthood, is characterised by the exploration of new and consequently somewhat risky behaviour (Hurrelmann, 1998; Knäuper, 2002). This means that development in adolescence is an active process during which the individual takes over or establishes developmental targets and actively strives to reach these (Pinquart & Silbereisen, 2004). The developmental tasks during this stage include: reaching independence from parents, establishing relationships with peers and partners, dealing with physical development, and developing an identity (Havighurst, 1972; Pinquart & Silbereisen, 2004). During this stage the family in particular and the allocation of roles in the family function as living models (Schnabel, 2004) that are tested in relationships within the peer group and in first (intimate) partnerships. An additional risk factor that should not be underestimated is the fact that adolescents tend to ignore potential long-term consequences of risky behaviour and consider themselves invincible – only later will their behaviour turn out to have a negative impact on their health (Knäuper, 2002). Seeing that during this phase the range of risk and protective factors changes and expands and health behaviour is established and strengthened, adolescence is regarded as another extremely important time for preventative measures (Pinquart & Silbereisen, 2004), especially in disadvantageous social conditions that encumber the realisation of developmental tasks.

In conclusion, fields of psychosocial risk and protective factors can be found in (physical) growth, (health) status, (mental) development, (social) competencies and adjustment, (school) achievement, and integration (Richter, Cameron, Norris, Del Fabro & MacKeown, 2004). This means, for example, that child development is a matter of continual adaptation to circumstances as the balance between these factors change (Compas, Hindon, & Gerhardt 1995 in Richter et al. 2004). In their report on children in South Africa, Berry and Guthrie (2003) identified poverty, diseases such as HIV/AIDS, and violence or child abuse as the main risk factors affecting child development, and most likely also affecting the development of health behaviour. The following three examples portray these research findings by Berry and Guthrie (2003) in more detail and, at this point, describe main risk factors which influence the development of health behaviour among South African children and young people.

### **2.3.2 Selected Sociodemographic Risk Factors – Poverty and Malnutrition**

The sociodemographic conditions in which South African children grow up, including insecure (environmental) living conditions and malnutrition, are considered to be one of the main factors which influences the quality of child health.

In urban South Africa, the poorest strata of society are concentrated in so-called townships. Townships are relics of the apartheid past when people of African origin were concentrated in urban and semi-urban areas. In recent years, townships are growing into overcrowded areas due to extreme migration processes from rural to urban areas in the search for work. The disadvantaged areas are mainly characterised by underdeveloped infrastructures, unhygienic living conditions, lack of security, high crime rates and poverty-related physical (e.g. malnutrition) and mental (e.g. depression) diseases. Children who grow up in impoverished living conditions might be subject to health risks in four predominant areas, namely:

- Inadequate housing and access to water and sanitation causing overt exposure to diseases such as tuberculosis and diarrhoea (Mathee, 2004);
- Exposure to indoor air pollution due to the use of polluting fuels and chemicals such as lead and pesticides (Mathee, 2004);
- Unintentional injuries (e.g. traffic injuries, drowning, poisoning, burn injuries or road accidents) due to living in an environment without a structured town layout or road maintenance and often inadequate care and protection (Mathee, 2004); and
- Intentional injuries can be caused by three categories of violence: (a) self-directed violence (e.g. suicide), (b) interpersonal violence (e.g. child maltreatment, intimate partner/group violence, sexual violence), and (c) collective violence (e.g. human rights abuse) that either result in or have a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation (see also Walker, Verins, Moodie, & Webster, 2005 in WHO, 2005).

Human beings living in disadvantaged, and therefore, poor living conditions are not only exposed to unhealthy and unsafe environments but also to unattained basic needs such as food, as a result of extreme poverty. It is estimated that approximately 19.3 million South African children under the age of 18 are living in poverty and that 11 million (60%) of these are living in absolute poverty with less than R200 per month (Streak, 2002). According to Berry and Guthrie (2003), this amount corresponds with half of the amount needed to satisfy basic needs for survival and food security. Approximately 30% of the South African population experience food insecurity, which affects mainly entire families in rural and semi-urban areas (Mvulane & Proudlock, 2002; Mvulane, 2003). This food insecurity also means

that a large number of children in South Africa are assumed to be undernourished, which, consequently, has long-term impeding effects on their physical and mental/cognitive development (learning ability and life task achievements).

Bray (2002, 2003) concludes that a wide range of growing risk factors on socio-economic level influence the physical, psychological and social well-being of South African children growing up in disadvantaged living conditions. Vergnani, Flisher, Lazarus, Reddy, & James (1998) agree that the living conditions or rather the sociodemographic situation of children and youth in South Africa provide major risk factors for developing unsafe health (sexual) behaviour later in life. Finally, as statistics suggest, while poverty, unemployment and inequality are on the increase in South Africa (Berry & Guthrie, 2003), the present AIDS epidemic functions like a catalytic converter that worsens the quality of life and creates a higher insecurity for the poorest strata and population groups in South Africa, especially children, who largely depend on adults and their environments.

### **2.3.3 The Sexual Abuse of Children in South Africa – Harmed Health**

Crimes against children include kidnapping, assault, murder and attempted murder, rape and incest, amongst others (Bower, 2003b). In South Africa 72 026 crimes against children were reported in 2000, with 66 957 in 1996 (Bower, 2003a), with an increasing tendency (Office on the Right of the Child, 2001). Due to a lack of accurate statistics on children's actual exposure to the different forms of violence (Berry & Guthrie, 2003) in South Africa, only the most frequent crimes against children are known, of which the most common is common and aggravated assault, with over 36 000 reported cases (Bower, 2003a). One form of assault is where the child is the target of or witness to domestic violence; this is related to the fact that one in six relationships in South Africa is of a violent nature (Resources Aimed at the Prevention of Child Abuse and Neglect [RAPCAN], 2001). Another form of assault is the exposure to physical punishment as a method of discipline in families (Swart-Kruger, 2001) and schools. Both forms affect children's emotional and physical safety within their family sphere.

The second most common type of crime against children is sexual violence (Bower, 2003a) including rape, sodomy, indecent assault and sexual offence. South Africa has one of the highest rates of rape reported to the police, with 52 425 cases of women and children reported between 2002 and 2003 (Human Rights Watch, 2004a; Christofides, Jewkes, Webster, Penn-Kekana, Abrahams, & Martin, 2005) in the world. The number of reported sexual crimes against children amounted to over 25 000 in 2000 (RAPCAN, 2001; Berry & Guthrie, 2003).



This means rape is among the most prevalent crimes against children, with many victims being infants or very young (Office on the Right of the Child, 2001), amounting to almost 42% of total crimes against children in 1998 (South African Police Services [SAPS], 2000). RAPCAN assumes that, in general, only one in 20 or even 1 in 35 rape cases are actually reported to the police (RAPCAN, 2001). This estimation might be applicable to statistics on child rape, too, because less injurious crimes than rape are far less likely to be reported (Dawes, 2002 in Berry & Guthrie, 2003). In addition, because it is unusual for children to be raped by strangers (Jewkes & Levin, 2002), the most common groups of sexual abusers of children are male relatives, boyfriends, male acquaintances and men in a position of power, notably teachers. The conviction rate in cases of rape of children is approximately 9% (Human Rights Watch, 2004a).

According to the South African Police Service (2000) children seem to be more vulnerable to being sexually assaulted if they live in impoverished areas, in poor living conditions with parents who are often absent or do not try to protect them, or come from homes where substance abuse is a problem (National Department of Health, 2004b). Berry and Guthrie (2003) support these findings and add accompanying factors that put children at extra risk for sexually related violence, namely limited opportunities for adolescents, alienation from school (National Crime Prevention Strategy, 1996), and violence against women and children in domestic and school settings (Office on the Right of the Child, 2001). According to the Human Rights Watch (2003) the problematic nature of sexual assault has been worsened through an increasing number of AIDS orphans and child trafficking in recent years.

Apart from the statistics documented above, child rape can have an enormous impact on the child survivor. Sexually abused children suffer a variety of physical, emotional and developmental problems that can interfere with their ability to live healthy and productive lives (Bowley & Pitcher, 2002). They may have physical disorders such as sexually transmitted infections, including HIV, constipation, genital injuries, recurrent urinary tract infections, abdominal pains and behavioural problems. Psychological effects of any kind of violence shatter four basic assumptions of the self and the world: (a) the belief in personal invulnerability; (b) the view of the self as positive, and the belief that the world is a meaningful and orderly place; (c) the attitude that events happen for a reason (Janoff-Bulman, 1985); and (d) the trust that other human beings are fundamentally benign (Hamber & Lewis, 1997). Hamber and Lewis (1997, ¶ 5) conclude:

These four assumptions allow people to function effectively in the world and to relate to others. However, after an experience of violence, the individual is left feeling vulnerable, helpless, and out of control in a world that is no longer predictable.

In regard to sexual violence, negative long-term outcomes in the psychology of the individual can be, for example, the development of post-traumatic stress disorders or risk-taking behaviour. Research findings show that sexual abuse during childhood seems to be associated with high-risk behaviour later in life that may also increase the risk of contracting HIV (WHO, 2000). The WHO (2002) states that there are findings that teenagers and adults who were sexually abused as children are at a greater risk of substance abuse, depression, mental health problems and engaging in high-risk sexual practices. Duncan and Rock (1997) researched risk-taking behaviour among children whose health was injured by a sexual offence. They postulate that violence has come to be seen as a 'normal' condition in a society where child survivors themselves show a tendency towards violence. In other words, many children become child rape perpetrators themselves (Jewkes & Levin, 2002) and are not only vulnerable to but also expressing risk-taking sexual behavioural patterns already at a young age and towards other young children.

Furthermore, the extent to which sexual abuse contributes to HIV infection in children is not well-known (Berry & Guthrie, 2003). Because of statistical constraints and the high incidence of underreporting of child abuse cases in South Africa it is most likely that there exists a higher proportion of undetected HIV infections among children, which are caused by a high number of acts of sexual violence committed without the use of protective barriers. Berry and Guthrie (2003) resume in their report that with an increase in HIV infections in the adult population, children face an increasing risk of inadvertently acquiring HIV through sexual abuse.

#### **2.3.4 Sexual Behaviour of South Africa's Young People – Complexity of Risks**

As the statistics above illustrate, the AIDS epidemic in South Africa is concentrated among the most productive section of the population, i.e. in 20- to 39-year-olds, starting at the age of 15 (Adler & Qulo, 1999; Eaton & Flisher, 2000), and mainly affects females between the age of 20 and 29, with a constant increase in numbers every year (HSRC, 2005). In the following

paragraphs South African research findings of the high-risk sexual behaviour among South African young people are described<sup>2</sup>.

#### **2.3.4.1 Sexual Debut**

At least 50% of adolescents in South Africa are sexually active by the age of 16, and probably 80% by the age of 20. Boys report an earlier sexual debut than girls whilst black (African) youth are more likely to start sexual activity in early adolescence than other ethnic groups (Eaton, Flisher, & Aaro, 2003).

#### **2.3.4.2 Condom Use**

In their study, Eaton et al. (2003) report that a maximum of 86% of sexually active respondents have used a condom. A maximum of 55% of youth use condoms at every sexual encounter. An overall estimate of 50% to 60% (the number varies between 23% and 85% in other studies) of the youth do not use condoms at all (Eaton et al., 2003). In Peltzer and Promtussananon's study (2005) one third of the learners stated that they had not used a condom at their first sexual encounter. Despite the fact that unprotected sex among youth places them at risk of unwanted pregnancies and sexually transmitted infections (STIs), including HIV/AIDS, the majority of sexually active adolescents in South Africa use condoms irregularly. Certain factors contribute to the non- or irregular use of preventive barriers. Campbell (2003), for example, found that women are being prevented from taking the sexual initiative, the focus being mainly on male desire and the satisfaction of male needs, also regarding the use of condoms. Women thus find themselves in a relatively powerless position. She explains this by defining the role of the female, especially the women with African ancestry in South African society, whose respectability is strongly associated with the role of wife, mother and homemaker, as well as with behaviour that reflects sexual fidelity (Campbell, 2003). In the same study, on the other hand, some of the men reported to be exposed to peer pressure and explained that male peers would sneer at them and belittle them if they decided to use condoms (Campbell, 2003). Further behavioural factors that contribute to risky sexual practices are drug and alcohol abuse, stress and various forms of violence, including peer pressure and sexual harassment (Everatt & Orkin, 1993; Duncan & Rock, 1997; Vergnani et al., 1998; Angless & Shefer, 1997; Magwaza, 1997).

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<sup>2</sup> Studies with young adolescents in primary schools are generally underrepresented (Kaaya et al., 2002). This literature review on unsafe sexual behaviour will therefore only focus on studies with adolescents older than 12 years.

### **2.3.4.3 Sexual Partnerships and Age Mixing**

Eaton et al. (2003) report in their study that between 10% and 30% of sexually active youth have more than one sexual partner at a given time, with more men than women engaging in a concurrent multiple-sex relationship. While boys seem to engage with more sexual partners, girls report sexual relationships with much older partners than boys. Peltzer and Promtussananon (2005) found that 25.6% of the learners had had sex with someone much older than themselves (above 30 years). Significantly more females (31.2%) than males (22.9%) made this statement (Peltzer & Promtussananon, 2005). One possible assumption is that such relationships are linked to impoverished living conditions that put young people in a position where they have to grant sexual favours in exchange for gifts in order to be able to pay their school fees, for example. In this regard Peltzer and Promtussananon (2005) reported that 27% of the learners had had sex in exchange for gifts. Nair (2005) undertook a study in a South African semi-urban community on how social exclusion of children and youth can encourage HIV transmission. Again, he reports that in conditions of poverty, girls in particular often depend on sexual partners for gifts such as money or clothing, and consequently have limited power to insist on condoms in such situations (Nair, 2005). For older men, preference for adolescent girls is partly driven by the belief that the girls are free of AIDS (UNAIDS/WHO, 2005b). However, these men have usually had a number of sexual encounters and are more likely to be infected with HIV and consequently transmit the virus to the younger female sexual partner.

### **2.3.4.4 Access to Information**

Another factor that contributes to risky sexual behaviour among youth is the difficult access to clear and unbiased information and services. Possible sources of information for the youth are parents, media, clinics, and schools; however, these sources of information are problematic. Firstly, South African adolescents report poor communication with parents about sexual matters (Boult & Cunningham, 1991; Kau, 1991; Kelly, 2000; Kelly & Parker, 2000; Visser, Roos, & Korf, 1995; Wood, Maepa, & Jewkes, 1997). As part of a strategy to encourage abstinence and undermining of the 'sex is taboo' message, teenage sexual activity is greatly denied (Campbell, 2003; Yoro Badat, 2004). Secondly, youth in rural and poor areas where media distribution is low, clearly require alternative sources of information (Flisher et al., 1993). The third problematic source is the community clinic. Clinics are not regularly used by the youth as a resource centre for health and prevention because young people report that clinic staff sometimes scold or mock them when they go there to obtain

condoms (McPhail & Campbell, 2000; Richter, 1996; Wood et al., 1997; Eaton et al., 2003). A visit to the clinic often is the beginning of being exposed to gossip and a bad reputation within the community (Campbell, 2003).

#### **2.3.4.5 Specific Historically-Based Factors**

Socially related risk factors that encourage highly unsafe sexual behaviour among South African youth are found in historical marginalisation and disadvantages (Dryfoos, 1991; Vergnani et al, 1998) in colonial times, during apartheid, as well as in current transformation processes in the social, political and economic system of a young democratic state. Gow and Desmond (2002) identified special sociodemographic conditions that determine young people's lives by increasing their risk of being exposed to diseases: the high level of poverty and unemployment, social and familial disruption through urbanisation/migration processes and the related migrant labour system, regular commercial sex practises, the low level of education in large sectors of society, and the low position of women in society and in relationships.

In their respective studies, Peltzer (2002a) and Campbell (2003) confirm that some of these risk-taking sexual behaviours, described on the case of condoms use, are affected by a wide range of situational, interpersonal and structural factors (peer norms and gender relations), such as knowledge about AIDS (access to information), behavioural intention, perceived vulnerability, perceived barriers (adults' disapproval of young people's sexuality or access to condoms), self-efficacy, demographic factors, and economic constraints. This means that all the psychosocial factors listed above strongly influence the health behaviour of South African children and youth.

## **2.4 Learning Processes to Enhance Health – The Application of the Social Cognitive Theory by Bandura (1986)**

Social and behavioural scientists have developed a number of cognitive and decision-making theories and models to explain and predict (health) behaviour of individuals and groups. A number of theories have specifically been used in the field of health promotion, namely the health belief model (Becker, 1974; Janz & Becker, 1984; Rosenberg & Rosenstock, 1966), the theory of reasoned action (Ajzen & Fishbein, 1970), the theory of planned behaviour (Azjen, 1985) and the social cognitive theory (Bandura, 1986, 1991). One of the most important, widely used and proved practical theories (see also Elkins, Maticka, Kuyyakanond, & Miller,

1997; Schinke, Botvin, Orlandi, & Schilling, 1990; Klepp, Ndeki, & Seha, 1994; Shuey, Babishangire, Omiat, & Bagarukayo, 1999) to promote condoms in particular (Aaro, Flisher, Kaaya, Onya, Fuglesang, Klepp, & Schaalma, 2005), is the construct of the social cognitive theory (Bandura, 1986).

The SCT, as part of a static motivational theory, explains how cognitive and social factors determine human health or rather human disease. This theory attempts to explain human behaviour by using a broad social perspective which is based on a triadic reciprocal determinism in which behaviour, personal factors (such as cognitive factors) and environmental events (environmental and internal forces) operate as interacting determinants. Here, the term 'reciprocal' refers to the mutual action between the factors, while 'determinism' refers to the production of effects by certain factors. The strength of the reciprocity between factors can vary according to the person and the situation and is subject to change over time as a function of maturation and experience. In other words, changes in any of these three factors are hypothesised to produce changes in the others.

In more specific terms, the *person-behaviour* interaction involves the bidirectional influences of one's thoughts, emotions, and biological properties and one's actions (Bandura, 1986). A bidirectional interaction also occurs between the *environment and personal* characteristics (Bandura, 1986). In this process, human expectations, beliefs, and cognitive competencies are developed and modified by social influences and physical structures within the environment. These social influences can convey information and activate emotional reactions through such factors as modelling, instruction, and social persuasion (Bandura, 1986). In addition, humans evoke different reactions from their social environment as a result of their physical characteristics, such as age, size, race, sex, and physical attractiveness. The final interaction occurs between *behaviour and the environment*. Bandura (1986) argues that people are both products and producers of their environment meaning a person's behaviour will determine those aspects of their environment to which they are exposed, and behaviour is, in turn, modified by that environment.

One of the key concepts in SCT is the environmental variable *observational learning*. In contrast to earlier behavioural theories, SCT considers the environment as not just a variable that reinforces or punishes behaviours, but one that also provides a milieu where an individual can observe the actions of others and/or learn the consequences of their behaviour (Bandura, 1986). This means the SCT adds a cognitive component by identifying that people can also learn from the experiences (observation) of others (e.g. living models) and takes into account

how the people's perceptions of their environment affect their decisions (Rotter, 1954; Bandura, 1977).

In other words, the SCT specifies factors which determine and drive competencies (e.g. self-efficacy), which in turn also influence physical and emotional well-being as well as self-regulation of health behaviour (e.g. health habits.) (Dohnke, 2003). The theory distinguishes between four psychosocial determinants: (a) self-efficacy, (b) outcome expectations, (c) goals, and (d) impediments (see also Figure 2.2). The two central cognitive determinants of intentions and health behaviour are self-efficacy and outcome expectation (Abraham, Sheeran, & Johnston, 1998; Armitage & Conner, 2000 in Dohnke, 2003). Bandura assumes that subjective expectations such as outcome expectations and self-efficacy strongly influence cognitive, motivational, emotional and active processes taking place within an individual (Knoll, Scholz, & Rieckmann, 2005).

Self-efficacy, hereby, holds a key position in SCT (Dohnke, 2003). This determinant refers to the perception that a person has the capacity to perform a behaviour (Skinner, 2000) and is presumed to have a direct or indirect (over other determinants) effect on behaviour (Dohnke, 2003). This means in the process of the behavioural change self-efficacy influences the range of specific situations, goals and actions (behaviour), the investment of efforts, persistence regarding experienced difficulties and barriers, recovery of setbacks, as well as degree of success (Bandura, 1997, 1998; Schwarzer, 1996 in Dohnke, 2003). Bandura names four sources for the development of self-efficacy within an individual (Bandura, 1986), listed from the strongest to the weakest source: (a) mastery experience, (b) vicarious experience, (c) symbolic experience, and (d) emotional arousal (Dohnke, 2003) encouraged through observing a model.

The second most important cognitive determinant, outcome expectations, predicts health behaviour by directly influencing goals (intention) or indirectly influencing goals (Dohnke, 2003). The development of positive (incentives) and negative (disadvantage) outcomes, which can be physical, social and self-regulatory, is always influenced by self-efficacy. The last two cognitive determinants of the SCT are goals (here also intentions) and impediments. Both determinants are influenced by self-efficacy. The determinant goals contain additional self-incentives to influence certain behaviour whilst the impediments are not only grounded in an individual but can also be determined by specific sociostructural factors.

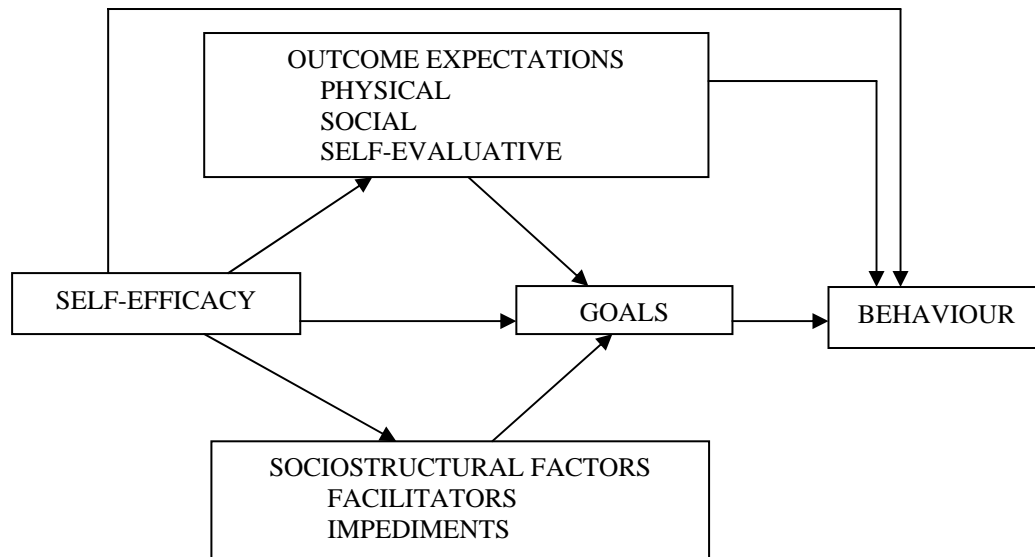


Figure 2.2. Model of the Social Cognitive Theory by Bandura (1998).

In summary, the social cognitive theory is a multidisciplinary approach that incorporates a wide range of psychosocial phenomena that can be fashioned by direct and observational experience into a variety of forms within biological limits. As it encompasses attention, memory and motivation it spans both cognitive and behavioural frameworks. In his theory of social learning, Bandura (1986) formulated conditions in which (positive and critical) behaviour is learned by social interaction, or in other words, the desired social behaviour is specifically practised and positively encouraged (Bühringer & Bühler, 2004) with the help of a model (intervention).

With regard to the prevention of HIV infection within individuals, the SCT has been applied extensively to understand the theoretical foundation of the technique of behavioural modelling. The theory is widely used in training programmes because it allows trainers (facilitators) to identify the environmental conditions that lead to the acquisition and preservation of behaviour and encourage behavioural change (Skinner, 2000). As the aim of this study is to enhance health promoting behaviour to reduce the risk of HIV infection among pre-adolescents (also later in life), the SCT (Bandura, 1986) forms the theoretical basis in the evaluation of cognitive and social variables among participants by way of a specific school-based life skills programme on AIDS and sex education (model).

#### 2.4.1 The Research Model and Underlying Assumptions

According to Gibney (1999), the following main components of the SCT should be reflected in any HIV prevention approach: (a) the promotion of knowledge about risks and prevention, (b) the acquisition of skills and competencies regarding the reduction of an HIV infection, (c)



the increase of self-efficacy, and (d) the promotion of peer norms reflecting protective behaviours (Gibney in Peltzer, 2002b). Furthermore, any intervention undertaken to increase competencies (e.g. self-efficacy) and to enhance the development of protective health behaviour should incorporate the following processes: (a) cognitive processes (knowledge, self-efficacy, self-esteem, reasoning and problem-solving skills, learning ability and achievement), (b) emotional processes (trust, empathy, positive social relationships, supportive social network), (c) affective processes (reduction of discrimination and fear), and (d) motivational processes (impulse control, constructive coping and goal-directed behaviour, development of social responsibility and interpersonal communication). Therefore, a specific research model for this study is applied to examine this pre-adolescent age group who are in their early phases of developing an attitude and value system. This model is set to encourage skills and competencies to cope with current prevailing life tasks and to prevent risk factors or increase protective factors to enable pre-adolescents to apply health behaviour later in life.

Figure 2.3 illustrates the presented model in combination with underlying assumptions. The research model depicts a reciprocal one-way process, in which individuals (participants, facilitators) in interpersonal relations act in an intervention (life skills programme on HIV/AIDS and sex education), or model (Bandura, 1998), in their closer environment (classroom). The intervention itself, as an independent variable, is an opportunity to encourage the individual to learn by experience (activity) and by the observation of others, and strengthens and reinforces individual behavioural capabilities such as symbolising, forethought, and vicarious, self-regulatory and self-reflective behaviour. The underlying assumption is that learners, first of all, acquire and experience their own cognitive and social competencies in a specific learning model.

The used dependent variables are regarded to reinforce cognitive and social competencies on the individual and interpersonal level by encouraging certain health-related outcome expectations among participants. First, *self-efficacy* is assumed to represent the individual's conviction in his/her own competencies to be able to keep goals while confronted with impediments that influence outcome expectations, goals, and sociostructural factors. Second, the development of general biological-medical *knowledge on HIV/AIDS* and ways of transmission is assumed to raise awareness towards this particular health risk among participants.

The variable *self-esteem* is assumed to be a psychological motivating stimulus to enhance the individual's confidence in his/her own competencies. The psychological factors in particular, such as self-esteem and self-efficacy, are assumed to critically affect interpersonal

factors that represent social competencies such as gender communication and social responsibility.

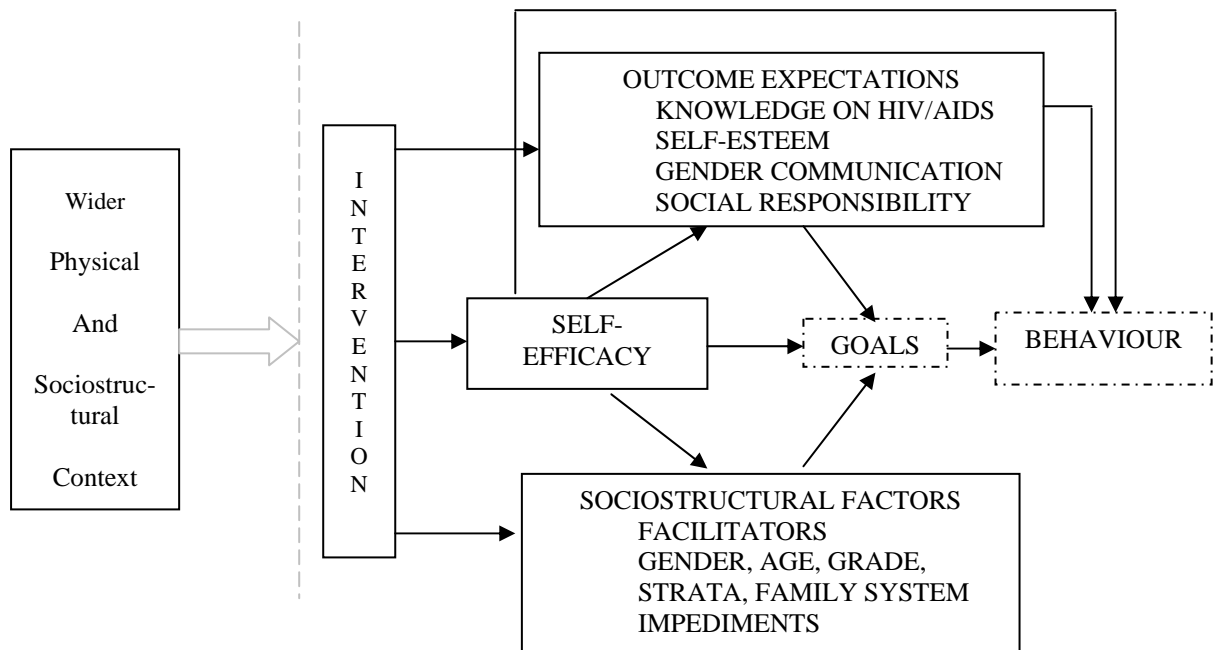


Figure 2.3. Research Model for Organising the Relationship between Psychological Competencies, Interpersonal Conditions, and Environmental Factors.

The encouragement of social responsibility and gender communication is assumed to form the basis for personal outcome expectations in relation to the establishment of positive relations to and with other peers of the same and other gender; with gender being viewed as both a physical and psychological term. The variable *gender communication* refers mainly to the quality of interaction between boys and girls in the class. Communication in the group or with other individuals about different topics will teach communication skills such as listening and discussion; the skills will in turn encourage the ability to trust and empathise with other individuals and an understanding of non-violent and communicative social relationships (e.g. family, friends). *Social responsibility* encompasses the development of the child's social skills, while enabling him or her to be an active and responsible member of his/her closer (class) and wider social community (Berman, 1997). Social responsibility as a variant is also examined, because it is assumed to have an effect on the children's cognitive development outside the intervention setting. Sociostructural factors, such as the quality of relations to health promotion trainers (facilitators) or other classmates (living models) are examined to broaden the understanding of underlying processes that influence the cognitive development of the participants. Other sociostructural determinants such as gender, age, grade, strata, and family systems function as a filter to identify possible subgroups within the group structure.

The physical and sociostructural environments encompass the wider learning environment (school), as well as the living environment of the participants (case study community). According to the SCT, all these factors are potentially equally determining (Bandura, 1991; Eaton et al., 2003).

Furthermore, there are several weaknesses of the research model. First, the SCT puts great emphasis on the assessment of attitudes related to, for instance, HIV/AIDS and sex. Attitudinal items that enquire about intimate convictions could not be formulated due to the young age of the samples and several contextual reasons as well as cultural convictions which are outlined in more detail in chapter 5. Goals (intention) and behaviour were not examined. The absence of intention is assessed as a factor that reduces the effectiveness of the research model used, because intention is seen as an important predictor of attitudes and behaviour in the field of health behaviour, and because intention, planning and other self-regulative capabilities seem to increase the effectiveness of self-efficacy (Schwarzer, 2002). Finally, behaviour could not be assessed because the examined participants were in the stage of pre-adolescence; the samples therefore were only in the formation process of developing health behaviour.

## **2.4.2 Depiction of Research Variables**

In the following section the research variables in conjunction with findings from other surveys are explained. Those findings shall well support the importance of research variables in the analysis of the effectiveness of the model. In the absence of studies with pre-adolescents, most of the presented results are gathered from studies examining adolescents.

### **2.4.2.1 Knowledge of HIV/AIDS**

Sufficient public knowledge about HIV/AIDS and prevention measures is an essential requirement for any society trying to limit the spread of HIV. According to Peltzer and Promtussananon (2005), knowledge is only part of what is needed to develop an adequate response to HIV/AIDS but it is certainly a commodity that has to be taken into consideration. Eaton and Flisher's (2000) literature review on knowledge about HIV/AIDS among South African youth shows two key findings.

The first finding is that most young people in South Africa have heard of AIDS. The percentage ranges from 85% (Richter, 1996) to 100% (Strebel & Perkel, 1991; Van Wijk, 1994; Varga & Makubalo, 1996). In a study of urban black youth (Richter, 1996), 73% of young men and 75% of young women had heard of HIV, compared to 92% and 85%

respectively having heard of AIDS. In a sample of 141 street youth (Van Wijk, 1994), nearly all had heard of AIDS, but none had heard of HIV. The second key finding is that, despite an overall high awareness of AIDS, the youth show highly variable actual knowledge about the illness itself. Some researchers concluded that their subjects had a good overall knowledge about AIDS; however, they also reported that knowledge was mediocre, that is, 40% to 60% as measured by knowledge tests (Everatt & Orkin, 1993; Kruger & Richter, 1996; Friedland, Jankelowitz, De Beer, De Klerk, Khoury, Csizmadia, Padayachee, & Levy, 1991; Heunis, 1994). Other studies reported that the majority of the subjects were very ill-informed about HIV and AIDS (Friedland et al., 1991; Ratsaka & Hirschowitz, 1995). Peltzer and Promtussananon (2005) revealed in their study that respondents showed less knowledge when assessed with open, rather than set-choice questions, suggesting low levels of spontaneous memory of AIDS information without a significant gender difference ( $t = 1.49$ ).

In South Africa, as elsewhere, results differ in studies on the relation between HIV/AIDS knowledge and gender (Peruga & Celentano, 1993; Eaton & Flisher, 2000). Two studies reported gender differences. A study among university learners found that female learners were significantly more knowledgeable about HIV/AIDS than their male peers (Strebel & Perkel, 1991). In a small study among adolescents the opposite was found, with the young men being significantly more knowledgeable than their female peers (Kaplan & Van den Worm, 1993). Three studies reported no significant differences regarding gender (Coughlan, Coughlan, & Jameson, 1996; Elkonin, 1993; Perkel, 1991).

On the other hand, Peltzer and Promtussananon (2005) report significant differences between genders in various HIV knowledge items. For example, more male than female learners believed that “People who have been infected with HIV quickly show serious signs of being infected”. In addition, the same study reports that English-speaking learners and learners from urban schools are much better informed than African learners from non-urban schools (Peltzer & Promtussananon 2005). The study concludes that knowledge of HIV/AIDS was not satisfactory enough to sustain adequate HIV/AIDS response in a context of high and widespread HIV/AIDS prevalence, and suggests that lower levels of knowledge in younger persons, gender, as well as racial and urban-non-urban differences should be clearly addressed by AIDS education efforts (Peltzer & Promtussananon, 2005).

Finally, knowledge of HIV/AIDS seems to increase from childhood to adolescence and then appears to reach a plateau during adolescence, with no appreciable gains during adulthood. This may be because school guidance programmes and adolescents’ increasing interest and participation in sexual activity enable teenagers to acquire knowledge on HIV/AIDS (Eaton &

Flischer, 2000). Once young people possess a basic knowledge, there may be little incentive for them to seek additional information, especially since most young people do not perceive themselves as being at a high risk of contracting HIV/AIDS (Blecher, Steinberg, Pick, Hennick, & Durcan, 1995; Everatt & Orkin, 1993; Friedland et al., 1991; National Progressive Primary Health Care Network [NPPHCN], 1996; Perkel, 1991; Ratsaka & Hirschowitz, 1995; Strebel & Perkel, 1991).

In South Africa, interventions that attempt to curb the spread of HIV are generally aimed at imparting knowledge about AIDS and promoting condom use (Eaton & Flisher, 2000). However, most studies clearly illustrate that gender tendency to use condoms and being sexually active have no significant relation to levels of knowledge (Peltzer & Promtussananon, 2005). An explanation is given by Campbell (2003) who states in her study that knowledge about HIV/AIDS seems to be far more complex and reflect local ideas of health, sexuality, traditional values and healing systems. Furthermore, she explains that such facts are embedded within a range of doubts, qualifications, contradictions and uncertainties, and are constructed in social conditions that shape and constrain individual sexual choices. These conditions serve to blunt the factual messages imparted by the programmes (Campbell, 2003), and also means that health education messages compete with alternative beliefs, experiences and logics that may be more compelling than the information health educators seek to impart (Campbell, 2003).

#### **2.4.2.2 Global Self-Esteem**

Self-esteem theorists Rosenberg (1979) and James (1983 in Hamber & Lewis, 1997) have suggested that self-esteem is a dynamic, changing construct. James (1983 in Hamber & Lewis, 1997) views self-esteem as the ratio of one's successes and pretensions, whereas Rosenberg (1979, p. 31) refers to self-esteem as a "positive or negative evaluation of the self". A combination of these two perspectives leads to the following proposition: "A positive evaluation of the self stems from having more success than expected, whereas a negative evaluation stems from having fewer successes than expected" (Rosenberg, 1979, p. 31). Clearly, this interpretation suggests that a person's self-esteem is not constant over time, but dynamic instead, depending on the individual's successes and expectations (Baldwin & Hoffman, 2002).

As noted by developmental theorists, these ebbs and flows of self-esteem are probably felt most strongly during the adolescent years. Long-term studies of adolescent self-esteem have revealed a decline in self-esteem at the age of 11, a low between the ages 12 and 13, and a

gradual, systematic improvement in self-esteem between ages 18 and 19 (Demo & Savin-Williams, 1983; Eccles, Midgley, Wigfield, Buchanan, Reuman, Flanagan, & Maclver, 1993; McCarthy & Hoge, 1982; Rosenberg, 1986). Cairns, McWhirter, Duffy, and Barry (1990), Chiam (1987) and O'Malley and Bachman (1983) support these findings and report that self-esteem is inconsistent during adolescence. However, some cross-sectional studies contradict these findings and have found that self-esteem either declines during the adolescent years (Brack, Orr, & Ingersoll, 1988; Brown, McMahon, Biro, Crawford, Schreiber, Similo, Waclawiw, & Striegel-Moore, 1998; Simmons & Rosenberg, 1975) or remains static (Bolognini, Plancherel, Bettschart, & Halfon, 1996; Chubb, Fertman, & Ross, 1997; Nottelmann, 1987; Savin-Williams & Demo, 1984; Simmons & Blyth, 1987; Wylie, 1979).

Despite all contradictory results about whether or not self-esteem changes significantly during adolescence (Baldwin & Hoffmann, 2002), it is safe to say that self-esteem during the adolescent years appears to undergo a process of metamorphosis (Quatman & Watson, 2001). Adolescence brings with it an increased differentiation in self-concept as well as an increased cognitive capacity for abstraction and self-reflection (Harter, 1990a, b). These changes, says Simmons and Blyth (1987) comprise the increase in self-determination, peer orientation, self-focus, self-consciousness, concern over opposite-sex relationships, and the capacity for abstract cognitive activity. All of these issues, which are salient in adolescence, occur simultaneously with bodily changes at the onset of puberty and gender intensification pressures (Hill & Lynch, 1983). Quatman and Watson (2001) argue that these issues mutually create significant challenges to a young person's self-esteem. Adolescence is clearly a pivotal and change-related time in the context of self-esteem, and has a unique transitional nature (Eccles et al., 1993) that necessitates adjustments to and changes in self-definition that appear to disturb global self-esteem (Wigfield & Eccles, 1994).

According to Polce-Lynch et al. (1994) global self-esteem, which refers to a person's general sense of worth or acceptance (Wylie, 1979), is recognised for its critical role in mental health and psychopathology (Bednar, Wells, & Peterson, 1989; National Advisory Mental Health Council [NAMHC], 1996; Rosenberg, 1979). Their study revealed that socio-cultural influences (peer and family relationships, gender harassment, and the media) might be associated with body image, and that these in turn are related to self-esteem (Polce-Lynch et al., 1994). Other studies (Goliath, 1995; Perkel, Strebel, & Joubert, 1991) on self-esteem in the context of sexual behaviour have found that a low self-esteem is associated with an earlier onset of sexual activity and having multiple sex partners. It has been hypothesised that a person with a poor sexual self-concept may rely on others for affirmation. This may lead him

or her to search for external affirmation in multiple sexual encounters. South African studies also indicate that young people with a low self-esteem may be more concerned with what their partners think of them; they also tend to avoid displeasure of or rejection by partners and people with more positive, self-affirming self-concepts (Perkel et al., 1991). A person with a low self-esteem is therefore more likely to think that condoms are offensive to their partner, that using condoms may make their partner think they are dirty, or to feel embarrassed about using condoms, and therefore are likely to have a negative attitude towards condoms (Perkel et al., 1991; Eaton et al., 2003). Low self-esteem also seems to undermine abstinence or monogamy (Eaton et al., 2003), which puts the individual at extra risk of becoming infected with HIV or any other sexually transmitted infection (STI).

### **2.4.2.3 Perceived Self-Efficacy**

Perceived self-efficacy refers to the perception that a person has the capacity to perform health-related behaviour and; consequently, a person's sense of his/her self-efficacy can influence his/her sense of capacity to be able to maintain safe behaviour. This capacity explicitly refers to one's competence to deal with challenging encounters (Schwarzer, 2001).

It is assumed that a higher self-efficacy promotes the chance of positive behaviour being performed, both of the person and that of others (Skinner, 2000). This perception of self-efficacy is adjusted over time by the person's experience in attempting different tasks, and observing other (similar) people doing tasks, through persuasion and personal changes. Success or failure is attributed to four factors, namely ability, effort, difficulty of the task or situation and luck (Leviton, 1989). Greater self-efficacy facilitates disclosure of an HIV-positive status to partners (Kalichman & Nachimson, 1999) and was also found to be relevant if women develop a capacity to insist on safer sexual practices (Soet, Dudley, & Dilario, 1999) in an intimate relationship.

Skinner (2000) criticises the concept of self-efficacy in relation to HIV in two ways. While self-efficacy does assist a person's capacity to perform the behaviour, on the one hand, it does not necessarily improve his/her desire to use safer sexual practices. On the other hand, self-efficacy may also be easily reduced when faced with a situation over which the person has reduced control. Campbell (2003) supports these findings in her study and argues that because of gender-specific socialisation in patriarchal societies such as South Africa, men are often encouraged to be macho risk-takers and have multiple sex partners whereas women are often hindered to take assertive control of their sexual health. Such critical points are assumed to be reduced if HIV interventions focus on self-efficacy and increase the latter by providing

education on how to perform safer behaviour and by providing support in the performance of such behaviour (Leviton, 1989; Soet et al., 1999; Sanderson, 1999). In contrast, two South African studies among young adults established that increased self-efficacy is indeed linked to higher self-reported condom use (Peltzer, 1999; Reddy, Meyer-Weitz, Van den Borne, & Kok, 2000), therefore, it can be posited that people consider positive and negative features when changing preventive behaviours. Weighing one feature against the other will influence their behaviour and perhaps determine the outcome.

In a study on motivation, attributions and self-efficacy among children, Smith (2002) found that children with a higher sense of self-efficacy showed higher levels of persistence and effort. He noticed that it takes time and practise for most individuals to gain proficiency in a new skill and to progress through the learning stages (cognitive, associative, and autonomous); if individuals give up quickly and easily, their learning stage will never move on to the associative or autonomous stage. Results from this study (Smith, 2002) support the assumption that individuals with higher self-efficacy believe their failures are due to a lack of *effort* and that those with lower self-efficacy believe their failure is due to a lack of *ability*. Smith (2002) states the reasons children give for failing are important to their future self-efficacy and motivation. If they believe they cannot change their ability, they probably will not want to continue to try to improve. Children should understand the role of effort, preparation and ability to learn and recognise that they are in control of their ability and that failure in a task may merely be due to a lack of effort or preparation (Smith, 2002).

#### **2.4.2.4 Intergender Communication**

Communication with a partner about the risk of STIs or condom use has been found to be strongly correlated with the willingness to use condoms and self-reported use (Reddy et al., 2000). Open discussion and mutual agreement to behavioural change can strengthen the relationship, increase partners' respect for each other, confirm that they care about each other's well-being, and enhance their sexual intercourse by removing any anxiety about the risk of infection (Wood & Foster, 1995; Eaton et al., 2003). However, sexual negotiation of any kind, be it about condom use, faithfulness, or about the nature and frequency of sexual intercourse, is missing from many sexual relationships between young South Africans (Eaton et al., 2003).

Studies have noted that pervasive, culturally entrenched gender discrimination especially increases the risk of HIV infection for South African women (Eaton et al., 2003). In certain communities, young South Africans' heterosexual relationships frequently involve sexual pressure on, and violence towards, the female partner. In such relationships, the male partner



largely controls sexual activity. The threat of violence or rejection prevents girls and women from insisting on condom use as a result (Meyer-Weitz, Reddy, Weijtze, Van den Borne, & Kok, 1998; Varga & Makulabo, 1996). While young women in such relationships may be violently punished for perceived unfaithfulness (McPhail & Campbell, 2000; Meyer-Weitz et al., 1998; Reddy & Meyer-Weitz, 1997; Whitefield, 1999), their boyfriends claim the right to have multiple sex partners (Meyer-Weitz et al., 1998; Reddy & Meyer-Weitz, 1997; Richter, 1996).

Other factors that were found to be closely linked with the ability and quality of protective communication, are peer pressure and harassment, as well as the quality of relationships with peers, family or intimate partners. For example, South African research has addressed the issue of peer pressure mainly in studies of black youth (Buga, Amoko, & Ncayiyana, 1996; Cassimjee, 1998; NPPHCN, 1996). This research indicates that both girls and boys experience considerable same-sex peer pressure to be sexually active. For boys, the pressure has to do with proving masculinity; having many sexual partners wins a young man status and admiration (Blecher, Steinberg, Pick, Hennick, & Durcan, 1995; McPhail & Campbell, 2000). For girls, pressure sometimes comes from sexually experienced peers who exclude inexperienced girls from group discussions because they are still 'children' (Wood et al., 1997). However, peer pressure does not have the same negative influence on all youth. Individuals differ in their susceptibility (Perkel, 1991), and young men appear to be influenced to a greater extent than young women (MacPhail & Campbell, 2000). Peer pressure is also not necessarily a negative influence; positive examples set by friends and role models can promote safer sexual behaviour (Perkel, 1991).

#### **2.4.2.5 Social Responsibility**

The concept of responsibility encompasses the developing of adolescents' social skills that enable them to be active and responsive members of their society and family (Berman & La Farge, 1993; Berman, 1997). Responsibility involves being accountable for things that need to be done and to fulfil one's duties and obligations to oneself and others (Flexner, 1980). In regard to health-related behaviour, therefore, social responsibility functions as a social competency that, on the one hand, strives to ensure personal health and, on the other hand, strives to ensure that the partner or other people will be protected by one's own actions.

Polk (2002) assumes that responsibility includes, among others, the recognition and acceptance of the consequences of one's actions, caring attitudes towards self and others, recognition and acceptance of basic human rights of self and others, resolving conflicts

peacefully, or the development of leadership, communication and social skills. The ability of adolescents to identify and define social responsibility is important in defining who they are, where they fit in the social world, and for building confidence (Berman, 1997). Children and adolescents learn responsibility and social skills through interaction with their families, peers, mentors and communities. When adolescents are offered participatory experiences that are meaningful, and when they are allowed to discover their potency and to assess their responsibility, they acquire a sense of commitment to a moral-ethical ideology (Youniss, McLellan, & Yates, 1997; Youniss & Yates, 1997). According to Davis and Palladino (2000) responsible youth are those who feel accountable for their actions and activities in their classes, at school and at home; they strive hard to achieve the goals they set and regulate their behaviour in directions that help them attain their goals.

## **2.5 Conclusion**

According to the WHO (2005) mental health and mental illnesses are determined by multiple and interacting social, psychological and biological factors. In accordance with the WHO's definition of health, chapter 2 explained the interconnection of factors that influence the child's physical and mental development in South Africa and also contribute to the wide distribution of HIV, especially among the youngest segments of South African society. For example, more than 15% of infected people in South Africa are between 20 and 24 years old (HSRC, 2005).

Identified risk factors for child health are the high level of poverty, the high number of sexual child abuse cases, and risk-taking health behaviour among youth. Poverty-related migration, for instance, forces large sections of the population to move from rural to often overcrowded, chaotic, and disadvantaged urban areas and lifestyles. Urbanisation and modernisation have not only prompted welcome shifts in gender roles and obligations of adults towards children (Barbarin & Richter, 2001), but have also caused confusing transmission processes of value systems for human beings and exerted pervasive influence regarding sexual and general health behaviour especially on children and youth who already experience confusing developmental processes in unstable social settings where the risk of HIV infection is high (Eaton et al., 2003). Furthermore, the widespread occurrence of rape and the low status of women in society and in relationships make it even more difficult for children and women to protect themselves in (sexual) relationships, leading to an increased risk of being exposed to diseases such as HIV.

From the list of different risk factors presented at the beginning of this chapter it becomes clear that South African children and adolescents, especially those from the lower strata of society, are faced with a multitude of difficult life tasks and are, therefore, at higher risk in unhealthy conditions. The WHO (2005) confirms this finding and states that child development is more exposed to psychosocial risks in a surrounding with a multitude of sociostructural and socioeconomic constraints (WHO, 2005). It can be argued, based on findings, that the health risk for children will become even higher during adolescence if no positive action is taken. This study thus assumes that it is extremely important to influence health behaviour among adolescents in an early stage of their lives. As is assumed that HIV infection is rare among children in South Africa below the age of 15, this age group should be the target of primary prevention.

Thus, to evaluate the effect of such a preventive approach, a life skills programme on AIDS and sex education for pre-adolescent children and a specific research model were applied theoretically based on the social cognitive theory (Bandura, 1986). The examination of the individual (psychological) learning processes and interpersonal interactions, with its underlying assumptions, are at the centre of this study. Some psychological variables (self-esteem, self-efficacy, knowledge on HIV/AIDS) and social variables (gender communication and social responsibility) are used to equip individuals with learning processes and to try to encourage skills and competencies in individuals to cope with prevalent life tasks. In addition, the programme also aims to prevent risk factors or increase protective factors that will enable pre-adolescents to apply health behaviour later in life. Another focus of the research model is the examination of the wider physical and socio-structural environment assumed to effect cognitive development of the participants outside of the applied model (intervention).