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UNIVERSITY OF THE WITWATERSRAND
SCHOOL OF HUMAN & COMMUNITY DEVELOPMENT

PSYCHOLOGY MASTERS RESEARCH THESIS

SOUTH AFRICAN PERCEPTIONS OF RISK AND THE SOCIAL REPRESENTATIONS OF HIV/AIDS.

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ABSTRACT

The mass media persistently thrusts the awareness of risk of HIV/AIDS into our lives. The question is: how do people respond to this increased awareness and how do people cope with living in what has been termed 'the risk society'? This can only be investigated within a given social and cultural context, in order to examine how individuals make sense of a perceived imminent crisis. This research has highlighted the prominent phenomenon of a widespread sense of personal invulnerability when faced with risk: the 'not me' dynamic in response to the negative **Social Representations** that surround this disease. Social representations Theory is a useful psychological framework as it approaches the study of perceptions of HIV risk by highlighting the emotional factors which are key to the human responses of risk while at the same time concentrating on the role of cognitive processing in the development of representations of social phenomena. The results from the HIV Knowledge, Perceptions & Practices questionnaire survey in this cross-sectional study with 200 Johannesburg university students indicate that while the large majority of the participants know a great deal about HIV, this knowledge is highly impacted upon by the Social Representations that exist around this virus. It is believed that the Social Representations surrounding HIV (death, pollution, the evil perpetrator etc.) can act as a barrier between intellectual knowledge of HIV and the related behaviour to reduce the risk of infection by distorting one's perception of susceptibility of infection through the process of 'othering'.

KEYWORDS

HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome), Social Representations, Social Representations Theory, HIV Knowledge, Perceptions & Practices.

DECLARATION

I hereby declare that this Psychology Masters Thesis is my own independent effort and has not been presented for any other degree at an alternative academic institution. It is submitted in partial fulfilment for the degree of Masters in Psychology (by Coursework & Research Report) at the University of the Witwatersrand, Johannesburg.

LYNLEE HOWARD

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CHAPTER NUMBER ONE – INTRODUCTION

BASIC OVERVIEW

HIV-AIDS is a global health concern as well as a human rights issue. Statistics reveal that existing intervention programs associated with educating South Africans with regard to HIV-AIDS transmission and prevention have been relatively unsuccessful in bringing about behaviour changes that would result in a decrease in incidence of HIV infections (Brannon & Feist, 2004). Considering the amount of time and resources that has been dedicated to the battle against HIV-AIDS in South Africa, as well as globally, these results yield little to rejoice over. This cross-sectional study reveals that while HIV knowledge on transmission and prevention may be high (considering that the sample is from a tertiary education institution in Johannesburg, n = 200), the existing dominant Social Representations of the disease impact on the way that this knowledge is translated into health-related behaviours.

Social representations theory can potentially help us appreciate young South African's understanding of HIV in a number of ways. Anecdotal evidence from lay conversations suggests that the participants anchor their understanding of HIV in a socio-political framework and there is clear empirical evidence that suggests that South Africans share a consensual belief attributing HIV infection to their social environment (Ahsan, 2002). This study sought to investigate the hypothesis that when these individuals, however, encounter other group members and discuss HIV-related issues, it is likely that they will experience ideologic strain and respond by identifying more closely with their in-group and its shared representation of HIV, thus actively resisting HIV awareness programmes and rendering them ineffective.

LITERATURE REVIEW

INTRODUCTION

Despite the remarkable advances in basic virology and microbiology, HIV infection has developed into a worldwide pandemic, with tens of millions of people being infected and affected by the virus (Cullinan, 2004). Worldwide, UNAIDS reckons that of the 40 million individuals living with HIV/AIDS, almost half are women, and approximately 10% are children (Hare, 2004). The most heavily affected area in the world is sub-Saharan Africa, with almost 30 million people infected with HIV (Ratele & Shefer, 2002). One must take the time to consider that statistics are often outdated even before being published and so uncovering the exact statistics for incidence and prevalence of HIV infections is virtually impossible. Nonetheless, UNAIDS describes the current situation regarding the impact of HIV all over the world in no unclear terms: an estimated 38.6 million (33.4 million – 46 million) people worldwide were living with HIV at the end of 2005. An estimated 4.1 million (3.4 million – 6.2 million) became newly infected with HIV and an estimated 2.8 million (2.4 million – 3.3 million) lost their lives to AIDS.

DEFINING HIV/AIDS

HIV (Human Immunodeficiency Virus) is a retrovirus that damages the immune system by invading the host cell and hi-jacking the host's genetic material, relying on its reproductive mechanisms for a mass production of the virus, leaving the infected person vulnerable to a variety of infections (Fipaza, 2000; Granich & Mermin, 1999; Hare, 2004). Diminution of CD4+ lymphocytes (the body's own 'soldier cells' that attack invading units) is the trademark of HIV infection, and predicts an individual's risk for infection with opportunistic pathogens (Edelston, 1988; Schuitemaker & Miedema, 2000; Valdiserri, 1989; Waldby, 1996).

The distinction between HIV infections vs. AIDS (Acquired Immune Deficiency Syndrome) is important. Ordinarily it takes many years for HIV to weaken the body's immune system to the point of full-blown AIDS (Ibikunle, 2003; Sabatier, 1988). Common opportunistic diseases that occur at this point include tuberculosis, weight loss associated with diarrhoea ("slim disease"), herpes zoster, dementia, Kaposi' sarcoma and pneumocystis carinii pneumonia (Bury, 1992; Sabatier, 1988).

More rapid HIV disease progression has been reported with behavioural and psychological factors such as having unprotected anal intercourse, smoking, poor nutrition, and depression; however, not all studies confirm these findings (Waldby, 1996). The non-specific symptoms of primary HIV infection may make diagnosis a challenge (Hare, 2004). This is why one cannot identify someone as being HIV+ purely from his or her physical appearance.

MODES OF HIV TRANSMISSION

HIV has been isolated from blood, seminal fluid, pre-ejaculate, vaginal secretions, cerebrospinal fluid, saliva, tears, and breast milk of infected individuals (Bury, 1992; Lane & Palacio, 2003; Valdiserri, 1989). Viral concentrations in non-bloody urine, tears or saliva are comparatively low and so these bodily fluids are highly unlikely sources of HIV transmission (Hare, 2004).

Sexual contact is the most common route of HIV transmission (Waldby, 1996). The first reported case of HIV infection in South Africa (1982) reflected trends established in westernised countries as male-to-male homosexual activity being the highest form of HIV transmission (Gilgen, Campbell, Williams, Talijaard, & MacPhail, 2000). By 1988, an increased spread of HIV amongst the heterosexual population was confirmed as developing countries (including those in Africa) reported escalated infections as HIV was transmitted between heterosexual couples (Mbengashe, 1996). This pattern has firmly established itself in our current context, as the group at highest risk of infection are heterosexual black females aged 14-35.

According to UNAIDS/WHO, South Africa estimates that 79% of HIV infections are due to heterosexual activities that result in HIV transmission, 7% of reported HIV cases are due to homosexual contact, 13% are due to mother-to-child-transmission, and 1% is due to blood transfusions (Elder, 1999). Studies of transmission provide strong epidemiological confirmation that heterosexual transmission of HIV does occur via penile-vaginal intercourse (Hare, 2004). Vaginal sex during menstruation may heighten the risk of transmission of HIV for the male if the female partner is HIV+ (Lane & Palacio, 2003). Clear cases of transmission via oral sex do exist, however these studies indicate that risk is low (Hare, 2004). Non-sexual HIV transmission can occur through transfusion with contaminated blood products, injection drug use, or occupational exposure (Hare, 2004).

PREVENTION AGAINST HIV INFECTION

Because sexual contact is the major transmission route for HIV infection, eliminating sexual contact (abstinence) reduces the risk of becoming infected with HIV is profoundly reduced (Schuitemaker & Miedema, 2000). Abstinence, however, may be neither desirable nor practicable for many people (Lane & Palacio, 2003). Given the importance of sexual transmission in the HIV epidemic, many HIV prevention strategies have focused on identifying and promoting safer-sex practices (Lane & Palacio, 2003). As the name implies, these practices are thought to be "safer" than other sexual practices in that they help reduce (but do not eradicate) the risk of transmitting HIV from one sexual partner to another (Brain, 2002).

In a meta-analysis completed in the US, it was found that the overall efficacy of condoms in reducing HIV transmission was 69% (Hare, 2004). Several laboratory experiments were conducted to test the ability of latex condoms to provide an effective physical barrier against HIV (King, 1993; Lane & Palacio, 2003). Studies have demonstrated a statistically significant negative association between condom use and risk of HIV infection (Lane & Palacio, 2003). It is generally accepted by the medical and public health communities that, when used properly, latex condoms can significantly reduce the risk of sexual transmission of HIV (Marseille, Morin, Collins, Summers, Coates & Kahn, 2002). However, condoms can fail to provide complete

protection for a variety of reasons, including failure to use them consistently, failure to use them properly, condom breakage, and condom slippage (Brain, 2002).

Although antiretroviral treatment (ART) can result in dramatic reductions in HIV viral load, it is not a cure for HIV disease; thus prevention should still be the first line of defense (Hare, 2004; Soul City, 2004). ART may reduce, but cannot be expected to eliminate, the potential for an infected individual to transmit HIV to an uninfected individual (Lane & Palacio, 2003).

COMMON MISCONCEPTIONS ABOUT HIV/AIDS

It is commonly assumed that no man can have the foolishness to invite his own mishap in life if he is pre-informed about the devastating consequences of risk-taking behaviour (Ahsan, 2002). Information and knowledge are ever powerful. It is due to ignorance and misconceptions of sexual behaviour that HIV infection rates continue to increase (Ratele & Shefer, 2002). However, representations of this disease creates curious dimensions within a social context, where individuals label those who have the disease as "others" and thus, different to themselves (Ratele & Shefer, 2002; Wetherell, 1997).

Countless fears arise from myths and misconceptions regarding the transmission of HIV (King, 1993). Many people still have unrealistic beliefs that you can contract HIV from toilet seats, from being near a person who is infected, from mosquitoes, from going to doctors or hospitals, from talking to homosexuals etc. (Brannon & Feist, 2004). On the other extreme are people who downplay the severity of the disease as well as their risk status based on their social group membership (Van Dyk, 2003). Denial of these issues creates massive obstacles in the education of young South Africans (Olanrewaju, Ademola, & Ojasanya, 2001). According to Smit (2001) the majority of individuals in this country (and globally) have responded to the dilemma of those infected with HIV/AIDS with intolerance, discrimination and fear. This is even more devastating when these attitudes reign in a South African environment where intergroup tensions and conflict already run high. It is everyone's constitutional right to be protected against stigmatisation and prejudice, and to be

accepted as having value within society. However, this is seldom translated into practice (Grogan, 2003).

PERSPECTIVES ON ISSUES REGARDING HIV/AIDS

Surveys of young people in various countries, including South Africa, consistently identify significant gaps in knowledge of HIV, especially regarding misconceptions about causal transmission and prevention (Peltzer & Promtussananon, 2003). At the same time, these young people have a high prevalence of behaviours that put them at risk of HIV infection, including early participation in sexual activities, infrequent condom use, and multiple sexual partners (Kalichman, Rompa, Luke & Austin, 2002).

Many young adults engage in sexual intercourse with multiple partners and without protection thus, engaging in sexual behaviours that place them at high risk of sexually transmitted diseases (STDs), including HIV (Kalichman, et al, 2002). About half of all new HIV infections worldwide occur among adolescents and young adults (Kirby, 2002). In sub-Saharan Africa, sexually active young adults aged 15 to 25 years have some of the highest reported rates of STDs (Cullinan, 2004). This may be due to the fact that during the last few decades of the previous century, the onset of puberty and initiation of sexual intercourse has occurred at an earlier age in many modern countries, whereas the average age of marriage was delayed (Kirby, 2002). Thus, many adolescents began having sexual intercourse with multiple sexual partners prior to marriage, and this, of course, facilitated the alarmingly rapid spread of STDs and HIV/AIDS (Kalichman, et al, 2002).

In addition to this, a large number of influences encourage young people to engage in sexual activity such as changing hormones, emotional and physical needs and desires, desires to be an adult and to take risks, peer pressures, norms that support sexual risk-taking, and the universally inaccurate portrayal of sex in the media (Darbes, Kennedy, Peersman, Zohrabyan & Rutherford, 2002). Bearing this in mind, this research aims to investigate the potential role of group identification within social categories on the development of the stereotyping of people living with AIDS (PLWAs), and it may be along this line of thought that young adults do not accurately assess themselves as being at risk of HIV infection (Wetherell, 1997).

This literature review will now discuss, in some detail, the features of Social Representations Theory and its potential link to the identification of the self via social categorisation, social identification, and social comparison (elements of Social Identity Theory) while considering its relation to traditional social cognitive theories.

INTRODUCTION TO SOCIAL REPRESENTATIONS THEORY

The theory of social representations has existed in Europe for some thirty years, however it is still a theory in the making (Moscovici, 1997). A theory can only exist if it cultivates a practice of discovery, where social concerns are addressed and so adds meaning to peoples' lives. The theory of social representations is complex and does not easily insinuate a scheme that one can use to simply verify or falsify what one is investigating (Moscovici, 1997). Social representations theory is a reciprocal theory that views individuals as being entities that are responsible for their circumstance, which may create an understanding of blaming attributes (Joffe, 1996). Social Representations Theory recognizes the role of the social beyond individuals' cognitions to explain how the social (media, culture and history) interacts with individual and their representative cultural groups (Fife-Schaw, 1997).

The socio-cultural context of HIV/AIDS with respect to social representations of beliefs about who is at risk of HIV infection as well as the role of the media and the cultural dimensions involved should be explored and the individuals and groups involved in HIV/AIDS education and behaviour change should join forces with the task of developing educational programmes that will be up to the challenge of creating an AIDS free South Africa (Ploghoft, 2000).

SOCIAL REPRESENTATIONS AS A WAY OF HUMAN COMMUNICATION

Moscovici's theory of social representations is launched from the diversity and unpredictability of individuals (attitudes, beliefs etc.) as the theory seeks to ascertain how individuals and groups construct a stable, predictable world out of such fantastic diversity (Moscovici, 1984). Social representations organises the social chaos by linking particular experiences with constructed meanings of the past, and these constructed meanings are made available for future encounters of similar events. Socially representing features of the social environment is a performance of selectively constructing a meaningful view of the world. Moscovici has encapsulated

the ‘to and fro’ travel between representing and experiencing, where representing is considered necessary for experiencing, while experiencing produces novel forms of representing.

In order for people to communicate with one another, they require a system of common understanding of concepts and ideas. Words inevitably become imbued with distinctive meanings within particular social groups (Wetherell, 1997). An article produced by Rämmer (2005) examines widespread beliefs held at a group level. Rämmer (2005) noted that there are no common terms for interpreting widespread beliefs in the social sciences. In the interpretation of such group held beliefs, the most known terminology revolve around notions of myths, norms, and stereotypes.

According to cognitive psychological accentuation, these terms have been applied in describing the beliefs created in human communication (Rämmer, 2005). Conversation is a fascinating phenomenon as there are no frozen meanings to words, the connections and unremitting emotional aspects to participating in a dialogue. Moscovici (1997) says quite eloquently that we think with our mouths- we think aloud. Moscovici’s theory of social representations revolves around the key ideas of considering society to be a “thinking system” of the common stock of concepts that are thus referred to as social representations (generative theories) that occur through communication (Moscovici, 1997).

The social environment - the thinking, feeling, and acting of human beings, is mutually created by the people who accept the recommended standard social representations, which are promoted by the dominant culture (Moscovici, 1987; p164). Cases in point are the phenomena abound in human history - Europe (1930s), the German citizens who saw the Jewish sent to concentration camps certainly did not think that the Jewish were innocent. Justifications for imprisonment were apt as it would have been impossible for the Germans to believe that they were accusing, ill-treating and torturing the Jewish for no good reason (Moscovici, 1984). The same can be said for the situation of Apartheid in South Africa no more than a decade ago. The generic message of the evil ‘other’ indicates that historical uses of social representations are not unique: the crusades and witch-hunting are of similar kinds.

Human beings create their own psychological realities, where social interactions see people having their roles and counter-roles. The generation of social reality may have general meanings of what occurs in that world, and these meanings may be vague but are powerful social regulatory processes.

Augoustinos and Walker (1999) communicate how more social and collective accounts based on Social Representations Theory, ideology and discursive psychology may enrich a psychological understanding of stereotypes and the process of stereotyping. Social representations are not simply understood to be the product of individual cognitive activity alone, but are additionally social and collective products which function ideologically by justifying and legitimising the existence of stereotypes within society (Augoustinos & Walker, 1999).

An important question to social psychology researchers invested in health-related behaviours is how do people develop general knowledge and understanding of new social phenomena such as AIDS? Moscovici's (1984) Social Representations Theory (SRT) advocates that individuals interact with each other as well as with existing cultural ideologies to form the collaborated understandings that make up their socially constructed reality (Schoeneman, et al, 2002). Communication is not seen as the transmission of information from a source to a passive receiver, but rather as the production of replicas of social representations, parading as common sense representations (Moscovici, 1997). Without a theory of social representations, the social construction of knowledge cannot be understood. One cannot give a testimony to thought and language without considering the implicit representations of the contributor as speech depends on a shared representation (Moscovici, 1997).

There is virtually no existing literature on social representations as stimulated by the identification of the self within social categories and the accurate assessment of perceived risk of HIV infection amongst the South African population. This provides further justification for the value of this study and the additional research that may be carried out based on this research. This study may produce significant results that may impact on the understanding of how people process information and awareness of HIV/AIDS so that educational awareness programmes are more explicitly directed to changing belief systems about the various social groups in South Africa and having

that information come from a socially credible source in the media. This research does not recommend that the media be limited on addressing AIDS-related issues, as this would not be advantageous. It is only this study's hope that these findings may inform and stimulate discussions about how to represent AIDS in a way that steers clear of its more arduous stereotypes.

DEFINING SOCIAL REPRESENTATIONS

Serge Moscovici's Social Representations theory differs somewhat from the traditional methods of interpreting group beliefs by joining together the psychological construction and social distribution machinery of representations (Rämmer, 2005). As a result, this theory enables researchers to relate the genesis, distribution, and conversion of representations in diverse social groups and cultures (Rämmer, 2005). SRT is proposed as a psychological approach that is concerned with cultural tools - symbols and instruments - as being mediums of managing the mistiness of the immediate future. The "meaning" in the present is intended for the making of the reality of the future. People create "meaning" mediators that establish the range for further expectations of forthcoming experience.

Moscovici (1984) expressed social representation as being systems of values, ideas and customs that have a duel function; firstly, to institute an order that will allow individuals to orientate themselves in their social world and to gain mastery over it; secondly, to facilitate communication between members of a community by supplying them with a system for social exchange that unambiguously names and categorises the various aspects of their reality. Social representations belong to the rank of pre-adaptational "meaning" mediating devices. They have an enormous range of psychological functions, extending from instantaneous, temporary sparks of meaning-in-context to careful cognitive recollections encoded in terms of being meaning complexes (Bartlett, 1932). Social representations are primarily considered as being processes of guiding human beings towards social futures where social interaction is umpired with the help of semiotic mediators - social representations.

Meaning is created through a system of social arbitration rather than being a fixed phenomenon, and interpretation may well require an understanding of additional aspects of that social environment (Wetherell, 1997). The supposition of social representations theorises that social thinking and language are flexible phenomena and that assorted hues of social knowledge co-exist in concert in communication.

Social representations are concurrently re-presentations of what already exists, and what is familiar on account of prior knowledge and experience as well as the re-presentations of what is expected - future experience. Thus, social representations are notion complexes that function as macro-level cultural restrictions of human conduct. These constraints instigate the generation of micro-level restrictions that guide precise thoughts, feelings, and acting processes.

Social representations are connotation and denotation complexes of multi-strata, which are relentlessly in the process of advancement. While social representations are often depicted as being static complexes, this notion intensely eliminates the major function of their guiding of the streams of social information that people consistently have to process. Moscovici has emphasized that it is of value that researchers investigate the making of social representations, both in the historical and developmental sense.

Augoustinos and Walker (1999) examine the varying and divergent ways in which stereotypes, as social representations of groups, and the process of stereotyping, have been constructed and recognized within modern social psychology. These distinct theoretical approaches include dominant traditional social cognition, which deems stereotypes as cognitive schemas that simplify reality, and self categorisation theory, which views stereotypes as being psychologically valid representations which mirror the actualities of intergroup relations and group identities (Moscovici, 1997). This literature review will now discuss each of these theoretical approaches in turn, always relating back to their role in Social Representations Theory.

Social schemas are knowledge constructs that form in the mind and are used as the basis of social categorisation as well as being representations of typical features of kind of events, roles, as well as people (Sternberg, 2003). These schemas provide space for interpretation; they create expectations and act as escorts for further information take-up. Schemas are viewed as being active constructions, based on one's experience of the social environment where individual and cultural factors play a role in the creation of social schemas (Sternberg, 2003). Social schemas of social reality are transmitted through groups of people via language and social representations.

Kaler (2004) modified the Health Belief Model to account for the cognitive conditions to be considered before an individual will contemplate changing their health related behaviours. The first is that one must believe that the health risk is dangerous; secondly, the individual must recognise that they are not immune to the disease, and finally, the individual must acknowledge that they have control over their health behaviours via monitoring their own actions and behaviours (Kaler, 2004). However, there appears to be some sort of dissonance between belief and behaviour as knowledge does not simply become concrete in the mind and so influence behaviour. Human beings tend to interpret information about HIV/AIDS in relation to other social phenomena and this information is then mediated by existing ideas about the world.

Many individuals do not perceive themselves to belong to a group that is at risk of HIV infection, and so they intellectually do not recognise any reasons to modify their behaviour (Kaler, 2004). The concern about this notion is that people are not always able to accurately evaluate their risk status. Often they have a bias that holds to the belief that they are unlikely to become infected with HIV as compared to other individuals, most probably members of another social group (Ratele & Shefer, 2002). This optimistic bias is often maintained via media reports that tend to frequently describe incidences of particular types of people becoming infected with HIV or dying from AIDS, as well as being influenced by the immediate cultural/social milieu (Adler, et al, 1992). This type of media influence maintains existing social representations of other group members and separates individuals from other groups

from the reality of the HIV threat through biases that cause denial and over-confidence in one's ability to accurately assess their own susceptibility (Moatti & Souteyrand, 2000).

In the exploration of notions of health, according to social representations of health, ideas about health/illness and individual/society are implicitly linked as concepts of health and illness (as dimensions of human experiences in society) are assigned meaning through the interaction (or lack of) of the individual in society. Health is expressed as a process of social engagement according to the social representations perspective, where a tension exists between the individual and the social environment for the responsibility for health (Flynn & Murray, 2005).

Moscovici (1997) argues that where the social cognitive paradigm is different from the theory of social representations is in the fact that social cognition is a paradigm of social stereotypes. In this paradigm of social cognition, public knowledge is shunned as being unscientific and ruled by stereotypes, and it is held that issues of social importance should be addressed by experts (who are immune from being absorbed into stereotypes) who have access to real scientific knowledge. This entire premise severely inhibits the notion of public debate. It is the age-old debate of "expert truth" vs. "novice opinion" in dealing with the issues of biases in social knowledge. Alternatively, social representations theory holds the belief that all people are rational in their views of the world because they are part of the social world (Moscovici, 1997). Shared representations have some coherence, as they contain rationality for those who hold those representations (Moscovici, 1997).

On this point, social cognitive psychology has traditionally made hypotheses that stereotypes, attitudes, and biases within the context of a representation, are historically normalised by the group that tries to legitimate those stereotypes. A French novelist elucidates how and why it is normal in a certain division of society to be racist, homophobic, etc., why it would be abnormal not to be, without having mis-cognition and lacking sensible understanding of social issues (Moscovici, 1997). Social Representations Theory does not do away with cognition altogether though, as it proposes that all thought and understanding is indeed based on the workings of social representations. This again highlights that people mediate new incoming

information about HIV (or some other social phenomenon) in relation to existing knowledge structures about the real world.

This is related to the notion of Assimilation as in Piaget's cognitive theory, as Piaget pre-empts this aspects of Social Representations literature. This is to be discussed in some greater detail in the future paragraphs. So in a sense, Social Representations Theory is both a critique of social cognitive psychology and is also responsive to it, as Social Representations Theory holds that there are situational determinants of action as well as the paradoxical relationship between social psychology and individually biased sociological social psychology to the understanding of social meaning (Potter, 1997).

SOCIAL IDENTITY THEORY

In the 1960's, Lippman and Allport investigated the evaluation processes involved in the development of stereotypes, where they discovered a definite link between social cognition and the cultivation of stereotypes as social representations of others (Wetherell, 1997). People do not exist in a vacuum but rather are in constant social interaction with others (Bernard & Krupart, 1994). This study focuses on the cognitive aspects of social interactions as experimental social psychologists are primarily concerned with cognitive processes and the effects of group membership. Social Identity Theory addresses these issues by scrutinizing three stages involved in the cognitive dimensions of social representations namely: social categorisation, social identification, and finally, social comparison (Wetherell, 1997). These aspects will be briefly concentrated on while tackling the processes involved in the development of social representations regarding the HI virus. Group dynamics are crucial in the formation of social representations, for example the intergroup biases involved in in-group and out-group categorization, and so on (Moscovici & Marková, 1998).

Social categorisation:

Tajfel and Turner's Social Identity Theory (1982) addresses the psychological developments that characterise group formation processes. Social categories (such as race, gender, sexual orientation, etc.) are socially constructed and have strong connections to social history (Wetherell, 1997). Many HIV awareness programmes rely on the media to educate people about the facts of the HI virus as a way of facilitating behaviour change (Elder, 2001). In order to do this, the media needs to rely on 'personalities' with whom the population can identify in order to find the information credible. The media, in this sense, has a profound discursive role in the creation of representations of people who are at high risk of HIV infection that may cause other individuals to believe that they are unrealistically immune to the disease (Ratele & Shefer, 2002). Social Representations Theory stresses "the role of the media in sustaining, producing and circulating social representations" that is not always accurate or bias free (Wetherell, 1997; p142).

Since the media frequently reports on HIV cases that involve black females (the majority of South Africa's population) it has led to the development of individuals believing that if they do not fall into this category, then they are not at risk of HIV infection (Dunkle, et al, 2004). Rather than educating society about HIV/AIDS, these media constructions seem to frequently cement existing feelings of denial of infection risks and omit factual information about the behaviours that place individuals in a situation where they are vulnerable to HIV infection (Ratele & Shefer, 2002). Essentially, the media may tend to focus on the construction of groups who are perceived to be at high risk of HIV infection, rather than to concentrate on the behaviours that place one at risk of HIV infection (as illustrated by the following example).

A similar example to this notion is the South African television advertisement that aimed at promoting Anti-Rape sentiments among the South African population. The advertisement (starring Charlize Theron), focussed on the statement that "real men do not rape". The advert was withdrawn after a high number of complaints from the white male population. Their primary complaint was that the advert portrayed rape as being a widespread problem, when in actual fact, rape was considered to be an issue that was confined to only certain groups. By having a white actress talk about rape, it

resulted in the white community being fearful of rape being associated with the white community. The media construction of rape was perceived as causing rape (and rapists) to be aligned with the speaker and the members of her social category (white South Africans).

Social constructionist views hold that attitudes towards people from other groups are macro social representations that reflect the way in which society constructs those views (Potter, 1997). The way that the media reports facts about HIV/AIDS influences individuals' internal dialogues and creates value-loaded representations that they carry about people in the world, which seems to emerge as a collective socio-cultural understanding of the disease and people infected with HIV (Potter, 1997; Ratele & Shefer, 2002).

One may very well question why social constructionism and social representations do not unite with each other (Moscovici, 1997). Social constructionism and the theory of social representations have some common aspects in that reality is socially constructed along cultural understandings of the world. Social constructionism presents itself in association with the linguistic crossroads and when social constructionism mentions truth, the connotations are predominantly negative (Moscovici, 1997). However, this notion is interesting for Social Representations Theory as knowledge retains "truth" and "falseness", as being basic cultural categories (Moscovici, 1997).

Social schemas (also known as stereotypes) are representations of typical characteristics of people (roles/groups, the self and familiar others) and events. They are viewed as being the underpinnings for social categorisation. Moscovici's social representations theory holds the premise that conceptions of social phenomena are held collectively in communication and seek to render the unfamiliar familiar by simplifying and concretising ideas about the social world. Perseverance often refers to the fact that schemas display resistance to re-categorisation of one's understanding about the world. This notion reflects the sentiments of Cognitive Dissonance Theory. Cognitive Dissonance Theory, developed by Leon Festinger (1957), is concerned with the relationships among cognitions. A cognition, for the purpose of this theory, may be thought of as a piece of knowledge, which is linked to an attitude, an emotion, a

behaviour, a value, etc. People hold a multitude of cognitions simultaneously, and these cognitions form irrelevant, consonant or dissonant relationships with one another.

Cognitive Irrelevance in all probability describes the bulk of the relationships among a person's cognitions. Irrelevance merely means that the two cognitions have nothing to do with each other. Two cognitions are consonant if one cognition follows from, or corresponds with, the other. People seek consonance among their cognitions. It is unknown whether this stems from the nature of the human organism or whether it is learned during the process of socialization, but people appear to prefer cognitions that fit together to those that lack this match.

Two cognitions are said to be dissonant if one cognition follows from the converse of another. The concern that founded the basic postulate of Festinger's theory, pivoted around the question of what happens to people when they discover dissonant cognitions? A person who has dissonant or discrepant cognitions is said to be in a state of psychological dissonance, which is experienced as unpleasant psychological tension. This tension state has drive-like properties, resulting in an unpleasant tension and is driven to reduce this experience. Reducing the psychological state of dissonance is not simple to resolve.

To understand the alternatives open to an individual in a state of dissonance, one must first understand the factors that affect the magnitude of dissonance arousal. First, in its simplest form, there is a positive correlation between dissonance and the degree of discrepancy among cognitions. Second, the same can be said for dissonance and the number of discrepant cognitions. Third, dissonance is inversely proportional to the number of consonant cognitions held by an individual. Lastly, the relative weights given to the consonant and dissonant cognitions may be adjusted by their importance in the mind of the individual. When one considers other social cognitive theories (such as Cognitive Dissonance Theory) one can see how Social Representations Theory is both responsive and reactive to these theories.

If dissonance is experienced as an unpleasant drive state, the individual is motivated to reduce it. Once the factors that affect the magnitude of this unpleasantness have been identified, it should be possible to predict what can be done to reduce it. If two cognitions are discrepant, it is possible to simply change one to make it consistent with the other. Or each cognition can be changed in the direction of the other. Alternatively, if two cognitions cause a certain magnitude of dissonance, that magnitude can be reduced by adding one or more consonant cognitions. Finally, if one considers that the discrepant and consonant cognitions must be weighed by importance, it may be advantageous to alter the importance of the various cognitions.

Moscovici (1997) explains that his effort in exploring Social Representations Theory was to simply offer a plausible alternative model of how knowledge and meaning are shared and transformed, meaning that the generation of knowledge cannot be a process at the level of the individual but must be a social process. This rests on the Vygotian idea that knowledge construction follows a social route. This not to say that the individual aspects are negligible, or that the individual is valueless in the process. But the social environment is inescapable as a basic factor in the construction of knowledge, because a way of representing is also a way of communicating.

To fully understand the process of the mental representation of objects in the world (social schemas or stereotypes), one should consider that this process might be conceptualised from two complementary perspectives, an individual (stereotypes residing within the mind of the individual person) as well as a collective approach (stereotypes are represented as functioning within the social network of society, shared along cultural lines) (Stangor & Schaller, 2000). The question now is no longer if social reality exists at the level of the individual or is a product of the group mind, as it has long been accepted that all social beliefs (stereotypes and representations) dwell in the minds of individual people. The focus of the modern debate is the assumed importance of the shared social beliefs (beyond that of the individual) in determining social behaviour. Individual approaches (such as the social cognition, group schemas, group prototypes, and exemplar perspectives) that focus on the beginnings of the cognitive-motivational processes of stereotypes, are not concerned with stereotype consensus but rather preoccupy themselves with the meaning of the stereotype to the particular individuals (Stangor & Schaller, 2000).

Theorists from the collective approach (perspectives orientated towards culture, language, social norms and roles) however, consider social consensus to be supreme in providing the basis for stereotypes, which only possess meaning as long as they are culturally shared (Stangor & Schaller, 2000). Once this has occurred, a stereotype seems to develop a force from within itself and influences social behaviour to an extent far beyond the level of the individual. It is at this point that stereotypes no longer rely on direct perception of the social environment to function, but rather operate simply as a manifestation of behaviour and language of particular cultural groups. It is in this way that stereotypes are maintained and reproduced in serving the interests of culturally shared values (Stangor & Schaller, 2000).

The trends in critical social psychology indicate a shift as one can see the heavy emphasis on constructionism; and for several years, researchers have discussed the idea that knowledge is constructed, not 'found' (Moscovici, 1997). We know reality as it is because we made it. Knowledge as a natural phenomenon depends on the observer.

The conception of social representations distances itself from the notion independence of attitudes and opinions, as social representations rest between the social perception and shared knowledge of HIV and the object of HIV/AIDS itself (Moscovici, 1997). Shared representations exist to create and unite a common reality that is perceived as being normal. Thus, Social Representations Theory is not concerned with the actual individuals infected with HIV but rather with the images (the social representations) of HIV/AIDS.

Social Representations Theory provides a framework for thinking about construction of shared schemas/representations, however; this theory falls short of addressing the problem of operationalisation (in terms of how one would empirically investigate the passage of shared knowledge across the individual-group boundary as well as the understanding of social phenomena at the group level). This theory is also silent on the actual process of construction, and it often treats categories as being static phenomena (Wetherell, 1997). Social Representations Theory fails to address the shifts that occur within social categories as the social climate evolves in the face of new social crises (such as HIV/AIDS).

Social identification:

Social identification is born out of social comparisons and Tajfel describes social identification as being the knowledge of belonging to a certain group, with all the emotional and ideological concepts that cluster around that knowledge, which one holds onto (Wetherell, 1997). Tajfel and Turner held vested interests in discovering how individuals obtained a sense of identity by belonging to a group and how personal identity recedes to make way for social identity as we absorb characteristics of that group into our individual make up (Brown, 1997). Personal identity becomes bound to the image that one holds (and others hold) of their own group. This leads to self-stereotyping (in accordance with the collective images of this particular social group (Ratele & Shefer, 2002; Turner, 1982).

If an individual believes that another person belongs to the same group to which the individual belongs, the individual will have more positive views of that person and potentially give them preferential treatment- In-group Bias (Ratele & Shefer, 2002). This functions because individuals build their self-esteem through belonging, and the presence of someone from an in-group reminds us of that belonging. The opposite of this phenomenon is that of Out-group Bias where, by inference, members of the out-group are viewed more negatively. This is often the basis of negative social representations (Ratele & Shefer, 2002).

Social identity is a primary factor of individual self-esteem, and so group members will always compare themselves to other groups (amplifying the differences between in-group traits and out-group traits) so as to gain a positive social identity (Wetherell, 1997). Social identity is highly relevant and apparent when tackling large-scale social issues like that of group categorisation with regard to perceived susceptibility to HIV infection as representations of the in-group and out-group may hinder the assimilation of factual HIV information into existing knowledge structures (Brown, 1997; Schack & Schack, 2005).

In this research project, social identity is understood as a multidimensional and relational construct, not limited to the participants' socio-demographic qualities or as the upshot of a social and cognitive classification but, more accurately, on the basis of the participants' sense of belonging. This concerns their own belief patterns, based on the processes of integration/differentiation of the different groups in relation to their mental maps, of which types of people are at risk of HIV infection (Moscovici, 1984). The difficulty with this understanding is that there may be a limited amount of understanding into the degree to which the individual identifies themselves with their socially defined group (and more so, which characteristics they choose not to align themselves with, as well as the reasons for this).

Social comparison:

Membership of association and the sense of belonging to a group of people usually involves acceptance of the ideology and value system of the group (Ross, 1995). While groups may unite people by generating a sense of belonging, it also constructs tension between groups that one can make social comparisons with (Wetherell, 1997). Representations of 'others' are behind the development of the identities of the self (Ratele & Shefer, 2002).

Stereotypes are defined as the types of social evaluations made of others, which highlight the beliefs and attitudes that one carries towards that group as a whole (Wetherell, 1997). Stereotypes are negatively biased overgeneralizations about members of the out-group so as to hold members of the in-group in a more positive light, creating negative notions about the out-group. Human beings rarely amend existing stereotypes. Even in the face of disconfirming evidence, people often cling to their existing beliefs. The existence of stereotypes impacts on one's ability to accurately perceive others as they really are, as people clutch onto a distorted reality where information about others is dealt with in an inflexible and irrational manner (Ratele & Shefer, 2002).

In line with Vygotian theory, social comparisons occur at an individual level yet transfer to a group level, thus it is suggested that the formation of stereotypes are in reaction to a massive social change as groups are forced to cope with new situations. Thus, social representations are formed as reactions to group dimensions of the social environment rather than in response to faulty information processing, as was illustrated in the past model of the formation of cognitive stereotypes (Wetherell, 1997). The social representations account addresses social cognition in terms of cultural psychology, where cognitive processes develop within particular social contexts and the individuals within that culture learn to think, evaluate and react in a certain manner. This emphasises that cognitive processes are not universal, but are highly dependent on the social environment that shapes one's way of coping with intergroup interactions (Wetherell, 1997).

Social Representations Theory builds on the foundation of Social Identity Theory in the sense that it distinguishes social groups with regard to the content of a group, as well as considering a potential homogenising force that unites or differentiates group members. Social representations give an indication of how people cope with new information regarding members of a different group. Promerantz (1984) found that these essential cognitive processes produce dramatically similar and organised patterns of attitudes (as cited in Potter, 1997). Synder and Uranowitz (1978) stress that people are more likely to remember information regarding others if that information is consistent with the existing knowledge (prototype) of that social category (Wetherell, 1997). Thus, people react to the world based on their existing cognitive schemas. According to SRT, information that is familiar to the individual will simply be assimilated into their existing knowledge framework while information that is unfamiliar (or not frequently provided) can be dealt with in one of two ways, anchoring or objectification.

Social representations shift AIDS and other unfamiliar phenomena with the purpose of making the unfamiliar familiar via two collective processes: Anchoring (generalisation, discrimination) and Objectification (reified vs. consensual universes). "Anchoring" involves the cataloguing of unfamiliar social stimuli by evaluating them in relation to an existing reserve of familiar and culturally comprehensible categories (Augoustinos & Walker, 1995, p. 138). Anchoring implies that new incoming information is manipulated so that it can better fit into existing cognitive schemas e.g. someone who does not believe themselves to be at risk of HIV infection because they belong to a certain low-risk group will cognitively manipulate information that proves that they are indeed at risk (for example: a member of the same social group discovers that they are HIV +), and so through Cognitive Dissonance Theory, the individual will find evidence (that that person is different to the rest of the group members in that they are promiscuous etc.) to support their original position that they themselves and the members of their social group are immune to social crises such as AIDS (Potter, 1997).

This notion is linked to the understanding of Individuation Theory, whereby the in-group members reject the social membership of a particular group member because this member does not conform to the ideology of the group in providing positive group identity. Thus, an in-group member who becomes infected with HIV is expressed (by the rest of the group) as being a separate individual, who does not meet the criteria necessary to belong to the group i.e. by reporting that this person was simply promiscuous (and quite unlike the rest of the social group) in a positive identity protective mode (Wetherell, 1997).

This is in direct contrast to Deindividuation theory, which is a social psychological account of the individual in the out-group. Deindividuation is a psychological state of decreased self-evaluation, causing anti-normative attitudes. The impact of deindividuation theory in science and society make it one of social science's more influential contributions, as it seeks to explain the apparent transformation of viewing individuals only in terms of their group membership and this often carries irrational beliefs about the group (Potter, 1997). Thus, deindividuation has been associated with other social phenomena such as stereotyping. It posits that the group provides an

environment in which the individual becomes submerged and anonymous, thus people will tend to judge this individual according to the standards of the group that this individual belongs to rather than perceiving the individual as a separate entity.

Deindividuation hinders reflection regarding the person as an individual and results in the vision of this individual as a mirror of their group norms. Deindividuation occurs when individuals in a group are not paid attention to as individuals (Festinger, Pepitone, & Newcomb, 1952). This is not to be confused with the thought that group membership causes a loss of self. Instead, it has been proposed that deindividuation marks a transition from individual identity to social dimensions of the self. This transition to a social identity may increase responsiveness to social norms particular to the group, instead of decreasing responsiveness to generic social norms, as suggested by deindividuation theory. It appears as though deindividuation is not a loss of individual identity, but may be better construed as a transition to a social identity (Diener, 1980).

Nonetheless, this may explain how when one encounters some evidence that challenges an existing stereotype regarding a particular group, the stereotype will not be dismissed as some disconfirming evidence offered by an individual is not enough to shatter the deindividuation of the image of the group to which this individual belongs. The primary aim of this process is to maintain the positive identity of the in-group in relation to the out-group. This is the theme of each phase in the anchoring and objectification processes in social representation formation.

Anchoring is the process of assimilating a new event in an identity-protective manner, where people link the "bad" (AIDS) to the "other" as a means of a positive identity protection. In doing so, they protect themselves and their in-group from the reality that HIV infection is not group specific (Joffe, 1997). As early as the late 1980s, several researchers had acknowledged that there are metaphoric cognitive attachments that serve to characterize AIDS. The disease and its victims are often equated with death, plagues, evil, punishment of immorality, sexually transmitted diseases, homosexuality, war, crime, rural areas, contamination, victim and perpetrator, and a general status as the "other" (Schoeneman, et al, 2002).

Personal interpretations of the social world assume the outline of objectification, which soaks an unfamiliar concept with previously experienced reality (Moscovici, 1981). Objectification involves the selective construction, structuring schematization of the cognitive whole, which is the social representation. When a social representation emerges (often originates from a repetition of clichés as they occur in causal conversations), it combines all these assorted elements of the social phenomenon into one entity and awards the new representation a fresh appearance. "The process of objectification is a discursive construction of a relatively stable and general meaning complex" (Augoustinos & Walker, 1995, p. 139).

Essentially, objectification makes the unfamiliar familiar by categorising new abstract information along with the things we can see and touch, and is the process of symbolising AIDS in an identity-protective mode (Moscovici, 1984). Thus, social representations allow people to perform two functions: Firstly, to make sense of the unfamiliar and; secondly to evaluate the unfamiliar in relation to the preservation of the positive group identity.

This process includes three sub-processes: "Figuration" which implies that notions of HIV/AIDS are transformed into metaphorical images. Thus, any of the anchors for AIDS discussed above can be turned into lucid images. Gilman (1988) provides an example where it has been shown that the ways in which an AIDS patient is represented pictorially in the 1980s corresponds with depictions of the syphilitic in pictures produced from the 14^{th} to the 19^{th} centuries that emphasize corruption, immorality, sexual transgression, physical and spiritual pollution, and isolation.

"Personification", the second sub-phase of objectification, is the alliance of a concept with a person (Potter, 1997; p144). HIV/AIDS can be personified through association with prominent celebrities who have contracted HIV or succumbed to AIDS such as Magic Johnson, Rock Hudson, or Freddie Mercury. Lastly, "anthologising" converts the concept of HIV/AIDS into something real, something that is imbued with physical properties (Potter, 1997; p144). This means that one gains an understanding of the HIV virus as an organism that attacks the immune system's helper T-cells, and while very few people may have the opportunity to view the virus under a microscope there is little doubt that the HI virus and the disease are real 'things' that exist in the world (Potter, 1997).

This study holds the view that constructionism by the media prolongs the anchoring and objectification process of socially representing HIV/AIDS (Moscovici, 1997). These two processes are socially mediated and differ from Piaget's process of Assimilation by virtue of the fact that anchoring and objectification are not individual processes. Joffe (1998) emphasises that it is the ideas, metaphors and images collectively shared by group members that guide the way in which members make the unfamiliar understandably familiar. These processes are "social forms of the more cognitive categorisation process" (Joffe, 1998, p26). Once the disease has been constructed, knowledge about the disease can persist for a long time and will require a great effort for that knowledge to be transformed.

The process of anchoring entails the establishment of the system of thought, an allotment of meaning, and instrumentation of knowledge. The newly objectified meaning complexes become attached to pre-existing complexes. These complexes may have a deep-rooted history within various groups of society. For example, the idea of conspiracy and HIV/AIDS exists among various groups in South Africa (Moscovici, 1987). The human mind seeks to contend with uncertainty within the existing social order by anchoring those within a notion of conspiracy. Through anchoring and objectification, persons create their psychomorphic universes, and coordinate those through communication.

THE ROLE OF THE MEDIA

While media may be deemed as simply a tool that is utilised to communicate information to the public, the media can also be a weapon used to slander certain groups and to defend others. This is clearly evident in the representation of the in-group and out-group (the Other), in ways that demonise the out-group. "In our information age, words have no innocence. Language is our weapon, our primary tool for dealing with the world around us… Language can be sly, manipulative and cunning: it can be ably employed to dominate and oppress" (Duncan, 2003, p71). The media is in the curious position of being able to recognise the conflict of different perspectives of viewing the world but since the media is human-made, it produces conflicting realities that largely reflect the dominant group's interests, social affiliations and worldviews.

Historically, representations of certain groups have been generally reproduced by and through the mass media in South Africa (Duncan, 2003). The media has continually played a principal role in the political agenda in South Africa. The media, historically, followed an ideological discourse that operated to reproduce relations of social domination by considering existing tensions between social groups while at the same time having the power to ensure that the connotations that they assign to these social issues are in accordance with the dominant cultural and political agenda of society (Duncan, 2003).

The media has traditionally possessed the function of reproducing certain discourses that can be interpreted as justifying negative representations of the out-group (the Other) and portraying such groups in a very negative light (Potter, 1997). Before the 1990's, the media was overt in its explicit justification of negative representations of certain groups (primarily along lines of racist sentiments) in South Africa. The media constructed stereotypical and prejudiced representations of certain group members (particularly black individuals) and produced favourable material towards other groups (particularly white individuals), all the while suppressing material that criticised the marginalisation of groups and held anti-racist views (Duncan, 2003).

While the media is still often overt in its statements and justifications of negative portrayals of certain groups, there is a current trend for these views to be revealed in a subtler manner. Images of certain groups are presented as being naturalised depictions of people, events and social phenomena, and these images are communicated and internalised without fully being explored and challenged by the public (Duncan, 2003). Thus, the South African media continues to maintain representations of dominant discourses of social groups, however it has become progressively more buried and challenging to distinguish these representations as being conveying of mere fact vs. ideological representations of marginalized groups (Duncan, 2003).

The media often has a profound role in constructing the social meaning of HIV/AIDS. In the early 1980's, HIV awareness campaigns centred on involvement of gay men, e.g. homosexual males at gay rights parades, carrying signs that say "SILENCE = DEATH". The public started to refer to HIV/AIDS as "the gay plague" (Carson, Butcher, & Coleman, 1988; p255). The first photographs of actual AIDS patients did not appear until the early 1990's. These pictures were of AIDS patients in support groups, images of young men with eyes closed, holding hands above the caption "Group support is one of the components of current therapy with AIDS patients" (Davison & Neale, 1990; p366).

The media has constructed AIDS as a concern for the "other" in countless ways. Conceptions of AIDS since its emergence have been anchored using categories of the "other" that have a long history: the homosexual, the drug addict, the uneducated and the promiscuous, and these conceptions persist to this day (Appleton, Rivers & Warwick, 2005; Gilman, 1988; Markova & Wilkie, 1987; Sontag, 1990). Gilman (1988) suggests that social depictions of the virus and who is at risk of infection may help individuals to project their fears of collapse and dissolution onto an "other"- someone who is "not me". This image of "otherness" supplies comfort to those who exploit it for the reason that it connotes they will be spared from infection and so there is no accountability.

As useful as Social Representations Theory may be in addressing the social understanding of HIV, it does, however, lack a clear description of the role of the media in the development of social representations - how do people use these media to make sense of AIDS and how does this become an interactional process (Fife-Schaw, 1997). Nonetheless, it is evident that the media proliferates social representations of AIDS that accentuate and fortify the anchoring of the disease in concepts such as "otherness". This may be done so unintentionally and, in fact, inescapably: As soon as there is public communication, there will be a resulting construction of an understanding of AIDS, and it is impossible to sidestep making use of those terms that have come to define the disease (Ratele & Shefer, 2002).

An article by Potter & Edwards (1999) compares and contrasts the way a set of fundamental issues are treated in social representations theory and discursive psychology. Over the two decades, discourse analysts and discursive psychologists have developed a related arrangement of critiques of social representations theory (Billig, 1993). The authors provide a synopsis of general issues with social representations theory as identified by discursive psychology and then underscore a range of primary differences in an effort to oppose the increasingly widespread stance that discursive psychology is merely "enlarging and detailing" or "complementing and deepening" central aspects of social representations theory (Flick, 1998, p. 6; Potter & Edwards, 1999).

One of the chief distinctions between social representations theory and discursive psychology rests in the way they depict action, as well as in the comparative significance that they consign to it (Potter & Edwards, 1999). Discursive psychology conceptualises action in terms of the massive array of practical, industrial and interpersonal tasks that people perform during their day-to-day lives (Potter & Edwards, 1999). Action is pivotal to people's lives, and is therefore central to the comprehension of those lives. Social representations theory does not provide any elaborate account of action and this lack of narrative may lead to methodological blindspots, as it encourages a sashay towards cognitive reductionism, and it places boundaries on the way in which representations are conceived (Potter & Edwards, 1999; Wagner, 1998).

Representation is an imperative concept in social representations theory as well as discursive psychology (Potter & Edwards, 1999). However, it seems to adopt almost the converse role in each perspective. Social representations theory holds that representations are predominantly cognitive phenomena (though they are often deemed as being cultural objects), which facilitate understanding of the world (Potter & Edwards, 1999). The collective makeup of this sense making is taken to enable intragroup communication and to offer a methodological meaning of the margins of social groups (Potter & Edwards, 1999).

In discursive psychology, representations are seen as discursive objects, which people assemble in conversations and texts (Wetherell, 1997). Analysis has concentrated on the way the representations are constructed to become concrete and factual, and how these constructs translate into actions (Potter & Edwards, 1999).

Social representations theory states that the primary role of social representations is to facilitate intragroup communication. Conversation has the role of being at the core of social representations theory as the engine for the generation and modification of representations. Discursive psychology rejects lay communication, as it is viewed as being ineffective for managing the true complexities of interactions between human beings (Potter & Edwards, 1999).

One of the attractive elements of social representations theory has been its preservation of principal elements of perceptual-cognitivism, which treats people as perceivers of incoming social information that is processed in various ways (Edwards & Potter, 1992). Representations are regarded as being cognitive grids, which are utilized to make sense of information, particularly about unfamiliar social objects (Potter & Edwards, 1999). Discursive psychology discards perceptual-cognitivism to rather adopt a systematic reformulation of cognition as a feature of participants' practices, where it is constructed, described and oriented to as people perform activities (Potter & Edwards, 1999).

It is fairly common in social psychology to now portray social representations theory and discursive psychology as constructionist approaches. Social representations are not simply tools that people use to perceive and make sense of their social worlds; they construct the nature and value of those worlds. These two approaches differ dramatically when one considers the nature and scope of this reality construction. Social representations theory proposes that representations are primarily perceptual-cognitive processes (via anchoring and objectification); while discursive psychology holds that construction is developed through talk and texts as detailed versions of the world are created and established (Potter & Edwards, 1999).

SUPPORTIVE LITERATURE FOR THIS STUDY

Several quantitative-qualitative orientated studies have been aimed at examining the HIV/AIDS knowledge, attitudes and beliefs of young people of particular populations. Various populations have revealed high knowledge of HIV transmission and prevention and while misconceptions regarding the disease were relatively low, there were significant negative attitudes toward the virus, toward those infected and living with AIDS, as well as a fear of and a stigmatisation of this group (Lanouette, Noelson, Ramamonjisoa, Jacobson & Jacobson, 2003; Ploghoft, 2000; Robinson, 2000; Shroti, Sutar & Joshi, 2003). It was emerged through this study that many HIV negative individuals have experienced situations where they have discriminated against people infected with HIV, which they admit to stem from a fear of these individuals (Lanouette, Noelson, Ramamonjisoa, Jacobson & Jacobson, 2003; Ploghoft, 2000; Robinson, 2000; Shroti, Sutar & Joshi, 2003).

Choi, Gibson, Han, & Guo (2004) investigated sexual risk, risk perception, HIV and condom knowledge, in a sample of MSM (Men who have Sex with Men) in Beijing, China. Less than one-quarter of the participants who reported having unprotected anal intercourse with men during the previous 6 months perceived that they are at risk for HIV and many had misconceptions about HIV transmission routes and limited knowledge about condoms. For example, 23 % believed that they will get HIV if they have sex with black foreigners; and only 18% believed that they would not get HIV if they have sex with someone they trust. An overwhelming majority (85%) of respondents believed that they were at either no risk at all or low risk for HIV, while only small proportions perceived that they were at somewhat high or very high risk for HIV. The most commonly cited reason for this low-risk belief was the perception that respondents' sexual partners were at low risk for HIV because they did not belong to the group that is socially represented as being a 'high-risk group' for HIV infection. Statistical analyses of results obtained from a similar study showed significant predictors of the likelihood of using recommended safe sexual practices were gender (in that females sought to use condoms in an attempt to practise safer sex yet lacked, for individual, interpersonal and social reasons, the ability to negotiate this desire with their partners), knowledge of AIDS, perceived susceptibility to AIDS, and perceived threat of AIDS (Maes & Louis, 2003).

A study by Schoeneman, Schoeneman, & Obradovic (2002) identified some one-hundred pictures relating to AIDS/HIV from abnormal psychology textbooks published from the mid 1980's to the new millennium. AIDS-related photographs appeared in almost 75% of all these textbooks. Consistent with Social Representations Theory and previous research, images of AIDS continue to be anchored to concepts of 'the other', death, victimization and immoral behaviour (Schoeneman, et al, 2002). Despite the attempts to educate people to the contrary, textbooks may also inadvertently present AIDS as a disease to be associated with immoral and uneducated individuals (Schoeneman, et al, 2002). The researchers expected that the increasing frequency of AIDS depictions in textbooks would elicit sympathy for AIDS sufferers, however; the transformation of the metaphoric anchors of AIDS into images in these textbooks presented an remarkable problem as AIDS was represented as to contamination, evil, the wrath of God and the like (Schoeneman, et al, 2002).

The Schoeneman, Obradovic, & Schoeneman (2001) study found that young adults perceived risk factors for contracting AIDS/HIV to be predominantly sexual intercourse (32%) with homosexual contact (11%) and heterosexual contact (9%) and the balance being unspecified sexual contact, intravenous drug use (16%), and mother to child transmission (4%); the remaining 49% were unspecified for risk factors.

Qualitative inspection of the responses given by participants revealed a number of themes. Prominent motifs depicted AIDS figures as being namely: The "junkie"; the "innocent child victim", almost exclusively born from African mothers; the "gay", the "promiscuous female", almost exclusively African women. The authors highlight an important finding involving race: none of the respondents identified white heterosexual couples as being at risk of HIV infection; most of the individuals coded as being at high risk were African (Schoeneman, Obradovic, & Schoeneman, 2001).

In a US study conducted on South African and British adolescents, Joffe (1996) explored the participants' knowledge and attitudes regarding the origin of AIDS, modes of HIV transmission, which group(s) may be at highest risk of HIV infection, and finally, the respondent's personal sense of risk in relation to HIV/AIDS. When enquiring about where AIDS originated from, more than 75% of the British participants indicated that AIDS originated in Africa (other), while over 85% of South African participants indicated that AIDS originated in the West (other). One third of all the participants denied that AIDS affects their in-group (denying personal and in-group responsibility and risk protects the individual and group identity from AIDS). Despite the majority of the participants practicing high-risk HIV behaviours, two thirds of participants indicated that their risk was below average.

In considering the process of objectification, over 67% of participants coupled the following features with HIV contraction: Aberrant sexuality, third World factors such as poverty etc., unhygienic practices, and the practices of uneducated people. Identity protection is achieved in objectifying AIDS in the 'sin cocktail' and anchoring it with 'the other' (Joffe, 1997). In order to briefly explain this notion, this 'sin cocktail' signifies practices with which participants and their in-group may not associate and therefore can be safely used to make sense of the illness without involving the identity of the in-group (Fife-Schaw, 1997).

The notion of identity protection is important to consider in terms of the group with which the participant associates. Out-groups in relation to the dominant representation take on these dominant representations and this results in spoiled group identity (Wetherell, 1997). Maintaining the identity of the in-group through the process and creating social representations serves to protect group members from the reality of HIV/AIDS.

RESEARCH RATIONALE

As a nation, South Africa recently celebrated the tenth anniversary of democracy in the country, a democracy that ensures freedom and equality for all within the Constitution and progressive Bill of Rights. By global standards, this still constitutes a very young democracy. These past ten years have been characterised by an optimistic focus on the future, reconciliation, national healing and the celebration of our status as a "rainbow nation" (Gibson, 2002). Yet, South Africa is still plagued by poverty, violence, crime, high rates of ill health and inequalities in service provision. Nowhere are these issues more evident than the case of HIV/AIDS in South Africa, where the complex climate of intergroup relations brings into question the related issues of social representations and group stereotyping, as well as the complicated relationship between members from various groups (London, 2002; Wetherell, 1997).

Young adults (age 15-25) in South Africa currently have the highest HIV/AIDS infection rates, and so attention must be focussed on how to reduce the spread of this disease amongst our country's youth (Ratele & Shefer, 2002). It seems likely that knowledge is the foundation that will bring about positive behavioural change as individuals seek to be informed about HIV transmission and modes of prevention. However, when discussing risk behaviours in reference to health in general, the question that cannot be ignored is why people continue with risky behaviour even when they understand the implications of such behaviour (Ross & Deverall, 2004).

The Knowledge, Attitudes and Behaviour (KAB) approach is personified currently in models of behaviour such as Health Beliefs Model and Theory of Reasoned Action (HBM and TRA), which suggest that constructs such as attitudes, beliefs, risk estimates, and intentions relate to behaviour in a linear or causal manner (Joffe, 1996). However, empirical evidence suggests that there is not a simple causal relationship between constructs such as knowledge and attitudes, and the behaviours related to HIV/AIDS infection (Joffe, 1997). Three theoretical assumptions have challenged in the KAB model: firstly that of Predictive Assumption (that knowledge leads to action); that the individual is the exclusive actor in decision making; and lastly that there no unconscious influences (such as culture or defense mechanisms) at play in health related behaviour issues (Fife-Schaw, 1997).

Many studies following the various health models that have sought to discover and solve this social mystery and have found a possible answer to be that ultimately people do not perceive themselves to be at risk of HIV infection (Adler, Kegeles & Genevro, 1992; Ratele & Shefer, 2002; Ross & Deverell, 2004). Mbengashe (1996) reminds us that perception of risk is a major factor in motivating individuals to change their health related behaviours. People need to first feel personally vulnerable and susceptible to contracting HIV, and social group category, social identity, and the social representations of AIDS have been shown to influence individuals' perceptions of susceptibility (Brannon & Feist, 2004).

The social representational approach emphasises the importance of developing an in-depth understanding via description and explanation of knowledge, attitudes and behaviour rather than generating a formal predictive model of these concepts. Social Representations Theory incorporates notions of unconscious influences in the construction of knowledge about AIDS (Joffe, 1996). The theory additionally incorporates affective and identity-based factors into the KAB model of HIV/AIDS as it explores the implicit understandings of groups and how they are shaped by social influences (such as the media) (Joffe, 1996).

The transformation of scientific knowledge into what is referred to as common sense or lay knowledge is addressed by social representations theory as it relates to the content (people's ideas about HIV/AIDS) as well as the process in which those ideas are formed (Fife-Schaw, 1997). Social Representations Theory holds that core to the process in which ideas about HIV/AIDS are formed is the relationship between science and common sense. It is on the basis of this notion that this study seeks to examine the level of HIV knowledge, individuals' HIV risk perceptions, and the social representations that may exist regarding HIV. Social Identity Theory, which considers identity and self-categorisation with the social climate to explain collective behaviour, will be useful as supportive theory for this study by pivoting around issues of social representations and how people socially situate themselves in terms of interpersonal and intergroup dynamics.

RESEARCH AIMS

The aim of this study is to investigate young adult South Africans' perceptions of their own susceptibility of becoming infected with HIV/AIDS in relation to dominant social representations of HIV. The purpose of the study is exploratory, to examine whether the social representations approach is potentially useful in understanding the responses of people belonging to various social groups to the perceived risk of HIV infection (Jarvis, 2003). This study intends to provide a comprehensive understanding of the usefulness of research in Social Representations in the South African context.

RESEARCH QUESTIONS

1. What are South Africans' self-perceptions of their susceptibility of HIV infection in relation to their social category and the social representations of HIV?
2. What are South Africans' beliefs as to which social group is at high- and low risk of HIV infection in relation to their social category and the social representations of HIV?
3. What do South Africans know about HIV/AIDS in relation to the social representations of HIV?
4. What are South Africans' sexual behaviours in relation to the social representations of HIV?

CHAPTER NUMBER TWO – METHODOLOGICAL APPROACH

SAMPLE/ SAMPLING

The sample participating in this study were volunteer male and female undergraduate students registered for Psychology from various racial, cultural, and religious groups, from the University of the Witwatersrand, Johannesburg. Psychology students were selected as the target sample for this study as they were considered to be the most easily accessible group due to the academic relationship established between the researcher, the course co-ordinators and the lecturers, who ultimately were the individuals who allowed the researcher access to the students, the lecture venue and time in which the questionnaires were to be completed. Verbal permission was obtained from the appropriate course co-ordinators and lecturers to use their lecture venue and time for the participants to complete the questionnaires.

The age of this sample ranged from 18-38 years [mode age 20 (25% of the total sample), mean age 20.72 and standard deviation 2.72]. This age group falls within the boundaries of high incidence of HIV in South Africa. Non-probability sampling procedures were utilised while relying on volunteer participation (Welman & Kruger, 2001). 200 individuals participated in this study by completing the self-administered questionnaire (an intentional sample size of n = 170 to complete the HIV Knowledge & Understanding section only and n = 30 to complete the entire survey).

Additional demographic information was collected on a sheet provided in the survey package to aid in the data analysis process (See Appendix C).

For the quantitative analyses of this study, the sample was divided into particular groups according to their demographic variables and compared according to the total scores obtained on the HIV Knowledge & Understanding instrument. For the qualitative analyses, only the data from the 30 participants who completed the full HIV survey, as data regarding their Knowledge, Attitudes and Practices were collected and utilized in the investigation of the dominant social representations of HIV.

PROCEDURE

The data collection process was carried out at the end of August 2005, after the instruments had been piloted on a representative sample of the target population (under the same conditions and procedures to be described below) and the relevant modifications made and sent to the expert judges for comment. It is important to note at this point that the researcher, being a Psychology undergraduate tutor for the university, personally knew a large number of the students and the ethical implications of this were considered. For this reason, it was arranged that a third party would be the person to be present throughout these procedures.

It was arranged with three undergraduate lecturers from the Psychology Department at WITS that the third party would visit the potential participants' lecture hall during a Psychology lesson and use that time as an opportunity to tell the students about the study and invite them to participate by completing the questionnaires provided. In order to ensure that there no possibility of coercion, the third party addressed the classes without the lecturers being present - the lecturers were asked to leave the class immediately after introducing the third party. The third party gave the students an opportunity to leave the lecture hall (after the lecturer had left and after the aim of the research had been explained) if they chose not to participate in the study.

The questionnaires were completed within the lecture time as pre-arranged with the lecturer. The survey consisting of all the described questionnaires was designed to be completed comfortably within 40 minutes (these participants were given Information Sheet labelled as Appendix A1). The individuals who agreed to complete the HIV Knowledge & Understanding section only were given 20 minutes to complete that questionnaire (these participants were given Information Sheet labelled as Appendix A2). The third party visited one First year, one Second year and one Third year class in one week, so that there were an equal number of undergraduates from each year of study in the sample.

INSTRUMENTS

Young adults may possibly be unwilling to answer specific HIV perceptions and practices items honestly when in personal contact with the researcher and so a questionnaire survey was the most appropriate instrument for collecting such data (Robinson, 2000). Data was gathered by means of a questionnaire survey complied from various scales and items designed specially for the purpose of this study. While it is noted that the most common form of collecting data regarding issues of social representations is to use one-on-one interviews, given the sensitive nature of the topic (people's opinions and experiences of HIV) as well as the time and financial constraints of this research, it was thought best to collect data in the form of open and closed items of an HIV Knowledge, Perceptions & Practices survey (Lévesque, Billette, Perreault, Bernèche & Lavoie, 2005; Terre Blanche & Durrheim, 1999). The HIV Knowledge, Perceptions & Practices questionnaire was created based on various HIV instruments that have been used in several South African based studies of a similar nature (Lebodi, 1999; Mbengashe, 1996). As WITS University is an English institution, the questionnaires were only provided in English.

The researcher chose to adapt this questionnaire survey from an instrument used in studies by Lebodi (1999) and Mbengashe (1996) in order to stay in line with current levels of scientific knowledge on HIV/AIDS as well as to accommodate the aims and context of this study. While a number of the Knowledge & Understanding items remained the same as the original HIV Knowledge scale (Items #1, 2, 3, 5, 6, 7, 10, 12, 14, 17, 18, 19, 21, 22, 24, 25) others were removed and replaced with items from other well-established questionnaires used previously in the area of HIV/AIDS namely The HIV/AIDS Workplace questionnaire (Items # 8, 15, 20, 23); as well as The HIV Knowledge Scale, developed in a collaborative environment between Health Initiates for Youth and The Measurement Group (1998) (Items #4, 9, 11, 13, 16).

This was done after being piloted as it appeared as the original HIV Knowledge scale was not entirely suited to the sample of this study (tertiary education students) as they all achieved incredibly high knowledge results (implying that the test was too basic for their level of understanding). This was confirmed by the tests of reliability (Cronbach's alpha 0.18) and data gathered for validity (very low item discrimination

power) on the piloted questionnaire. So the 'bad' items (those not adding to the overall value of the instrument by virtue of the fact that they were repetition items, irrelevant to the needs of the study, or too 'easy' for this particular sample) were removed and these more advanced items were added, based on the pilot study and the feedback from the expert judges.

The Perceptions of HIV section was designed based on the needs of this study, while the Build-A-Character instrument was used for triangulation purposes, and finally the Practices regarding HIV was created by including some items from the Practices regarding HIV & Risk Assessment section of the HIV Knowledge, Attitudes & Practices questionnaire form the Lebodi study (1999)- Items #1a, 3, 4a, 4c, 5, 6; and some items from the KPC 2000 HIV/STI Module (section concerned with Risk Factors) used by CSTS and the Core M & E working group (2000)- Items # 2, 7a, 7b. The remaining items were open-ended items added by the researcher, as it was felt necessary to gain explanations to the related close-ended items in order to obtain the necessary data in relation to the dominant social representations of HIV.

Once the all the questionnaires had been modified, they were then given to two Expert Judges to comment on comprehension and readability of the survey, as well as to provide input on the content validity for the items of the instruments, and based on their comments and suggestions various amendments were made to the questionnaires (Rosenthal & Rosnow, 1991). Based on the feedback received, alterations were made i.e. rephrasing and/ or deleting items that appeared to be repeating similar question content or which were not relevant to the needs of this study. Admittedly, these modifications impacted on the reliability and validity of the original HIV instruments however; these modifications were necessary to accommodate the aims of this study and to best suit the context of this research piece (Welman & Kruger, 2001).

MEASURING INSTRUMENTS

A hybrid of open- and close-ended questionnaire design was employed in this study to collect various types of information from the participants. The questionnaire used for the purpose of this study was composed of five sections, each containing several related questions. Each section is described in more detail as follows:

1. **Demographic Information**
2. **HIV/AIDS Knowledge & Understanding**
3. **Perceptions of HIV**
4. **Build-A-Character questionnaire**
5. **Practices relating to HIV & Risk Assessment**

Demographic Information

Demographic information section remained similar to the HIV questionnaire, except that categories regarding socio-economic status, religion, and social support were excluded, and that new categories of race and sexual orientation were included. The inclusion of these categories was considered to be of particular importance because these would be used in the analyses of data gathered to see if there is a process of "othering" in relation to the social representation of HIV according to how participants categorise themselves.

HIV Knowledge & Understanding

The self-administered HIV Knowledge & Understanding measure was used to collect information regarding the participants' level of HIV knowledge as well as any misconceptions regarding the HI virus. All 200 of the participants received this questionnaire, while only 30 participants were given the full HIV questionnaire survey (HIV Knowledge & Understanding, Perceptions of HIV, the Build-A-Character questionnaire measures as well as Practices regarding HIV and Risk Assessment - all to be described shortly).

The HIV Knowledge & Understanding section of the questionnaire consists of 25 items regarding the HI virus itself, HIV transmission and HIV prevention statements that participants respond to as being true or false (yes/ no style). A score of '1' was assigned for every correct response and a score of '0' for every incorrect response.

Thus, the highest score an individual could receive was 25 (100%). The use of this questionnaire was to provide quantitative data about the fact that participants may have a high intellectual knowledge about the disease yet their beliefs/perceptions and behaviours may be impacted on by the social representations that exist for the individuals (Jarvis, 2003). The final item of this instrument asks the participants to indicate which source they most rely upon to gain information regarding HIV/AIDS, namely friends, siblings, parents, relatives, written media, consulting health care professionals, television, lecturers or school teachers, or the church.

Cronbach's alpha total reliability score was calculated for this instrument in order to determine the internal consistency between items on the scale – Cronbach's a = 0.804318. The items of this measurement were analysed to produce findings on Construct validity and it was found that there were the following themes to the items:

Knowledge regarding the virus
Knowledge of casual transmission
Knowledge of sexual transmission
Knowledge of modes of prevention.

The instrument was then divided according to these variables and a reliability score provided for each variable, as indicated by Table 1.

TABLE 1: The reliability score for each variable in the HIV Knowledge & Understanding questionnaire

VARIABLE	CRONBACH'S a
Knowledge regarding the virus	0.602181
Knowledge of casual transmission	0.449763
Knowledge of sexual transmission	0.476873
Knowledge of modes of prevention	0.491467

While the calculations produced low reliability co-efficients according to the division across the variables being measured, it is suspected that this may be due to the low variability (variance) of the scores according the variables, which then artificially produces a low reliability score (Rosenthal & Rosnow, 1991). The participants, being

tertiary education students are expected to score highly on the items of the HIV Knowledge & Understanding section thus, producing low variability within the variables of this instrument.

In addition to the reliability information provided for this created instrument, an item analysis was carried out. Item analysis essentially involves issues of facility and discrimination for the individual items in the questionnaire. Facility is defined as the extent to which respondents answer an item in the same way, giving an indication of the variation of responses and the possible redundancy of an item (Rust & Golombok, 1992). The facility index is calculated by dividing the number of respondents with the correct score by the total number of respondents. Ideally, an item should score IDI between 0.25 and 0.75, and an item with an index below this range may be too difficult and one above it, too easy (Huysamen, 1980).

Discrimination is the ability of an item to discriminate between the participants according to what the question is measuring. This is calculated by grouping the top and bottom 25% achievers of this instrument and calculating the proportion of participants who get each item correct according to the total number of person in either group (Rust & Golombok, 1992). A minimum IDsI score of 0.2 is considered acceptable, however the higher score, the higher the ability of that item to discriminate between the participants who have an advanced understanding of HIV and those who do not (Huysamen, 1980). An IDsI score of below 0.2 may indicate that the item is too basic for this level of education or that knowledge is simply very high in that particular area (a phenomena which would be the ultimate goal in terms of HIV education).

The following table offers the IDI and IDsI for each item of the HIV Knowledge & Understanding Questionnaire. Those values indicated by an (*) are items that are considered to be items of acceptable to the overall value of the instrument.

TABLE 2: A dissection of each item according to its IDI and IDsI

ITEM NUMBER	IDI	IDsI	ITEM NUMBER	IDI	IDsI
1	0.95	0.06	**14**	0.98	0.08
2	1	0	**15**	0.785	0.52 *
3	0.995	0	**16**	0.655 *	0.54 *
4	0.38 *	0.82 *	**17**	0.945	0.08
5	0.725 *	0.4 *	**18**	0.97	0.06
6	0.98	0.08	**19**	0.73 *	0.34 *
7	0.975	0.02	**20**	0.745 *	0.62 *
8	0.46 *	0.92 *	**21**	0.97	0.04
9	0.695 *	0.92 *	**22**	0.955	0.1
10	0.905	0.28 *	**23**	0.725 *	0.66 *
11	0.686 *	0.84 *	**24**	0.48 *	0.68 *
12	0.925	0.1	**25**	0.94	0.16
13	0.515 *	0.9 *			

Based on the expert judges' feedback (who were Junior and Senior Lecturers from the University of the Witwatersrand, all of whom had years of experience in the area of HIV/AIDS as well as psychological research, specifically that of instrument design), the following Content Validity is available on the modified questionnaire:

Face Validity - the expert judges commented that the appearance of the HIV Knowledge & Understanding test reflected to be authentic in its presentation of items in line with questioning participants about their knowledge regarding the HI virus, modes of transmission and methods of prevention against HIV infection.

Relevance of each item – the expert judges independently scrutinized each item of the instrument and commented on the strength of the item's relevance in terms of its content in relation to HIV knowledge. This is then a "measure" of the degree to which the items are relevant to the study (taking the number of items upon which both judges found to be relevant, divided by the total number of items in the instrument) (Finchilescu, 2002). Thus, the content validity of this instrument was 0.92 (92%).

Perceptions of HIV

The measure to investigate perceptions of HIV was designed to enquire about the social representations of the HI virus and to identify consensual beliefs about HIV (Jarvis, 2003). This consisted of closed-ended and open-ended items investigating the participants' perceptions of the HIV pandemic and the possible social representations about people who are perceived as being at high-risk of HIV infection (See Appendix D). The open-ended items afforded the participants an opportunity to justify the representations that they hold regarding HIV/AIDS and the groups of people who they feel are at risk etc. The first item asked the participants to indicate where they thought AIDS originated. This was included so as to indicate the social representation of 'othering' and blame across the groups. The next item asked participants if they thought that South Africans continued to partake in high-risk behaviour even though they may know the associated risks involved, and then to justify their answer. This item sought to again thread out 'othering' but also to gain an understanding of why knowledge does not translate into low-risk behaviour.

The following item asked the participants to predict the future of AIDS in South Africa. This item was included as it teases out the social representation of AIDS in both a negative and positive light (as well as to connect it to any possible contradictory responses in the previous item). The final item asked if the participants had ever known a person infected with HIV. This item was included so as to divide participants into two groups (those who have known a PLWAs vs. those who have not) for further analyses in differences of the levels of knowledge regarding HIV as well as additional qualitative analyses. These open-ended items were content analysed individually by the researcher.

Build-A-Character Questionnaire

Respondents were given a short Build-A-Character questionnaire, used to confirm the reliability of their stated beliefs about which group they believe to be at high risk of HIV infection (as in the Perceptions of HIV) and to gain some additional information regarding their social representations of the virus by getting them to create an HIV+ character – such as how their character became infected with HIV (Jarvis, 2003). In short, this instrument was used for triangulation purposes.

The Build-a-character questionnaire is thought to encourage individuals to think about their social representations of people who are perceived as being at high risk of HIV infection (Appleton, Rivers, & Warwick, 2005). The Build-A-Character questionnaire items were modified from the original instrument that was used in an American project by Appleton et al (2005), where they investigated the effectiveness of an HIV/AIDS awareness programme in stimulating young adults to think about their representations of people who are seen to be at high risk of being infected with the HI virus. The questionnaire was originally used in a workshop where students were asked to create a character and then describe this character to the rest of the group. They were then asked to list ten ways in which their fictitious character would be differently described if they were HIV +.

Many students changed their character to be a poor, black, uneducated, and promiscuous female (Appleton, et al, 2005). Thus, these findings provide the basis for the use of this instrument (simply as a tool for triangulation) in this current study, bearing in mind that while the context is different and it used in a different manner, its purpose is nonetheless the equivalent of the American study (See Appendix E).

The participants were asked to complete the questionnaire, thus building a character, while imagining that the character was infected with the HI virus. Category information obtained from the Build-A-Character questionnaire resembled the information obtained from the Schoeneman, Obradovic, & Schoeneman (2001) study (e.g. gender, race, AIDS risk status, sexual orientation, etc).

Practices relating to HIV & Risk Assessment

The first item of this instrument was a close-ended question that asked the participants to assess their own susceptibility to HIV infection and then to justify their response. This item was then compared to the responses to the items that followed to gauge the match between perceived risk of HIV infection and the participants' actual behaviour with regards to HIV.

The following item questioned the respondents' belief with regards to the usage of a condom during sexual activity. This item sought to reveal the social representation of the condom within a sexual relationship and the implications thereof. Item #3 asked the participant if they have been tested for HIV infection in the hopes of revealing the social representation attached to VCT and discovering one's HIV status in South Africa.

The questionnaire then gives the instruction that the remaining items are only to be completed by those participants who have ever been sexually active. This was then the end of the survey for the individuals who are not sexually active and served as a split of the sample into two groups: one where participants have been sexually active and one where they have not been sexually active. The remaining items are predominantly closed ended items (yes/ no responses) that questioned the participants' sexual behaviour regarding condom usage (with open-ended justification), condom initiation, their belief in monogamy, and ability to discuss important sexual issues with their partners. These items prove a general link between the responses proved on the HIV Knowledge & Understanding section and the Perceptions of HIV measurement in the enquiry of the dominant social representations of HIV in South Africa.

RESEARCH DESIGN

This empirically driven research adopts a non-experimental approach as there is no manipulation of any variables, and there is no random selection of the participants to form a sample (Rosenthal & Rosnow, 1991). This study is largely descriptive and exploratory in nature. A cross-sectional mode of data collection is the appropriate measure to discover (in relation to the dominant social representations regarding HIV/AIDS) the level of knowledge regarding HIV transmission and prevention amongst these individuals, as well as their HIV related practices, and to establish the beliefs regarding one's own susceptibility to HIV infection in relation to the social representations of HIV and other social groups (Ratele & Shefer, 2002; Welman & Kruger, 2001).

This study relies on a multi-method approach to data analysis and interpretation of the ensuing results, as a large portion of the sample (n = 170) was used to gather quantitative data and a smaller proportion of the sample (n = 30) provided quantitative and qualitative data (Rosenthal & Rosnow, 1991).

DATA ANALYSIS

This study relied on a multi-method approach to data analysis, as there were quantitative and qualitative elements to this study. In this way, data was analysed to produce rich results that brought together quantitative and qualitative approaches to research in the social sciences and the weaknesses of one approach were balanced by the strengths of the other (Golding, 1999; Hammersley, 1992; Holsti, 1969).

The research questions were answered by making use of the data gathered by the HIV survey instruments, which provided categories of groups of people that the participants viewed as being at highest - and least risk of HIV infection.

Quantitative analysis was done on the close-ended items of the HIV Knowledge & Understanding questionnaire to discover the level of HIV knowledge. The instrument was scored and analysed using one-way frequencies to uncover common misconceptions and trends in knowledge, and further analyses were carried out to compare the groups across the various demographics and other identified variables, etc. Since the HIV Knowledge score was not normally distributed nonparametric equivalents of Two-Independent Sample T-tests and nonparametric One-Way ANOVAS were utilised in the investigation of differences in HIV Knowledge across these groups. These statistical analyses were performed on SAS (a computer software package specialising in the analysis of quantitative data).

The HIV Knowledge & Understanding Questionnaire items are predominantly yes/no answers, thus a frequency count was done on the proportions of correct and incorrect responses for each individual. The items with low correct answer frequencies were interpreted as being areas where HIV knowledge was low or possible areas where misconceptions of the virus existed. The item concerned with where the participants obtain their information regarding HIV transmission and prevention was also analysed

with descriptive statistical procedures of frequency counting in order to uncover which sources were those most commonly and least commonly used by young South Africans to learn about HIV/AIDS.

Qualitative analysis in the form of Thematic and Quantitative Content Analysis was performed using manual analysis as well as utilising ATLAS TI (a computer software programme specialising in the visual data analysis of text, images, audio & video materials) to reveal trends and frequencies in the responses to the Perceptions of HIV, Build-A-Character, and the Practices relating to HIV & Risk Assessment Questionnaires. These analyses were performed so as to uncover the social representations of HIV held by the participants and to relate the function of these representations regarding the participants' perceptions and HIV related behaviours.

The Build-A-Character Questionnaire was content analysed according to the themes of the categorical descriptions of the character created in the questionnaire. Items related to the gender of the character, race, age, education level, socio-economic status, etc. and once the theme of the character had emerged, this was compared with Item 2a of the Perceptions of HIV Questionnaire for the purpose of triangulation to ensure that the participants were providing reliable responses to this item. The additional item asking the participants to detail how their character became infected with HIV was also content analysed to reveal trends of metaphoric language that indicated the formation of the social representation through the anchoring of blaming and punishment.

Content analysis is the most common qualitative analyses carried out on the materials used in research on social representations (de Rosa & D'Ambrosio, 2002). After classification, the data was analysed using frequency counts to establish illustrative variables of which groups are socially represented as being at high- and low risk of HIV infection and the reasons for this belief. The Practices relating to HIV & Risk Assessment was content analysed to investigate any discrepancies between the expressed knowledge of HIV modes of transmission and methods for prevention of HIV infection. The discrepancies are explained by making use of the social representations of HIV as expressed in the choice of metaphoric images (anchors) used to explain and justify the participants' views and behaviours.

ETHICAL CONSIDERATIONS

Each participant was provided with a letter of information regarding the nature of the research at the start of data collection, as this study considered individuals who may have be particularly sensitive to discussion of HIV/AIDS (See Appendix A1 and A2). Participants were also notified that they could omit the answers to any questions that they felt ill at ease about, and that they could also abandon the study at any given moment without questions or any negative consequences (See Appendix A1 and A2). The potential participants were informed that participation or non-participation would have no effects whatsoever on the outcome of the students' academic results in any of their registered courses. Participants were given concise understandable instructions as to how to complete the questionnaires in the survey package.

Contact details for loveLife were made available to the participants in case any individuals required psychological counselling as a result of participating in study (See Appendix A1 and A2). This was arranged with several of the counsellors at loveLife and they had indicated that they would eagerly assist any students who chose to make use of their counselling services. loveLife was selected as an assisting counselling service because of their unique dedication to managing issues of sexual health and HIV/AIDS specifically, their ability to address their callers in the native tongue (counsellors who speak all the official South African languages were available) as well as rapport established between the researcher and the counsellors in previous academic encounters. The participants were informed that they might have access to this final dissertation, while the data obtained from the questionnaires would be destroyed after the data analysis had been completed. In the interim, the data remained under lock-and-key at a private location.

CHAPTER NUMBER THREE - RESULTS

INTRODUCTION

The following results were obtained from the various analyses performed on the data collected. The results are presented in a tabular form so as to allow for easy reading of the findings from the numerous items in the survey questionnaire pack. The results to the various items are presented according to each questionnaire, as each questionnaire does indeed cover a different aspect of the issues regarding HIV/AIDS in relation to the dominant social representations of HIV/AIDS.

DEMOGRAPHIC DETAILS OF THE SAMPLE

TABLE 3: Descriptive statistics on composition of the total sample

N = 200

GENDER

FEMALE	MALE
n = 158 (79%)	n = 42 (21%)

RACE

BLACK	WHITE	INDIAN
n = 83 (41.5%)	n = 88 (44%)	n = 29 (14.5%)

SEXUAL ORIENTATION

HETEROSEXUAL	HOMOSEXUAL
n = 172 (86%)	n = 28 (14%)

YEAR OF STUDY

FIRST YEAR	SECOND YEAR	THIRD YEAR
n = 61 (30.5%)	n = 74 (37%)	n = 65 (32.5%)

DEGREE BEING COMPLETED

BACHELOR OF ARTS	BACHELOR OF SCIENCE	BACHELOR OF COMMERCE
n = 159 (79.5%)	n = 27 (13.5%)	n = 14 (7%)

It should be noted that while the category of race on the demographic appendix included all race groups (Black, White, Coloured, Indian, Asian, and Other) no individual in the sample identified themselves as being Coloured, Asian, or Other and so these categories were excluded from the analyses for descriptive statistics. The

same should be noted for the classification of participants according to their sexual orientation as being bisexual.

HIV KNOWLEDGE & UNDERSTANDING FINDINGS

The following results indicate the total knowledge scores (Dependent Variable) to the HIV Knowledge & Understanding Questionnaire as prepared by performing various statistical analyses as to ascertain the distribution of scores, the potential differences between the various demographic (and other identified) variables.

FIGURE 1: Distribution of Total Knowledge Scores

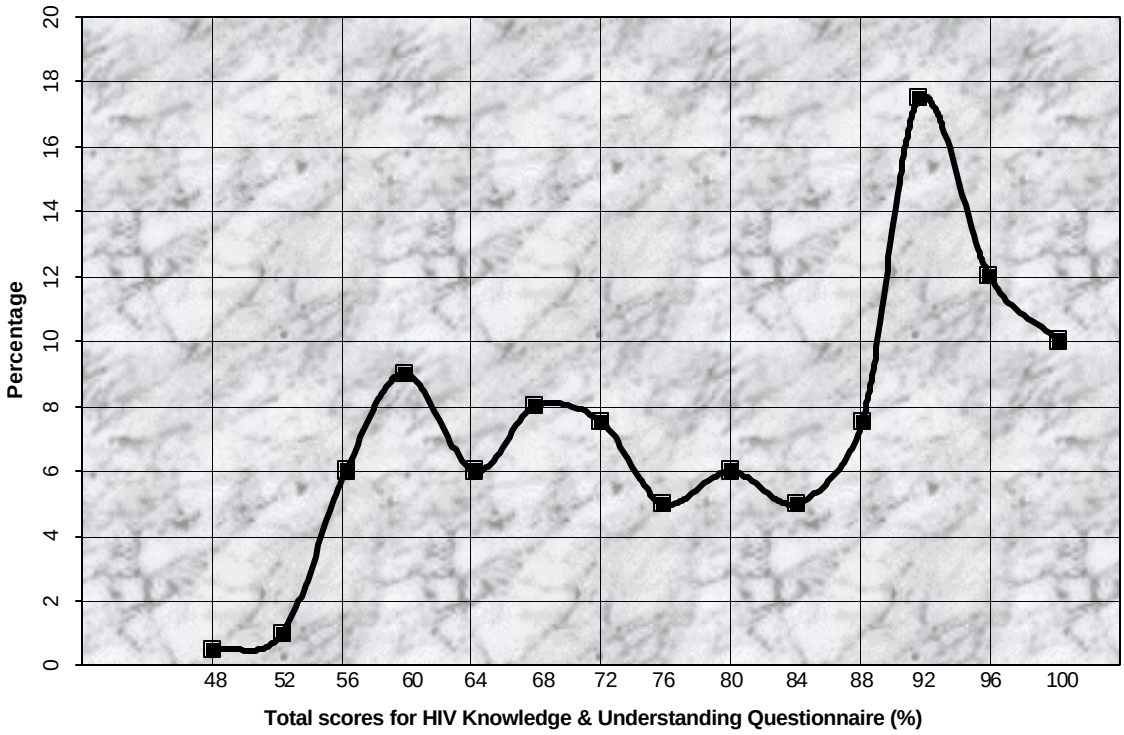


FIGURE 1 indicates that less than 1% of the sample (n = 200) answered only 48% of the HIV Knowledge & Understanding questionnaire items correctly, some 17% of the sample answered 92% of the questionnaire items correctly (making this the mode for the Total Knowledge Scores), and 10% of the sample answered every item of the HIV Knowledge & Understanding questionnaire correctly. The appearance of the graph's

distribution led to the suspicion that the data may not be normally distributed, thus a test for normality was performed.

The following tables offer the Summary Statistics for the Total Knowledge Scores. The results are presented in relation to the alternative hypothesis that the distribution of the means for the Total Knowledge Scores is not normal.

TABLE 4: Summary Statistics of the Total Knowledge Scores (Dependent Variable)

MEAN	STANDARD DEVIATION	MODE	NORMALITY		SCALE OF MEASURE
80.3%	0.1473	92%	Skewness ? -0.2966	Kurtosis $?_2$ -1.2825	Interval

TABLE 5: Test for Normality of the Total Knowledge Scores

TEST	W-VALUE	P-VALUE
Shapiro-Wilk	0.915457	P < a (0.05)

The result is insignificant thus, the alternative hypothesis was accepted i.e. that the distribution of these scores is not normal, and this then dictates that nonparametric test statistics are to be used in the analyses comparing the various demographic variables (and the other groups identified according to the items in the various questionnaires).

The variables marked with (*) indicate a significant difference (at the significance level of 5%) between the groups being compared, regarding the hypothesis that there is some difference in the level of HIV knowledge between these groups.

TABLE 6: Nonparametric Two Independent sample T test (Wilcoxons Two-sample Test) for Gender, Sexual Orientation, and Knowing a person infected with HIV/AIDS

GENDER

WILCOXON SCORES (RANK SUMS) FOR VARIABLE TOTAL CLASSIFIED BY VARIABLE GENDER					
GENDER	N	SUM OF SCORES	EXPECTED UNDER H0	STD DEV UNDER H0	MEAN SCORE
MALE	42	4392.00	4221.00	331.69	81.24%
FEMALE	158	15708.00	15879.00	331.69	80.05%

WILCOXON TWO-SAMPLE TEST	
STATISTIC (S)	4392.0000
T APPROXIMATION	
TWO-SIDED PR > |Z|	0.6078
Z INCLUDES A CONTINUITY CORRECTION OF 0.5.	

SEXUAL ORIENTATION

WILCOXON SCORES (RANK SUMS) FOR VARIABLE TOTAL CLASSIFIED BY VARIABLE SEXUAL ORIENTATION					
SEXUAL ORIENTATION	N	SUM OF SCORES	EXPECTED UNDER H0	STD DEV UNDER H0	MEAN SCORE
HETEROSEXUAL	172	17533.00	17286.00	282.57	80.67%
HOMOSEXUAL	28	2567.00	2814.00	282.57	78%

WILCOXON TWO-SAMPLE TEST	
STATISTIC (S)	2567.0000
T APPROXIMATION	
TWO-SIDED PR > |Z|	0.3841
Z INCLUDES A CONTINUITY CORRECTION OF 0.5.	

KNOWING A PERSON INFECTED WITH HIV/AIDS

WILCOXON SCORES (RANK SUMS) FOR VARIABLE TOTAL CLASSIFIED BY VARIABLE KNOWING A PERSON INFECTED WITH HIV/AIDS					
KNOWING A PERSON INFECTED WITH HIV/AIDS	N	SUM OF SCORES	EXPECTED UNDER H0	STD DEV UNDER H0	MEAN SCORE
YES	14	225.50	217.00	23.84	81.43%
NO	16	239.50	248.00	23.84	80.75%

WILCOXON TWO-SAMPLE TEST	
STATISTIC (S)	225.5000
T APPROXIMATION	
TWO-SIDED PR > |Z|	0.7396
Z INCLUDES A CONTINUITY CORRECTION OF 0.5.	

These results indicate that there is no significant difference in the level of HIV Knowledge & Understanding scores between males and females, between heterosexuals and homosexuals, and between the individuals who know a person infected with HIV/AIDS and those who do not. The statistics revealed that there was no significant interaction of these variables on the level of HIV Knowledge & Understanding scores.

TABLE 7: Nonparametric One-Way Analysis of Variance for Race, Year of study, and Degree being studied

RACE

WILCOXON SCORES (RANK SUMS) FOR VARIABLE TOTAL CLASSIFIED BY VARIABLE RACE					
RACE	N	SUM OF SCORES	EXPECTED UNDER H0	STD DEV UNDER H0	MEAN SCORE
BLACK	83	8472.00	8241.00	400.53	81.17%
WHITE	88	9123.00	8944.50	404.71	80.67%
INDIAN	29	2505.00	2914.50	286.74	76.69%

KRUSKAL-WALLIS	
CHI-SQUARED	2.0481
DF	2
PR > F	0.3591

YEAR OF STUDY *

WILCOXON SCORES (RANK SUMS) FOR VARIABLE TOTAL CLASSIFIED BY VARIABLE YEAR OF STUDY					
YEAR OF STUDY	N	SUM OF SCORES	EXPECTED UNDER H0	STD DEV UNDER H0	MEAN SCORE
FIRST	61	5408.00	6130.50	374.94	77.44%
SECOND	74	6877.50	7437.00	393.18	78.27%
THIRD	65	7814.50	6532.50	381.43	85.29%

KRUSKAL-WALLIS	
CHI-SQUARED	11.4819
DF	2
PR > F	0.0032

Upon further analysis, it was revealed that the individuals in their third year of study know more about HIV/AIDS related facts than their first and second year counter parts (with no significant difference in HIV knowledge between the individuals in these first and second years of studies).

DEGREE *

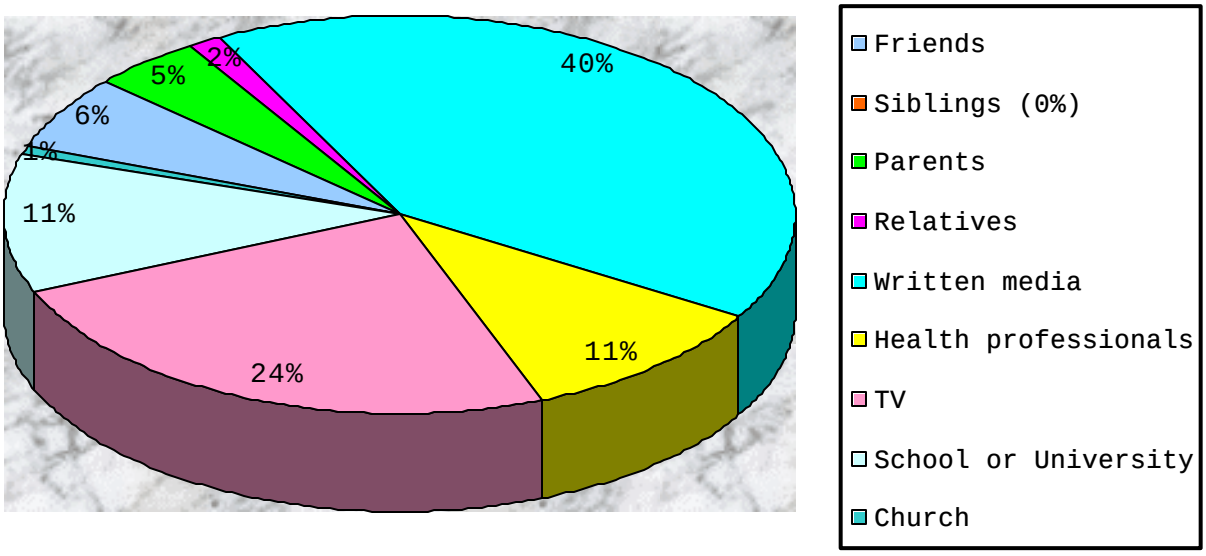
WILCOXON SCORES (RANK SUMS) FOR VARIABLE TOTAL CLASSIFIED BY VARIABLE DEGREE					
DEGREE	N	SUM OF SCORES	EXPECTED UNDER H0	STD DEV UNDER H0	MEAN SCORE
BA	159	15455.00	15979.50	328.76	79.47%
BSc	27	3444.50	2713.50	278.29	86.81%
BCOM	14	1200.50	1407.50	207.00	77.14%

KRUSKAL-WALLIS	
CHI-SQUARED	7.4089
DF	2
PR > F	0.0246

There is a significant statistical difference between the HIV Knowledge & Understanding scores across the various degrees. Those students who were currently completing a BSc degree scored higher on the HIV Knowledge & Understanding questionnaire, than those completing a BA or BCom degree (there is no significant difference between the HIV Knowledge & Understanding scores of these latter degrees). The statistics revealed that there was no significant interaction between these variables and the level of HIV knowledge held by the participants.

Data regarding the sources of HIV/AIDS information utilised by sample was collected when the participants completed Item #26 on the HIV Knowledge & Understanding Questionnaire. A One-Way Frequency count revealed the following results.

FIGURE 2: Sources of HIV information



Thus, 40% of the participants make use of Written Media to gain access to information regarding HIV/AIDS, 11% talk to their health care providers and a further 11% gather HIV/AIDS information as provided by their secondary and tertiary educators. None of the respondents relied on their siblings for information regarding HIV/AIDS, and less than 1% ever received information on HIV/AIDS from the church.

The following table offers the results from the analyses comparing the difference between the scores of the HIV Knowledge & Understanding questionnaire according the various sources relied upon to gain information regarding HIV/AIDS.

TABLE 8: Nonparametric One-Way Analysis of Variance for Source of HIV/AIDS information utilised by the sample

WILCOXON SCORES (RANK SUMS) FOR VARIABLE TOTAL CLASSIFIED BY VARIABLE SOURCE OF HIV INFORMATION					
SOURCE OF HIV INFORMATION	N	SUM OF SCORES	EXPECTED UNDER H0	STD DEV UNDER H0	MEAN SCORE
TELEVISION	49	5016.00	4924.50	350.25	80.49%
WRITTEN MEDIA	82	8204.00	8241.00	400.53	80.63%
HEALTH PROFESSIONALS	21	2146.00	2110.50	249.64	80.95%
PARENTS	9	769.50	904.50	168.82	75.56%
FRIENDS	12	1200.00	1206.00	193.40	79.33%
SCHOOL/UNIVERSITY	23	2291.50	2311.50	259.80	79.48%
RELATIVES	3	333.00	301.50	98.99	82.67%
CHURCH	1	140.00	100.50	57.44	92%

KRUSKAL-WALLIS TEST	
CHI-SQUARE	1.2618
DF	7
PR > CHI-SQUARE	0.9894

There is no statistical difference in the level of HIV knowledge possessed by the participants as depending upon the source of HIV/AIDS information utilised. While a nonparametric one-way ANOVA was utilised to perform this analysis, so as to compensate for the lack of the normal distribution of the HIV Knowledge & Understanding scores, the primary caution in analysing these results lies with the small group sizes i.e. there is only 1 individual in the CHURCH group, 3 in the RELATIVE group etc. One would have to regard this particular analysis with some caution, however one would expect (considering the level of education of the student sample) that the source of the HIV/AIDS information should have little effect on the level of knowledge possessed by the participants but rather that they do in fact rely on some source of information in order to maintain up to date with new findings pertaining to HIV/AIDS.

A Thematic Content Analysis was carried out to investigate the possible themes and the sort of variables that link the items that have a high number of correct responses as compared to those items that have a low correct response rate.

- **Basic knowledge about the HI virus itself:**

Q1: AIDS is caused by the Human Immunodeficiency Virus (HIV).

Q7: AIDS can be cured by taking certain medications prescribed by doctors.

Q13: HIV antibodies can take up to 10 years to show up.

Q18: A person who has HIV/AIDS might look healthy.

Q20: A strong and healthy person cannot get HIV because of his/her strong immunity.

Q23: Taking certain medication after sex will cure HIV infection.

- **Knowledge of modes of HIV transmission (casual):**

Q2: A person can get HIV/ AIDS by sharing food and eating utensils with someone who has HIV.

Q5: One can become infected with HIV by donating blood to the SA blood transfusion services.

Q6: HIV can be transmitted by sitting on a public toilet seat.

Q8: A child born from a mother who is HIV+ will automatically become infected with HIV.

Q12: HIV can be transmitted by mosquito bites.

Q16: A hangnail is a potential route for HIV infection.

- **Knowledge of modes of HIV transmission (sexual):**

Q3: The HI virus can be transmitted via sexual contact with an infected person.

Q4: You can get HIV by performing oral sex.

Q11: Mucous membranes in the anus are more delicate than membranes in the mouth.

Q14: Someone can get HIV by having one sexual encounter with an HIV infected person.

Q15: During vaginal sex, it is easier a women to receive the HI virus than for a man.

Q19: Having a Sexually Transmitted Infection (STI) increases your risk of getting HIV/AIDS.

- **Knowledge of prevention against HIV infection:**

Q9: Cleaning injection equipment with water is a good way of killing HIV.

Q10: Condoms can reduce the risk of HIV infection.

Q17: A women using oral contraceptives as a method of birth control is protected against getting HIV/AIDS.

Q21: People should use condoms for every sexual encounter, even with their usual partner.

Q22: Abstaining from any sexual contact is the most effective way of not becoming HIV+.

Q24: Having sexual intercourse less frequently may reduce your risk of becoming infected with HIV.

Q25: Being faithful to one sexual partner reduces the risk of HIV infection.

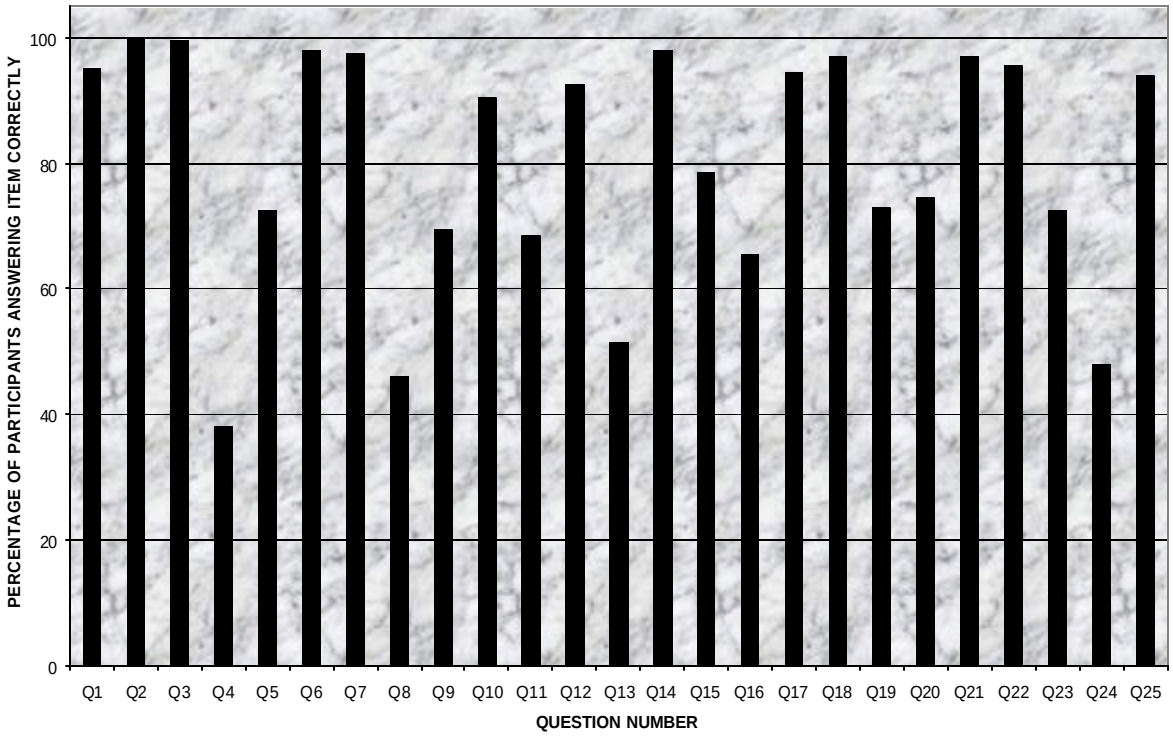
A further Thematic Content Analysis was performed so as to link the participants expressed Social Representations of HIV/AIDS to the content of each item. The table below offers a presentation of the social representations linked to the content of the items in the HIV Knowledge & Understanding Questionnaire.

TABLE 9: Social Representations of HIV/AIDS emerging from the content of the HIV Knowledge & Understanding Questionnaire

ITEM NUMBER	THEME
1	HIV/AIDS is death.
2	AIDS is contamination.
3	HIV is a sexually transmitted disease.
4	HIV is a punishment for "immoral" sexual acts.
5	HIV is the evil perpetrator that seeks out innocent victims.
6	AIDS is contamination.
7	HIV/AIDS is death but hope for salvation.
8	HIV is the evil perpetrator that seeks out innocent victims.
9	AIDS is contamination.
10	HIV is the evil perpetrator that seeks out innocent victims.
11	HIV is a punishment for "unnatural" sexual acts/ homosexuality.
12	HIV is the evil perpetrator that seeks out innocent victims.
13	HIV/AIDS is evil/death.
14	HIV is the evil perpetrator that seeks out innocent victims.
15	HIV is a punishment for "immoral" sexual acts.
16	HIV is the evil perpetrator that seeks out innocent victims.
17	HIV is a punishment for "immoral" sexual acts.
18	HIV is the evil perpetrator that seeks out innocent victims.
19	HIV is a sexually transmitted disease
20	HIV is the evil perpetrator that seeks out innocent victims.
21	HIV is the evil perpetrator that seeks out innocent victims.
22	HIV is a punishment for "immoral" sexual acts.
23	HIV/AIDS is death but hope for salvation.
24	HIV is a punishment for "immoral" sexual acts.
25	HIV is a punishment for "immoral" sexual acts.

An analysis that indicates where knowledge on HIV/AIDS in general, modes of transmission (casual and sexual), and methods of prevention, is particularly high or low for this specific student sample, was carried out. A basic one-way frequency count was performed in order to indicate the average number of participants answering each item correctly.

FIGURE 3: Correct responses to each item of the HIV Knowledge & Understanding questionnaire



Based on the results from the above analysis, there are obvious areas were there are high and low levels of knowledge regarding the HI virus, modes of HIV transmission (casual and sexual), and methods of HIV infection prevention.

The 4 items that yielded a low correct response rate were Items: 4, 8, 13 and 24. Each of these items are from the various categories as listed above, and while there appears to be no obvious link in terms of the content of these items, the Thematic Content Analysis revealed that each of these items represent HIV/AIDS as being the evil perpetrator that seeks out its victims with the punishment of death for their sexual transgressions.

The 13 items that yielded a high correct response rate were Items: 1, 2, 3, 6, 7, 10, 12, 14, 17, 18, 21, 22, and 25. 5 of these items were HIV prevention related items, 3 were general virus knowledge questions, and 5 were transmission related items (2 sexual transmission and 3 casual transmission questions). This indicates that these items correspond to areas where HIV/AIDS knowledge is high, but also that the social representation persists that HIV/AIDS is the result of a punishment for the individual polluting and contaminating the body with sexually transmitted infections and that the hope of redemption in the form of a cure is simply beyond these victims.

PERCEPTIONS OF HIV FINDINGS

The following results were obtained from the Thematic Content Analysis of the responses to the items of the Perceptions of HIV Questionnaire.

Based on the findings below, the researcher was able to separate the participants into four distinct groups, according to whether the participants placed their social group as being the same group that is identified as the group that is stereotypically represented as being the high-risk group (HIGH RISK) vs. those participants who categorise themselves as belonging to that group at least risk for HIV infection (LOW RISK) vs. those who elected to place their own social group in neither of these categories (OTHER) vs. those who claimed that one should be unable to estimate a group as being at high or low risk of HIV infection based on their social category (NO CATEGORY). This self-categorisation information was obtained from the demographic information sheet of the survey while the social representations of the types of people who are at high- and low risk of HIV infection was obtained via the items of the Perceptions of HIV Questionnaire.

The table below offers a statistical representation of the composition of these groups according to the demographic classification of the sample.

TABLE 10: Descriptive statistics of the demographic composition of the groups in terms of own-group and HIV risk classification (n = 30)

HIGH RISK	LOW RISK	OTHER	NO CATEGORY
26.67% n = 8 8* Black Female HT	46.67% n = 14 7 * White Female HT 2 * White Male HT 1 * White Male HM 2 * Indian Female HT 1 * Indian Female HM 1 * Black Male HT	13.33% n = 4 2 * White Female HT 1 * White Male HT 1 * White Male HM	13.33% n = 4 3 * Black Female HT 1 * Black Female HM

Please note: ABBREVIATIONS

HT = Heterosexual

HM = Homosexual

Thus, some 27% of the sample classified their social group as being at high risk of HIV infection, almost 47% reported that their social group at least risk of HIV infection, 13% did not place their social group in either category (high or low risk), and a further 13% did not complete this section, reporting that one could not classify a group as being at high or low risk of HIV infection simply according to their social group categorisation but rather by the risk behaviours and activities being performed.

As mentioned in the discussion of the instruments used in this HIV/AIDS questionnaire survey, the Build-A-Character questionnaire was used as a tool for triangulation so as to indicate the degree to which the participants reliably held the belief that certain people are socially represented as being at high risk of HIV infection.

The following table offers a frequency breakdown of the type of character they constructed in the Build-A-Character questionnaire in relation to the group they indicated as being at highest risk of HIV infection in the Perceptions of HIV Questionnaire.

TABLE 11: Triangulation of persons considered to be at high risk

TRIANGULATION	RELIABLE	SEMI-RELIABLE	ONLY BUILD-A-CHARACTER
FREQ	23 (76.67%)	3 (0.1%)	4 (13.33%)

In terms of the placement of the participants into the described groups for Thematic Content Analysis, it may be of value to provide further details of the information that arose in the triangulation process (of information obtained in the Build-A-Character Questionnaire).

- 23/30 (76.67%) of the participants reliably created an HIV+ character according to the group that they indicated as being at highest risk for HIV infection.

- 3/30 (0.1%) of participants created characters as being different from the group that they stated was at highest risk of HIV infection. However, when they described how their character became infected, 1/3 described their character as being infected by the character indicated as belonging to the high risk group and 2/3 described that the character they created infected an individual that belongs to the group that they indicate as being at highest risk of HIV infection. It is interesting to note that in all three of these instances, no matter the manner in which one looks at it, a Black, male, heterosexual infects a Black female (according to the characters created in this questionnaire).

- 4/30 (13.33%) of the participants chose not to select a group as being at highest or at least risk of HIV infection in the Perceptions of HIV questionnaire yet they selected to complete the Build-A-Character questionnaire. Each of these participants highlighted that they were creating a character that they considered to be at low risk of HIV infection to stress their feelings that anyone can be at risk of HIV infection. They all created an HIV+ White, female, heterosexual. In doing so, they revealed their social representation of HIV even more so than the other respondents because they contradicted their indicated feelings that everyone is at risk only to create a character based on their opinion that this group is at low risk.

The results from each item of the Perceptions of HIV Questionnaire will now be presented, all the while bearing in mind the impact of the dominant social representations of HIV/AIDS in the formation of these perceptions. While the results are elaborated upon after each table of results, the findings are to be discussed in great detail in the following discussion chapter.

TABLE 12: Item #1: Origins of HIV/AIDS (n = 30)

THEME	HIGH	LOW	OTHER	NO CATEGORY	DESCRIPTION	EXAMPLE	FREQ
No Response	4	3	1	2	Item was not answered	X	10 (33%)
Africa	0	8	2	0	Statements that represent the belief that AIDS originated and spread from the Northern parts of Africa.	"Congo (DRC) from monkeys in the caves and forests that people ate"	10 (33%)
USA/ Gay Community	3	3	0	0	Statements that reflect the belief that AIDS originated in the USA and/or homosexual men.	"It first appeared amongst homosexual men in San Francesco"	6 (20%)
Conspiracy	1	0	1	2	Statements that indicate the belief that a certain group created and spread AIDS to oppress another group.	"I have heard that the USA mutated SIV in apes and spread it to their POWs to wipe them out"	4 (14%)

One third of the sample chose not to respond to this item. A further third of the sample reported that HIV/AIDS originated from Africa, 20% expressed that it originated in the USA amongst the homosexual population, and some 13% said that HIV originated as a man-made weapon to mass-murder the populations being attacked during periods of war.

TABLE 13: Item #2a: Group at highest risk of HIV infection (n = 30)

GROUP	BLACK FEMALE HT	BLACK FEMALE HM	BLACK MALE HM	WHITE FEMALE HT
HIGH	8	0	0	0
LOW	5	6	3	0
OTHER	3	1	0	0
NO CATEGORY	0	0	0	4
TOTAL	16 (53%)	7 (23%)	3 (10%)	4 (14%)

Over 50% of the participants expressed that the group that is at highest risk of HIV infection in South Africa was Black Female Heterosexuals, with over half of these responses coming from Black Female Heterosexuals themselves. Some 23% responded that it was Black Female Homosexuals that were at highest risk of HIV infection, 3% saying that Black Male Heterosexuals, 10% stating that Black Male Homosexuals, and 13% that White Female Heterosexuals were at highest risk of HIV infection. As mentioned earlier, this 13% that described White Female Heterosexuals as being at highest risk of HIV infection did not explicitly report this in the Perceptions of HIV Questionnaire, choosing to state that one's social/biological category does not place individuals at high or low risk of HIV infection. However, they did select to create a HIV+ character on the Build-A-Character Questionnaire. This character was a White Female Heterosexual, and the reason provided as to why they created this character, was that they wanted to highlight how everyone could be at risk of HIV infection, even White Female Heterosexuals. In offering this reason, these participants expressed (indirectly) that White Female Heterosexuals are socially represented as being at least risk of HIV infection.

Thus, the dominant social representation is that HIV/AIDS targets Black Females (Heterosexuals more so than Homosexuals) but that in general the Black community is likely to fall victim to the HI virus.

The tables that follow offer the reasons for these perceptions.

TABLE 14: Item #2b: Reasons for BLACK FEMALE HETEROSEXUAL (n = 16)

TABLE 14.1: HIGH GROUP (n = 8)

THEME	EXAMPLE	FREQUENCY
Fragile anatomy	"Women have more fragile private parts, making them prone to infections"	1 (12.5%)
Lack of Knowledge resources	"There is information lacking in the Black community because of Apartheid"	3 (37.5%)
Gender Power Dynamics	"Black men wont wear condoms and their partners don't have the power to ask them to"	2 (25%)
Transactional Sex	"They have to have more than partner for the sake of money and other necessary things"	2 (25%)

This group reported that their own social category was at highest risk of HIV infection, predominately for socio-economic factors that lay beyond their control. These include the gender issues that Black Female Heterosexuals have to endure, as well as the social effects that result in this group not having access to information or resources that would reduce their risk of HIV infection.

TABLE 14.2: LOW GROUP (n = 5)

THEME	EXAMPLE	FREQUENCY
Immoral Culture	"It is in their culture to be promiscuous and they choose not to be educated about HIV/AIDS"	1 (20%)
Gender Power Dynamics	"Black men dominate black women by raping them etc"	3 (60%)
Majority in South Africa	"They are the largest grouping South Africa, meaning they will have the most number of infections"	1 (20%)

The reasons provided by the group that considered themselves to be at LOW RISK of HIV infection offered some similar themes (compared to the HIGH RISK group) as to why Black Female Heterosexuals are at high risk of HIV infection, however, the reasons to support these themes are condemning in their assignment of blame in the sense that these Black Female Heterosexuals actively resist placing themselves at risk of HIV infection. Rather than considering the social, political, and economic factors that may contribute to the statistics that support that fact that this group is in fact at high risk of HIV infection, the reason offered in this item resort to placing this group at a naturally inferior position.

TABLE 14.3: OTHER GROUP (n = 3)

THEME	EXAMPLE	FREQUENCY
Gender Power Dynamics	"Black females are most likely to get raped or forced to have unprotected sex"	3 (100%)

Again, the theme of gender inequalities and gender violence is highlighted as the primary reason as to why Black Female Heterosexuals are at highest risk of HIV infection as compared to any other social group.

TABLE 15: Item #2b: Reasons for BLACK FEMALE HOMOSEXUAL (n = 7)

TABLE 15.1: LOW GROUP (n = 6)

THEME	EXAMPLE	FREQUENCY
Fragile Anatomy	"Because women's sex organ are internal and cannot be cleaned after homosexual sexual contact"	3 (50%)
Lack of Protection	"Black lesbians don't use protection because they don't worry about falling pregnant"	2 (33.33%)
Rumour turned into fact	"That is just what I have heard"	1 (16.67%)

Half of the participants stated that is the nature of sexual contact in combination with the fragile anatomy of the Black Female Homosexual that places members of this group at highest risk of HIV infection. Additionally, the fact that condoms are not used as there is no concern for pregnancy is a contributing factor to the belief that this group is at highest risk of HIV infection. Statistically, Heterosexual females are at least risk of HIV infection due to the sort of sexual contact that minimises the exchange of bodily fluids, yet it is evident that the representation of HIV being a homosexual related disease still persists.

TABLE 15.2: OTHER GROUP (n = 1)

THEME	EXAMPLE	FREQUENCY
Lack of Protection	"Black lesbians don't use protection because they don't worry about falling pregnant"	1 (100%)

The notion that Black Female Homosexuals are at highest risk of HIV infection is the primary theme amongst the group that classified a different group to their own as being at highest risk of HIV infection.

TABLE 16: Item #2b: Reasons for BLACK MALE HOMOSEXUAL (n = 3)

TABLE 16.1: LOW GROUP (n = 3)

THEME	EXAMPLE	FREQUENCY
Immoral Culture	"It is in their nature to live sinful lifestyles by being promiscuous"	2 (67%)
Lack of Education	"They are uneducated about the virus and so don't know not to have unprotected sex"	1 (33%)

Some 67% of the sample cited that there are factors in the African culture that makes the Black Male Homosexual at highest risk of HIV infection. The cultural factors are described in an essentially negative light and viewed as being innate to the Black Male Homosexual, with 33% considering the social factors (like the lack of education) that may place this group at high risk of HIV infection.

TABLE 17: Item # 3a: Group at Least risk of HIV infection (n = 26)

GROUP	N	INDIAN FEMALE HT	INDIAN FEMALE HM	WHITE MALE HT	WHITE MALE HM	WHITE FEMALE HT
HIGH	8	4	0	4	0	0
LOW	14	3	1	2	1	7
OTHER	4	4	0	0	0	0
TOTAL	26	11 (42%)	1 (4%)	6 (23%)	1 (4%)	7 (27%)

42% of the sample reported that Indian Female Heterosexuals are at least risk of HIV infection, with approximately 27% believing that White Female Heterosexuals, 23% White Male Heterosexuals, and about 4% thinking that Indian Female Homosexuals and White Male Homosexuals, being at least risk of HIV infection.

TABLE 18: Item #3b: Reasons for INDIAN FEMALE HETEROSEXUALS

(n = 11)

TABLE 18.1: HIGH GROUP (n = 4)

THEME	EXAMPLE	FREQUENCY
Asexual	"They are less sexually orientated and have less sex drive than any other race"	3 (75%)
Marry within race group	"They are not allowed to marry outside their race so there is less risk of being infected"	1 (25%)

The reasons offered that support the opinion of those who classified their own social group as being at highest risk of HIV infection, that Indian Female Heterosexuals are at least risk of HIV infection, range from the restrictive culture that limits the sort of people with whom sexual activities that can be undertaken to the fact that Indian people in general are asexual as they do not have strong sexual urges.

TABLE 18.2: LOW GROUP (n = 3)

THEME	EXAMPLE	FREQUENCY
Restrictive Culture	"They are very conservative and high morals are valued in their culture and religion"	3 (100%)

Each of the Indian Female Heterosexual participants who classified there own group as being at least risk of HIV infection reported that it was their moral culture that encouraged low-risk behaviour that did not put them at risk of HIV infection.

TABLE 18.3: OTHER GROUP (n = 4)

THEME	EXAMPLE	FREQUENCY
Asexual/ Restrictive Cultural	"Because they are very religious and so sex is frowned upon because they think it is a sin"	4 (100%)

100% of the participants failing to classify their social group as being at high or low risk of HIV infection, said that Indian Female Heterosexuals are at least risk of HIV infection because of their moral obligations entrenched in their cultural upbringing, which in turn resulted in a lack of interest in sexual activities that reduced the risk of infection.

TABLE 19: Item #3b: Reasons for WHITE MALE HETEROSEXUAL (n = 6)

TABLE 19.1: HIGH GROUP (n = 4)

THEME	EXAMPLE	FREQUENCY
Superior Anatomy	"Their physical makeup of their sex organs hinder the transmission of the HI virus during sex"	1 (25%)
Superior Culture	"White men are more in control, more informed and their family unit means that their parents talk them about sex from a young age"	3 (75%)

Of the participants who classified their social category as being at high risk of HIV infection and felt that White Male Heterosexuals were at least risk of HIV infection, 75% said it was because of their culture and the associated benefits that White Male Heterosexuals were at least risk of infection, with 25% stating that it was the nature of their anatomy that reduced the risk of HIV infection.

TABLE 19.2: LOW GROUP (n = 2)

THEME	EXAMPLE	FREQUENCY
Socially Privileged	"We are better educated and can make more informed decisions"	1 (50%)
Moral	"We are upper-class, live clean lifestyle"	1 (50%)

Each of the White Male Heterosexuals, who classified their group as being at least risk of HIV infection, expressed that it was because of this groups' social standing and moral behaviour that reduced their risk of HIV infection.

TABLE 20: Item #3b: Reasons for WHITE FEMALE HETEROSEXUAL (n = 7)

TABLE 20.1: LOW GROUP (n = 7)

THEME	EXAMPLE	FREQUENCY
Moral	"We take better care of our bodies by not being promiscuous"	3 (43%)
Othering	"It is just opposite to who I think is at highest risk"	4 (57%)

Almost 60% of the White Female Heterosexuals who classified their own group as being at least risk of HIV infection reported that they simply did not fall into the high risk group (othering) while just over 40% stated that it was their morality in not being sexually promiscuous that reduced their risk of HIV infection.

TABLE 21: Item #3b: Reasons for INDIAN FEMALE HOMOSEXUAL (n = 1)

TABLE 21.1: LOW GROUP (n = 1)

THEME	EXAMPLE	FREQUENCY
Restrictive Culture	"The culture is very strict about being not being promiscuous"	1 (100%)

This participant classified her group (Indian Female Homosexual) as being the group at least risk of HIV infection, citing the strict culture that did not tolerate promiscuous behaviour as the primary reason for the reduced risk of infection.

TABLE 22: Item #3b: Reasons for WHITE MALE HOMOSEXUAL (n = 1)

TABLE 22.1: LOW GROUP (n = 1)

THEME	EXAMPLE	FREQUENCY
Superior Anatomy	"We are able to wash our genitals after sex"	1 (100%)

This participant (White Male Homosexual) reported that his group was at least risk of HIV infection because of the design of their sexual organs that allowed for hygienic practices after sexual contact.

While some of the responses given as to why a certain group is at high or low risk may appear to be contradictory or not be factually correct, the reasons are nonetheless valid to those who hold these socially represented stereotypes. The interest lies in the highly evident "othering" process in classifying the Black community as being at high risk of HIV infection and the identity protective manner in which participants justify why their social group is at least risk of HIV infection.

TABLE 23: Item #4a: The continuation of high-risk behaviour despite HIV awareness programmes (n = 30)

GROUP	N	YES	NO
HIGH	8	8	0
LOW	14	14	0
OTHER	4	4	0
NO CATEGORY	4	4	0
TOTAL	30	30 (100%)	0

100% of the participants felt that people continued to participate in high risk behaviours even though they may be aware of the risks involved with regards to HIV transmission.

The table on the following page offers a list and description of the themes extracted from the explanations provided by the participants as to why they believe that young adults in South Africa continue to participate in high risk behaviours while being aware of the risk of HIV infection associated with such behaviours.

TABLE 24: Item #4b: Reasons for this high risk behaviour (n = 30)

THEME	HIGH	LOW	OTHER	NO CATEGORY	DESCRIPTION	EXAMPLE	FREQ
Immune to infection	3	7	2	2	Statements that reflect the sense of denial or invincibility regarding HIV infection.	"People still think that it will never happen to them"	14 47%)
Lack of protection	3	0	1	0	Statements that reveal the lack of condom usage for various reasons.	"People don't want to use condoms because it shows that you don't trust your partner, it kills the mood, or girls are not assertive enough to ask their partners to use condoms"	4 (13%)
Influence substances	2	2	0	0	Statements that indicate that alcohol or drugs impact on decision-making to avoid low risk behaviours.	"As long as there are substances that cloud judgement, people will take risks without considering the consequences"	4 (13%)
Instant Gratification	0	5	1	2	Statements that show unconcern for the impact of HIV infection.	"When people want to have sex it is in that moment, they want pleasure now and HIV takes 10 or 20 years to kill you"	8 (27%)

TABLE 21 reveals that 47% of the sample believes that most people feel immune to HIV/AIDS because of the 'othering' process. 27% believes that the need for instant gratification outweighs the fear of HIV/AIDS because death is not an immediate threat. Some 13% expressed that people choose not to use condoms (that will reduce the risk of HIV infection) for a number of reasons, ranging from wanting to trust one's partner to not having the social power to negotiate condom usage. A further 13% expressed that the use of alcohol and chemical substances impair cognitive functioning to the degree that individuals are unable to make decisions that avoid high-risk behaviours.

TABLE 25: Item #5: Predicting the AIDS situation in South Africa (n = 30)

GROUP	POSITIVE	NEGATIVE
HIGH	5	3
LOW	4	10
OTHER	2	2
NO CATEGORY	2	2
TOTAL	13 (43%)	17 (57%)

The participants were virtually equal in terms of the positive and negative predictions for the future of South Africa with regards the HIV/AIDS infection rate and the hope for a cure for AIDS in the future.

The following tables reveal the extracted themes according the statements that reflected a positive future and those that predicted a negative future for South Africa in terms of HIV/AIDS.

TABLE 25.1: Reasons for POSITIVE PREDICTION (n = 13)

THEME	HIGH	LOW	OTHER	NO CATEGORY	DESCRIPTION	EXAMPLE	FREQ
Decrease in number of new infections because of increased awareness	3	2	1	1	Statements that indicate that with the increase of awareness campaigns that there will be a reduction on new HIV infections.	"There will be less infections as people continue be educated and aware of how to protect themselves"	7 (54%)
Cure	2	2	1	1	Statements that reveal the hope for a cure for AIDS.	"There are so many people working in the AIDS field, they are bound to find a cure"	6 (46%)

Of the sample that predicted a positive future in South Africa regarding the HIV/AIDS pandemic, half felt that the hope rested with education in creating awareness of HIV/AIDS so that people will take the appropriate measures to reduce their risk of infection, while the other half expressed a hope for a cure of HIV/AIDS.

TABLE 25.2: Reasons for NEGATIVE PREDICTION (n = 17)

THEME	HIGH	LOW	OTHER	NO CATEGORY	DESCRIPTION	EXAMPLE	FREQ
Dramatic increase in number of new infections	2	2	1	2	Statements that predict a general increase in HIV infections.	"There will be a huge increase in the number of HIV infections across South Africa"	7 (41%)
Restricted to Black population	1	8	1	0	Statements that reflect the belief that the increase in HIV infections will be restricted to the Black population in South Africa.	"Over 80% of the Blacks will be wiped out, while the other groups will stay the same or even decrease"	10 (59%)

Almost 60% of the participants who predicted that there could only be a negative future for South Africa in terms of the AIDS pandemic said that this was because there would be an increase in HIV infections amongst the Black population (the majority in South Africa) and that there will be a massive reduction in the size of this population. Some 41% of these participants, on the other hand, expressed that there would be a dramatic increase in new HIV infections across all social groups and this would have devastating effects on the economy of South Africa.

TABLE 26: Item #6: Knowing a person with HIV (n = 30)

GROUP	YES	NO
HIGH	7	1
LOW	5	9
OTHER	0	4
NO CATEGORY	2	2
TOTAL	14 (47%)	16 (53%)

Half of the sample knew someone who had been infected with HIV. Almost 90% of the HIGH GROUP knew some who had been infected with HIV, whilst only 36% of the LOW GROUP knew a person infected with HIV, 100% of the OTHER GROUP has never known a person infected with HIV, and 50% of the NO CATEGORY GROUP knew someone infected with HIV.

BUILD-A-CHARACTER FINDINGS

The Build-A-Character Questionnaire was a useful tool in the investigation of the dominant social representations of HIV in South Africa as it was reported as being a novel experience, a creative task that afforded the participants the opportunity to express their opinions in a fresh and imaginative manner.

As discussed in Chapter 2, the primary purpose of including this instrument was to act as a tool for triangulation with regards to the response to Item #2a of the Perceptions of HIV Questionnaire that asked the participants to indicate which social group they considered to be at highest risk of HIV infection and compared this response to the type of character created in the Build-A-Character Questionnaire.

Furthermore, this questionnaire included a final item that required the participants to report as to how the character became infected with HIV. The table below provides an indication of the themes and description of the reasons offered by the student sample, as to what causes HIV infection.

TABLE 27: Item #9: Reasons as to why individuals become infected with HIV (n = 30)

THEME	HIGH	LOW	OTHER	NO CATEGORY	DESCRIPTION	EXAMPLE	FREQ
Promiscuity	0	8	4	3	Statements that report promiscuous sexual behaviour as being the cause of HIV infection.	"She slept around until she slept with this guy who was infected"	15 (50%)
Sexual Violence	2	2	0	0	A statement indicating that HIV infection was a result of a sexual assault by an infected man.	"She was gang raped in the township and the guys were HIV+"	4 (14%)
Transactional Sex	3	0	0	0	A statement reflecting that infection is a result of transactional sex between one woman and multiple men.	"She has sex with all the men in the community in exchange for money and other things, otherwise she wouldn't be able to survive"	3 (10%)
General Sexual Contact	0	4	0	0	Statements that regard any sexual contact as the cause of HIV infection.	"She got HIV from sex"	4 (13%)
Accidental Exposure	1	0	0	0	Statements that reveal that HIV was contracted through a medical needlestick injury"	"He was a brilliant doctor until he accidentally got stuck with an infected needle"	1 (3%)
Sexual contact with unfaithful infected partner	2	0	0	1	Statements that indicate that HIV infection occurs when one's partner is unfaithful.	"Her boyfriend was promiscuous but she never knew. She trusted him"	3 (10%)

Half of the participants believed that promiscuity would result in HIV infection. 13% expressed that sexual contact in any form would be the likely reason for a person contracting HIV. 10% reported that having an unfaithful partner, with whom one does not use condoms during sexual activity because of trust in each other's fidelity, would be the primary cause for HIV infection. A further 10% indicated that transactional sex, where a woman has to rely on material and financial benefits in exchange for sexual favours with various men, was a primary cause of HIV infection. 3% reported that accidental exposure to HIV such as needlestick injuries in the medical profession, caused most of the current HIV infections, and 14% indicating that sexual violence such as rape, was the chief cause of HIV infections.

One should bear in mind that over 60% of these characters created were Black Female Heterosexuals thus; the majority of the reasons offered in the table above pertain to the causes of HIV infections amongst Black Female Heterosexuals. The finding of interest at this stage is the general comparison of the reasons for infection provided by the HIGH GROUP (n = 8 Black Female Heterosexuals) with the reasons offered by the other GROUPS. 100% of the HIGH GROUP provided socio-economic factors and misfortune as the causes of HIV infection, while the other GROUPS provided reasons that indicate promiscuous, immoral sexual behaviour as being the primary cause that places Black Female Heterosexual at highest risk for HIV infection.

Each of the reasons offered by the NO CATEGORY GROUP pertained to HIV infections of White Female Heterosexuals, chosen by this group to prove that social classification does not dictate risk to HIV infection. 75% of the reasons offered as to why White Female Heterosexuals would contract HIV indicated that promiscuous, immoral sexual behaviours were the main cause.

PRACTICES RELATING TO HIV & RISK ASSESSMENT FINDINGS

The following results are representative of the responses to the Practices relating to HIV & Risk Assessment Questionnaire.

TABLE 28: Item #1a: Self-risk assessment (n = 30)

RISK	HIGH GROUP (n = 8)	LOW GROUP (n = 14)	OTHER GROUP (n = 4)	NO CAT GROUP (n = 4)	FREQUENCY
NONE	3 (38%)	4 (29%)	1 (25%)	1 (25%)	9 (30%)
LOW	5 (62%)	8 (57%)	2 (50%)	2 (50%)	17 (57%)
MEDIUM	0 (0%)	2 (14%)	1 (25%)	1 (25%)	4 (13%)
HIGH	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

None of the sample reported that they were at high risk of HIV infection. More than half of the sample indicated that they were at low risk of HIV infection, 30% expressed that there was no risk of them contracting HIV, and 13% stated that they were at medium risk of HIV infection.

The HIGH GROUP reported that they were at no risk (38%) or low risk (62%) of HIV infection. None of the participants of this group expressed that they were at medium or high risk of HIV infection though they had identified their social group as being at highest risk of HIV infection.

The LOW GROUP expressed that they were at no risk (29%), low risk (57%), and medium risk (14%) of HIV infection. Thus, more than half of this group reported that they were at low risk of HIV infection, which is congruent with the response given in Item #2a of the Perceptions of HIV Questionnaire that their social group was at least risk of HIV infection. The OTHER GROUP as well as the NO CATEGORY GROUP

indicated they were at no risk (25%), low risk (50%), and medium risk (25%) of HIV infection.

TABLE 29: Item #1b: Reasons for risk assessment (n = 30)

TABLE 29.1: NO RISK (n = 9)

THEME	HIGH	LOW	OTHER	NO CATEGORY	DESCRIPTION	EXAMPLE	FREQ
Combination of low-risk behaviours	1	1	0	1	Statements that indicate the use of protection, being monogamous, and having been tested.	"I have been tested, I have only one partner and we are both faithful and use condoms regularly"	3 (33%)
Not Sexually Active	2	3	0	0	Statements that express the absence of sexual activity as a reason for no risk of HIV infection.	"I am not sexually active and intend to wait for marriage"	5 (56%)
Contradictions	0	0	1	0	Statements that do not indicate low-risk behaviours.	"I often use protection with all partners, they seem healthy but I don't know their status"	1 (11%)

Over half of the participants reported that they had no risk of HIV infection because they have never been sexually active. One third of the respondents expressed that the fact that they practiced a combination of low-risk behaviours regarding their sexual activities, put them at no risk of HIV infection. 11% reported that they were at no risk of HIV infection yet the reasons provided to support this self assessment are contradictory to this rating as the behaviours reported would classify them as being at high risk of HIV infection.

TABLE 29.2: LOW RISK (n = 17)

THEME	HIGH	LOW	OTHER	NO CATEGORY	DESCRIPTION	EXAMPLE	FREQ
Not sexually active but acknowledge that no one is immune	2	3	0	1	Statements that indicate that participant practices low-risk behaviours but acknowledges that external factors could place them at risk.	"I am not sexually active but work as a paramedic and so there is some risk of infection. Also you never know… you could get raped etc."	6 (35%)
Combination of low-risk behaviours	1	3	0	1	Statements that indicate the use of protection, being monogamous, and having been tested.	"My one partner and I are mutually faithful and use protection"	5 (29%)
Not Sexually Active	0	1	1	0	Statements that express the absence of sexual activity as a reason for low risk of HIV infection.	"I choose not to have sex at the moment"	2 (12%)
Contradictions	2	1	1	0	Statements that do not indicate low-risk behaviours.	"I don't have sex with various partners and they are always people I trust so I wont have to worry about condoms"	4 (24%)

Most of the participants (35%) reported that they were not sexually active but they acknowledge that since no person can be sure that they at no risk of HIV infection (due to external factors i.e. rape or accidental exposure to HIV) they rated themselves as being at low risk for HIV infection. 29% cited their low-risk sexual behaviours as the reason for expressing that they are at low risk for HIV infection. 24% of the participants provided reasons that contradict the understanding of what constitutes low-risk behaviour by reporting that they actually participate in rather high-risk sexual behaviours but that they still did not consider themselves to be at high risk of HIV infection. 12% of the participants simply reported that they were not sexually active and this placed them at a low risk for HIV infection.

TABLE 29.3: MEDIUM RISK (n = 4)

THEME	HIGH	LOW	OTHER	NO CATEGORY	DESCRIPTION	EXAMPLE	FREQ
Acknowledgement of potential high-risk behaviours	0	0	1	0	Statements that indicate that participant acknowledges potential high-risk behaviours.	"I have not taken this thing seriously at all. I never thought that I could be at risk so I never use protection etc."	1 (25%)
Some low- and some high-risk behaviours	0	1	0	1	Statements that indicate that no protection is used with sexual partner/s.	"I am faithful to my partner but I don't use protection, which is bad"	2 (50%)
Combination of relatively low-risk behaviours but acknowledge that no one is immune	0	1	0	0	Statements that express the practicing of low-risk sex behaviour but acknowledge the external factors that may result in HIV infection.	"My partner and I are both loyal but it is always possible to get raped etc."	1 (25%)

50% of the participants in this group stated that it the lack of protection during sexual activity with their usual sexual partner placed them at medium risk for HIV infection. 25% acknowledged that they did partake in high-risk behaviours (yet they did not classify themselves as being at high risk for HIV infection, rather selecting to rate their risk for infection as being medium risk). The remaining 25% cited that they practiced some low-risk sexual behaviour but the concern of external causes (rape or accidental exposure to HIV) prevented them from selecting a lower risk assessment.

TABLE 30: Sexual Status according to group (n = 30)

GROUP	N	ACTIVE	NOT ACTIVE
HIGH	8	5 (63%)	3 (37%)
LOW	14	8 (57%)	6 (43%)
OTHER	4	4 (100%)	0 (0%)
NO CATEGORY	4	2 (50%)	2 (50%)
TOTAL	30	19 (63%)	11 (37%)

More than 60% of the student sample is sexually active, with 63% being in the HIGH GROUP, 57% being in the LOW GROUP, 100% being in the OTHER GROUP, and 50% being classified as being in the NO CATEGORY GROUP. The following table investigates if being sexually active impacts on the belief regarding the usage of condoms during sexual activity.

TABLE 31: Item #2a: Belief in condom usage (n = 30)

GROUP	ACTIVE		NOT ACTIVE	
BELIEF	YES	NO	YES	NO
HIGH	2	3	2	1
LOW	2	6	2	4
OTHER	3	1	0	0
NO CATEGORY	0	2	1	1
TOTAL	7 (37%)	12 (63%)	5 (45%)	6 (55%)

Over 60% of the sexual active sample felt that condoms were not necessary during sexual activity, while slightly more than half of the sample who is not sexually active expressed that was unnecessary to use condoms. Thus, the overall report was that 60% of the total sample did not think that condoms were necessary during sexual activity.

TABLE 32: Item #2b: Reasons for this belief (n = 30)

TABLE 32.1: Reasons for belief that condoms are necessary [ACTIVE (n = 7)]

THEME	HIGH	LOW	OTHER	NO CATEGORY	DESCRIPTION	EXAMPLE	FREQ
Mistrust of partner	2	2	3	0	Statements that indicate that one should not simply trust one's partner.	"You never know what your partner does behind your back."	7 (100%)

All of the sexually active participants who felt that condoms should be used during sexual activity indicated so because they believed that one's health should take priority over trusting the loyalty of one's partner (in terms of fidelity and verbal report on HIV status).

TABLE 32.2: Reasons for belief that condoms are necessary [NOT ACTIVE (n = 5)]

THEME	HIGH	LOW	OTHER	NO CATEGORY	DESCRIPTION	EXAMPLE	FREQ
Protection of health in general	2	1	0	0	Statements that reflect that measures should always be taken to protect one's health.	"It's good to protect your health."	3 (60%)
Mistrust of partner	0	1	0	1	Statements that indicate that one should not simply one's partner.	Even committed couples can't be sure that partner will stay faithful.	2 (40%)

60% of the sample that is not sexually active and who felt that condoms should always be used during sexual activity expressed this as one should always follow the necessary measures to protect one's health regardless of the situation. The remaining 40% reported that one should not rely on one's partners' fidelity when it comes to one's own health and the prevention of STIs and HIV.

TABLE 32.3: Reasons for belief that condoms are not necessary [ACTIVE (n = 12)]

THEME	HIGH	LOW	OTHER	NO CATEGORY	DESCRIPTION	EXAMPLE	FREQ
Trust	3	3	1	1	Statements that indicate that when there is trust one does not need a condom.	"When you have love and trust condoms are not necessary"	8 (68%)
Other forms of Birth-Control	0	1	0	1	Statements that reflect the opinion that birth control is a greater concern than STIs or HIV infection.	"If you are on the pill, you don't need a condom"	2 (16%)
Limited to Promiscuous People	0	2	0	0	Statements that regard promiscuous individuals as being the only ones who would need condoms.	"Condoms should be used by people who are loose"	2 (16%)

Almost 70% of the sexually active participants who believed that condoms were unnecessary for sexual activity indicated that trust replaced the need to ask one's partner to use a condom. 16% reported that pregnancy was a greater concern than HIV infection thus; other forms of birth control were used in favour of the condom. A further 16% felt that only promiscuous individuals needed to use condoms, inferring that individuals in committed relationships did not require the use of condoms (linking repetitively to the notion of trust within the sexual relationship.

TABLE 32.4: Reasons for belief that condoms are not necessary [NOT ACTIVE (n = 6)]

THEME	HIGH	LOW	OTHER	NO CATEGORY	DESCRIPTION	EXAMPLE	FREQ
Trust	0	2	0	0	Statements that indicate that when there is trust one does not need a condom.	"I love and trust my boyfriend, so condoms are not necessary"	2 (33%)
Other forms of Birth-Control	0	0	0	1	Statements that reflect the opinion that birth control is a greater concern than STIs or HIV infection.	"If you are concerned about pregnancy you can use the pill"	1 (17%)
Limited to Promiscuous People	1	2	0	0	Statements that regard promiscuous individuals as being the only ones who would need condoms.	"Sex should only be within marriage, so condoms are not necessary"	3 (50%)

50% of the participants who are not sexually active and who thought that condoms are not necessary in a sexual relationship reported this because they believed that sexual intercourse should be reserved for marriage, in which case a condom was not necessary in a relationship of that level of commitment. Each of these participants had expressed that the reason for them abstaining from sexual contact was because of their commitment to remain virgins until they are married. 33% expressed that trust within a sexual relationship meant that one did not need a condom. 17% felt that birth control was the primary concern in a sexual relationship thus; condoms were unnecessary if other forms of birth control were being utilised.

TABLE 33: Item #3: Been tested for HIV (n = 30)

TESTED	N	YES	NO
ACTIVE	19	9 (47%)	10 (53%)
NOT ACTIVE	11	1 (9%)	10 (91%)
TOTAL	30	10 (33%)	20 (67%)

Some 67% of the total sample had never been tested to discover their HIV status. Almost half of the sexually active participants had been tested for HIV, while less than 10% of the participants who are not sexually active had been tested for HIV infection. This may led to the conclusion that it is perceived by the majority of the participants that the primary cause of HIV infection was via sexual contact, and for those who are not sexually active, there lies no reason to be tested for the presence of the HI virus.

TABLE 33.1: Tested for HIV according to groups (n = 30)

GROUP	ACTIVE (n = 19)		NOT ACTIVE (n = 11)	
TESTED	YES	NO	YES	NO
HIGH	4 (80%)	1 (20%)	0 (0%)	3 (100%)
LOW	4 (50%)	4 (50%)	1 (17%)	5 (83%)
OTHER	0 (0%)	4 (100%)	0 (0%)	0 (0%)
NO CATEGORY	1 (50%)	1 (50%)	0 (0%)	2 (100%)
TOTAL	9 (47%)	10 (53%)	1 (9%)	10 (91%)

80% of the sexually active participants who classified their social group as being at highest risk of HIV infection had been tested for the presence of the HI virus. None of the participants in this group who were not sexually active had been tested for HIV.

Half of the sexually active participants who classified their social group as being at least risk of HIV infection had been tested for HIV. Only 17% of the participants in this group who were not sexually active had been tested for HIV infection.

All of the participants, who failed to classify their social group as being at highest- or at least risk of HIV infection, were sexually active, and none of them had been tested for the presence of the HI virus.

Half of the sexually active participants who did not select any group as being at highest or least risk of HIV infection had been tested for HIV. None of the participants in this group who were not sexually active had been tested for HIV.

Please note that the following results were obtained only from the participants who expressed that they are currently or have ever been sexually active. Thus, the sample size was reduced quite dramatically (n = 19) and so further discussion of the participants' responses to the Practices relating to HIV & Risk Assessment Questionnaire in terms of any quantitative statistical analysis is meaningless.

TABLE 34: Item #4a: Do you use a condom during sexual activity? (n = 19)

GROUP	N	CONDOM USAGE	
PRACTICE		YES	NO
HIGH	5	2	3
LOW	8	2	6
OTHER	4	3	1
NO CATEGORY	2	0	2
TOTAL	19	7 (37%)	12 (63%)

63% of the sexually active sample does not use condoms during sexual activity.

40% of the HIGH GROUP uses condoms during sexual activity, 25% of the LOW GROUP, 75% of the OTHER GROUP use condoms, and none of the sexually active who were allocated to the NO CATEGORY GROUP use condoms during sexual activity.

The following tables provide a list and description of the themes extracted from the reasons provided for the use (or lack thereof) of condoms during sexual activity.

TABLE 35: Item #4b: Why?

TABLE 35.1: Reasons for using condoms (n = 7)

THEME	HIGH	LOW	OTHER	NO CAT	DESCRIPTION	EXAMPLE	FREQ
Fear of Pregnancy	2	0	2	0	Statements that indicate that condoms are used as a birth control measure.	"I am terrified of falling pregnant"	4 (57%)
Fear of HIV/STI infection	0	2	1	0	Statements that reflect that condoms are used to prevent STI/HIV infection.	"I don't want to have to worry about diseases and infections later"	3 (43%)

Some 57% of the sample who use condoms during sexual activity expressed that they chose to do so out of a fear of pregnancy as a result of the sexual encounter. All the HIGH GROUP members and 67% of the OTHER GROUP cited this as their reason for using a condom during sexual activity.

43% of these participants responded that they chose to use condoms during sexual activity to avoid HIV/STI infection that may result from the sexual encounter. All of the LOW GROUP members and 33% of the OTHER GROUP members stated that this was their primary reason for using condoms.

TABLE 35.2: Reasons for not using condoms (n = 12)

THEME	HIGH	LOW	OTHER	NO CAT	DESCRIPTION	EXAMPLE	FREQ
Other Birth Control Measures	2	2	1	1	Statements that indicate that other birth control methods are used in favour of condoms.	"I use the pill so that we don't have to be concerned with condoms"	6 (50%)
Trust in Partner	1	4	0	1	Statements pivoting around notions of love and trust that emerge in a committed intimate relationship.	"I trust and love my boyfriend, we are 100% faithful to each other"	6 (50%)

Half of the participants who do not use condoms during sexual activity reported that the other forms of birth control that were used replaced the need for condom usage. This indicates again that the fear of pregnancy is greater than the concern of HIV/STI infection. The other 50% of this sample reported that their love and trust in their partners afforded them the peace of mind that they would not have to be concerned with issues of HIV/STI infection thus, a condom was no longer necessary within the sexual relationship.

TABLE 36: Item #4c: If you do use a condom, who initiates the use of a condom in your relationship? (n = 7)

PERSON	HIGH	LOW	OTHER	NO CATEGORY	FREQ
Yourself	1	1	1	0	3 (43%)
Your partner	0	0	0	0	0 (0%)
Both	1	1	2	0	4 (57%)

In the case of most of the participants (57%) who used condoms during sexual activities, both partners took that responsibility to initiate the use of the condom. The remaining 43% reported that they themselves were the ones who bore the responsibility of initiating condom usage, while none of the participants relied on their partners alone to initiate condom usage.

TABLE 37: Item #5: Would you reveal your HIV status to your partner if you were found to be HIV+? (n = 19)

RESPONSE	HIGH	LOW	OTHER	NO CATEGORY	FREQUENCY
NO	1	0	1	0	2 (11%)
YES	4	8	3	2	17 (89%)

Almost 90% of the sexually active participants expressed that they would tell their partners if they were to discover that they were infected with HIV. 11% admitted that they would not tell their partner about their HIV status if they had been tested and found to be HIV+. These participants were from the HIGH and OTHER GROUPS.

TABLE 38: Item #6a: Do you have more than one sexual partner? (n = 19)

RESPONSE	HIGH	LOW	OTHER	NO CATEGORY	FREQUENCY
NO	4	6	3	2	15 (80%)
YES	1	2	1	0	4 (20%)

80% of the participants reported that they have only one current sexual partner and 20% admitted that they have more than one current sexual partner.

TABLE 39: Item #6b: Do you think your partner has other sexual partners? (n = 19)

RESPONSE	HIGH	LOW	OTHER	NO CATEGORY	FREQUENCY
NO	4	7	3	2	16 (84%)
YES	1	1	1	0	3 (16%)

Some 84% of the partners believed that their partners did not have any other sexual partner, while 16% reported that they either knew for certain or suspected that their sexual partners had other sexual partners. Of these participants who believed that their partners had other sexual partners, 75% of these participants had admitted that they have more than one current sexual partner.

CHAPTER NUMBER FOUR - DISCUSSION

INTRODUCTION

This research piece was dedicated to discovering the dominant social representations of HIV in South Africa in relation to the knowledge, perceptions and practices held by young South African adults (mean age 20.72 and standard deviation 2.72). 200 individuals participated in this study by completing the self-administered questionnaire (n = 170 completed the HIV Knowledge & Understanding section only and n = 30 completed the entire survey). This chapter of this research study discusses the findings presented in tabular form in the previous chapter. The findings are discussed according to each questionnaire completed by the participants; however, some of the variables discussed are linked via the understanding of the connection of the factors in HIV Knowledge, Perceptions and Practices in relation to the social representations of HIV/AIDS.

HIV KNOWLEDGE & UNDERSTANDING

Based on the results obtained from the various statistical analyses performed on the data from the HIV Knowledge & Understanding Questionnaire, as expected, it was revealed that the level of knowledge regarding the HI virus, casual and sexual transmission of HIV, and methods of HIV prevention, are relatively high in the student sample participating in this study.

Some 1% of the sample answered less than half of the HIV Knowledge & Understanding Questionnaire correctly. This may be as a result of these participants having relatively low knowledge regarding the various aspects of HIV/AIDS or other reasons not foreseen or accounted for such as deliberate misrepresentation or misreading or questions. 17% of the sample answered 92% of the questionnaire correctly, and 10% answered the entire questionnaire correctly. Thus, the Total Knowledge Scores for this questionnaire produced a skewed distribution as most of the sample scored highly on this instrument.

As expected, there was no statistical difference between the level of HIV knowledge across gender, sexual orientation, and race. While one may have expected there to be some difference in the scores of the participants who have actually known a person infected with the HI virus, due to the impact in the direct contact with the effects of such an infection (which would of course, depend on the nature and degree of the interpersonal contact) the nonparametric Two Independent Sample T Test indicated that there was no difference between these groups. This may be because of the various aspects involved in the individuation of the person who has been infected with HIV, whereby the respondents can no longer identity with the person who is infected with HIV as this person does not conform to the ideology of the group in providing positive group identity, or that the person would seek to avoid contact with this person for fear of the disease (as the virus being an evil perpetrator that attacks the innocent), resulting in no further assimilation of information regarding HIV/AIDS.

This same analysis revealed there was a statistical difference between the levels of HIV knowledge across the Year of Study and the Degree being completed. This may be due to the fact that at the university where this study took place (University of the Witwatersrand) the Psychology students in their third year of study complete a Health Psychology course where HIV/AIDS is discussed in great detail. Additionally, those students completing their BSc degree have to take a compulsory course of Introductory Microbiology (Virology) where the biology of the HI virus is discussed at length. These factors may be pivotal in producing the difference in HIV Knowledge & Understanding scores between the Year of Study and Degree variables, and while there may have been other degree components present, these factors were limited to this sample in particular.

Item #26 indicated that the source of HIV information utilised by the participants the most appears to be the written media (40%) and TV (24%). The sources used least often are the church (< 1%) and none of the participants rely on their siblings for information regarding HIV/AIDS. While a one-way nonparametric ANOVA was performed in investigate if there were any differences in the level of HIV knowledge possessed by the participants according to the source relied upon (and the result was that there was no difference in the level of HIV knowledge according to this variable)

one would have to be cautious in interpreting this result because of the reduced group size per each of the nine groups.

While one would expect no difference in the level of HIV knowledge across the various groups, it would be expected (as indicated by the findings) that people would rely on more scientifically credible sources, such as the factual information provided in the written media or presented on television, as opposed to talking to one's peers or family. Responses to risk and even health knowledge at times, has nothing to do with awareness of "expert" vs. "lay" knowledge, rather preference, and this is intrinsic to cultural contexts. It is also possible that HIV/AIDS has been represented and internalized as a "medical" and "expert" domain of understanding and analysis. Thus, information about sex, etc. is shared in a peer or informal group setting while information regarding STI's and HIV is provided through an "other" medium (such as television or other media, health professionals). An additional feature of the media is the individualization of mass education regarding HIV. The information is presented in a way that highlights the personal control and power of the individual in choosing health and health related behaviours that will minimize the risk of HIV infection.

Although the KAP model is a widely acknowledged phenomenon in the field of health, there appears to be a fundamental gap in our current understanding of people's behaviour regarding HIV, when one attempts to account for a crisis in the translation of knowledge into health-related behaviours (Jarvis, 2003). This is a contradiction that is worth exploring a bit further through a theoretical engagement on the understanding of health related behaviour and perception of risk of infection. It may very well be that the more people know about the nature and severity of HIV infection, the more fearful they become of it, which further encourages and maintains the "other" social representation of HIV (Broekmann, 1997).

HIV KNOWLEDGE & UNDERSTANDING FINDINGS AND SOCIAL REPRESENTATIONS OF HIV/AIDS

The items that had a low correct response rate (Item #4, 8, 13, 24) pivot around notions of HIV infection being a punishment of immoral sexual behaviour or that HIV is an evil perpetrator that seeks out innocent victims, bringing death and suffering to the infected.

In terms of the items concerned with casual transmission of HIV, the majority of the respondents possessed the knowledge that one could not become infected with HIV through the use of the same public facilities or through casual contact. This result indicates that HIV education has shifted the social representation of HIV from being a socially contagious disease to one that is separate to its victim – by virtue of the fact that the public has been encouraged to consider PLWHAs as firstly being people, who happen to be infected with the HI virus rather than simply being HIV infected people. However, many of the negative views of HIV transmission reflect partial biological knowledge about HIV transmission and the beliefs regarding this has spread to related indigenous, cultural concepts of illness, healing, contagion and the body (e.g., transference of bodily substances). This may be the basis for the low correct response rate for Item #8 regarding the Mother-To-Child-Transmission resulting in automatic HIV infection in the infant, as AIDS has the ability to evoke an irrational fear that AIDS is the evil perpetrator and will find a way to harm even the innocent.

In relation to some of the interesting responses in the other HIV instruments, it is necessary to highlight the possible social representations that may be hindering the translation of HIV knowledge into low-risk behaviours. This will be discussed under the headings of the various other questionnaires, while bearing in mind the high correct response rate in the HIV Knowledge & Understanding Questionnaire.

The responses to Item #1, regarding the origins of AIDS, may have been greatly influenced by the mass media. One third of the sample chose not to respond to this item. There may be various reasons for this, least of which may be that there has been no real scientific, factual information that could offer individuals the answer to this question. It is suspected that AIDS was first recognized as a disease in 1981. The virus was isolated in 1983 and was ultimately named the human immunodeficiency virus (HIV). There are two forms of the HIV virus, HIV-1 and HIV-2. The majority of cases worldwide are caused by HIV-1. In 1999 an international team of genetic scientists reported that HIV-1 can be traced to a closely related strain of virus, called simian immunodeficiency virus (SIV), that infects a subspecies of chimpanzee (*Pan troglodytes troglodytes*) in W central Africa. Chimpanzees are hunted for meat in this region, and it is believed the virus may have passed from the blood of chimpanzees into humans through superficial wounds, probably in the early 1930s (Hare, 2004).

A further third of the sample reported that HIV/AIDS originated from Africa, 20% expressed that it originated in the USA amongst the homosexual population, and some 13% said that HIV originated as a man-made weapon to mass-murder the populations being attacked during periods of war. It is of interest to note that none of the participants expressed that AIDS may have originated in South Africa or in sub-Saharan Africa, where the number of HIV/AIDS infections are the highest in the world, indicating that there is an element of 'othering' in terms of assignment of blame for the origins of this virus i.e. that South Africa (or sub-Saharan Africa) was NOT the location where the virus originated from. By 'othering' HIV, one is able to maintain a sense of immunity and positive group identity. However, an alternative explanation to this finding is that people have the ability to critically assess information provided by the mass media and not necessarily have reported their beliefs about the origins of AIDS based on blame assignment, as human beings have the capacity for active engagement with knowledge to some degree.

In terms of indicating which social group was at highest risk of HIV infection, more than half of the sample identified Black Female Heterosexuals as being the group at highest risk of infection. Both the HIGH and LOW GROUPS identified the gender inequalities that place all females at a higher risk of HIV infection than males. In many regions around the world, gender discrimination is persistent, affecting all aspects of the lives of women and girls. Its powerful influence on a young girl's life is evident as the families decide whether their daughters should attend school or not, as many poverty-stricken families believe educating their girls is money and time wasted, and that such practices go against the grain of culture that dictate appropriate sex-roles of dominance and submission. A husband may request that his wife submit to him sexually and refuse to use protection during sexual intercourse even though he is aware that he is HIV+. While the wife may be sexually faithful to her husband yet gets infected with HIV from him due to his infidelity, her husband is often unsupportive (Ahsan, 2002).

In some cultures, powerful norms about masculinity discourage condom use and encourage sexual risk-taking by men such as having multiple sex partners. Having female conquests, engaging in unprotected sex, and fathering babies are important gender role expectations amongst males that may influence sexual behaviour and attitudes regarding behaviour changes (Malebranche, 2003). Many young men will adopt risk-taking sexual behaviours despite awareness of HIV and STI risk, in pursuing an ideal of masculinity. Further exploration of these dynamics is needed to explain the gap between HIV knowledge and behaviour. In Africa especially, social and cultural norms (particularly gender norms) often discourage people from using condoms even when they are aware that they are at high risk of contracting HIV (Waldby, 1996). Women still do not have equal economic or educational or occupational or social options- men have greater power than women, and the imbalance in power negatively affects women's abilities to prevent being infected with HIV and other STD's.

Some of the problems directly facing women in the fight against AIDS are the extraordinarily high rape statistics in South Africa and the continued disempowerment of women, especially relating to sexual and reproductive rights, particularly in male-dominated cultures. Women cannot request, let alone insist on using a condom or any form of protection. In many sub-Saharan African countries, myths and misconceptions persist in the belief that having sexual intercourse with a virgin is a method of curing AIDS; this results in countless brutal and violent sexual crimes against infants and young girls. Norms encourage men to take sexual risks and also discourage women from questioning their partners about sexual activity. Many wives fear that asking to use condoms would provoke their husband to accuse them of infidelity, to react violently or abandon them (Ahsan, 2002).

23% of the respondents indicated that Black Female Homosexuals were at highest risk of HIV infection. The participants who responded in this manner, categorized themselves as being White Female Heterosexuals (29%), White Male Heterosexuals (42%), and Indian Female Heterosexuals (29%), indicating that while this group is rather diverse, none of the respondents themselves classified themselves as Black Female Homosexuals, or Black Homosexual, regardless of gender. AIDS is often anchored to homosexuality as the initial constructions of AIDS converged on the first-identified risk group: homosexuals. An exploratory label for the syndrome in the early 1980's was GRIDS (Gay-Related Immunodeficiency Syndrome), and the media reports illustrated HIV/AIDS as "the gay plague" (Gilman, 1988).

While various other high-risk groups have in the interim been acknowledged, AIDS has remained tied to concepts of homosexuality, and, more loosely, 'improper and unnatural' sexual behaviour. Time is the supreme constraint for human being making sense of the world. This could be the reason why almost one quarter of the participants clung to the past notion that HIV was a 'black' or 'gay' disease, and simply merged these two separate social representations into one that 'fits' the current statistical trend that Black Females are at highest risk of HIV infection, and anchored this to a new understanding of HIV – that it is a Black Female Homosexual disease. This has been statistically proven to not be the case. The potential explanation for this is discussed in some detail below.

This also indicates that AIDS has been socially represented through the objectification process of personification, whereby AIDS is implicitly associated with a particular group. HIV/AIDS has been personified through the association with Black South Africans because of the prominent featuring of Black individuals infected and affected by HIV in the media. Social depictions of the virus as being a 'Black disease' may supply non-Black individuals with a degree of comfort as they believe that they will be spared from infection, regardless of any high-risk behaviours. This may be the reason that only eight Black Female Heterosexuals reported that their social group was at highest risk of HIV infection. This may imply that there is some degree of self-group stereotyping at play at this point. This is indicated by the self-risk assessment whereby these participants rated themselves as being at no or low risk of HIV infection yet indicated that their social group was at highest risk of HIV infection. This may indicate that self-individuation whereby those who classify their social as being at high risk of HIV yet they do not identify with these members.

It is quite evident in the interpretation of the Item #2a and Item #3a, that 'othering' is the primary anchor in operation as 60% of the participants sought to maintain a positive group identity by rating some other social group as being at highest risk of HIV infection, and 47% of the participants went as far as to identify their own social group as being at least risk of HIV infection. The reasons provided by those who identified 'the other' as being at highest risk of HIV infection described 'the other' as a group with various damaging associations: homosexual, drug addict, immoral and promiscuous, the uneducated and dirty. At different points in time (and perhaps even presently to some degree) these have been social representations of HIV/AIDS.

The participants in the LOW or OTHER GROUP describe 'the other' at the level of being innately, naturally, and culturally inferior, dooming the group considered to be at highest risk of HIV infection to an inescapable fate. The eight participants in the HIGH GROUP who identified their social group as being at highest risk of HIV infection, offered socio-political reasons (such as inequalities of the past years of Apartheid, which placed them at a socio-economic disadvantage and continues to dictate their behaviours for survival e.g. transactional sex that places them at high risk for HIV infection yet ensures their economic survival) that shift the negative

association of HIV away from the innately positive traits of the group. On the other hand, the LOW GROUP then offered innately superior cultural/biological traits as the reasons for why their groups are at least risk of HIV infection (e.g. that their cultural encourages "moral" sexual behaviour by having the family unit teach the children control and restraint regarding sexual contact).

All of the participants indicated that they believed that young adults continued to practice high-risk behaviours even though they are aware of the risk of HIV infection associated with these behaviours. The reasons offered to support this opinion range from people believing that they are immune to HIV infection, the psychosocial rejection of condom usage, the impact of substance abuse on decision-making, and the need for instant gratification and the pursuit of pleasure over-riding the concern of HIV infection. HIV is not perceived as being an immediate threat to young adults as a person can live for over 20 years without any sign of illness, making the seriousness of the disease easier to deny.

A primary contradiction arises when the participants are asked to predict the future of the AIDS pandemic in South Africa in 10 years time. Approximately half of the participants predicted a positive and half predicted a negative future in South Africa. 50% of those who predicted a positive future believed that there would be decrease in the number of HIV infections as there is an increase in education and HIV awareness. However, all the participants had just expressed the belief that young adults continued to practice high-risk behaviours regardless of the amount of knowledge and awareness of the disease that they may have. This may reflect the social representation that HIV is an evil perpetrator that causes violent harm, which cannot be contained simply by human force but that some salvation will appear to relieve the pandemic. Or it might imply a 'belief' in knowledge and awareness, as Piaget may have addressed in his understanding of assimilation i.e. "How do we make sense of contradictory evidence?" as opposed to the understanding of the role of anchoring in attitude and belief formation of HIV/AIDS in relation to the dominant social representation of HIV/AIDS.

The remaining 50% believed that a cure will be discovered in the near future, even though there was an understanding that no cure for HIV/AIDS exists at this time (Item # 7 in HIV Knowledge & Understanding Questionnaire).

Based on the statements of hope in this item, one would expect the psychological and social representations on HIV/AIDS to shift and transform over time as access to ART's (possibly being a main agent of change) increases and media representations of the disease change with the social climate. AIDS may than be anchored to the metaphor of manageable disease, and with that re-shaping the manifestations of the cognitive and emotional reactions to the disease and the people infected with HIV. AIDS is associated with death, suffering and pain, as it has been represented for the larger part of the past two decades. With the improvements of modern science and medicine, there lies a faint thread of hope for a cure to be found for HIV infection, and linked to this hope is a representation of salvation and, according to the participants' responses, it seems to be of paramount importance to the disintegration of the prejudice and stigmatisation of PLWAs.

The 50% that predicted a negative future regarding the AIDS pandemic reported that this would be due to a dramatic increase in HIV infections amongst the general population (41%). The participants describe the future as being filled with death and suffering for those infected by the HI virus. When the anchor of AIDS is death it is because AIDS is by and large characterised as being an inescapably fatal syndrome. This finding again indicates that the attitudes and perceptions that people hold regarding HIV/AIDS, is mediated by the social representations of HIV/AIDS through the media.

This also indicates that AIDS had been socially represented through the objectification process of figuration, which implies that notions of HIV/AIDS are transformed into metaphorical images. Thus, any of the anchors for AIDS mentioned in the literature review can be turned into lucid images. AIDS patients are often represented pictorially as corresponding with depictions of suffering, death, and poverty. Although it is doubtful that the media intends to promote this kind of distance by objectifying AIDS, it does seem unavoidable: images of people who are HIV+, and especially those who are visibly sick, cannot dodge putting the HIV-

negative viewer and the people being depicted, on opposite sides of the boundary between health and HIV infection.

59% reported that this increase in HIV infections would be confined to the black population. This again reflects the notion that AIDS is a "Black disease".

CHARACTERISATION OF HIV INFECTION

The Build-A-Character instrument provided the participants the freedom of honestly expressing their socially valid representations of HIV by creating a fictitious character that is infected with HIV. The majority of the items were used to cross-validate the opinions expressed in the Perceptions Questionnaire but additional items were included to investigate the social representations of HIV with regards to the cause of HIV infection. The majority of respondents thought that HIV/AIDS infection is a result of punishment for immoral behavior (e.g. improper sexual relations and drug use). Three quarters of the respondents also thought that that PLWHA become infected as a result of their willing involvement in unacceptable or "bad" behavior, and so are responsible for contracting the illness.

There is often a frequent and inevitable inclination in the conceptualisation of diseases such as AIDS, as there is a shift from the demonisation of the disease to the demonisation to the people who become infected with the disease. Many people view AIDS as a disease that is controllable by its victims. As a result, people infected with HIV are seen as being responsible for their own hardship.

While the media may often be careful not to assign blame to AIDS victims (by providing a wide variety of "real life" stories [documentaries] about the social conditions and limited options available to the many people who discover that they have become infected with HIV), the images and descriptions of the people infected with HIV themselves are enough to create the social representations of HIV and the types of people who are considered to be at high of infection and send a message of blame. Even HIV awareness campaigns may be responsible for this notion by virtue of the fact that condoms are punted as being the primary resource to be used in the

prevention of HIV infection. If this is the primary understanding of HIV prevention (without the contextual understanding of cultural and gender-related issues of condom usage in South Africa), then the assignment of blame originates from the notion that HIV infection or prevention is within the individuals' control and that actually they 'selected' to become infected by not using a condom during sexual activity.

PRACTICES RELATING TO HIV & RISK ASSESSMENT QUESTIONNAIRE

The participants' self-risk assessment provided further evidence that the social representations of HIV/AIDS produce the denial of susceptibility to the disease regardless of the potential high-risk behaviours at play. 30% of the sample indicated that they were at no risk of HIV infection, 57% saying that they were at low risk, and 13% reporting that they were at medium risk of HIV infection. None of the participants indicated that they were at high-risk of HIV infection. This could be a result of their "individualizing" risk-behaviour as opposed to group presentation of risk of HIV infection.

37% of the sample reported that they were not sexually active and intended to reserve sexual intercourse for marriage, and that they also do not participate in any other high-risk behaviours. 45% of these participants rated themselves at no risk and 55% at low risk of HIV infection. The anchor of AIDS being a punishment for evil or sin exists because traditionally, unusual and sinister events have repeatedly been rationalised by making reference to God's punishment to mankind. It could be because of this mindset that it has been considered that pandemics of dreaded afflictions trigger an uproar against tolerance, which is viewed as condoning immoral and punishable behaviour. It may appear as though those who are not sexually active and who rated themselves at no risk of HIV infection may believe that by abstaining from sex until marriage, they will receive the reward of being certain that they will never become infected with HIV. This interpretation is supported by the numerous quotes that highlighted that these participants did not consider the past sexual behaviour of their partners but rather focused on their dedication to abstinence as placing them at no risk of HIV infection e.g. "I am at no risk for HIV infection because I am saving myself for marriage, so I know that we will be bringing that into

our marriage. We will never have to worry about using condoms or things like that, by avoiding the sins of premarital sex; we will deserve the benefit of never having to worry about diseases like this [HIV/AIDS]".

60% of the respondents think that it is unnecessary to use a condom during sexual activity, which contradicts Item #10 and Item #21 on the HIV Knowledge & Understanding Questionnaire where these respondents indicated that it is necessary to use a condom even with one's usual sexual partner, as it reduces the risk of HIV infection. This opinion was justified with notions of trust in one's partner to remain faithful, the fact that other methods of birth control were being used, and that condom usage was perceived as being reserved for those who are promiscuous. The fact that the participants revealed that they are more concerned with avoiding pregnancy rather than avoiding HIV infection, yet did not consider themselves to be at high risk for HIV infection, contradicts the high correct response rate to Item #17 on the HIV Knowledge & Understanding Questionnaire, where participants indicated that they understood that oral contraceptives did not protect a women from HIV infection. These statements are again related to the "othering" of people who should be concerned with the risk of HIV infection as well as the anchoring of the condom within the sexual relationship.

Those who believed that condoms should always be used during sexual activity (40% of sample) reported this opinion because trust that one's partner would not infect you with STI/HIV was not enough of an assurance and that it was one's primary responsibility to protect one's health. The anchoring of AIDS to metaphors of contamination and pollution imply the degeneration of the soul due to sexual fault. By using a condom during sexual activities, one reduces the risk of contamination and may avoid being associated with immoral acts e.g. "By using a condom, you are protecting your health because there is no way for the dirt or poison of whatever disease your partner may be carrying of getting into your body. If you never get an STI or fall pregnant (and if you use a condom, you never will), then no one will ever know what you get up to!"

33% of all the participants had not been tested regarding their HIV status. More than half of the sexually active participants had not been tested and still none considered themselves to be at high risk for HIV infection. 91% of the participants who are not sexually active had not yet been tested for HIV infection. This indicates that HIV/AIDS is associated with sexual activity and that those who abstain from sexual intercourse are exempt from HIV infection. Voluntary counseling and testing (VCT) is not a magic bullet.

Evaluations of VCT programmes have consistently concluded that HIV testing was never intended to stand alone as a prevention intervention. To be effective, testing must comprise one part of a larger portfolio of HIV prevention services. Just as counsellors must link HIV+ clients to clinical services providing "combination therapy", high-risk HIV- clients must be connected to "combination prevention" services such as ongoing individual or group counselling. Unfortunately, many of these complementary prevention services were never implemented because of funding restrictions imposed on explicit safer sex workshops targeting high-risk populations such as sexually active individuals not using protection, injection drug users, etc. As a result, media campaigns promoting HIV prevention have tended toward euphemistic vagueness, emphasizing abstinence, monogamy, and routine HIV testing (Joffe, 1998). Current models of VCT are unlikely to have an impact on HIV prevention and actually may contribute to the trend toward complacency about HIV infection among populations that test routinely. New approaches to VCT clearly are needed because people will continue to seek testing. But these must be supplemented with other services such as individual and small group counselling, community organizing, and other interventions that have proved effective.

The anchor of AIDS being a Sexually Transmitted Disease (STD) stems from early medical conceptualisations of AIDS revealed that while HIV could be transmitted in a number of ways, the primary mode of transmission was identified as being through sexual contact (Gilman, 1988). If considered accurately, this disease could have been categorised in many number of different ways, however, it was not simply characterised as a viral disease (Hepatitis B) but specifically as a sexually transmitted disease (Syphilis). Thus, HIV/AIDS adopted the conceptualisation that is an extension of the social constructions of syphilis and other STDs, meaning that the

sexually promiscuous are the carriers of this disease and that if one is sexually conservative, one will be spared from infection.

Perhaps, in order to understand the social representations (constructions) of HIV/AIDS, we need to understand the social constructions of "risk". The most common ways of addressing the notion of risk are the realist and cognitive science perspectives (Lupton, 1999). The cognitive science approach combines the notion of danger with the "accurate and objective" calculation of probability. However, this approach fails to address how risks are constructed as social facts and does not acknowledge the subjective facet of human evaluation of risk. Thus, the social representations of various phenomena, which cause human evaluations of risk to be biased, are largely neglected in this perspective. An alternative perspective is social constructionism, which considers the social and cultural aspects of risk. The implication of this perspective is that human subjectivity, with notions of choice, responsibility and blame, whereby there is a dialectical relationship between humans and their social world. Thus, all knowledge and evaluations regarding risk is linked to the socio-cultural context from where the knowledge is generated, making both expert and lay knowledge equally valuable as human knowledge is never neutral (Lupton, 1999).

The sort of metaphor of victim and perpetrator draws lines between the innocent and enemies. The person who becomes infected with HIV becomes the AIDS victim, and AIDS the evil perpetrator. The most interesting dimension of this study was revealed in the analysis of condom usage amongst the student population. Less than 40% of the sexually active participants use condoms during sexual activity. This may be because of the dynamic that exists in a sexual relationship when one would use a condom. The condom is protection, protection against one's partner. The individual becomes the victim and one's partner becomes the perpetrator, the partner becomes AIDS. One chooses to not look at one's partner as being all the "bad" things that AIDS is and so to avoid this ideologic strain, one will remove the cause of this anchor, the condom, and replace it with notions of trust and emotional trust in one's partner to prevent HIV infection.

This links to the responses to Item #25 in the HIV Knowledge & Understanding Questionnaire, where participants indicated that being faithful to one partner reduces the risk of HIV infection. However, trust in one's partner and their fidelity rests on the physical appearance of the partner. Item #18 on the HIV Knowledge & Understanding Questionnaire reveals that the participants understand that a person with HIV may still appear to be healthy, yet they place their faith in their partners' appearance of health as a sign of their fidelity. However, 11% of the participants indicated that they would not reveal their status to their partners, should they ever discover that they are HIV+.

These participants may have not been able to even consider this option (as they reported that they only had one current partner - with whom they did not use protection - and that they believed that their partners were completely faithful to them). The combination of these factors allow for these individuals to deny their susceptibility to HIV infection as they did not meet the socially represented criteria for those considered to be at high-risk of HIV infection.

Remaining with this line of thought, 20% reported that they had more than one current sexual partner and of these 16% indicated that they believed that their partners had several other sexual partners. While 80% of these participants reported that they used condoms during sexual activity, each of them considered to be at low risk of HIV infection. Their level of HIV knowledge was relatively high (mean Total Knowledge Score 75%, n = 5), yet it is evident that the social representations involved in characterising which groups of people are at high risk of HIV infection, act as hindrance to individuals who are not within that group classification to accurately identify their risk of HIV infection due to their high-risk behaviours.

RECOMMENDATIONS

This study has produced some valuable findings that support the following recommendations for future research studies in this area as well as recommendations for the direction of current HIV awareness programmes targeting tertiary education level South African adults.

While knowledge of the HI virus, its modes of transmission and methods for prevention of HIV infection is rather high in this particular group, there remains a need for aggressive awareness, educational and advocacy programmes to inform and educate members of society about HIV/AIDS in a manner that is free from the existing negative social representations of AIDS. Piaget's suggestion of "dis-equilibrium" in order for learning to occur is potentially a highly useful alternative to the current educational HIV programmes (Sternberg, 2003).

Piaget identified the mind as having structures which he named schemas the mental counterparts of biological means of adapting. When a child is born they have few schemata, but as a child develops, his/her schemata gradually become more generalized, more differentiated and progressively more adult. These schemata never stop developing or becoming more refined. According to Piaget, assimilation, accommodation, and equilibrium interact to form the foundation for intellectual growth (Sternberg, 2003).

Adaptation is the process of adjusting these mental structures (schemata) to cope with the child's environment. It involves two parts, assimilation and accommodation. Assimilation involves the process of fitting new information into existing cognitive structures. Accommodation involves adjusting mental structures to cope with new information when assimilation doesn't work and therefore develops a new concept (Sternberg, 2003).

People will continue to assimilate till it no longer works, putting them into a state of disequilibrium, which is not a liked state. This then leads to equilibration, which is the process of making it right. This is done via accommodation, and puts the individual into a state of equilibrium (Sternberg, 2003). However, this doesn't last long and the individual will continue accommodating as they come across new

environmental information (stimuli). This process basically leads to a more effective way of processing information regarding HIV/AIDS.

Thematic content analysis of open-ended items of the Perceptions of HIV Questionnaire suggested that participants anchored their understanding of HIV infection in the social domain rather than the psychological. It is proposed that HIV awareness programmes would benefit from a greater understanding of the social context of sexual health, and that social representations theory provides a useful framework with which to achieve this.

Perhaps information on the progression of HIV, especially its long periods of latency and inactivity before symptoms of AIDS appear, needs to be emphasized in the new "dis-equilibrium educational programmes" as individuals cling to the notion that the appearance of physical health allows them to deny that their selected sexual partner simply cannot be an HIV carrier. It is interesting that images of health and vigor have been represented not only as the ideal, but also representations of health in relation to HIV infection. It is thus ironic that HIV awareness programmes ask people to reject this understanding i.e. they are asked to pursue the image of health but not to trust this image when selecting a sexual partner, as once again attitudes towards HIV/AIDS are informed by the social representations of HIV.

Social Representations Theory shows how is it possible for individuals to have contradictory perceptions regarding the same issue i.e. that there is hope for HIV awareness programmes to reduce the rate of new HIV infections in the future, yet these programmes are currently failing to yield this result. It indicates how people reflect certain social representations according to their existing belief structures, regardless of the contradictory nature of these reflections. Thus, they may reflect accurate objective HIV/AIDS facts as indicated by the media and educational programmes at a particular time (e.g. people infected with HIV may still look healthy) but reveal the contradictory social representation at another moment (e.g. physical health is the ideal that we should pursue). Therefore, educational programmes should look to create mass dis-equilibrium by shattering the core belief that physical health is the ideal and therefore is disease-free, by having the media represent people who are

infected with HIV as being the picture of health. This may cause people to react to this dis-equilibrium by reconstructing their understanding of HIV/AIDS and risk.

The media should increase the amount of coverage on the potential for PLWAs to have a long and productive life with the increased roll out of ARTs, and PLWAs should perhaps be involved in the design and delivery of these programmes so as to lay testimony to the shift of the social representations of AIDS as becoming a manageable chronic disease.

HIV awareness programmes are perceived by young adults as being "boring and over done". In response to this perception, the programmes should be provided at various levels of society and specifically targeted to young adults, and perhaps more importantly, the social representations of sub-cultures, who cognitively cope with more details and a deeper understanding of how the virus operates within their specific social contexts. These programmes should be delivered in a manner that directly targets the existing negative social representations of HIV/AIDS (which render current HIV awareness and education programmes ineffective) so as to improve the transition of accurate HIV knowledge into low-risk health-related behaviours.

This study considers some collective South African community dynamics of peer influence, empowerment and self-efficacy, perceived personal vulnerability and knowledge of the HI virus and the disease, to be key contributing factors that determine the adoption of safe sexual behaviours. Gender-equality awareness should be incorporated into life skills training programmes to persuade people to value basic human dignity and respect between individuals irrespective of gender, culture and race. HIV/AIDS awareness programmes should focus not only on information regarding the disease but also tackle societal issues concerning assertiveness training and sexual negotiation skills.

It is partly due to the negative social representations regarding HIV/AIDS as well as the misconceptions of sexual behaviour that HIV infection rates continue to increase. Educators have the unique opportunity to discuss topics of an intimate nature in a professional setting with young people who need to hear the facts about HIV/AIDS but in a way that targets the subjective experiences of the various sub-cultures and their social representation of HIV/AIDS. The goal of teaching safer sex is to provide not only information, but also counselling to help individuals or groups to make the most appropriate choices for risk reduction.

Traditionally, the critical study of health and social issues are limited to a positivist epistemology, however; critical approaches should challenge mainstream from different epistemological positions, as such using Social Representations Theory from a social constructionist interpretation. There are various aspects of context that social representations play a profound role i.e. the symbolic contexts of HIV stigma (mapping out the wider field of social representations within which stigma is located); the economic, political, and local community contexts within which these representations are constructed; and the organizational context of efforts to address HIV/AIDS in South Africa.

By understanding the social representations of AIDS, and people's associations with the illness, it can provide vital information about risk perceptions and related behaviour. This research stresses the role of social representations theory in society's understanding of how people transform information presented in media by informing people of science and creating issues. However, this relay of information creates complex notions of how in-groups and out-groups make sense of information on HIV/AIDS.

LIMITATIONS OF THIS STUDY

The use of students in a tertiary educational community in South Africa for the sample, limited the study in terms of population and ecological validity as it would be a highly complex to infer the results from this study to the general adult population in South Africa. To be more direct, there is poor external validity for this study.

It may have been useful to measure the respondents' attitudes towards PLWAs in general so as to gain additional information regarding their representations of those infected by the HI virus etc, however; due to time constraints and the research necessary at a Masters level, it was decided to omit this instrument.

The instruments used in this study were largely constructed using various other related HIV KAP questionnaires, making the reliability and validity of these instruments questionable. Even though this study proved these measures to be high in both reliability and validity, the ecological validity of these results should be explored in future studies. The instruments should be re-piloted and further refined to ensure that they yield meaningful results when used on various other target populations.
The Practices regarding HIV Questionnaire may have provided a limitation as the instrument only questioned the participants assuming that (if they were sexually active) they had a one usual partner and, due to the ethical constraints as well as avoiding items that would personally probe the participants on very intimate details (which may result in the participants being offended and choosing not to complete the questionnaire), it was decided to omit items that would question participants' more casual sexual behaviour. More interesting and valuable results may have emerged had participants been willing and able to offer information regarding the sort of sexual partners they select (in terms of social group categories etc.) and the reasons for this.

While the Build-A-Character Questionnaire may not be considered to be a scientifically sound psychological instrument, it was very useful as it adds a creative dimension to an otherwise "standard" data collection procedure. It afforded the participants the freedom and safety of expressing their honest beliefs about the sort of person who is likely to become infected with HIV as well as providing reasons that justify their opinions. This was a useful tool for triangulation of the answers provided

as to which social group is at highest risk for HIV infection in South Africa, further adding to the confidence of the psychometric qualities of the instruments that were modified for this study.

A prominent limitation of this study lays in the fact that one can never be certain to what degree (if at all) the participants identified themselves according to the social categories defined in the Perceptions Questionnaire. This may have a significant impact on the interpretation of the results of the various questionnaires according to the groups specified as being HIGH, LOW, OTHER, and NO CATEGORY GROUPS. Additionally, as with all questionnaires, these instruments assumed that the participants possessed the answers to these introspective items, however; the case may have been that the respondents have never considered why they hold the views that they do. It may have been useful to rely on follow up interviews to allow the participants time to consider their beliefs about people who they consider to be at high- and low risk of HIV infection and then afford them the opportunity to relay this new-found understanding.

The researcher undoubtedly believes that these instruments would have stimulated much thought and discussion among the participants, which in itself is a desired outcome. Nonetheless, due to the various time, financial, and ethical constraints of this study, the researcher decided not to perform individual interviews (or focus groups, which would have provided a dynamic setting for participants to express and absorb the various opinions offered in this social interaction) but it is recommended that future research include these forms of data collection so as to obtain richer data to answer these complex questions.

There may have been other theories, aside from Social Representations Theory, that may have been able to better explain inconsistencies. While it is beyond the scope of this chapter to explain and describe in any great detail the possible alternative theories that may have been useful as theoretical foundations for this study, this research piece acknowledges that psychodynamics, or evolutionary and psychobiological psychology, may have been effective alternatives to the Social Representations Theory utilized in this study.

FUTURE RESEARCH

The topic of HIV/AIDS and attitudes regarding sexual behaviour is highly personal and sensitive. Although the internal validity of the scales may be at acceptable levels, the responses may possibly be affected by social desirability and research topic bias. Research participants may have been unwilling to reveal certain perceptions and practices for fear of discrimination, as well as distrust or fear that this confidential information about their sexual behaviour or attitudes will be disclosed, or they may report what they think researchers want to hear. To solve these problems, future research should be conducted in environments that provide a more comfortable atmosphere in which to talk openly about sensitive sexual issues. Such research will ultimately guide the development of culturally and age appropriate assessment techniques.

Once the psychosocial variables involved in social issues such as the HIV/AIDS pandemic and the related concerns are better understood, further research can be done to create revised AIDS awareness and education programmes that can be explicitly directed to young adults within various sub-cultures, and so possibly be more effective in bringing about an understanding about the disease, which may hopefully aid in positive behavioural change that will curb the spread of HIV/AIDS. Experimental views of social psychology that incorporate intergroup dynamics in its account of perception of HIV/AIDS may be considered valuable in the investigation of young South African adults' reports as they share their knowledge and opinions of this disease, and their own perceived vulnerability to the disease. This study sought to initiate this investigation by focussing on the exploration of the social representations of HIV as a disease as well as the implications of these social representations on group identity and the formation of social representations of those groups who are considered to be at higher risk of HIV infection.

CONCLUSION

Human immunodeficiency virus is not just a ‘gay’ disease or a ‘black’ disease; it is an epidemic that affects all South Africans, whether directly or indirectly. The myths surrounding HIV, however, have remained pervasive in South African society. Representations, as perpetuated by much of the media, have contributed to a situation where there are widespread beliefs that only certain groups are at risk of HIV infection, and this may result in the socially represented stereotyping of people living with HIV/AIDS. Currently there is much “awareness” regarding HIV/AIDS but awareness cannot be equated with knowledge and understanding. While efforts are feverishly being made to provide South Africans with accurate HIV/AIDS information, it appears that culturally imbued knowledge and attitudes regarding this disease are not easily replaced. Rife ignorance and fear create an ideal breeding ground for stereotyping. This study sought to initiate the exploration for the field of social representations may be based on norms and narratives research in which one may explore the sense of identity in relation to the social environment and the dominant culture of that society in people’s description of health related behaviours and AIDS prevention.

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INFORMATION SHEET

Good day,

My name is Lynlee Howard; I am a Masters student in research psychology from WITS. I am conducting a research study in fulfilment of the requirements toward my degree.

The focus of my study is to investigate the level of knowledge regarding HIV transmission and prevention, and investigate self-risk perceptions of HIV infection among students at WITS. I am also investigating how young adults socially represent AIDS in South Africa. By completing this study I hope to then be able to add to the understanding of young people's knowledge, behaviour and attitudes regarding HIV.

I am therefore inviting you to participate in my study. I would like for you to be aware that **participation is completely voluntary and there will be no consequences if the decision is made not to participate**. Participation or non-participation will have no effect whatsoever on the outcome of your studies. If you choose to participate but then choose to withdraw from the study at any time, no questions will be asked. You may also omit answers to any questions that you do not feel comfortable answering. Please note that anonymity is guaranteed, as your name will not be written on the questionnaire. Furthermore, the questionnaires will be destroyed once data analysis is complete.

The questionnaire will take about 40 minutes to complete. I will be available during, and for 30 minutes after, the questionnaire is completed if you want to ask questions regarding my research, which I may be able to answer. Should you require any further information after completing the questionnaire, please feel free to contact me on (cell) 082 677 0696 or e-mail lynleehoward@hotmail.com. Should you require any assistance with regard to dealing with any issues or questions that arise after completing the questionnaire, the telephone number for loveLife is (011) 771 6800, where trained counsellors will eagerly assist you.

If you choose to be part of this study, please fill out this questionnaire given to you and then leave it in the box provided in the front of the lecture hall.

Thank you for taking the time to consider participating in my study.

Lynlee Howard - MA Psychology (by coursework and research report)
e-mail: lynleehoward@hotmail.com (cell) 082 677 0696

Department of Psychology
University of Witwatersrand.

INFORMATION SHEET

Good day,

My name is Lynlee Howard; I am a Masters student in research psychology from WITS. I am conducting a research study as I am conducting a research study in fulfilment of the requirements toward my degree.

The focus of my study is to investigate the level of knowledge regarding HIV transmission and prevention, and investigate any possible misconceptions about the virus that may exist among students at WITS. By completing this study I hope to then be able to add to the understanding of young people's knowledge, behaviour and attitudes regarding HIV.

I am therefore inviting you to participate in my study. I would like for you to be aware that **participation is completely voluntary and there will be no consequences if the decision is made not to participate**. Participation or non-participation will have no effect whatsoever on the outcome of your studies. If you choose to participate but then choose to withdraw from the study at any time, no questions will be asked. You may also omit answers to any questions that you do not feel comfortable answering. Please note that anonymity is guaranteed, as your name will not be written on the questionnaire. Furthermore, the questionnaires will be destroyed once data analysis is complete.

The questionnaire will take about 20 minutes to complete. I will be available during and for 30 minutes after the questionnaire is completed if you want to ask questions, which I may be able to answer. Should you require any further information after completing the questionnaire, please feel free to contact me on (cell) 082 677 0696 or e-mail lynleehoward@hotmail.com. Should you require any assistance with regard to dealing with any issues or questions that arise after completing the questionnaire, the telephone number for loveLife is (011) 771 6800, where trained counsellors will eagerly assist you.

If you choose to be part of this study, please fill out this questionnaire given to you and then leave it in the box provided in the front of the lecture hall.

Thank you for taking the time to consider participating in my study.

Lynlee Howard - MA Psychology (by coursework and research report)

E-mail: lynleehoward@hotmail.com (cell) 082 677 0696

Department of Psychology
University of Witwatersrand.

APPENDIX B

HIV/AIDS QUESTIONNAIRE SURVEY

- Please do NOT write your name on this form.
- Please answer all the questions to the best of your ability, however you may leave out answers to questions that you feel uncomfortable answering.
- If there is anything that is unclear or that you do not understand, please raise your hand and you will be assisted.

Thank you very much for your time and co-operation!!

APPENDIX C

DEMOGRAPHIC INFORMATION OF PARTICIPANT

Please note that the following data is for statistical purposes only and is not intended to be offensive.

1) Age:

2) Year of Study:

3) Degree currently being completed:

4) Gender: (Please mark one with an X)

❑ Male

❑ Female

5) Ethnic group/ Race: (Please mark one with an X)

❑ Black

❑ White

❑ Coloured

❑ Indian

❑ Asian

❑ Other

Please specify: _____

6) Sexual Orientation:

❑ Heterosexual

❑ Homosexual

❑ Bisexual

Please turn over this page and complete the questionnaire by marking with a cross (X) the answer that you find appropriate for each question and fill in the appropriate answer where necessary.

If you have any questions regarding the questionnaire or the research, please do not hesitate to ask me.

Thank you for your co-operation!!

APPENDIX D

HIV/AIDS KNOWLEDGE & UNDERSTANDING QUESTIONNAIRE

Statement	TRUE	FALSE
1. AIDS is caused by the Human Immunodeficiency Virus (HIV).		
2. A person can get HIV/ AIDS by sharing food and eating utensils with someone who has HIV.		
3. The HI virus can be transmitted via sexual contact with an infected person.		
4. You can get HIV by performing oral sex.		
5. HIV can be transmitted by donating blood to the SA blood transfusion services.		
6. HIV can be transmitted by sitting on a public toilet seat.		
7. AIDS can be cured by taking certain medications prescribed by doctors.		
8. A child born to an HIV infected mother will automatically be HIV+.		
9. Cleaning injection equipment with water is a good way of killing HIV.		
10. Transmission of HIV/AIDS can be prevented via the use of condoms during sexual activities.		
11. Mucous membranes in the anus are more delicate than the membranes in the mouth.		
12. HIV can be transmitted by mosquito bites.		

13. HIV antibodies can take up to 10 years to show.		
14. Someone can get HIV/AIDS by having one sexual encounter with an HIV infected person.		
15. During vaginal sex, it is easier for a woman to receive the HI virus than for a man.		
16. A hangnail is a potential route for HIV infection.		
17. A women using oral contraceptives as a method of birth control is protected against getting HIV/AIDS.		
18. A person who has HIV/AIDS might look healthy.		
19. Having a sexually transmitted infection (STI) increases your risk of getting HIV/AIDS.		
20. A healthy person cannot get HIV because of their strong immune system.		
21. People should use condoms even with their usual partner.		
22. Abstaining from any sexual contact is the most effective way of not becoming HIV+.		
23. Taking certain medications after sex will cure HIV infection.		
24. Having sexual intercourse less frequently may reduce your risk of becoming infected with HIV.		
25. Being faithful to one sexual partner reduces the risk of HIV infection.		

26. Source	**Please tick ONE.**
Where do you mostly get information about HIV/AIDS from?	
1. Your friends.	
2. Your brothers and/or sisters.	
3. Your parents.	
4. Your relatives.	
5. By reading newspapers and/or magazines.	
6. By asking health professionals.	
7. By taking note of information given on radio and/or television.	
8. Your University Lecturers/School Teachers	
9. Your church.	

APPENDIX E

PERCEPTIONS OF HIV QUESTIONNAIRE

Q1: Where did AIDS originate?

_____

_____

_____

Q2a: Who do you think is at **highest risk** of HIV infection?

(Please Circle One Per Category)

Gender:

MALE FEMALE

Race:

ASIAN BLACK COLOURED INDIAN WHITE

Sexual Orientation:

HETEROSEXUAL HOMOSEXUAL BISEXUAL

Q2b: Why do you say that?

_____

_____

_____

Q3a: Who do you think is **least likely** to become infected with HIV?
(Please Circle One Per Category)

Gender:

MALE FEMALE

Race:

ASIAN BLACK COLOURED INDIAN WHITE

Sexual Orientation:

HETEROSEXUAL HOMOSEXUAL BISEXUAL

Q3b: Why do you say that?

_____

_____

_____

Q4a: Do you think that young adults continue to behave in ways that may allow them to become infected with HIV even if they know how it is transmitted and how to protect themselves?

YES	**NO**

Q4b: If yes, why do you think that is?

_____

_____

_____

_____

Q5: If you could predict the AIDS infection rates in South Africa 10 years from now, what do you see happening with particular groups and/or the population in general?

_____

_____

_____

_____

Q6: Do you know anyone who is infected with HIV or has died from AIDS?

YES	**NO**

APPENDIX F

BUILD-A-CHARACTER QUESTIONNAIRE

Please complete the following questionnaire and imagine that the person you are creating is a South African character. **This character is HIV+**. Please describe them according to the following questions. Fill in the necessary details on the spaces provided.

1 Name:

_____

2 Age:

_____

3 Male/Female
(Please Circle One)

4 What race group does this person belong to? (Please Circle One).

Asian Black Coloured Indian White

5 Does this person attend school/university?

Yes/No (Please Circle One).

6 Does this person have a job?

Yes/No (Please Circle One).

7 If yes, what is it?

_____

_____

8 What is this person's sexual orientation?

Heterosexual/ Homosexual (Please Circle One).

9 How did this person become infected with HIV?

_____

_____

_____

_____

10 Why did you describe this character in the way that you did?

_____

_____

_____

_____

_____

_____

APPENDIX G

PRACTICES REGARDING HIV

Q1a: If you were asked to assess your own susceptibility (risk and vulnerability) of HIV infection, what would your assessment be?

0 = No risk of HIV infection

1 = Low risk of HIV infection

2 = Medium risk of HIV infection

3 = High risk of HIV infection

Self-Assessment of risk of HIV infection

0	1	2	3

Q1b: Why do you rate yourself as such?

_____

_____

_____

_____

Q2a: Do you believe that a condom should always be used during sexual intercourse?

YES	NO

Q2b: Why do you say so?

_____

_____

_____

Q3: Have you been tested for HIV?

YES	NO

Please only answer the following questions if you have ever been sexually active.

Q4: Are you free to discuss sexual activities including condom usage with your partner?

YES	NO

Q5a: Do you use a condom during sexual activity?

YES	NO

Q5b: Why?

_____

_____

_____

Q5c: If you do use a condom, who initiates the use of a condom in your relationship?

PERSON	PLEASE TICK ONE
Yourself	
Your partner	
Both	

Q6: Would you feel comfortable asking your partner to go for an HIV test?

YES	NO

Q7: Would you reveal your HIV status to your partner if you were found to be HIV+?

YES	NO

Q8a: Do you have more than one sexual partner?

YES	NO

Q8b: Do you think your partner has other sexual partners?

YES	NO