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What constitutes a 'risky' identity? : the social representation of the risk of contracting HIV among South African students.

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CHAPTER 2: Literature Review

2.1 Introduction

The following is a literature review providing a brief critique of some of the theories that are used to understand the decision to engage in risky sexual behaviour. This is followed by an exploration of social representations theory as a means of explaining how knowledge generated in the social context influences the way that individuals understand HIV and their perceptions regarding their level of risk. Age, gender, race, socio-economic status, and substance use are all factors that are considered in terms of the way in which they are socially represented with regard to the perceived risk of HIV infection.

2.2. A critique of some of the theories utilised to understand sexual behaviour

Numerous theories have been developed in order to understand the processes underlying the decision to change one's behaviour. However, these theories of behaviour change have tended to either focus on individual, interpersonal, or structural and environmental factors, and it is important to note that this separation is artificial as there is inevitable overlap between the categories (UNAIDS, 1999). Nevertheless, a brief account and critique of the theories within these categories is provided.

Focusing on the individual, the most common theories of behaviour change include the health belief model, social cognitive (or learning) theory, the theory of reasoned action, the stages of change model, and the AIDS risk reduction model (UNAIDS, 1999). In brief, the health belief model is one of the earliest models and it was developed in the 1950's. It maintains that behaviour is a function of one's socio-demographic characteristics, knowledge and attitudes, and that in order to change behaviour, the following factors are important to consider: perceived susceptibility, perceived seriousness of the illness, belief in the efficacy of the new behaviour, perceived benefits of new behaviour, barriers to taking action and cues to action, such as the death of a relative due to HIV. (Rosenstock, Strecher & Becker, 1994; UNAIDS, 1999). With regard to the social cognitive theory, Bandura proposes that two other important factors to consider are self-efficacy and outcome expectancies (Rosenstock, Strecher & Becker, 1988; UNAIDS, 1999). Furthermore, the theory of reasoned action, put forward in the 60's by Ajzen and Fishbein, is conceptually

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similar to the health belief model, except that it also considers intention when determining whether a behaviour will occur, and intention is said to be a function of one's attitude towards the behaviour and subjective norms (UNAIDS, 1999). Then, somewhat different from the previous theories mentioned, the stages of change model was developed in the 1990's and this theory sets out a list of stages that individuals go through when considering a behaviour change. Finally, the AIDS risk reduction model was developed in 1990. It draws on the health belief model, social cognitive theory and the diffusion of innovation theory. Three stages are identified for reducing the risk of HIV in this model. As a whole, knowledge, perceived susceptibility, and aversive emotions characterise the first stage, known as behaviour labelling. The second stage, the commitment stage, examines perceptions of enjoyment, self-efficacy, social norms and aversive emotions, and the last stage, the stage of taking action, once again explores aversive emotions, as well as communication, help-seeking behaviour and social factors (Catania, 1990). Overall, according to UNAIDS (1999), these theories have been useful for identifying individual behaviours associated with high transmission rates, but these theories alone do not explain why some populations have higher infection rates than others, or the complex interaction between the individual and the context.

Given the above, it is apparent that there is a need for theories to go beyond cognitive explanations of behaviour, to examining how that which is social, cultural or economical may influence individual behaviour. Such theories include the diffusion of innovation theory, the social network theory, social influence or social inoculation model, and the theory of gender and power (UNAIDS, 1999). These theories 'see individual behaviours embedded in their social and cultural context, and instead of focusing on psychological processes as a basis for sexual behaviour, it tends to be social norms, relationships and gender imbalances that are said to influence behaviour' (UNAIDS, 1999, p. 10).

Lastly, behaviour can also be seen as a function of structural and environmental determinants, with the theory for individual and social change or empowerment model, and the social ecological model for health promotion being central, as well as the focus on socio-economic factors. These models tend to focus on linking the individual to the surrounding system and while they do consider intrapersonal factors, interventions tend to operate at the level of community, organisations and policy (UNAIDS, 1999).

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Overall, the difficulty with the present means of understanding behaviour is that it tends to result in the isolation of individual, interactive and community processes in understanding behavioural change. One factor which is typically viewed from the perspective of individual processes is that of perceived risk, but more recently it has been acknowledged that individuals may not perceive themselves to be at risk because of their own behaviour, but rather because of the behaviour of their partners, thereby highlighting the importance of interpersonal and possibly environmental factors as well (UNAIDS, 1999). This once again points to the need to understand risk perceptions in a more complex, multi-faceted manner. Social representations theory enables such a process, as it can be used to understand how risk perceptions are maintained and justified. The construct of social representations is useful as these are not conceptualised as being solely intrapersonal factors influencing behaviour; rather, social representations are understood as being meanings that are shared amongst individuals and that emerge out of a particular context, thereby enabling a more comprehensive exploration of the interaction between the context, interpersonal and intrapersonal processes that can influence risk perceptions and opinions (Potter & Wetherell, 1987). Subsequently, the nature of social representations theory remains to be explored in more depth.

2.3 Social Representations Theory

Social representations theory seeks to understand people's philosophies about new societal events and processes, as well as how different groups make meaning of such events (Joffe, 1999). An epidemic is the perfect example of such an event and, as a result, this framework can be used to generate an understanding of how people understand and perceive the HIV epidemic.

In introducing social representations theory, it is important to first look at what social representations actually are, as well as how are they are generated. Social representations are mental entities and they are made up of both concrete and abstract elements, i.e. concepts and images respectively (Potter & Wetherell, 1987). They can be understood as the mediating factor influencing perceptions of a particular thing, object or person. For example, it is the meaning that is made with regard to an object which influences the perception of the object (Potter & Wetherell, 1987). Thus, according to Wagner (1995), social representations can be conceived of as social processes of communication in which

meaning and social objects are generated. However, they can also be conceptualised as individual attributes; as individual structures of knowledge, symbols and effect that can be shared with other people (Wagner, 1995). Therefore, social representations can refer both to the process of communication, as well as to the process of establishing order in the world, thereby allowing individuals to orientate themselves in the world and to master it (Moscovici, 2000). In other words, social representations can be understood to comprise 'common sense' and everyday knowledge that can be shared amongst group members (Moscovici, 2000; Wagner, 1995).

In the process of trying to understand how social representations influence perceptions, it is important to note that social representations theory adopts a social constructionist perspective, but it is unusual in that it does not subscribe to the notion of 'subjectivity'; rather, it is argued that there is a degree of coherence in the social representations held by groups (Joffe, 1999; Moscovici, 2000). This is an important aspect of the theory as it enables an understanding of how interactions with others can influence individuals, rather than only focusing on purely intrapersonal factors influencing behaviour. Furthermore, social representations theory is useful as it does not elevate textual discourses over images and rituals in order to explain how meaning is given to new events (Joffe, 1999). Thus, social representations theory provides a framework for examining the way in which groups communicate and generate social representations in terms of language, as well as symbols.

In addition to defining social representations, it is important to also consider their function in more depth. Social representations are used to familiarise the unfamiliar (Moscovici, 2000). This means that when individuals encounter new experiences, objects, people and events, new experiences can be added to a reality which has already been pre-determined owing to the representations and culture which already exists (Moscovici, 2000). Not only do representations make the unfamiliar familiar, but Moscovici (2000) argues that they also impose themselves upon us with an irresistible force. This is subsequently a result of the fact that existing representations affect the incorporation of new experiences. Hence, social representations have a powerful influence, which is why it so important to examine the way in which HIV is socially represented.

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In relation to the above, exploring the way in which HIV is currently socially represented is especially important given that social representations play an important role in helping people to perceive themselves to be at low-risk while constructing others as being at high risk. This process is useful as it helps individuals to maintain a positive self-identity, but the inherent risks associated with low risk perceptions highlights the importance of exploring these perceptions in more depth (Rohleder, 2007).

2.4 Perceived Invulnerability: I am not at risk, 'others' are

Research has shown that the role of knowledge in influencing behaviour is limited, and that behaviour is largely affected by the level of risk at which one considers oneself to be (Barden O'Fallon, deGraft-Johnson, Bisika, Sulzbach, Benson, & Tsui, 2004). However, it has often been found that people have a tendency to inaccurately calculate their level of risk and to consider themselves to be at minimal risk in relation to anything negative (MacIntyre, Rutenberg, Brown & Karim, 2004). The phenomenon of considering oneself to be invulnerable to anything negative has received much attention in the literature and, as a result, there are many terms available to explain this phenomenon including optimistic bias, unrealistic optimism and perceived invulnerability (Branstrom, Kristjansson & Ullen, 2005; Dew & Henley, 1999; Johnson, McCaul & Klein, 2002; Macintyre et al., 2004, Weinstein, 1987).

'Optimistic bias' refers to the tendency to claim that one is less at risk for a negative event than one's peers (Joffe, 1999; Weinstein, 1987), and this may result in one believing that one has a low risk of contracting HIV (MacIntyre et al., 2004). When this perception is unrealistic, it is termed 'unrealistic optimism' (Johnson et al., 2002), and this places a person at risk as one may engage in unsafe behaviour thinking that one is safe, when the opposite is true (Hendriksen et al., 2007). Thus, perceived risk can play an important role in the behavioural decisions that an individual makes and people can be put at considerable risk if they deny their actual risk of contracting HIV. Consequently, perceived risk and perceptions of invulnerability need to be addressed when trying to encourage behaviour change.

From the above, it is clear that perceived risk has been highlighted as an important factor with respect to decisions regarding sexual behaviour. It also shows that inaccurately

perceiving oneself to be low risk can be risky (Hendriksen et al., 2007). However, in order to establish the best method of encouraging accurate perceptions, it is important to explore the purpose and consequences of these inaccurate perceptions. It has been suggested that the reason for considering oneself to be at low risk for anything negative, despite contradictory evidence, is a defence mechanism against anxiety created by threats to the self (Rohleder, 2007). Such a perspective draws on psychodynamic theory as well as social representations theory, and Joffe (1999) also subscribes to the notion that there is a tendency to consider oneself to be invulnerable. In fact, Joffe (1999) explains that people attempt to allay their anxiety evoked by the threat of HIV/ AIDS by portraying 'others' as more likely to be at risk, and so inaccurate risk perceptions seem to be protective from a psychological perspective.

While perceiving oneself to be at a low risk of HIV infection is a mechanism to protect oneself psychologically (Joffe, 1999), the outcomes of this behaviour need to be considered. A person who perceives they are a low-risk candidate for HIV infection may engage in risky behaviour, thus becoming high risk (Hendriksen et al., 2007). Also, in terms of the 'other', the impact of being the out-group has significant consequences (Joffe, 1999). In particular, research has shown that many individuals internalise stigmas concerning their group and identify with similarly stigmatised group members. Moreover, the stigmatised often manifest shame in relation to this identity (Joffe, 1999), although it must be said that while this is not the case with everyone, it is an important consideration. Thus, it is evident that perceiving oneself to be at low-risk, while constructing others to be risky, has been shown to have some harmful consequences for both the self and the 'other', which is why it is important for interventions to target inaccurate perceptions of risk. But this requires an understanding of how low-risk perceptions are constructed.

Some of the reasons cited for perceiving oneself to be at low-risk and for not adequately protecting oneself include: perceiving the outcome as not being serious, with distant outcomes being considered as being less serious than imminent ones; seeing the risks as outweighing the immediate benefits; considering the recommended behavioural action to be ineffective in reducing the risk and thus disregarding it; being reluctant to adhere to recommended behaviour if it is perceived to have costs or disadvantages; or the individual may feel unable to implement the recommended action (Sutton, 1999). From this, it is

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evident that low-risk perceptions are related to the perceived severity of the outcome, as well as to perceptions regarding the ability to prevent the outcome.

In light of the above and the importance given to the perceptions regarding behavioural actions and associated outcomes, it is important to consider the use of condoms in the HIV epidemic. This is a significant mode of prevention (Barnett & Whiteside, 2006). However, the myths about condom use need to be explored because it is believed that the social representations around condom use may result in people believing that they are unable to prevent HIV/ AIDS, which could lead to unsafe sexual behaviour (Simbayi et al., 2005). Condoms are an effective way of preventing the transmission of sexually transmitted diseases such as HIV/AIDS, they are inexpensive and relatively easy to use (Myer, 2005). Myths and misconceptions about condoms are problematic as, if these social representations result in their decreased use, peoples' risk of contracting HIV will rise (Sutton, 1999). It is therefore important to investigate the way in which condoms are socially represented. Also, seeing as Moscovici (2000) highlights that social representations enter everyday conversations, it is very important to examine the judgments that peers make about condoms, as such representations can influence individual behaviour. In particular, it has been found that, where individuals have a negative attitude towards using condoms, they encourage their friends to not use them and, in turn, such individuals tend to internalise their friend's attitudes (MacPhail & Campbell, 2001; Zambuko & Mturi, 2005).

MacPhail & Campbell (2001) conducted research in which the following myths concerning condoms emerged: that they are generally unnecessary in 'steady' relationships and for a steady partner to insist on condom use indicates a lack of trust and respect; individuals make distinctions between partners who require the use of condoms and those that do not based on appearance and reputation; and women who keep condoms are exceptionally sexually active or promiscuous. Moreover, Myer (2005) highlights the following barriers to condom use: the fact that carrying condoms is viewed as being an indicator of a high-risk sexual partnership and that using condoms is regarded as making sexual intercourse less pleasurable. Interestingly, it is also thought that even the notion that condoms are easy to use may need to be explored further as this may generate a sense of inadequacy and reluctance to ask for help in instances where individuals are unable to properly use a condom. Hendriksen et al. (2007) found that 80% of individuals in their study reported having been shown how to use a male condom and felt that they were responsible, wise and

mature. However, 41.8% still reported feeling somewhat anxious, 16.3% felt afraid and 11.8% felt uncomfortable about using condoms (Hendriksen et al., 2007). Given the above, it is important to examine the social representations of condoms and condom use, as well as the more individual factors that may influence condom use, such as issues of self-efficacy. A multi-faceted perspective is necessary in order to enhance understanding of what it is that acts to inhibit condom use.

In conclusion, social representations theory provides a useful way of conceptualising the process of estimating one's level of risk in relation to other groups in society, as well as for understanding the characterisation of HIV, and the decision to engage in unsafe sexual behaviour. It is important that such mechanisms are well understood given that adolescents and young adults are particularly vulnerable to subscribing to the phenomenon of perceived invulnerability, and they can be easily influenced by their peers. As such, they form the focus of this research (MacIntyre et al., 2004; Zambuko & Mturi, 2005).

2.5 Developing an 'Identity': Who I am in a context of social representations

Social representations have been shown to affect the way in which people familiarise themselves with new events, and are said to impose themselves upon people with an irresistible force which exists prior to thought and decrees what one should think (Moscovici, 2000). Thus, Moscovici (2000) argues that while we may, with effort, become aware of and evade some constraints, we can never be free of all convention; hence, it is better to make explicit a single representation. This is particularly true given that social identities emerge from belonging to certain social groups or from our positioning within networks of power relationships shaped by factors such as gender, ethnicity or socioeconomic position, and that different identities are associated with different behavioural positions (Campbell, 2004). These identity-linked behaviours have a range of potential consequences for people's vulnerability to HIV infection (Govender, 2006). It is subsequently important to explore the various social representations associated with aspects of identity in order to understand how risk perceptions are justified and maintained, and to contrast this with the actual risks that identity markers may expose one to.

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2.6 Youth: Young people at risk of HIV infection?

The statistics show that the highest incidence of HIV occurs in people between the ages of 15 and 24 (UNAIDS, 2008). Thus, it can be said that the HIV epidemic is taking an enormous toll on the youth, and in order to develop an understanding of the high incidence rate in this age group, it is important to explore the factors which serve either to encourage protective behaviour or to promote risky behaviour.

An important factor to consider is the developmental stage that adolescents experience in the transition to adulthood. Adolescence is said to be a unique stage of the human life cycle, a period of rapid development where individuals are faced with many new situations and acquire many new capabilities (Irwin, Scott & Cart, 2002). This developmental stage of adolescence involves physical, psychological and social development (Strunin, 1991). Such individuals are in the process of 'finding themselves' and this process needs to be explored further, with particular attention being given to the social representations that exist within this context.

2.6.1 Challenging the social representations of the youth in relation to the HIV epidemic

While it is important to consider the social representations of the youth, it is also important to not refer to all youths as one homogenous group and to recognise that there are individuals that challenge stereotypical norms in the face of social representations and restrictive contexts (MacPhail & Campbell, 2001). Nevertheless, the general social representations that exist with regard to the youth need to be carefully considered.

2.6.2 Experimental behaviour: Normalised or discouraged?

In exploring the social representations of risk with regard to the youth, it is important to reiterate that many traditional psychology textbooks speak of adolescence as a period of transition. During this time adolescents start to become sexually mature as a result of increased hormone production but they are also still portrayed as being emotionally immature, thereby providing an explanation for the difficulty that adolescents are said to experience (Wilbraham, 2004). In relation to this, it is thought that while such changes do

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take place at a physical level, the subsequent social representations can have an important impact on the behaviour that individuals engage in (Campbell, 2003).

In relation to the above, it seems that on the one hand risky behaviour and experimentation is considered to be a normal part of development, but on the other hand, this process is considered problematic as it still holds the potential for risk because of the emotional immaturity of the youth. Furthermore, risky behaviour is targeted in health promotion programmes (Wilbraham, 2004), which once again implies that such behaviour should be avoided. Hence, there seem to be two competing social representations of the process of development. The discouragement of risky behaviour is based on the understanding that risky behaviour may expose adolescents to many hazards that may jeopardise their health and development (Hurrelman & Richter, 2006). However, this process plays an important role in development as it allows for coping styles to begin consolidating (Hurrelman & Richter, 2006). As such, the discouragement of experimentation is potentially problematic as such behaviour can fulfil important social functions and plays an important role in psychosocial development. Such experiences can also build character (Hurrelman & Richter, 2006). This highlights the problem regarding the presence of problematising and/or normalising social representations. These competing social representations mean that, on the one hand, sexual behaviour may be recognised but, on the other hand, it may become a problem. Hence, adolescents get competing perspectives and sexuality is treated in multiple and contradictory ways (Macleod, 2006). This is problematic where it may create difficulty for adolescents to adopt health-promoting behaviour and where it may influence their perceptions of risk.

2.6.3 Sexual behaviour as a means for the youth to gain power from custodians - the role of guardians in the HIV epidemic

It has already been shown that adolescence poses a risk from the perspective that adolescents experience a mismatch between their body and psyche. However, it is also said that this period is risky as it can serve as a means for adolescents to claim their power from their custodians (Wilbraham, 2004). It is argued that young people may experience their parents as restrictive and as fearing the body's capacity for sex and pleasure, and the youth are then 'impelled to reject such neurotic parental advice as instances of false consciousness' (Wilbraham, 2004, p.516). Adolescents subsequently gain sexual knowledge

from outside sources such as their peers and the media, which allows them to become well informed about sex (Wilbraham, 2004).

In relation to the above, parents might take a backseat to their children's knowledge and behaviour because of the social representation that parents do not have the power to inform their children of the potential risks regarding sexual behaviour (Wilbraham, 2004). But the problem is that parents may then be blamed for taking a backseat because they are expected to be primed to expect moodiness, embarrassment, hostility and resilience owing to the fact that this model sees adolescence as a time of conflict between the psyche and the body (Wilbraham, 2004). As such, parents are either faced with being considered to be overbearing or absent regarding sexual education, with both social representations minimising their power to influence children. In sum, the influence that parents have over children in the face of the HIV epidemic is complicated as the transition from adolescence to adulthood in and of itself suggests increasing independence, yet this can come with many risks in light of the decreased parental influence and increased peer and media influence.

2.7 Gender: Differential HIV risk?

Social or gendered identities are said to occur from the positioning of individuals within networks of power relationships that are historically and contextually bound (Govender, 2006). The gendered subject is said to be located within discursive power relations that result in men and women being positioned differently and unequally in relation to power and control (Govender, 2006), and it is noted that gender and identity are also inextricably intertwined with the concept of empowerment (Campbell & MacPhail, 2002). Differences in power have different implications for males and females and it is subsequently thought that this will also result in different conceptualisations of what is perceived to be risky for the different genders in terms of HIV. Consequently, it is important to investigate gender issues related to HIV and the social representations that influence the perceptions of risk and the ability to engage in safe sexual behaviour.

2.7.1 Diverse gender roles

In developing an understanding of what it means to be male or female, this study focuses on the different gender roles and expectations that are intertwined with each sex. It is important

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to explore the origin and development of the present day gender roles as past representations influence present social representations (Moscovici, 2000).

Conceptualisations of masculinity and femininity have evolved over time as a result of changes in the social context. Broadly speaking, before the 19th century, men and women lived and worked on farms together. But the industrial revolution brought about significant changes whereby men had to move to the cities to earn money, and women were left at home to manage households and children (Brannon, 2008). Brannon (2008) states that this forced men and women to adapt to their new environment and roles. This resulted in the Cult of True Womanhood whereby women were promised happiness and power if they adhered to four values — piety, purity, submissiveness and domesticity. Women were expected to be refined, tender, dependent, timid, sensitive and bound to their domestic duties. Men, on the other hand, were expected to be strong, forceful and wise. It is this divide between men and women that has implications for their level of power in relationships and their behaviour. Despite fluid conceptualisations of men and women, boys and men are still characterised as aggressive, dependable and masculine in the present day (Brannon, 2008). However, having considered the broad power differences that have been constructed between men and women, it is important to consider the power inequalities between the sexes in present day South Africa.

2.7.2 Gender in the South African context

Following the shift in political power in 1994, the new democracy envisaged a society with equality between men and women, and people of all races (Albertyn, 2003). Women were granted greater representation in politics and state institutions, and there was a focus on the development of laws that accorded rights to women in the public and private spheres (Albertyn, 2003). In spite of these efforts at transformation, by 1999 there were increasing levels of poverty, gender-based violence, and increasing HIV infection rates among women, thus highlighting that the goals of social and economic equality for women remained unfulfilled (Albertyn, 2003). This is particularly important when considering the risks of HIV infection, as HIV infection rates are fuelled by gender inequalities and these infection rates compel ‘us to confront the power that men have over women, and how this is differentially constructed, reinforced, and reinvented through cultural norms about gender and sexuality’(Albertyn, 2003, p.596).

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From the above, it is evident that within the South African context, gender inequalities prevail and that this plays a significant role in HIV risk. In addition, Albertyn (2003) argues that while gender inequalities play a role in the level of risk of HIV infection for the different genders, women are not equally vulnerable. African women are highlighted as being particularly vulnerable and this is linked to cultural, social and economic factors. With regard to culture, it is said that traditional African cultures may place African women at greater risk as they maintain certain oppressive practices and ideologies with regard to women (Airhihenbuwa, 1995). In particular, cultural norms such as polygamy and the right of a man to demand sex whenever he likes might be influencing the safety of women (Albertyn, 2003). As such, culture may play a part in HIV risk and gender equality. In terms of inadequate access to economic resources, this is linked to apartheid and the fact that separate development and migrant labour policies damaged the social fabric of African families and communities, as well as reinforced racial poverty and inequality (Albertyn, 2003). This enhances the risk for women as the subsequent socio-economic reliance of women on men may serve to minimise the power of such women (Brannon, 2008; Eaton, Flisher & Arro, 2003), also, some women may resort to exchanging sex for material goods (Albertyn, 2003). Finally, with reference to social norms, Jewkes, Levin and Penn-Kekana (2003) state that high stakes are attached to females having a partner and that this is problematic as it may increase women's fear of abandonment, which could then compromise their power in relationships. Thus, it is apparent that the notion of gender in relation to HIV risk is complex. Social, economic and cultural factors all seem to play a part in reinforcing gender inequalities. It is important to explore the social representation of these factors in order to understand how these influence risk perceptions, and it is also necessary to examine the actual risks of HIV infection, for the different sexes, from a physiological perspective.

2.7.3 HIV: Differential gender risk

With respect to women, their physiology places them at a greater risk for HIV infection than men, owing to the nature of the disease and the fact that infection requires the transmission of bodily fluids (Van Der Walt, Bowman, Frank & Langa, 2007). Thus, men are not as easily infected with HIV. The consequences of this need to be understood in relation to the discourses and social representations associated with issues of gender.

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2.7.4 Challenging the social representations of gender in the face of the HIV epidemic

2.7.4.1 Males as sex crazy: social representation of males as drivers and spreaders of HIV

The social representation of males in the HIV epidemic needs to be carefully examined in order to identify some of the social representations which place males and females at risk. So far, it has been demonstrated that masculinity is associated with being forceful, dominant, sexually active, and aggressive (Brannon, 2008). Moreover, Hollway (1984) explains that this social representation is reinforced and justified by the male sex drive discourse which proposes that men are driven by the biological necessity to seek out heterosexual sex, and that sex for a male is a natural need. Men are constructed as being sexually insatiable and male sexuality is understood as naturally being linked to an uncontrollable drive (Hollway, 1984). Thus, this discourse perpetuates the belief that there is a natural need for men to behave in a sexual manner. Such a discourse needs to be challenged as it serves only to reinforce the notion that it is considered socially acceptable for males to be sexually active, and that such behaviour is expected and considered to be part of 'what it means to be a man'. The problem with such a discourse is that women are seen as the objects of the male sex drive discourse, whereas men maintain the dominant position of being the subject (Govender, 2006; Hollway, 1984). Additionally, this discourse can be problematic as the idea that the power of the penis is incontestable allows for the reproduction of violent manifestations of patriarchy, such as rape, pornography and sexual harassment (Hollway, 1984). Thus, the notion that males have a natural need for sex is a concern, as it justifies the sexual behaviour of men. It may also absolve women from the responsibility of protecting themselves and from exerting any power they do have, as well as from reclaiming their power from men. In particular, the situation is made more complicated where the discourse that justifies the forceful and sexual behaviour of men (Brannon, 2008), simultaneously reduces the power of women to negotiate sexual interactions and the use of condoms. In relation to this, it is argued that women fail to recognise that men need relationships, and that they have power within their relationships with men (Hollway, 1984). As such, the discourse of women as being helpless victims must be challenged. Where power is resisted, this in and of itself is resistance, with women no longer being 'victims' of power (Foucalt, 1982; Hollway, 1984).

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2.7.4.2 Females as subordinates, helpless victims

Just as the social representation of males needs to be considered, the social representation of females in the HIV epidemic also needs to be addressed. Femininity is typically associated with women being expected to be sensitive, submissive and timid (Brannon, 2008). It is interesting that these traits are the direct opposite of the traits expected from males, who are expected to be dominant and aggressive. This demonstrates how gender has historically been constructed as difference and it is this focus on difference which has served to legitimate ideologically the continued reproduction of inequality (Shefer, 2004).
This is evident where being the 'other' is often associated with 'being-less-than'. Where males are seen to be strong, women are seen as being weak, and it is these opposites which need to be critically evaluated. Shefer (2004) deconstructs some of the conventional views of the binarism of the male-female issue and argues for a picture of multiplicity and fluidity. This is evident where one begins to imagine multiple sexes, genders and sexualities with diverse relationships between bodies, subjectivities and sexual practices (Shefer, 2004). Thus, it is important to challenge the social representations associated with masculinity and femininity and it is necessary to critically explore the discourses underlying these social representations.

With regard to the above, it is apparent that the social status of women is typically found to be inequitable to that of men, but it is important to remember that women are regarded as being a vulnerable group primarily because of their social location and status (Swart, 2007). It is thought that the potential problem with this is that while women are seen as being vulnerable, it is the very power structures that locate women unequally that contribute to their vulnerability, and to ignore this fact while stating that women are vulnerable may serve to further negate any power they do have. Furthermore, the problem also lies in the fact that where sexual rights documents stipulate the unacceptability of violence, coercion and exploitation of women, they do not address 'the fact that masculinity requires the sexual subordination and exploitation of women as a male right and as a form of male pleasure' (Oriel, 2005, p.402). From this perspective, Oriel (2005) clearly highlights the view that men's rights to sexual pleasure demand the exploitation of women. As such, it seems that on the one hand women are regarded as vulnerable and requiring protection

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whereas, on the other hand, they are regarded as objects of men's sexual desires. In both instances, it is thought that the power of women to negotiate their own safety and sexual desires is negated, and this is cause for concern.

2.7.5 Whose decision counts with regard to condom use?

It has been shown that gender roles have a substantial impact on the decision of whether or not to engage in safe sexual practices. This is particularly evident where gender power inequalities affect the ability to negotiate condom use (Raijmakers & Pretorius, 2006; Shefer & Potgieter, 2006). Eaton et al. (2003) state that such discussions are not easy and sexual negotiation of any kind is said to be lacking among South African youth. It once again appears that women are 'meant' to be submissive and passive; while men are 'meant' to be in control of relationships and sexuality (Shefer & Potgieter, 2006). Such ideas can place individuals at great risk and it is clear that one needs to be critical about social representations related to condom use and the discourses underlying them.

2.7.6 Homosexuals at increased risk for HIV infection

Having explored some of the ways in which gender roles are perceived to influence the safety of sexual interactions, another aspect of sexuality which is frequently said to increase the risk of HIV infection is homosexuality. This is of interest as, in the early stages of the HIV/AIDS epidemic, the first cases of HIV infection were found among homosexual men and as a result, the disease was called Gay-Related Immune Deficiency Syndrome (GRID) (Barnett & Whiteside, 2006). Given that social representations from the past are said to impose themselves upon us with an irresistible force in the present (Moscovici, 2000), it is subsequently important to consider the social representations of HIV infection with regard to sexual orientation. Although it is recognised that, statistically, men who have sex with men are at a disproportionately increased risk of contracting HIV/AIDS (UNAIDS, 2008).

Overall, it is clear that gender differences are associated with different forms of behaviour owing to the social representations and discourses associated with each gender. It is subsequently important to explore the social representations and discourses that arise with respect to each gender, and to investigate how these social representations affect perceptions of risk with regard to HIV.

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2.8 Race

South Africa has had a turbulent history and, with the end of apartheid in 1994, the government faced many challenges with respect to removing the legal pillars that had reinforced and sustained apartheid (Duncan, Bowman, Stevens & Mdikana; 2007). While the government has managed to remove the racist legislation of the apartheid era, an assessment of the present reality of South Africa reveals that race and racism are still central to the social organisation of this country (Duncan et al., 2007). As a result, race still plays a role in the social constructionist aspect of identity formation and therefore it is important to investigate the social representation of the risk of HIV infection in terms of race. But first it is important to explore the role of apartheid in creating racial difference in more depth.

2.8.1 The emergence of diverse racial roles

When exploring the notion of 'race', it is essential to recognise that it is integrally linked to the ideology of racism that characterised the apartheid years (Duncan & de la Rey, 2000). At this time, 'race' served as a significant symbolic marker of social, political and economic entitlement and organisation, particularly until the 1990's (Duncan, 2003). Four 'race' groups were classified, namely, 'Whites', 'Indians', 'Coloureds', and 'Africans', and there was a strict hierarchy of privilege based on 'race'. Thus, apartheid brought about the segregation of racial groups and maintained this separation by allocating resources to Whites at the expense of other racial groups (Mayekiso & Tshemese, 2007). 'Race' was used as a means to divide people into social categories and to justify domination, exclusion and entitlement (Balibar, 1998), and as a result, it cannot be looked at as a factor on its own, as it is inextricably linked to other factors such as socio-economic status, power, etc. From this, it becomes clear where the origin of diverse racial roles and power inequalities emerged. Since 1994, the government has managed to remove this racial legislation but, as mentioned previously, 'race' and racism remain central to the social organisation of this country (Duncan et al., 2007). It is therefore important to investigate the racialisation of HIV.

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2.8.2 HIV: Differential racial risk

Before the racialisation of HIV is explored, it is important to consider the actual risks associated with race. These statistics are not meant to stigmatise a particular racial group, but are rather intended to demonstrate the risks associated with all racial groups. This is so that, even where some groups may be socially represented as being more risky than others, it can be demonstrated that no group is immune and that everyone is at risk of contracting HIV. Hence, it was found that among the youth, the incidence rates of HIV per year were as follows: Blacks, 3.4%; Indians, 0.5%; Coloureds, 0.3% and Whites, 0.3% (Shisana et al., 2005). More recent statistics of the prevalence of HIV show that 13.6% of Africans and 1.7% of Coloureds are infected with HIV, while 0.3% of Whites and 0.3% of Indians are infected with HIV (Shisana et al., 2009). These statistics will be explored in relation to the social representation of HIV risk regarding race.

2.8.3 Challenging the racialisation of HIV: Social representation of Black people as victims of HIV

The statistics reveal that Black people are worst affected by HIV (Shisana et al., 2009), and in research conducted by Stadler (2008), it was found that Black people are considered to be at the most risk of infection. While the social representation of Black people being at high risk is true to some extent, it is thought to be problematic. It can result in risky behaviour among individuals perceived to be at a low risk, and those who are stigmatised often manifest shame in relation to being identified as high risk (Joffe, 1999). As such, these risk perceptions remain to be challenged and it is particularly important to consider the role of apartheid in relation to the risk perceptions for the different racial groups. Also, seeing as socio-economic status is closely tied to race and gender in the South African context, it is important to consider this as a factor influencing risk perceptions, as well as the actual levels of risk regarding HIV infection.

2.9 Socio-economic status

The discussion on race and gender has shown that power inequality shapes the relationships between men and women, as well as those between and within racial groups. While

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structural shifts have and are taking place in terms of legislation regarding the rights of racial groups and the different genders, the impact of the past still lingers. In particular, it is known that poverty occurs differently among racial groups, and it is of interest that there is now also an intra-group divide regarding wealth among individuals within the Black population (Landman, 2003). This unequal distribution of finances is thought to be particularly problematic where socioeconomic status intersects with health. Charasse-Pouele and Fournier (2006) explain that differences in health between Whites and other racial groups are attributed not only to differences in education, income and the consequences of apartheid, but that they are also a result of persistent discrimination regarding access to healthcare facilities and the type and quality of care provided. Moreover, power inequalities may emerge in situations where women are economically dependent on men (Eaton et al., 2003). As such, it is evident that socio-economic status is an important factor to consider when exploring power inequalities, as well as the actual and perceived risk of HIV infection (Brannon, 2008; Eaton et al., 2003; Mayekiso & Tshemese, 2007). There appears to be a complex interaction between socio-economic status, health and demographic variables.

2.9.1 Money talks: Wealth as a predictor of health

It has been mentioned that low socio-economic status affects health and access to healthcare (Charasse-Pouele & Fournier, 2006), and as such, it is important to explore how socio-economic status is perceived to influence the risk of HIV infection. Interestingly, it has been found that a well-ordered environment, typically associated with higher socioeconomic strata, may result in the perception that individuals within the community are at low risk for everything negative (Macintyre et al.,2004). This highlights the perception that wealth is associated with low risk. Subsequently, the perception of risk for more impoverished communities remains to be explored.

2.9.2 The need or desire for money leads to risky behaviour

With regard to the risks that poverty may expose one to, it is known that in such situations individuals may use sexual relations for financial gain, and the power that one has to protect oneself in such situations is questionable. For example: in situations of prostitution or, in relationships with sugar daddies or sugar mummies, it is argued that the partner who provides financial rewards holds the power. The problem with this is that it can reduce the

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ability for the negotiation of safe sex and this holds the potential for the transmission of HIV and other sexually transmitted diseases (Kuate-Defo, 2004; Wojcicki & Malala, 2001). As such, the need to earn money can reduce one's power, however, it must be reiterated that this notion of reduced power in such situations needs to be challenged as this can maintain power differences.

In conclusion, having considered the way in which age, race, gender and socio-economic status intersect with power, as well as both perceived and actual HIV risk, it is necessary to consider how behaviour also plays a role. In particular, attention needs to be given to substance and alcohol use, given that this has typically been associated with an increased risk of HIV infection (Shisana et al., 2005).

2.10 Substance and alcohol use

While certain demographic and environmental factors can affect one's actual risk for HIV infection, and may influence perceptions of risk as well, it is also important to investigate behaviours that are risky, as well as those which are perceived to be risky in terms of HIV infection. One such type of behaviour is substance use.

2.10.1 Substance and alcohol use among South African youth

Alcohol and substance use can play a role in the level of risk for HIV infection, as the use of these substances impairs judgements and can lead to risky behaviour (Shisana et al., 2005). According to the study done by Shisana et al. (2005), a low proportion of substance use was found among participants, but the overall prevalence of alcohol consumption was 27.9%, with 18.8% of participants being classified as low risk and 7.2% as high risk. Furthermore, it was found that a higher proportion of males than females were both low- and high-risk drinkers, and analysis by race showed that Coloureds were the most high-risk drinkers (17.8%), followed by Whites (7.2%) and Blacks (6.4%), while Indians were proportionately the least high-risk drinkers (2.5%) and an overwhelming 53% of White participants were found to be low-risk drinkers. Additionally, individuals aged between 25 and 49 were more likely to be high-risk drinkers than 15-24 year olds; while individuals aged 24 years and less were found to have the least number of low-risk drinkers, with individuals older than 50 having the most low-risk drinkers (Shisana et al., 2005).

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The results of the above-mentioned study are of particular interest as it highlights that while individuals aged 15-24 are second to 25-49 year olds regarding the prevalence of high-risk drinking, they are last out of three age groups regarding low-risk drinking. This is important to consider in light of the discussion of earlier social representations of the youth being most likely to engage in risky behaviour owing to their stage of development (Wilbraham, 2004). However, it is important to note that this does not negate the level of risk of the youth but rather serves to show that relative to other age groups, alcohol and substance use do not feature as strongly. Nevertheless, this age group is still at a significant level of risk. This is particularly true given the risks associated with high-risk drinking.

Having examined the statistics, it is interesting that, statistically-speaking, females are shown to consume less alcohol than males, Coloureds are most representative of high-risk drinkers, while Whites are most representative of low-risk drinkers and second in terms of high-risk drinking (Shisana et al., 2005). Knowing the statistical risks regarding race, age and gender, it is of interest to explore the social representations of substance use maintained by students.

2.10.2 Exploring the risks of substance use

Substance and alcohol use is thought to be an important factor to consider when thinking about HIV risk as the use of substances and alcohol can impair judgment and increase risky behaviour, thereby posing a risk for HIV infection if such substances are used before sex (Shisana et al., 2005). Additionally, in certain instances, alcohol can precipitate sex by serving as a commodity that can be exchanged for sexual interaction, such as in the case of transactional sex (Norris, Kitali & Worby, 2009). Moreover, in this instance, the participants in this study thought that risk may be exacerbated owing to power differentials. In accordance with this, the risk for a sexually transmitted infection (STI) was found to increase with an increase in transactional incidences, together with an increase in alcohol use (Norris et al., 2009). Thus, it is clear that substance use can prove risky from multiple perspectives.

It is also important to note that the risks associated with substance use are enhanced by the fact that peers can play a considerable role in influencing drinking behaviour. In fact, it is known that peer influence can take place in two ways: modelling and persuasion (Graham,

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Marks & Hansen, 1991). According to this understanding, friends may copy one another's behaviour or friends may influence and pressure one another to behave in particular ways (Graham et al., 1991). Thus, it is the social representations of substance use that are generated among friends, as well as the social representations of behaviour engaged in when intoxicated, which are of interest. This is because it is thought that these social representations may ultimately influence one's decision to use substances and that this may affect the sexual behaviour one engages in.

In summary, this chapter has attempted to provide the reader with a review of the literature that is relevant to the study. It has provided a discussion of the theoretical framework underlying this research and it has critically discussed the social representations that appear to exist with regard to the perceived risk of HIV infection. These relate to issues of age, gender, race, socio-economic status and substance use.

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