THE SHADOW OF FEAR

AN EXPERIMENTAL STUDY ON EXTERNAL STIGMA AS A SIDE EFFECT OF FEAR APPEALS IN HIV/AIDS EDUCATION TEXT MESSAGES AMONG BLACK ADOLESCENTS AND ADULTS WITH A LOWER SOCIO-ECONOMIC STATUS IN SOUTH AFRICA.

Rafaëla Feddes
Nijmegen, the Netherlands, 19 February 2006

Department of Business Communication, University of Nijmegen, the Netherlands
Supervision: Prof Dr C Jansen (University of Nijmegen, the Netherlands),
Ms D Ehlers (UNISA, Pretoria, South Africa)
PREFACE

My parents have always taught me that people should not just focus on their own country, you have to keep your eyes open to perceive what happens in the rest of the world. I have always kept this life motto in mind. I have tried to bring an international focus to my studies by means of learning Spanish and following courses in Development Studies. When considering my student career, I realized that I wanted to use my knowledge of communication science for the benefit of projects supporting development in underdeveloped countries in the world. When I heard about EPIDASA (a project that has as its objective improving the effectiveness of public information documents on HIV/AIDS in South Africa), I became very interested. In the beginning of 2005, I went to South Africa to conduct a study that could contribute to the improvement of HIV/AIDS education, which is so important in order to fight the HIV/AIDS pandemic in this country.

My time in South Africa was an eye-opening experience. I am very grateful for the chance that I was given to experience the South African culture and to meet many great persons from its diverse population. I think South Africa is a magnificent country with a remarkable identity.

I would like to use this opportunity to thank Prof Carel Jansen and Dineke Ehlers for their supervision during my project. Moreover, I would like to thank my cultural brokers, Vusi Ngambe, Martha Chabalala and Jan Mahlangu. I would also like to thank my sister, Deirdre, and my parents who have supported me in every way during this year. Furthermore, I would like to thank the Centre for the study of AIDS at the University of Pretoria for giving me so much information and for interesting discussions. Finally, I am very grateful for the pleasant collaboration with the following institutions: the Assembly of God's congregation situated in Pretoria, the Gatang high school and Samafco high school.

Nijmegen, 31 December 2005
Rafaela Feddes
SUMMARY

In spite of a large number of HIV/AIDS education campaigns that have taken place in South Africa over the years, this country is still home to the highest number of people infected with HIV in the world (i.e. 5.3 million people, CIA 2005). South Africa’s population consists of several ethnic groups and each group distincts itself from the others by its own unique culture. The ethnic groups that are hit hardest by the HIV pandemic are the black ethnic groups. The type of locality most hit in South Africa by the HIV pandemic is the informal urban settlement such as townships, which shows a higher number of people infected with HIV/AIDS than other locality types (NMF/HSRC 2002).

HIV/AIDS education is considered to be one of the ways to prevent more people from contracting HIV. Therefore, it is crucial that HIV/AIDS education campaigns anticipate on the background of the target group in order to be effective. Cultural aspects must be taken into account since culture influences a person’s beliefs, values and norms regarding issues such as illness, life, death and sexual activity (Van Dyk 2001).

In the past, fear messages in HIV/AIDS education campaigns have been used as a strategy to grab people’s attention regarding the HIV/AIDS issue (Coulson 2003). A well-known theory that promotes the use of fear messages in HIV/AIDS and other health education campaigns is the Extended Parallel Process Model, “EPPM” (Witte 1992, 1998, 2001). This model explains how people may react to a fear appeal, i.e. a persuasive message that conveys the negative consequences of what happens when people do not change their risky behaviour (such as having sex without a condom, which may lead to HIV infection). The EPPM claims that using threat and evoking fear in education material, provided it is used in combination with a high efficacy message (a message that recommends a solution to prevent the threat), may be an effective strategy to make people change their risky behaviour (Witte 1992, 1998,
However, research has also shown that evoking emotions such as fear may lead to stigmatising behaviour (Dijker & Koomen 1996). Stigma is the process in which a person is being discredited in the eyes of others and is a big issue for those living with HIV/AIDS (UNAIDS 2002). Stigma may manifest itself externally or internally. External stigma refers to treating persons with HIV/AIDS inferiorly such as blaming, harassing and excluding people living with HIV/AIDS (PLHA's) because they are HIV-infected. Internal stigma is defined as a way to protect oneself from external stigma (Siyam’Kela 2003). Stigma is an important barrier in the fight against the HIV/AIDS pandemic. It negatively affects preventive behaviour regarding HIV infection, such as taking an HIV test. Because of stigma, PLHA’s may feel discouraged to disclose their status. As a consequence, they may feel discouraged to take action in order to receive antiretroviral medication. This has a negative influence on the physical health and well-being of a PLHA (Herek 1999). Stigma should therefore be reduced. The premise that the use of fear may lead to stigma was the motivation of this research. As far as I know, no studies have been conducted investigating the relation between fear appeals in HIV/AIDS education and external stigma. Therefore, by means of experimental research, it was investigated to what extent the use of fear appeals in HIV/AIDS education material among black adolescents and black adults with a lower socio-economic status in South Africa would lead to external stigmatisation of HIV/AIDS-infected people.

This experimental research was based on a so-called 2 x 2 design in which external stigma was investigated by means of two different fear appeal text versions distributed among young and medium aged black South Africans with a lower socio-economic status. Text version 1 included a high threat and a high efficacy text message and text version 2 included a low threat and high efficacy text message. The text messages were set out as a narrative that was related to someone’s experience with HIV. Each participant received one of the two text versions, followed by a
questionnaire including statements measuring the participant’s evaluation of the text messages, the variables included in the EPPM (i.e. perceived severity, perceived susceptibility, perceived response efficacy and perceived self-efficacy), and seven indicators of external stigma (i.e. avoidance, rejection, moral judgement, stigma by association, unwillingness to invest in people living with HIV/AIDS, discrimination and abuse). The participants’ responses towards the statements were analysed by means of a univariate analysis of variance in order to investigate possible significant interaction or main effects between text version (text version 1 versus text version 2) and age group (adolescents versus adults) on each variable.

The results of the univariate analyses of variance revealed no significant interaction effects between age group (i.e. adolescents and adults) and text version (text version 1 and text version 2) on the variables evaluating the text messages, the variables included in the EPPM, and the indicators of external stigma.

No main effects were found on the variables evaluating the text messages, including the variable level of fear that was expected to show a significant difference between participants who read text version 1 and participants who read text version 2.

A number of main effects were found on the variables of the EPPM. The results showed that the participants in general considered themselves able to perform the recommended behaviour in order to avert the threat of HIV infection. On average, the participants also believed that the use of a condom is an effective way to prevent oneself from HIV infection, while having sex only with people one knows was not considered effective. Mostly, the participants were aware of the severity of HIV/AIDS, but did not know whether they would be at risk of contracting it. Furthermore, the adult participants were significantly more convinced of the effectiveness of staying faithful to one’s partner than the adolescent participants were. The adolescents had significantly more faith in praying to God than the adults had in order to prevent oneself from HIV infection.
Main effects of age group were found on five indicators of external stigma. All five main effects showed that adolescents were more inclined to display external stigma than adults were. However, the univariate analyses did not reveal stigmatising behaviour.

Furthermore, the relation between level of fear and the indicators of external stigma was analysed by means of correlation analyses. Four significant positive correlations were found between the level of fear and four indicators of external stigma: rejection, moral judgement, stigma by association, and abuse. This positive correlation implies that the higher the level of fear is, the more likely the participants would stigmatise PLHA’s, i.e. rejection, moral judgement, stigma by association and abuse. Finally, the correlation analyses did not reveal a correlation between external stigma and the level of fear for the nine participants who experienced a high level of fear and a low level of perceived efficacy.

Thus, in contrast to predictions from theory, it turned out that in this study the use of a fear appeal in HIV/AIDS education text messages did not cause black adolescent and black adult participants with a lower socio-economic status in South Africa to display external stigma. The results showed that the adolescent participants were more inclined to stigmatise persons infected with HIV/AIDS than the adult participants were. Furthermore, it can be concluded that there is a positive correlation between the level of fear and external stigma, which the authors of HIV/AIDS education material using fear appeals should take into account.

Some points of discussion have arisen during this experimental research about possible intervening factors that may have influenced the research’s outcomes, i.e. the effect of text version in HIV/AIDS education material, the methodological problem regarding the outcome of the relation between fear and external stigma, and problems regarding the procedure, such as people’s fatigue of HIV/AIDS education and the taboo surrounding HIV/AIDS.
# TABLE OF CONTENTS

1 **INTRODUCTION** ........................................................................................................... 11

1.1 Motivation .................................................................................................................. 11

1.2 Structure of thesis ..................................................................................................... 14

2 **THEORETICAL FRAMEWORK** ..................................................................................... 17

2.1 Fear appeal ................................................................................................................ 17

2.1.1 *What is a fear appeal?* ......................................................................................... 17

2.1.2 *The dominant approaches* ................................................................................... 19

2.1.2.1 Fear-as-acquired drive model ............................................................................ 19

2.1.2.2 The Parallel Process Model .............................................................................. 19

2.1.2.3 Protection Motivation theory ............................................................................ 20

2.1.3 *Extended Parallel Process Model* ....................................................................... 21

2.1.3.1 The appraisals .................................................................................................. 22

2.1.3.2 The processes .................................................................................................. 23

2.1.4 *Perspectives on the use of fear appeals in HIV/AIDS education* ..................... 26

2.1.4.1 Results from research that supports the use of fear appeals ......................... 26

2.1.4.2 Stimulating instead of intimidating .................................................................. 28

2.1.4.3 Counterproductive effects of fear appeals ....................................................... 30

2.1.4.4 Ethics ............................................................................................................... 33

2.1.4.4.1 Relation between fear and stigma ............................................................... 34

2.2 Stigmatisation ............................................................................................................ 37

2.2.1 *What is stigma?* .................................................................................................. 37

2.2.2 *Why do people stigmatise?* .............................................................................. 38

2.2.3 *Manifestations of stigma* .................................................................................... 42

2.2.3.1 Internal stigma .................................................................................................. 43

2.2.3.1.1 Self-exclusion from services and opportunities .......................................... 44

2.2.3.1.2 Perception of self (self esteem) ................................................................... 44

2.2.3.1.3 Social withdrawal ....................................................................................... 44

2.2.3.1.4 Overcompensation ...................................................................................... 45

2.2.3.1.5 Fear of disclosure ........................................................................................ 45

2.2.3.2 External stigma ................................................................................................ 45

2.2.3.2.1 Avoidance .................................................................................................... 45

2.2.3.2.2 Rejection ...................................................................................................... 46

2.2.3.2.3 Moral judgement ........................................................................................ 47

2.2.3.2.4 Stigma by association ................................................................................ 47

2.2.3.2.5 Unwillingness to invest in PLHA’s ............................................................... 48

2.2.3.2.6 Discrimination ............................................................................................. 48

2.2.3.2.7 Abuse .......................................................................................................... 49

2.2.4 *Consequences of stigma* ................................................................................... 49

2.3 Narratives ................................................................................................................... 51

2.3.1 *The concept of narratives* .................................................................................. 51

2.3.2 Types of narratives related to illness ..................................................................... 54
5  CONCLUSIONS, DISCUSSION AND RECOMMENDATIONS...................................... 116

5.1 Conclusions.............................................................................................................. 116
  5.1.1 The evaluation of the message .................................................................. 116
  5.1.2 The components of the EPPM ................................................................. 117
  5.1.3 The indicators of external stigma .............................................................. 118
  5.1.4 Relation between fear and external stigma ............................................ 119

5.2 Discussion.................................................................................................................. 121
  5.2.1 Discussion regarding the effect of the text versions.................................. 121
  5.2.2 Discussion regarding the relation between fear and external stigma .... 122
  5.2.3 Discussion regarding problems with the procedure................................. 123

5.3 Recommendations.................................................................................................. 123

5.4 Final thoughts.......................................................................................................... 124

LIST OF REFERENCES

APPENDICES
  A: Introduction questionnaire
  B: High Threat and High Efficacy text message of text version 1
  C: Low Threat and High Efficacy text message of text version 2
  D: Questionnaire
  E: Definition Appendix
CHAPTER 1
1 INTRODUCTION

Since the first victims of the Acquired Immune Deficiency Syndrome (AIDS) were reported in the early 1980s, this syndrome has overwhelmed mankind. All over the world Human Immuno-deficiency Virus (HIV)/AIDS is claiming its victims. These days, fighting HIV/AIDS has become a high priority on a global level (The Panos Institute 2003). Action is needed to prevent the world from facing a major and catastrophic public health crisis.

1.1 MOTIVATION

According to United Nations AIDS (UNAIDS) and the World Health Organisation (WHO) (2004), South Africa continues to have the highest number of people infected with HIV in the world. An estimate made by the Central Intelligence Agency (CIA) (2005) indicated that at the end of 2003 in South Africa, approximately 5.3 million people were infected with HIV and 370 000 people died of AIDS. At present, HIV/AIDS affects South African society on all levels. HIV/AIDS-care, for instance, has become a substantial part of the health care expenditure of the national budget. Business has to deal with higher employment costs because of absence through HIV/AIDS-related illness of their employees. In addition, most of all, HIV/AIDS infects and affects South Africans regardless of their socio-economic status or ethnicity.

At the moment, there is still no medical cure for HIV/AIDS. Therefore, HIV/AIDS education and prevention programs are of extreme importance in reducing the spread of HIV/AIDS in South Africa. An incredibly large amount of education material about HIV/AIDS is published and distributed in South Africa with the purpose of educating the population to fight the HIV/AIDS pandemic (Swanepoel 2003). However, in spite of all these HIV/AIDS education programs, the prevalence figures indicate that the number of HIV/AIDS victims remains high in South Africa (Swanepoel 2003; AIDS Foundation of South Africa 2000).
A well-known strategy used often in HIV/AIDS campaigns is the use of fear messages, which attempt to instil fear in the audience in order to educate people on how to prevent HIV infection. Such fear-arousing messages are commonly known as fear appeals. An influential model developed to measure and explain the effect of fear appeals is the Extended Parallel Process Model (EPPM) (Witte 1992; 1998; 2001). The EPPM, presented in figure 1 on page 24, claims that when people experience a certain level of threat during the first appraisal of a persuasive message, they are willing to undertake action to remove the uncomfortable feelings caused by the fear that the threat has evoked. This action can include adjusting their behaviour by following the recommended response perceived to be effective during a second appraisal of the message. In this second appraisal, the perceived efficacy (effectiveness) of both the recommended response and self-efficacy is weighed against the perceived threat, consisting of severity of as well as susceptibility to the threat. When the perceived efficacy exceeds the perceived threat, the individual becomes motivated to protect himself/herself from the danger. As long as the perceived efficacy exceeds the perceived threat, fear can be cognitively appraised and the recipient may accept the message and its recommended response. In the EPPM, this reaction to the message is called the danger control process.

On the other hand, when the perceived threat exceeds the perceived efficacy, the fear originally evoked becomes more intense and leads to uncomfortable feelings. As a consequence, such an individual becomes completely preoccupied with the threat because the perception is that he or she is not able to control the danger. Such an individual will thus focus on how to control the fear instead of the danger, which may result in rejecting the message. This reaction is called the fear control process in the EPPM.

Much criticism has been levelled at the use of fear appeals in HIV/AIDS education. Dijker and Koomen (1996) state that emotions such as anger and fear may lead to stigmatising behaviour. Stigma is an important barrier for the effectiveness of
HIV/AIDS education campaigns. Stigma may prevent people infected with HIV/AIDS from disclosing their status or seeking medical and/or psychological help, because they feel threatened by the stigma related to HIV/AIDS. According to Parker and Aggleton (2002:6), stigma forms a 'roadblock to concerted action against the HIV/AIDS pandemic, whether at local community, national or global level, so action against stigma ramifies across every single aspect of HIV work'. However, stigma is not the only obstacle in HIV/AIDS education. Dixon and Springham (1991) mention that health promotion focusing on HIV/AIDS is confronted with numerous obstacles, such as prejudice, discrimination, loss of employment and fear. Fear in particular is seen as an important barrier. As Nelson Mandela once stated in his presidential inauguration speech: “As we are liberated from our own fear, our presence automatically liberates others”. In other words, when people no longer fear something, they become better at fighting it and helping others. These words can also be applied to the situation of HIV/AIDS. If people no longer fear this disease or fear people living with HIV/AIDS, then they can help those who are infected and/or affected by this disease and the need to stigmatise them will lessen. This is where HIV/AIDS education can play a role.

Emotions such as fear are partly shaped by an individual's cultural beliefs and values. Parker (2004) mentions that cultural beliefs and values are in part determined by contextual factors such as poverty, unemployment and rapid urbanization that mediate the risk of HIV infection. In relation to HIV/AIDS, these contextual factors disable volitional control over sexual activity and may contribute to a higher rate of HIV infections (Parker 2004). According to CIA (2005), the informal urban area (a term that refers to informal urban settlements such as squatter camps) has the highest prevalence of HIV infections compared to other locality types. The Nelson Mandela Foundation/Human Sciences Research Council report (NMF/HSRC) (2002) mentions that looking at the different ethnic groups in South Africa is relevant, black people are more affected by the HIV/AIDS pandemic than other ethnic groups. In addition, NMF/HSRC (2002) shows that black people, poor people and uneducated people
tend to stigmatise more. The cultural background of these people may be related to such stigmatising behaviour. However, as Dijker and Koomen (1996) state, fear may be causing stigmatising behaviour as well. Therefore, the question arises whether the use of fear appeals in HIV/AIDS campaigns could evoke more stigma among the population groups affected most by the HIV/AIDS pandemic. The presumed relation between fear appeals in HIV/AIDS education and external stigma in the poorer sections of society have lead to the research set out in this thesis. The two questions researched in this paper are the following:

(i) To what extent does the use of fear appeals in HIV/AIDS education material among black adolescents and black adults with a lower socio-economic background in South Africa lead to external stigmatisation of HIV/AIDS-infected people?

(ii) To what extent do levels of external stigmatisation differ between adolescents and adults?

In an experiment, the relation between fear and stigma has been investigated among black adolescents of 14 to 20 years old and adults of 35 years and older. Each individual target group received either a so-called high threat and high efficacy text message (text version 1) or a low threat and high efficacy text message (text version 2). The text messages of the two text versions were set out as a narrative (story) that was related to someone’s own experience with HIV. The reason for using a narrative was the way in which a narrative structures information and includes belief systems and values concerning various domains of social life (Carstens 2003). In addition, a narrative increases the vividness and perceived authenticity of the experience and the level of interest from the recipient (Brosius & Bathelt 1994).

1.2 STRUCTURE OF THESIS

The structure of this thesis is as follows; chapter 2 discusses the theoretical framework underlying this research, including the four central theoretical components used in this study, being:
– fear appeal (focusing on the Extended Parallel Process Model or EPPM);
– stigma (in particular external stigma);
– narratives; and,
– African cultural background.

Chapter 3 discusses the methodology of the experimental research that was undertaken. The results of the experiment are presented in chapter 4. This thesis is concluded with chapter 5, which presents the conclusions, discussion and recommendations.
CHAPTER 2

THEORETICAL FRAMEWORK
2 THEORETICAL FRAMEWORK

In this chapter, the theoretical framework underlying this research will be presented. This framework refers to four core components, i.e. fear appeals, stigma, narratives, and the African cultural background.

2.1 FEAR APPEAL

According to Leclerc-Madlala (1997), the first two victims of HIV/AIDS were identified in South Africa in 1982. These victims were white. It took five more years before the first black HIV-infected persons became known. In those days people talked about the white disease and gay disease. However, a rapidly increasing number of HIV victims among the black heterosexual population soon became a serious cause for concern (Leclerc-Madlala 1997). The population needed to be informed and educated about this new threat. Education material developed in those days was mainly focused on the awareness and the severity of the disease. An often-used strategy to get people’s attention on the HIV/AIDS issue was the use of fear and alarm (Coulson 2003). But why do some institutions that are involved with HIV/AIDS education support the use of fear appeals in HIV/AIDS education campaigns whilst others denounce its use? What are the effects of this strategy? What are the advantages and disadvantages? In this section, the theoretical basis for the use of fear appeals within the context of HIV/AIDS education will be discussed.

2.1.1 WHAT IS A FEAR APPEAL?

“A fear appeal is a persuasive message that arouses fear by outlining the negative consequences that occur if a certain action is not taken” (Witte 2001:2).

An addition to this definition according to Rogers (1983, quoted in Ruiter, Abraham and Kok (2001:613) is that ‘a fear appeal is a persuasive message that arouses fear to promote precautionary motivation and self-protective action’ to protect the receiver of the message from experiencing potential negative consequences, such HIV infection. Before discussing the theories and point of views on the topic of fear
appeals, the three central components of the theory of fear appeals as well as some definitions relevant to this theory should be explained first.

The first component is *fear*, defined as ‘a negatively valued emotion accompanied by a high level of arousal and (which) is elicited by a threat perceived to be significant and personally relevant by the audience’ (Lang 1984 in Witte 1992:331). This component is thus an emotion, not a rational consideration and can be categorised as a form of affect.

The second component is *threat*, which is an external stimulus variable. No objective measure exists to measure level of threat, because threat is present only in the subjective perception of the individual. It is therefore more correct to speak about *perceived threat*. Perceived threat consists of two subcomponents: perceived severity and perceived susceptibility. *Severity* of the threat refers to the seriousness of the threat mentioned in the message. *Perceived severity* is the individual’s belief or perception of the seriousness of the threat. Apart from perceiving the severity, we can also perceive our *susceptibility* to the threat: how likely is it that the negative consequence will befall us? *Perceived susceptibility* indicates the person’s appraisal of his/her own susceptibility: what risk does s/he run to experience the threat? In contrast with the affective character of fear, perceived severity and perceived susceptibility are categorised as forms of *cognition* (i.e. thinking, ratio).

The third element *efficacy* (a synonym for effectiveness, which refers to ability) is also categorised as a form of cognition. Efficacy consists of the subcomponents response efficacy and self-efficacy. Response efficacy deals with the question whether or not the recommended response is effective in averting the threat; perceived response efficacy refers to the person’s perception of the effectivity of the recommendend response. *Self-efficacy* deals with the ability of a person to perform the recommended behaviour to avert the threat. *Perceived self-efficacy* refers to the individual’s perception of whether or not he or she is able to perform a certain
recommended behaviour.

In short, the components of a fear appeal and some related terms have been explained. The Definition Appendix gives an overview of all the relevant terms used in this thesis. In the following sections, the construct fear appeal will be discussed and clarified in more depth.

2.1.2 THE DOMINANT APPROACHES

There are three dominant approaches within the theoretical models of how fear appeals work in health risk messages. These approaches are integrated in the Extended Parallel Process Model (EPPM) which attempts to explain how people process health risk messages such as HIV/AIDS risk messages. The three dominant approaches are the following:

- Fear-as-acquired drive model (Hovland, Janis & Kelly 1953; Janis 1967);
- The Parallel Process Model (Leventhal 1970, 1971);
- Protection Motivation Theory (Rogers 1983).

2.1.2.1 Fear-as-acquired drive model

This theory supports the belief that fear is a powerful drive that would motivate action. Fear causes an unpleasant emotional state or unpleasant feelings that people want to be rid of. Therefore, they are willing to change their unsafe behaviour into the rewarding behaviour that can eliminate the threat.

2.1.2.2 The Parallel Process Model

According to Leventhal, the Fear-as-acquired drive model brings emotional processes into focus, while he argues that cognitive processes also play a role. He explains that when people think about the danger and how to control it, they are likely to adopt a behaviour that protects them from this danger. This process is called the danger control process. It is a cognitive process that deals with the threat rather than the evoked fear (Ruiter, Abraham & Kok 2001). However, Leventhal distinguishes another process namely the fear control process. This process is based on the premise
that people can be more emotionally involved in controlling their (anxious) feelings. Emotions play a more important role in the fear control process than cognition. If a person turns towards the fear control process, he or she is more likely to perform maladaptive behaviour to control their fear that may lead to ignoring the danger.

Leventhal (1970, 1971) discusses the fact that fear and danger control processes can operate separately, but one process may dominate the other. For example, someone who has low self-esteem will fall more easily into the fear control process and will only follow the danger control process if the fear has been reduced. On the other hand, people with high self-esteem may take action immediately when confronted with fear (Leventhal 1971). In general, Leventhal concludes that fear arousal can lead to two kinds of actions, cognitive or emotion-focused processes. Job (1988:164) argues the premise that the model is difficult to test empirically, because danger and fear are being varied independently’.

2.1.2.3 Protection Motivation theory

Rogers (1983) acknowledges the danger control part of the research of Leventhal’s Parallel Process Model, but emphasizes threat perception more than fear arousal. He formulates two dimensions each with two components of danger control processes. The first dimension is the threat appraisal including the severity of the threat and the personal susceptibility (or vulnerability) of a person. The second dimension is the coping appraisal based on the effectiveness of potential responses (response efficacy) and to what extent someone is able to perform an effective response (self-efficacy). The motivation to perform protective behaviour is the highest when the coping appraisal (response efficacy and self-efficacy together) reaches a high level. If this is the case, a radical attitude or behaviour change can be the result. Increases in response costs (time, expense, and difficulty) decrease the likelihood of adaptive behaviour. The threat appraisal and coping appraisal together lead to the danger control process.
The weakness of the theory is that threat appraisal and response efficacy are not the best variables to predict concurrent and future behaviour. On the other hand, self-efficacy, response costs, and intention have proven to be strong predictors. Witte (1992) claims that the Protection Motivation Theory fails to explain why fear appeals are rejected.

2.1.3 EXTENDED PARALLEL PROCESS MODEL

Witte (1992) was aware of the paradox concerning the different points of view on fear appeals. ‘The overemphasis on cognitions in current theories on fear appeals coupled with the relative neglect of emotions, are potential reasons for the lack of convergent findings’ (Witte 1992:337). She integrated the three previously discussed dominant approaches into the Extended Parallel Process Model (EPPM) (Witte 1992; Witte 1998). The EPPM represents a ‘holistic view of responses and reactions to fear appeals’ (Witte 2001:24). With this model it is possible to explain why the use of fear appeals can be an effective persuasive strategy under certain conditions.

Witte (1992) mentions that efficacy and threat are causal variables in study outcomes of fear appeals, i.e. message acceptance or message rejection. However, she argues that it is not explained why they are causal variables. In the EPPM, she therefore expands the theoretical functions of these variables. Furthermore, she uses the Parallel Process Model of Leventhal (1970) as a blueprint to distinguish two processes: the danger control and fear control process. Next, the EPPM continues with the Protection Motivation Theory of Rogers (1983). ‘The EPPM adopts the explanation of the danger control process and defines and expands the fear control process’, (Witte 1992:337). In short, the Extended Parallel Process Model is called an extended model because it fills the void in the dominant approaches, which have been discussed in the former section.

According to Witte (1998:428), a fear appeal consists of threat appraisal and efficacy appraisal. Depending on how strong the appraisals are present in the mind of a
person, they determine how a person reacts to the threat, i.e. no response, message-acceptance, or message-rejection (Witte 1998). In the next section, the appraisals will be explained more detailed in the context of HIV/AIDS education.

2.1.3.1 The appraisals

According to the EPPM (presented in figure 1 on page 24), when a person is confronted with a fear appeal regarding HIV/AIDS, he or she may react in different ways. For instance, he or she may not perceive HIV/AIDS as a severe disease and may not consider himself or herself at risk for HIV infection (perceived threat). The fear appeal will be ignored and no further information on what to do to prevent the threat or to change one’s unsafe behaviour will be processed, resulting in no response to the message.

In contrast to the result of no response, the recipient may perceive HIV/AIDS as a threat. Once that happens, the emotion of fear will be evoked. Every time an individual is confronted with the threat of HIV/AIDS, he or she starts to think more about the severity of HIV/AIDS and his/her own susceptibility to it. The threat becomes stronger and more fear will be evoked. This is the threat appraisal within message processing that occurs first.

When the perceived threat reaches a certain level, people are ready and willing to undertake action to prevent them from experiencing the threat. At this point, the individual becomes motivated to begin the second appraisal concerning, perceived efficacy. In this appraisal ‘the efficacy of the recommended response is weighed against the perceived strength of the threat’ (Witte 1998:428). The second appraisal concerns someone’s belief about the effectiveness and feasibility of the recommended behaviour to avert the threat (perceived response efficacy) and to what extent that person is able to perform the right behaviour (perceived self-efficacy). An example of a message part focusing on response efficacy would be: ‘Using a condom is effective in protecting oneself from HIV infection’. Self-efficacy can be
exemplified by a message such as: ‘I consider myself able to use a condom every
time I have sex’. Influenced by the persons’ psychological reactions to fear, a person
can cope with the threat in two ways, he or she can control the danger or control
their fear of the threat (Witte 1998:428). In other words, the Extended Parallel
Process Model recognizes two distinct processes in response to a fear appeal, danger
control process and fear control process, which will be discussed in the next section.

2.1.3.2 The processes

Whether a person ends up in danger control mode or in fear control mode depends on
how strong the threat and efficacy components are perceived. When the perceived
efficacy exceeds the perceived threat, the person will exhibit the danger control
mode. In such cases, individuals are aware of the threat and think carefully about the
recommended response, and how to realize this response. They have become
motivated to protect themselves from danger and accept the message. As long as the
perceived efficacy is higher than the perceived threat, fear can be cognitively
appraised and the individual will enter this mode. This is one possible outcome of a
fear appeal message according to the Extended Parallel Process Model.

The other outcome envisaged in the model is reached when the perceived threat
exceeds the perceived efficacy. The fear originally evoked has become more intense
because the person is completely preoccupied with his or her fear and how to
diminishing this uncomfortable feeling. The person is not convinced that he or she is
able to control the danger because the recommended response is too hard to perform,
too costly, etc. As a consequence, such individuals will turn to maladaptive responses
(Hovland et al. 1953), such as:

- aggression towards the communicator (e.g. defiance towards the
  communicator);
- defensive avoidance (e.g. avoid HIV/AIDS education brochures); and,
- tuning out of the message (ignoring or inattentiveness towards the message).

At this point, the strong emotion of fear has lead to defensive motivation resulting in
The possible reactions of a person towards the perceived threat become clear in figure 1, the Extended Parallel Process Model (Witte 2001:432).

Figure 1. The Extended Parallel Process Model (EPPM)

<table>
<thead>
<tr>
<th>EXTERNAL STIMULI</th>
<th>MESSAGE COMPONENTS</th>
<th>MESSAGE PROCESSING (1st &amp; 2nd Appraisals)</th>
<th>OUTCOMES</th>
<th>PROCESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>No threat perceived</td>
<td>(No Response)</td>
<td>Protection Motivation</td>
<td>Message Acceptance</td>
<td>Danger Control Process</td>
</tr>
<tr>
<td></td>
<td>Individual differences</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No threat perceived</td>
<td></td>
<td>Message Rejection</td>
<td>Fear Control Process</td>
</tr>
</tbody>
</table>

Witte (2001) explains that fear may contribute to the motivation to process a message
provided it is cognitively appraised. A health campaign will fail if it only scares the audience and does not teach them how to protect themselves from a certain threat. Only projecting threat without advice on how to avoid such a threat may lead to fear control coping (preoccupied with diminishing their fear) rather than danger control coping (adopting the recommended behaviour).

Whether the recipient of a fear appeal message ends up in the danger or fear control mode also depends on the type of person (Ruiter et al. 2001). For instance, a person who has low self-esteem and is terribly anxious about HIV/AIDS, may be more occupied with controlling his or her fear and therefore end up earlier in the fear control mode. Furthermore, Ruiter, Verplanken, De Cremer and Kok (2004:13) explain that only recipients of fear appeals who have a high need for cognition resort to adaptive coping (i.e. danger control). The need for cognition influences the way people process persuasive messages. Cacioppo et al. (1983; quoted in Ruiter et al. (2004)) indicate that people who have a high need for cognition process persuasive messages more systematically, based on the presented arguments. They have the capacity to discriminate between weak and strong arguments (Ruiter et al. 2004:15). People with a low need for cognition have been found to be more persuaded by characteristics of the message (e.g. the attractiveness or the expertise of the source). It is therefore important to identify the need of cognition of the target audience when creating the content of HIV/AIDS education messages.

The EPPM does not take into account a person’s motivation to stop performing unsafe behaviour. The fact that people sometimes are not willing to change certain behaviour could have an important impact on the effect of fear appeal in public health campaigns. For instance, fear appeals in HIV/AIDS campaigns that try to stimulate people to use a condom during sexual intercourse may not succeed because the audience does not want to use a condom; they believe that sex is better without one.
2.1.4 PERSPECTIVES ON THE USE OF FEAR APPEALS IN HIV/AIDS EDUCATION

A lot of research has been conducted on the effectivity of fear appeals. However, the results so far have been inconclusive. In this section, different perspectives on fear appeals will be discussed to create a more objective picture of this phenomenon.

2.1.4.1 Results from research that supports the use of fear appeals

Rhodes and Wolitski (1990) conducted an experiment in the United States to investigate the perceived effectiveness of fear appeals in AIDS education posters to motivate people to use condoms. Two types of posters were used. One type was aimed at creating a high level of fear among the audience by showing scary pictures of the consequences of AIDS. The other type of poster did not include pictures that would instill fear at all. The results of the experiment supported the idea that a poster that creates a high level of fear among the audience may be more effective than a neutral poster (regardless of gender, age or ethnicity). One of the major effects in this study was the strong overall influence of the fear level of pictures (showing the severity of the disease) on the perceived effectiveness of the experimental posters in motivating people to use condoms (perceived self-efficacy).

Another result of Rhodes and Wolitski's experiment (1990) was that fear-oriented posters persuading people to use condoms to prevent HIV infection were considered more effective than non fear-oriented posters. Posters designed to elicit the highest level of fear (represented by pictures of dead bodies, graves and emaciated people disfigured by disease) were perceived as most effective. Gomers (2004) confirms the effectiveness of fear-oriented photographs in a fear appeal brochure promoting safer sex in South Africa. However, she adds that after comparing the effect of four terrifying photographs\(^1\), she concluded that the most terrifying photograph was the photograph of a boy with the AIDS-related skin rash instead of the other three photographs, which were similar to those used by Rhodes and Wolitski in the United States.

\(^1\) i.e. a corpse in a body bag, a boy suffering from AIDS-related skin infection, a dead girl in bed surrounded by boys and a dying black man in a hospital surrounded by family.
States (1990). Hence, the effectiveness of the kind of photographs used in HIV/AIDS education messages may depend on the type of culture.

Furthermore, Rhodes and Wolitski (1990) suggest that fear appeals may be effective in promoting changes in community norms and motivating individuals to adopt an approach to reduce the risk of contracting HIV/AIDS. However, this conclusion does not seem to be solid. Changing community norms is a process that involves many complicated aspects, such as the cultural background of a society and other external restraints that can block this process. Section 2.4 will be devoted to this topic.

According to King (2002), the use of fear appeals in government and health care communication campaigns motivates changes in attitude, intention, and behaviour. In addition, credibility of the message plays an important role. King (2002) studied the credibility of fear appeals in government and health care communication campaigns. He claims that credibility determines the success or failure of the fear appeal, something that previous research on fear appeals did not always recognize (King 2002).

Das and Fennis (2004) conducted experimental research on the effect of warning messages contained on cigarette packages (e.g. smoking is lethal, smoking causes lung cancer), which are accompanied by a message regarding the recommended behaviour. They claim that fear messages without recommendations on how to stop smoking are not effective, because people who are at risk can perform defensive behaviour or deny the possible dangers of the risky behaviour. Therefore, only scaring people who are at risk without offering a solution to the problem can actually diminish the effect of the campaign. Das and Fennis (2004) argue that, to prevent defensive behaviour and denial, fear appeals should be accompanied by a recommendation (such as the use of nicotine plasters in the case of smoking) that is comforting and offers a solution for a particular health risk. In those circumstances people who smoke will more easily quit smoking. Suggesting a recommendation to
avert the danger is in line with the EPPM’s prediction that fear appeals are effective when they contain a strong efficacy component (Witte 2001). Unfortunately, fear appeals on cigarette packages do not always contain a recommended behaviour.

Jansen, Van de Berg, Buurman and Smits (2005b to appear) recommend the use of fear messages accompanied by explicit, scary photographs on cigarette packages. Based on the findings of their experimental research in which the effects of verbal anti-smoking warnings on tobacco packaging were compared, it may be expected that the combination of verbal and visual warning messages will increase the users’ perceived severity of smoking and will decrease the intention to smoke. However, this research, as well as the research conducted by Das and Fennis (2004) measures the behavioural intention and no actual behaviour has been examined, as in most studies on this topic. Therefore, it is not possible to be specific about the effects of fear appeal on real behaviour. Moreover, Das and Fennis (2004) and Jansen et al. (2005b to appear) studied the effect of warning messages regarding smoking, which differs in important aspects as a health threat from HIV/AIDS.

In the past couple of years, a wave of criticism on the use of fear appeals in HIV/AIDS education has gone around the scientific world of health education. The next section discusses why stimulating people with efficacy messages rather than threatening them with fear messages may be a more effective strategy in persuading people to perform the recommended behaviour.

2.1.4.2 Stimulating instead of intimidating

Ruiter and Kok (2005) indicate that fear messages, including the severity of the health threat and the audience’s susceptibility to it in public health campaigns, are not effective in changing people to perform the recommended behaviour, especially not among adolescents. They state that health education is not only about making people aware of the dangers of unsafe behaviour, but also about influencing very complex behaviour. Smoking for instance, is an addiction; as a consequence, it makes it more
difficult for someone to stop this unhealthy behaviour permanently. Ruiter and Kok (2005) indicate that there is no strong relation between feelings of susceptibility and severity on one hand and behaviour change on the other hand. Milne, Sheeran and Orbell (2000) argue that severity, susceptibility and response efficacy outcomes do not predict concurrent and future behaviour, whereas self-efficacy, recommended response and intention strongly do.

As mentioned before, Ruiter and Kok (2005) as well as Das and Fennis (2004) agree that in combination with threatening information, a proper recommendation of behaviour is necessary to make sure that people will perform healthy behaviour. Job (1988) confirms this theory by claiming that fear messages should be followed by an explicit reinforcement message that leads to a positive response. He argues that many health campaigns use the strategy of punishment wrongfully, e.g. having sex without a condom may lead to HIV infection, sleeping around may lead to HIV infection etc. An important disadvantage of such a strategy of punishment is that it only scares the audience without suggesting what needs to be done to prevent it. Ruiter et al. (2001) state that health campaigns should highlight the personal relevance and the feasibility of precautionary action. It is better to underpin the solution to change the complex and unsafe behaviour. Rothman, Martino, Bedell, Detweiler and Salovey (1999) suggest that precautionary behaviour is best promoted by presenting the positive consequences of performing that safe behaviour while behaviour focused on the early discovery of health problems is best promoted by presenting the negative consequences of not performing the safe behaviour. HIV/AIDS is not in the phase anymore of early discovery. These days promoting precautionary behaviour has become crucial to stop further spread of HIV/AIDS. Based on this assumption, no fear should be elicited by presenting the negative consequences of not performing the safe behaviour, which does not correspond with the EPPM’s basic principle.

Considering the previously discussed research results in the context of the fight against the HIV/AIDS pandemic in South Africa, it becomes clear that emphasizing
precautionary information of action, building confidence, and skills are more effective strategies in HIV/AIDS campaigns than the strategy of frightening people with messages and images about death and injury. This concerns children in particular. As Austin (1995 p. 130) states: “Campaigns should promote the development of skills in non-threatening ways and providing appealing alternatives to risk taking that can help put children in control of some aspects of their lives, perhaps for the first time.”

2.1.4.3 Counterproductive effects of fear appeals

Another point of discussion regarding the use of fear appeals is their potential counterproductive effect, such as denial of the threat and avoiding information about the threat. These effects are caused by the experience of negative stress, because individuals do not see themselves able to deal with the threat. As mentioned before, Ruiter et al. (2001) state that the character of an individual plays a role in how (s)he processes a fear appeal. The EPPM fails to include individual characteristics such as personal relevance, experience, and chronic fear. When these characteristics are not under control, they can lead to defensive reactions to health information such as, avoiding HIV/AIDS education messages, denying the severity of HIV/AIDS, or denying one’s susceptibility to it (fear control process). These defensive reactions may lead to no change in attitude or behaviour towards HIV-prevention. Therefore, these reactions may be called counterproductive outcomes.

In the case of the fight against the HIV/AIDS pandemic in South Africa, these counterproductive effects could have major consequences. If the fear appeal strategy appears to be ineffective it has more negative consequences than just a waste of money, time, and effort. A severe consequence is that ‘ineffective fear campaigns may immunize their audience against the message’ (Job 1988:165). Moreover, the target group of HIV/AIDS campaigns may continue with its unsafe behaviour, leading to more HIV-infected people. This is a serious concern for the future. If people do not want to pay attention to the threat anymore, how can they be persuaded
of the gravity of HIV/AIDS? Job (1988) stresses that the use of fear in health campaigns should be dealt with very carefully.

Another counterproductive outcome of fear messages is that it frightens people beyond control. Rassin (2001) suggests why some people are almost paralysed with fear by terrible, fearful imaginary situations. He mentions that people think that these thoughts represent their deepest wishes or desires. Someone who has these fearful thoughts tries to avoid them. The more they try not to think about them, the more they actually will. Next, this will lead to even more fear, which makes it increasingly difficult to suppress these thoughts. All efforts made to block these terrible thoughts will end up being related to it. This is why eventually, these fearful thoughts will remind the person every time of the threat. They will end up in a downward spiral brought on by fear appeals.

Rassin (2001) suggests that these fearful thoughts can be related to taboos and that this relation may be the reason why it is so difficult to get rid of fearful thoughts. He therefore explains the relationship between taboos and neurosis. The more the topic is taboo, the more chance there is for neurosis to occur. For instance, in a community where HIV/AIDS is a taboo, people may feel the need to discriminate and blame PLHA's to suppress the fearful thoughts they have about contracting HIV (more reasons why people would stigmatise PLHA's will be discussed in sub-section 2.2.2). People with fearful thoughts of for example HIV/AIDS may end up in this negative pattern of neuroses that they cannot come out of anymore. The theory of Rassin (2001) stating that fearful thoughts can be related to taboos and causing people to suffer from neurosis, is particularly pertinent to the content of the HIV/AIDS education and prevention campaigns in South Africa, because in this country there is a big taboo surrounding the issue of HIV/AIDS. The supporters of fear appeals in HIV/AIDS campaigns in South Africa should take the possible negative consequence of fear into account.

The EPPM suggests that perceived threat evokes fear. Every time an individual is
THE SHADOW OF FEAR

confronted with a fear message about HIV/AIDS, he or she becomes more aware of the threat. According to the EPPM, there needs to be a certain level of threat before a person starts the efficacy appraisal. Taking the theory of Rassin (2001) into account, increasing fear is not advisable, since it can cause psychological damage. Not only could it affect people psychologically (through neurosis), it may also affect people for whom the fear appeal was never intended. Thesenvitz (2000) for example, asks herself whether people who are not the target of certain fear appeals would be negatively affected as well.

Research by The Panos Institute (1990) indicates that people in general have fear of exposure to HIV. Fear of HIV infection is a normal human reaction (Brown et al. 2001). Therefore, everyone may experience fear of HIV/AIDS, including for example health care workers. Weinberger, Conover, Samsa and Greenberg (1992) as well as Gerbert, Maguire, Bleeker, Coates and McPhee (1991) suggest that the fear of infection among health care workers influences their attitude towards HIV-infected people negatively. Their negative attitude affects the way they treat people with HIV/AIDS. It may be possible that the health care workers turn into denial towards HIV/AIDS. As a consequence, some health care workers do not see themselves as able to work anymore, whereas others are affected by the fear-related stress. In each case, the health care worker and the quality of his or her work is affected by the created fear. The case of the health care workers is an answer to the question of Thesenvitz (2000). That is, the health care workers, who are not part of the target audience of HIV/AIDS education programmes, are affected by fear. The health care workers are a very crucial professional group in the fight against the HIV/AIDS pandemic. Their fear should not be aroused to even higher levels than those already existing.

This section explored some counterproductive effects that fear appeals may cause. Should we take the risk that people who are not target audience become frightened too? Is it ethically justified to scare people? The next section discusses this topic by
way of a case study in Botswana.

2.1.4.4 Ethics

Mapara and Morley (2004) believe that the effects of fear arousal will be greater when pictures are included in the message. In 1990, Mapara and Morley (2004) set up a project to raise community awareness concerning AIDS in Botswana. They tried to elicit discussion about HIV/AIDS and people living with it. To emphasize the threat of HIV/AIDS, they used photographs of black Africans who showed signs of the symptoms of HIV and other sexually transmitted diseases on their genitals. People who were shown these photographs (local people of the Lobatse region of Southern Botswana) were deeply shocked by the sight of these photographs. Some of those participating in the project talked about a ‘lack of respect’ towards them. Adults did not want their youngsters to see the photographs at all, because it would ‘corrupt their morals and young minds’ and it would ‘encourage them to experiment with sex’ (Mapara & Morley 2004). However, ten years later, the people who originally participated had changed their minds. Mapara and Morley (2004) concluded that the initial shock needed to be overcome and after that (more or less ten years later), people would be more receptive to the photographs that clearly presented the realities of the disease. The project of Mapara and Morley developed into one of the most successful AIDS programmes in Botswana. Their overall conclusion was seeing is believing. They concluded that verbal messages using fear appeals are not sufficient and that the use of graphics such as photographs to show symptoms of sexually transmitted diseases is a powerful teaching tool.

In the beginning of the project undertaken by Mapara and Morley (2004), the adults who participated were shocked because of the explicit photographs that were used. The adults were even trying to avoid their youngsters from a confrontation with the reality. Instead of becoming motivated to explain the symptoms and the danger of HIV/AIDS to their children, they decided to keep the topic silent. In this case, the fear appeal did not contribute to fighting the HIV/AIDS pandemic. Instead, the
fearful thoughts created a taboo and were counterproductive to the ultimate goal of the campaign. One may ask oneself if this method of shocking and ‘humiliating’ people is the right method. Is it ethically and morally justified that people need to overcome the first shock to create awareness? Vedder and Van der Burg (1989) wonder if it is ethically acceptable to influence the unconscious mind and emotions to create a change in people’s behaviour when it has these unwanted outcomes. In the next section another subject for a debate on ethics is enlightened namely, fear that may cause stigmatising behaviour towards PLHA’s.

2.1.4.4.1 Relation between fear and stigma

Brown, Trujillo and Macintyre (2001) mention that fear of a disease such as HIV/AIDS, fear of contracting it from someone else and fear of death are the base for stigma. Siyam’Kela (2003) confirms this:

‘Fear and moral judgment are considered to be the root sources of HIV/AIDS stigma. HIV/AIDS is associated with many different fears. People may fear the casual transmission of the virus, fear the loss of productivity of people living with HIV/AIDS, fear that resources may be wasted on people living with HIV/AIDS, fear living with the disease or fear imminent death’ (Siyam’Kela 2003c:4).

Dijker and Koomen (1996) developed a cognitive-emotional model of stigmatisation of people with HIV (see figure 2). According to this model, stigmatisation of a person living with HIV/AIDS (PLHA) is determined by pity, anger and fear. The model shows cognitive variables that contribute to emotional reactions (including fear) that lead to stigmatisation of PLHA’s.
Figure 2. A cognitive-emotional model of stigmatisation of people with HIV.

The model shows that the emotion of anger increases stigmatisation of people with HIV. Pity on the other hand, reduces the amount of stigmatising behaviour, whereas fear increases stigmatisation of PLHA’s. AIDS is considered a contagious and serious disease by most people. According to Bishop, Alva, Cantu and Rittiman (1991), the contagiousness of AIDS contributes to people’s fear and making them unwilling to associate with people with HIV/AIDS. This premise of Bishop et al. (1991) is in line with a part of the model of Dijker and Koomen (1996) in which the contagiousness of a disease such as HIV/AIDS is presented as a determinant that triggers pity and fear.

The EPPM claims that fear is evoked by the perceived threat (i.e. perceived severity and perceived susceptibility). These two variables can be compared to the two cognitive variables presented in the cognitive-emotional model of stigmatisation of people with HIV of Dijker and Koomen (1996), i.e. seriousness and contagiousness of the disease. Furthermore, the EPPM states that when a high threat is perceived, a cognitive process starts that may persuade people to perform the recommended behaviour (efficacy appraisal). On the other hand, Dijker and Koomen (1996) claim
that the evoked fear (together with anger and pity) may lead to unwanted behaviour, namely stigmatising people with HIV/AIDS. Therefore, it is possible that people who perceive a high threat may perform the recommended behaviour but they may also perform stigmatising behaviour towards people living with HIV/AIDS as a side effect.

In the previous sections, it has become clear that much uncertainty concerning the effect of fear appeals exists in the theory and practice of health education. One of the main points of discussion is whether health education messages should focus only on the efficacy components instead of on the threat components. Another topic of debate is the premise that fear may lead to counterproductive outcomes, such as avoidance and denial of the health education message or no change in attitude or behaviour at all. The use of fear-based health education campaigns can even lead to immunizing the audience against the health message. It has also been suggested that fear increases the chance for a neurosis to occur and may create a taboo. Finally, some researchers argue that fear may lead to stigmatising people with HIV/AIDS. As a consequence, they wonder whether using fear in HIV/AIDS education is ethically justified considering the premise that it may lead to stigmatisation of PLHA’s.

This research is specifically focused on the relation between the use of fear appeals in HIV/AIDS education and stigmatising behaviour towards PLHA’s. Fear appeals have been discussed in this section. The phenomenon stigma will be discussed in more detail in the next section.
2.2 STIGMATISATION

Stigmatisation in relation to HIV/AIDS has existed since the first incident of HIV/AIDS occurred in the eighties in the United States (Herek 1999). In those days, the fear of AIDS was extremely high in the United States, because people did not know how AIDS was transmitted (Perloff 2001). Since then, the lack of knowledge about HIV/AIDS has continuously increased the stigma associated with it in the United States (UNAIDS 2005). However, stigma is not an exclusively American phenomenon. The Panos Institute (1990) notes that stigma related to HIV/AIDS occurs throughout the entire world. However, the manifestation of stigma differs from country to country. In South Africa stigma is thwarting the fight against the HIV/AIDS pandemic. Stigma is therefore an important issue to consider. But what is stigma exactly? Why do people stigmatise? Moreover, why is it a big problem in South Africa? These questions will be discussed in this section.

2.2.1 What is stigma?

The term *stigma* derives from the ancient Greeks who used this word to refer to visual marks branded on the bodies of slaves, traitors and criminals to indicate their status within the society. The mark was clearly visible and decreased the status of the individual enormously. ‘This stigma showed that the marked person was blemished, ritually polluted and to be avoided’ (Goffman 1963:1). Originally, the meaning of the word stigma did not refer to an illness but to a certain behaviour, causing a lower status in society. However, UNAIDS (2002:8) defines stigma as a social process:

“Stigma is a process in which an individual is being discredited significantly in the eyes of others. Within a particular culture or setting, certain attributes are seized upon and defined by others as discreditable or unworthy”.

This explanation is in line with the definition of Goffman (1963) who maintains that people apply a negative label to an individual based on whatever characteristic makes that individual different. Stigma as a social process changes the relations between
people and creates a social inequality within a society. According to Stein (2003), the stigmatised person was once a member of a certain group, but now that he or she has been labelled with a new and degrading identity that does not fit the group, he or she becomes unwanted.

Stigma is one of the most difficult problems to solve within the fight against the spread of HIV/AIDS. Many studies have been conducted to understand stigma in the context of HIV/AIDS. One of the main questions concerns the reason why people who see themselves as normal feel the need to stigmatise others who have contracted HIV/AIDS. The next section will throw more light on this topic.

2.2.2 WHY DO PEOPLE STIGMATISE?
For decades, people living with HIV/AIDS have been feared and threatened. There are many different views as to why people stigmatise those persons who are infected with HIV/AIDS. UNAIDS (2005:4) notes that:

'Stigmatisation associated with AIDS is underpinned by many factors, including lack of understanding of the illness, misconceptions about how HIV is transmitted, lack of access to treatment, irresponsible media reporting on the epidemic, the incurability of AIDS, and prejudice and fears relating to a number of socially sensitive issues including sexuality, disease and death, and drug use.'

Perloff (2001) suggests that there are several reasons why people stigmatise HIV/AIDS-infected people. First of all, Perloff (2001); Brown et al. (2001); Herek (1999) and Pryor and Reeder (1993) say that people fear to be in contact with HIV/AIDS-infected people because they are afraid that they or their loved ones might contract the disease. After all, it is an infectious disease and once someone is infected with HIV/AIDS, he or she may die because of it. This deep-rooted fear feeds the AIDS stigma, although this fear is understandable and, in a way, a natural human
reaction to a deadly disease (Perloff 2001).

Secondly, Rozin, Amrkwith and Nemeroff (1992; quoted in Perloff (2001:128)) maintain that ‘when two objects come into contact, they exchange properties and will continue to influence each other from that point, a magical law of contagion’. An example is the belief that drinking out of the same glass as an HIV-infected person can lead to HIV infection. Even if the glass has been properly cleaned, people are still afraid of becoming infected with HIV. ‘Although the HI virus can only infect a living creature, the AIDS stigma can infect or contaminate virtually anything associated with an HIV-infected individual’ (Pryor and Reeder 1993:265).

Thirdly, Perloff (2001:128) refers to AIDS as a social symbol. In this case, people make a connection between HIV/AIDS and groups they dislike. People may have an aversion to gay people, because they must have HIV/AIDS. On the other hand, as I have personally experienced in South Africa, white people who have an aversion to black people express this by statements such as: “HIV/AIDS is a black issue, it does not concern us”.

Herek and Glunt (1999) explain that HIV stigma often occurs on top of another, pre-existing stigma. This type of stigma is associated with a certain group of people who are differentiated by race, class, sexual orientation, gender etc. ‘Normal’ people expect these groups to behave in a way that is neither acceptable nor correct in ‘normal’ society. HIV/AIDS is therefore seen as a natural consequence of this unacceptable behaviour and these groups will be avoided for reasons of the HIV stigma. Siyam’Kela (2003) indicates that PLHA’s are often blamed or seen as responsible for their ‘faults’ and consequently deserve to become infected. Herek (1999) adds that PLHA’s are considered to have behaved irresponsibly by contracting HIV/AIDS and therefore having HIV/AIDS is perceived as being their own fault.

Bishop et al. (1991) suggest that the connection between HIV/AIDS and certain
stigmatised groups in society can be so strong that people automatically associate AIDS sufferers with these groups. This leads to widely held notions such as *anyone with AIDS is a prostitute*, even if it concerns children who may have become infected through mother-to-child transmission. PLHA’s are labelled as inferior or dangerous and are classified into an inferior or bad group in society. Siyam’Kela (2003); Stein (2003); Brown et al. (2001) and Goffman (1963) indicate that stigma does not only affect the infected people, but also those closely connected to PLHA’s such as family, friends, or health care workers. It appears that stigma can be transferred to other members through the so-called existing *lineages* (Goffman 1963:14). In other words, people believe that stigma is passed on to those who are in contact with PLHA’s.

Jones, Farina, Hastorf, Markus, Miller and Scott (1984) present four possible reasons to explain the fear of HIV/AIDS and the urge to stigmatise. Firstly, the stigmatised person is just like anyone else who contracted the disease. This refers to the vulnerability of regular people to become infected too. Secondly, when people are in a way related to the bearer of the stigma, they fear that they will also be labelled as HIV-positive or AIDS sufferers, because of the relation they have with the stigmatised. For instance, someone in the family is infected with HIV/AIDS and that makes it probable for a relative of the family to have to share the stigma of HIV/AIDS too. In this case, the bearer of stigma does not necessarily need to be HIV-positive. Thirdly, Jones et al (1984) indicate that the bearer of HIV/AIDS stigma may have tried to persuade a person to perform risky behaviour (i.e. unprotected sex, sharing needles) that can infect the ‘victim’ with HIV/AIDS as well. This would confirm the immoral behaviour of the person who is labelled as discreditable and unworthy (see also Herek (1999)). Fourthly, people may fear that they are obliged to help the stigmatised, while they prefer to stay away from them. According to Jones et al. (1984), these four reasons contribute to the fear of interacting with the stigmatised.
As mentioned before, lack of knowledge about the disease and its transmission creates stigmatising behaviour. It derives from the fear of not knowing (Perloff 2001). According to Zuberi, Jones and Viljoen (2004), members of the PLHA’s family stigmatise the PLHA the most. This behaviour derives from the fear of what the neighbours and others in the community might say.

Stein (2003) indicates that stigma is a way of protecting oneself from something bad and making one feel safe, as opposed to what happened to the victim. It is to affirm that one did not do anything wrong to deserve the dreaded disease. ‘Stigma is a psychological defence mechanism which serves to control anxiety in the face of danger’ (Stein 2003:98). The psychological defence mechanism that is used to control one’s anxiety can be compared to the fear control process as presented in the EPPM. This model explains that when the perceived threat exceeds the perceived efficacy, the fear originally evoked becomes more intense. When the person is not convinced that he or she is able to control the danger, and as a consequence, becomes preoccupied to loose this fear, then he or she will perform maladaptive responses, such as aggression towards the communicator, defensive avoidance and inattentiveness towards communication (Hovland et al. 1953). At this point, the strong emotion of fear has lead to defensive motivation. In addition to the EPPM, especially people who enter the fear control process, who are confronted with very strong emotions of fear of HIV infection and who do not consider themselves able to control the threat of HIV/AIDS (low perceived efficacy), may perform defensive behaviour to control their anxiety, such as stigmatising behaviour.

Furthermore, the role of the media in informing people on issues regarding HIV/AIDS also contributes to fear and may feed stigma. According to Siyam’Kela (2003), the media should show that people from all backgrounds are susceptible to HIV/AIDS. Phrases in articles that depict HIV/AIDS as mainly affecting people who are poor, black or living in developing countries, would perpetuate the negative evaluation of these people. Moreover, such phrases suggest that people who are
white, rich or living in developed countries are not susceptible to HIV/AIDS. In addition, terms used by the media, such as victim and AIDS carrier, promote the image of powerlessness of the PLHA (Siyam’Kela 2003d:4). Carstens (2004) explains that the AIDS carrier is seen as the guilty person who infects other innocent people with HIV and therefore, he or she is to blame for all the suffering. The media spread a lot of negative information such as ‘the AIDS carrier is a villain and tries to infect innocent people on purpose’. AIDS carrier as a term of abuse has been used for many subgroups in society, such as gay people and black men. But sometimes, black mothers and pregnant woman have also been regarded as AIDS carriers while their babies were viewed as the victims (Gevisser 1995). Depicting people as either victims or villains can disrupt the balance of the community or society and can lead to stigmatising behaviour. These phrases or expressions as set out above are a threat to the community and may negatively influence people’s perception of PLHA’s.

In summary, people stigmatise PLHA’s because they fear to become infected with HIV and they do not want to be associated with PLHA’s. Stigma is a way to control one’s fear. Stigma can be expressed in different ways. In the next section the various manifestations of stigma will be discussed.

2.2.3 MANIFESTATIONS OF STIGMA

Herek (1999) indicates that for as long as people have lived with HIV/AIDS they have been discriminated against. This discrimination manifests itself in several ways, such as firing PLHA’s from their jobs or denying them access to healthcare, insurance, or education. These examples are only some manifestations of stigma and in general, manifestations of stigma can vary from mild reactions such as silence and denial, to severe violence (Brown et al. 2001). Allport (1954, quoted in Bos (2001)) discusses the manifestations of stigma according to five levels of negative reactions towards people living with HIV/AIDS. The five levels of Allport (1954) are listed below.

1. Antilocution. People will only talk about the stereotypes of PLHA’s and the
prejudices. The effect of all this negative talk and gossip about PLHA’s is that it affects their self-esteem. Once the PLHA is labelled as HIV-positive, he or she is confronted continuously with these stereotypes and prejudices. Zuberi et al. (2004:24) indicate that PLHA’s will become ostracised by the society, because they will withdraw from the social activities to protect themselves from the gossip.

2. **Avoidance**. People will avoid any form of social interaction with the stigmatised persons. Herek (1999) believes that fear of HIV/AIDS causes avoidance, which is a defensive behaviour.

3. **Discrimination**. People can discredit and discriminate against the stigmatised individual.

4. **Physical attack**, such as physical intimidation, threat and violence can be used against the stigmatised person.

5. **Extermination** (i.e. murder and lynching) is the most severe manifestation of stigma. ‘It is the ultimate degree of violent expression of prejudice’ (Allport 1954:15).

These manifestations are all relevant and applicable to the stigmatisation of persons with HIV/AIDS (Bos 2001). However, recently several studies have been conducted to identify the manifestations of stigma more elaborately, such as the study on stigma of Siyam’Kela (2003). Siyam’Kela (2003) and Malcolm et al. (1998) divide the manifestations of stigma into two categories, i.e. internal and external stigma.

2.2.3.1 **Internal stigma**

**Internal stigma** is defined as a way to protect oneself from the ‘evil’ and the harsh world around oneself. It manifests itself in shame, guilt, depression, and hopelessness in its victims. As a result, the stigmatised may live in denial, neither willing to do an HIV test, nor seeking health care and social support (Brown et al. 2001, Stanley 1999). After all, to protect oneself from external stigma, one can refuse to take an HIV test, or to disclose one’s HIV status. As a consequence, PLHA’s may not seek
medical and/or psychological help, because that would confirm that they are HIV-positive (Siyam’Kela 2003; Parker & Aggleton 2003). Carstens (2004) suggests that the protective reactions of PLHA’s against the harsh world around them can also be expressed in maladaptive, aggressive behaviour like deliberately infecting people by rape or by dripping blood on them. As such, internal stigma may manifest in an aggressive form of protecting oneself.

According to Siyam’Kela (2003), there are twelve stigma indicators, divided across two categories, namely internal and external stigma. Those pertaining to external stigma will be discussed in paragraph 2.2.3.2. The themes of internal (felt or imagined) stigma (Siyam’Kela 2003:19) are elaborated in the following subsection.

2.2.3.1.1 Self-exclusion from services and opportunities

‘Some PLHA’s do not seek out services or opportunities associated with HIV/AIDS because of their fear of stigmatisation,’ (Siyam’Kela 2003:19). These services or opportunities associated with HIV/AIDS, such as clinics where people can take an HIV test or institutions where people can seek health care and social support, would confirm their HIV status and open the door to stigma.

2.2.3.1.2 Perception of self (self-esteem)

PLHA’s often have a low self-esteem. For them it is difficult to cope with a non-supportive environment or with bad experiences with external stigma. They become vulnerable and insecure, which may lead to a low self-esteem.

2.2.3.1.3 Social withdrawal

After discovering the HIV status, PLHA’s may not feel comfortable anymore in their social environment because of manifestations of external stigma. They withdraw socially in order to protect themselves (and/or their family and friends) from stigmatisation and discrimination (Siyam’Kela 2003c:21).
2.2.3.1.4 Overcompensation

PLHA's may feel the need to show everyone that they contribute to the society by hard working, and making enough or even more effort than people who are not infected with HIV/AIDS. This is a way to prove themselves to the society and to protect themselves from stigmatisation and discrimination.

2.2.3.1.5 Fear of disclosure

PLHA's do not easily tell people about their HIV status, because of the fear of stigmatisation and discrimination. PLHA's may decide just to tell their sexual partners. In that case, PLHA's do not completely disclose their status. The more PLHA's tell others about being HIV-positive, such as family, children, friends or the rest of the community, the more they disclose.

The other stigma indicators mentioned by Siyam’Kela (2003) are discussed in the next section on external stigma.

2.2.3.2 External stigma

**External stigma** can be defined as 'actual experiences of domination, oppression, exercise of power or control, harassment, categorising, accusation, punishment, blame, exclusion, ridicule or resentment,' (Siyam’Kela 2003:4). External stigma can put people into isolation (Siyam’Kela 2003) and they may suffer from discrimination and ostracization (Siyam’Kela 2003; Brown et al. 2001; Stanley 1999). Allport’s five levels of stigma (i.e. antilocution, avoidance, discrimination, physical attack, and extermination) fall into the external stigma category. The indicators that refer to external (enacted) stigma according to Siyam’Kela (2003:8) are summarized in the following sub-sections.

2.2.3.2.1 Avoidance

'PLHA’s indicate that they are being avoided by others, because of the fear of transmission or the perception that PLHA’s are dirty and immoral,' (Siyam’Kela 2003c:8). The indicators of **avoidance** are:

- the number of people who do not share objects, like utensils, furniture and
equipment, with PLHA’s;

- the number of people who distance themselves socially from PLHA’s and/or their friends and family. Distancing refers to spending less time together, excluding PLHA from social events or conversations etc.;

- the number of people who do not consider PLHA’s as a normal person anymore but as a person with HIV;

- the number of people who distance themselves physically from PLHA’s, including avoiding any physical contact with a PLHA and spreading rumours about PLHA’s.

Zuberi et al. (2004), who conducted a study in the Hammanskraal community (Gauteng Province in South Africa), add that there is a belief among people that being touched by a PLHA can cause HIV infection. This fear of infection is based on a lack of knowledge about the disease and how the transmission can take place. ‘The lack of knowledge and fear of infection can lead to behaviour such as not shaking hands, being scared of someone coughing in your presence, not sharing food or other utensils and eating beetroot at funerals,’ (Zuberi et al. 2004:36). The people from this community consider this behaviour as a way to prevent HIV infection. “Sometimes when I am cooking, if maybe one (e.g. a family member) comes to visit me at home and finds me cooking, he or she will tell me hey my friend, don’t dish for me. I’m full’ (Zuberi et al. 2004:30). This anecdote told by an anonymous female participant in the study of Zuberi et al. (2004) poignantly illustrates avoidance behaviour caused by stigma and lack of knowledge of HIV/AIDS. Zuberi et al. (2004) state that most people know about the available information on HIV/AIDS but they choose to ignore it.

2.2.3.2.2 Rejection

‘Many PLHA’s suffer from rejection by their friends, relatives, family and colleagues, due to the perception that PLHA’s deserve the illness or that HIV can be transmitted through casual contact,’ (Siyam’Kela 2003c:10). The indicators for
rejection are:

- the number of PLHA’s who have been abandoned by significant people in their lives or the number of people who would abandon PLHA’s in the future;
- the number of PLHA’s who have been forced to leave their work, home or social setting after disclosing their HIV status or the number of people who feel that PLHA’s should not be welcome in their home/social setting/organisation.

2.2.3.2.3 Moral judgement

People may judge PLHA’s for their immoral beliefs and immoral lifestyle and as a consequence believe that PLHA’s were punished with HIV. Moral judgement involves either viewing PLHA’s as guilty or innocent in terms of how they contracted HIV. Such thinking allocates blame and allows people to distance themselves from PLHA’s. This othering perception dismisses PLHA’s as promiscuous, sinful or irresponsible and allows discrimination to appear justified (Siyam’Kela 2003c:11).

According to Zuberi et al. (2004), the members of the Hammanskraal community in South Africa believe that those infected with HIV have been sleeping around even though they were aware of the risk. In most cases, the these people will blame every person infected for leading a bad lifestyle, not only prostitutes. In other words, in people’s minds there is a strong relation between HIV infection and promiscuity, which makes all of those infected guilty and therefore, rightfully subject to stigmatisation. The indicators for moral judgement that Siyam’Kela (2003) lists are the following:

- the number of people who use the concept of blame to inform their response to PLHA’s;
- the number of people who present HIV/AIDS in terms of a moral judgement.

2.2.3.2.4 Stigma by association

According to Siyam’Kela (2003), stigma by association is another indicator of external stigma. It refers to the number of people who stigmatise those who are associated with PLHA’s. ‘As a result of the silence surrounding HIV/AIDS and fear
of casual transmission, a culture of suspicion has been created whereby some people try to identify possible PLHA's through associations,' (Siyam'Kela 2003:13). For instance, associations include those with certain medical conditions which tend to accompany HIV/AIDS (e.g. skin rash), people working with PLHA's, friends and relatives of PLHA's and those who are part of a group that is more vulnerable to becoming infected, such as prostitutes.

2.2.3.2.5 Unwillingness to invest in PLHA's

Siyam'Kela (2003) indicates that people are less likely to disclose their HIV status if they have been told or have seen evidence of the lack of career possibilities caused by such disclosure. There is a commonly held belief that investing in PLHA's in the workplace is a waste of money, because they are not as productive as healthy people are and will die sooner. As a consequence, PLHA's are less willing to disclose their illness in order to avoid this type of stigma in the workplace. The indicators for unwillingness to invest in PLHA's used by Siyam’Kela (2003) are listed below:

- 'the number of PLHA's who are marginalized within their organisations after having disclosed their HIV status, despite adequately performing their assigned roles' (Siyam’Kela 2003c:13);
- the number of leaders within different organisations who do not consider investing in PLHA's as beneficial.

2.2.3.2.6 Discrimination

PLHA's experience unequal treatment because they are HIV-positive. Insurance companies and financial institutions often deny PLHA's access to their services. The indicators for discrimination that Siyam’Kela (2003) lists are:

- the number of PLHA's who have been denied services because they are HIV-positive, or the number of people who would deny services to them;
- the number of reported cases of HIV/AIDS stigma and discrimination within an organisation/social setting.

Research of the The Panos Institute (1990:53) indicates that discrimination is a phenomenon, which cuts across cultures and nations, irrespective of gender, age or
social status of the individual and irrespective of how he or she contracted the virus. Furthermore, discrimination creates and reinforces the stigma of AIDS.

2.2.3.2.7 Abuse

People may use verbal or physical violence against PLHA’s as a reaction to show their disapproval and rejection towards PLHA’s. ‘Some PLHA’s experienced abuse because they were seen as immoral or as a threat to the community,’ (Siyam’Kela 2003c:17). According to Siyam’Kela (2003), abuse can be measured by:

- the number of PLHA’s who have been verbally or/and physically abused;
- the number of people who think that verbally or/and physically abuse is justified.

According to Stein (2003), people have become aware of the fact that judging and discriminating people with HIV/AIDS is morally wrong, but that does not mean that their attitude and behaviour in respect of HIV/AIDS patients is free from stigmatisation. People may not admit that they stigmatise, to prevent others from finding out that they do treat PLHA’s unequally. HIV/AIDS has become a taboo subject that people do not wish to talk about with outsiders. The resulting silence surrounding HIV/AIDS makes it difficult to measure and to understand the aspects of external stigma towards PLHA’s properly.

2.2.4 CONSEQUENCES OF STIGMA

Having discussed the phenomenon stigma and the manifestations of external and internal stigma, this section will deal with some of the consequences of stigma. In particular, this section throws light on the consequences of stigma (caused by fear) within the context of the use of fear appeals in HIV/AIDS education campaigns.

First of all, stigma affects the mental status of a person living with HIV/AIDS. It causes stress and mental anguish. Stigma can also affect the medical condition of a PLHA. For instance, stigma can discourage people from taking an HIV test to find out whether they are HIV-positive, or from returning to the clinic once tested as HIV-
positive, to receive antiretroviral medication. This has a negative influence on the physical health and wellbeing of a PLHA. Furthermore, stigma negatively affects preventive behaviour, because it can provoke ‘self-destructive behaviour, self-blame and self-loathing’ (Herek 1999:4).

Apart from the individual consequences, stigma causes problems on all levels, even on national level. For instance, fighting stigma attitude and behaviour has become an extra concern within the context of HIV/AIDS care and prevention. Brown et al. (2001) suggest that stigma gets worse in developing countries where the availability of proper health care and treatment is insufficient. Investments need to be made in health care, treatment, and education to fight the HIV/AIDS pandemic. Because HIV/AIDS is a serious threat to the South African future, health care spending has become an ever increasing and substantial part of the national budget.

This section discussed the phenomenon stigma and its manifestations particularly within external stigma. It has become clear that the consequences of stigma are severe and that stigma hinders the fight against the HIV/AIDS pandemic. HIV/AIDS health education and prevention messages are necessary to educate people about HIV/AIDS in order to reduce not only the number of PLHA’s but also manifestations of external stigma and internal stigma. The choice of media and the content of the messages regarding HIV/AIDS prevention and education are important tools to transmit the message to the receiver and to make members of the target group accept the persuasive message. In the next chapter I will discuss the use of narratives as a way to educate people about HIV/AIDS.
2.3 NARRATIVES

According to Zuberi, Jones and Viljoen (2004), there is a relation between the lack of knowledge about HIV/AIDS and manifestations of stigma towards PLHA's. For instance, people, who do not know how HIV/AIDS is transmitted, are more likely to stigmatise PLHA's (e.g. avoiding PLHA's and not shaking hands with PLHA's because of the fear of contracting HIV/AIDS). The mediating effects of AIDS-related knowledge on the relationship between traditional beliefs about the cause of HIV/AIDS and AIDS stigma are crucial in combating stigma (Kalichman & Simbayi 2004). This is where HIV/AIDS education can play a role. HIV/AIDS education campaigns may create AIDS-related awareness and knowledge, and may change someone's attitude and behaviour towards HIV/AIDS. Therefore, HIV/AIDS education campaigns are essential in the fight against the HIV/AIDS pandemic in South Africa. The mass media play an important role in HIV/AIDS education and prevention programmes. HIV/AIDS education messages reach the population through television, radio, billboards, brochures, community health workers, etc. A popular method to educate people about risks is through narratives or story-telling (Golding, Krimsky & Plough 1992). This chapter discusses the use of narratives as a possible format for HIV/AIDS education messages in the fight against HIV/AIDS.

2.3.1 THE CONCEPT OF NARRATIVES

A narrative is a story that reflects a certain experience of the author. It judges the actions taken by the character in the story to make ‘sense of the social world’ (Hydén 1997:49). A narrative structures information and includes belief systems and values concerning various domains of social life (Carstens 2003). According to Brosius and Bathelt (1994), a narrative increases the vividness and perceived authenticity of the experience, and the level of interest from the recipient.

Green (2002) conducted experimental research in which she took a closer look at how narratives affect someone’s beliefs and whether a true narrative or imaginary
narrative makes a difference in changing his/her beliefs. Green (2002) claims that a powerful narrative can captivate a person into the world of the narrative, making it seem so real that it feels like a personal experience to the recipient. When the narrative feels like a personal experience, the recipient can become so captivated by the narrative that he or she is no longer critical towards the content of the narrative. The reason for this is that people do not want to interrupt an exciting narrative by evaluating the implications; it ruins the 'pleasure of the experience' (Green 2002:3). Once the reader of the narrative has been captivated by the narrative, the narrative affects the 'real-world knowledge structures' (Green 2002:2). At that point, the content of the narrative is able to change a person’s attitude and beliefs. Green’s research shows that the level of captivation and someone’s beliefs are not more affected or less affected when the narrative includes a real or an imaginary story. The narrative needs to feel real and engaging Green (2002) also mentions the importance of the main character(s) in the narrative. If the reader can identify with the main character(s), he or she may copy the opinions or situations experienced by that character to his or her own situation. The main character(s) in the narrative may play a crucial role in captivating the recipient. The more the reader is captivated by the narrative, the more powerful that narrative becomes in changing a persons’ attitude and beliefs.

Jansen, Croonen and De Stadler (2005a) agree that a narrative needs to feel real to be effective. Jansen et al. (2005a) conducted a study into the effects of short anecdotal narratives (exemplars) about PLHA’s in HIV/AIDS education material in South Africa. The effects of two distinctive narratives were compared. The difference between the narratives concerned was whether the main character was personally to blame for contracting HIV. The difference between the two narratives did not influence the belief of the participants towards the responsibility in general of PLHA’s in contracting HIV/AIDS. However, a statistically significant effect of the exemplar was found on the willingness of the participants in the study to support PLHA’s. Those who read the narrative where the character was portrayed as innocent
were more willing to support a PLHA. Furthermore, the results showed that when the narrative was felt to be unrealistic, it seemed to contribute to the belief that PLHA's in general were to blame for their infection. The narrative that was not felt to be realistic also influenced the attitude that PLHA's do not deserve full support. It seems important that before narratives are used in HIV/AIDS brochures, they should be carefully tested to verify the perceived authenticity of the story (Jansen et al. 2005a).

Rhodes and Wolitski (1990) claim that personalizing a risk is important when high threat messages are to succeed. That is what Golding et al. (1992) tried to achieve in their experiment. They conducted an experiment on informing the audience about the risk of radon in which they tested whether technical or narrative forms of risk communication are more effective in drawing a person's attention, providing information and modifying behaviour. Golding et al. (1992) tried to encourage the reader to personalize the risk of radon through a set of narratives in which people explained how they coped with the threat of radon. In addition to the series of narratives, Golding et al. (1992) used a series of technical articles that were scientifically written, with facts and according to a reporting style, such as an article in a newspaper. The outcome of the experiment showed that the two forms of risk communication were equally effective in raising the level of knowledge. Both the narratives and technical articles increased the level of knowledge about radon. However, the researchers also found that narratives might be better at retaining the attention of readers. On the other hand, the technical article appeared to be more effective in attracting initial readings (persons who read a text for the first time).

To summarize, some studies have found that a narrative can be an effective method to retain the attention of the reader and to change a person's beliefs and attitudes. With respect to HIV/AIDS, it seems important that the narratives in HIV/AIDS education material are felt to be realistic in order to captivate people, and that these messages persuade them to adopt the right behaviour, e.g. HIV prevention. The next section discusses two types of narratives in more detail, especially, in relation to
illnesses that are important within the context of HIV/AIDS.

2.3.2 TYPES OF NARRATIVES RELATED TO ILLNESS

Hydén (1997) describes two different types of narratives related to illness in general, that can be used within AIDS education material, i.e. *illness as narrative* and *narrative about illness*.

2.3.2.1 Illness as narrative

Hydén (1997) explains that *illness as narrative* is often used within social science and medicine. This type of narrative is comparable to an autobiography in which events and symptoms of the illness are explained and also what kind of influence the illness has on the life of the narrator. The writing style is as if the ill person shares his/her personal experience of the illness with the reader. For example, the narrator is a person living with HIV/AIDS who shares his/her experience of HIV/AIDS with the audience. This example is also sometimes referred to as *autobiographical illness narrative*.

2.3.2.2 Narrative about illness

A *narrative about illness* (Hydén 1997:54) is used when an outsider related to an ill person tells his/her story. There are different subtypes, which are called *co-experiential illness narrative*, *reported illness narrative* and *lay illness narrative*. The writer of a *narrative about illness* may be a relative or health care professional who is related to the HIV/AIDS patient. The relative or health care professional also experiences the illness because of his/her close interaction with the PLHA. In the case of (close) interaction with the PLHA, the narrative will be called *co-experiential illness narrative*. Then there are narratives about HIV/AIDS written by the media, such as articles in newspapers. This subtype differs from *co-experiential illness narrative*, because the story of the author is not based on a personal experience with HIV/AIDS. This subtype is called *reported illness narrative* (Hydén 1997:64). Another subtype, *lay illness narrative* (Hydén 1997:51), exists where a person who is not infected with HIV/AIDS and has never been in contact with an HIV/AIDS patient.
tells his/her story. The various types and subtypes of narratives that can be used in HIV/AIDS education material are presented in figure 3 in a diagram, as developed by Carstens (2003:5):

Figure 3. A typology of illness narratives

The previous sections discussed the narrative as a possibly effective method within the HIV/AIDS campaigns. However, the effectiveness of an HIV/AIDS campaign is also influenced by other aspects, such as the cultural background of the reader. The existing beliefs that derive from the culture in which a person has been brought up may carry more weight than the information received via public health campaigns.
and other sources. Stein (2003) argues that HIV/AIDS education programmes sometimes lack the ability to offer information to remove the erroneous beliefs in respect of transmission of HIV/AIDS. According to Swanepoel (2003), HIV/AIDS campaigns in South Africa do not appear to be very effective. The prevalence figures still indicate a high rate of new infections, especially among women aged 15 to 24 years old in South Africa. Van Dyk (2001) and Sobo (1999) state that many HIV/AIDS education campaigns in Africa have not achieved their goals, because of the lack of attention that was paid towards the local culture. The next chapter takes a closer look at the African cultural background and its influence on HIV/AIDS prevention campaigns.
2.4 CULTURAL BACKGROUND

According to Van Dyk (2001, 2005) many HIV/AIDS education and prevention programmes created by Western organisations have not been very successful in sub-Saharan Africa. One of the reasons for the alleged failures might have been the lack of representation of African culture and belief systems in HIV/AIDS campaigns. Most HIV/AIDS prevention and education campaigns in sub-Saharan Africa have been based on Western principles. It is important to acknowledge the cultural differences between the sub-Saharan African and Western countries (e.g. countries in Western Europe and the United States), such as the different views of African people\(^2\) on health, sickness and sexuality (Van Dyk 2001). This chapter will give a short sketch of the cultural background of sub-Saharan African countries in as far as it is possible to summarise the cultural background of an almost entire continent in one short chapter.

2.4.1 SUB-SAHARAN AFRICAN CULTURAL BACKGROUND

Van Niekerk (1996) argues that black Africans are focused on their community and moreover on the cosmos, which signifies the whole (the entire universe) including the power of spirits, ancestors, God, life and death. Van Dyk (1991) adds that traditional Africans consider humankind as the centre of the universe. According to Van Niekerk (1996), the cosmos can be represented as a circle of which a person is a part. Within this circle, everything and everyone is related to each other and each relation needs to be in harmony. Traditional Africans perceive illness as a factor that can disturb this harmony. They try to explain the cause of illness by means of three levels in which the cosmos is divided: macro-cosmos, meso-cosmos, and micro-cosmos. These three levels will be discussed in the following sections.

---
\(^2\) The African people equal the population living in traditional black societies in Sub-Saharan countries. Even though people living in Sub-Saharan Africa may differ in terms of culture, language, religion, way of life etc., there are similarities in terms of socio-religious philosophy (Sow, 1980 in Van Dyk, 2005). These similarities are discussed in section 2.4.
2.4.1.1 Macro-cosmos

The macro-cosmos is the highest universe, consisting of God, ancestors and spirits (Van Dyk 2001:60). The role of the church and God is extremely important. Van Niekerk (1996) mentions that the church offers a safe environment, which is important for people who struggle to survive and are faced with an insecure future. African people have faith in God. They believe that if you live a good life according to God’s rules, He will protect you, but if you do not lead a good life, He will punish you. Van Dyk (1991) also mentions the school of thought among some black Christians that AIDS is a punishment from God for living a sinful and immoral life.

The ancestors are spirits who preserve the honour and traditions of a tribe (Van Dyk, 2001:60) and are requested for their counsel in case of, for example, illness. The ancestors need to be kept satisfied, as they protect the people from evil and bad forces. If someone defiles the honour of the ancestors or violates the social norms, the ancestors can punish that person with illness or another misfortune.

Van Dyk (2001:61) makes a distinction between the alleged ‘immediate’ and ‘ultimate’ cause for illness or misfortune. The immediate cause for illness may be a virus. For example, an HIV patient may completely understand that he or she became infected because of contact with HIV-infected blood. However, the ultimate cause of illness is related to the question why that person in particular suffered the misfortune of contracting HIV and not another person from the community. South Africans hold the traditional belief that the ultimate cause of illness often is a punishment by God or ancestors (Sow 1980, quoted in Kalichman & Simbayi (2004)). As Van Dyk (2001) suggests, Africans believe that God or the spirits send illnesses as a way of punishment when someone angered them. People may believe that a person has become infected with HIV because he or she did something immoral that brought the environment (the circle in which everything is related to each other) out of balance, and because of that he or she was punished for it. When people suggest that God or the ancestors are responsible for someone’s HIV infection, it leads to stigmatising
beliefs about PLHA’s (Goffman 1963). After all, God or the ancestors only punish someone when he or she did something immoral or committed a sin. However, the cause for illness can also be explained by means of the meso-cosmos.

2.4.1.2 Meso-cosmos

The meso-cosmos is the intermediate universe that helps people to understand why unfortunate things, such as illness, happen to them (Van Dyk 2001:61). The meso-cosmos refers to evil spirits, witchcraft and sorcery. Most of the time, nearly all forms of suffering, misfortune, illness, and death is blamed on evil spirits, witchcraft and sorcery (Sow 1980 and Viljoen 1997; quoted in Van Dyk (2001)).

Van Dyk (2001) explains that if African people believe that witchcraft is the cause for someone to contract HIV, they are more willing to help this HIV-infected person because the illness is beyond his or her control. Moreover, Van Dyk states that people do not like taking responsibility for their own actions especially those, which may cause negative consequences, such as having unprotected sex resulting in HIV infection. Blaming witchcraft for having contracted HIV allows a person to avoid taking responsibility for his or her own actions, and as such using witchcraft as a tool in the education campaigns to combat the HIV/AIDS pandemic is dangerous. Moreover, Van Dyk (2001) mentions that the belief in supernatural powers causing HIV infection is an underlying source of AIDS-related stigma in South Africa. Kalichman and Simbayi (2004:573) confirm this premise by stating that ‘attributing illness to spirits and supernatural forces may be related to stigmatising afflicted persons’. They investigated whether associations between the belief that AIDS is caused by spirits / supernatural forces and AIDS-related stigma are mediated by AIDS-related knowledge among men and women from a black township in Cape Town. The outcome of the study confirms the hypothesis. It shows that the participants who believed HIV/AIDS is caused by spirits and supernatural forces were less educated about HIV/AIDS, were less likely to have work or to use condoms. Moreover, this particular group of participants was significantly more
likely to stigmatise PLHA’s. However, it is important to note that these results do not mean that people who do not believe in witchcraft do not stigmatise.

2.4.1.3 Micro-cosmos

The micro-cosmos represents the everyday life of an African. Besides explaining the illness on a macro- and meso-cosmic level, the illness can also be explained by means of the level of the micro-cosmos. ‘Pollution and germs are also believed to be the cause of a certain illness’ (Van Dyk 2001:61). To give an example, Leclerc-Madlala (2001) argues that Zulus in South Africa believe that the womb of a woman is not only the environment where babies grow. They also believe that germs grow there. In contrast, pollution and germs are also believed to be a cure against illness. In addition, Leclerc-Madlala (1997) illustrates that African men in Durban rape Indian women because they believe that these women have AIDS-antibodies in their body. Furthermore, Mitchell and Capel (1995) in Leclerc-Madlala (1997) refer to the belief among Zulus in South Africa that sexual intercourse with a child virgin cures HIV/AIDS-infected people of HIV.

The African beliefs reflect the psychological adaptation of people to HIV infection (Stanley 1999). African beliefs, such as the African beliefs in the light of macro-, meso-, and micro cosmos differ in many aspects from Western beliefs, in particular regarding sexual activity that will be discussed in the next section³.

2.4.1.4 African perceptions related to sexual activity

Perloff (2001) indicates that the meaning of sex in the African countries differs from the meaning of sex in the Western countries. In African countries, sex is seen as an essential form of recreation, but within the boundaries of the men’s world. In this man’s world, men have the liberty to have more wives and/or sexual partners. In contrast, women can only have one husband/sexual partner who must be obeyed. In

³The African worldview is a generalization for many black African cultures. The black African individual may share this African worldview to a certain extent, depending on external factors such as language, religion, way of life (Van Dyk, 2005).
the African culture, there is a strongly felt need to create offspring. 'A man’s wealth depends upon the growth of his tribe' (Van Dyk 2005:121). On the other hand, women gain respect in terms of the number of children they have. The more children a woman has, the more respect she gains (Perloff 2001). But those are not the only reasons why having children is very important to African families. Children are seen as a guarantee for the future (Van Dyk 2005). To give a few examples: they take care of their younger brothers and sisters, they help with cleaning and cooking, they take care of the cattle, and they can work to earn money. Moreover, many traditional Africans believe that the deceased ‘acquires personal immortality through their children’ (Van Dyk 2005). Mbiti (1969; quoted in Van Dyk (2005)) explains that the traditional Africans believe that when a person grows older, he or she gradually moves from the present to the past. After someone dies, he or she can continue to exist in the present as a *living dead* as long as the relatives and friends who have survived the deceased, remember him or her. To be forgotten after one’s death and to be cast out of the group of the ‘living dead’ into the world of the past, is the worst possible punishment for a traditional African. That is why kinship is important in traditional African cultures, because it helps the deceased to stay linked to the present.

Another widespread phenomenon which is important within the context of sexual behaviour and which is crucial to the HIV/AIDS pandemic is the occurrence of sexual violence. Community Information and Epidemiological Technologies (CIET) (2003) conducted a study in the Southern Metropolitan Local Council (SMLC) area of Johannesburg on the culture of sexual violence. The outcome of this study provides information on the views of adults and adolescents on sexual violence in South Africa. 25% of the adult men believe that when a woman says *no* to sex, she actually means *yes*. 20% of those men questioned by CIET have said that they have had sex with a woman without her permission. 60% of the women questioned knew that they have the right to avoid sexual violence, but because of their economic dependence on men, they accept the abuse. 32% of male adolescents questioned have
said that forcing sex on someone you know is never sexual violence. By the age of 18 years old, 25% of the male adolescents have had forced sex on someone. 75% of the female adolescents questioned have said that sexual violence is the woman's own fault and 27% said that forcing sex on someone you know is never sexual violence. According to CIET, 50% of rapes happen in the home and 60% of the rapists know the victim.

Condom use is not very popular in Africa (Van Dyk 2001, 2005). Using a condom is perceived as a loss of face for the man. That is because the man sees the request for using a condom as a sign that he could not be trusted in respect of fidelity towards his wife, and may have contracted a STD (Sexually Transmitted Disease). Males also often see a request for condom use as a sign that the female partner has been unfaithful. However, not only men have problems with condoms. Some women in South Africa fear that the condom may get stuck in the vagina (Zazayokwe's 1989, quoted in Van Dyk 2005). Zulus in South Africa often believe that the condom blocks the development of the foetus, because semen is needed to stimulate the growth of the foetus (Van Dyk 2001, 2005).

Polygamy (having more than one partner) is generally accepted and plays a noticeable role in African cultures. Polygamy often helps to prevent or reduce unfaithfulness, HIV infection, etc. (Van Dyk 2005). Faithfulness in this context refers to not having sexual intercourse with people outside the group of partners. For instance, rural men who need to go to the urban area to look for work may not see their wife/wives in the rural area very often. These women stay at home, to take care of their children and property. Polygamy offers the possibility for these men, who are forced to work far away from their family, to have a wife in the city/town where they are working. In such a way, polygamy prevents husbands to turn to casual sex and they thus stay faithful to a select number of partners (Van Dyk 2005:121). In traditional communities polygamy is also a common phenomenon. A man can marry several women who then all live together in the same home or homestead. There is a
hierarchy among the husband’s wives. In both described scenarios it is important that all partners in the relationship are HIV-negative and that they (especially the man) stay faithful to their select number of partners and do not have sexual intercourse with people outside this group.

In designing HIV/AIDS education messages, attention should be paid to the issue of fidelity and loyalty between the husband and his wife/wives. They should be discouraged to have sex outside that group (Van Dyk 2002). Next, the importance of condom use and disapproval of sexual violence should also be taken into account in HIV/AIDS education. Sexual violence might reduce someone’s perceived self-efficacy (CIET 2003), e.g. the victim does not see himself/herself able to persuade his/her partner to use a condom during sexual intercourse for fear of being abused. Therefore, it is important to emphasize self-efficacy in the HIV/AIDS campaigns. In general, to make HIV/AIDS education programmes successful in South Africa, it is important not to condemn or ridicule African beliefs, but to take these beliefs, norms, and values into account when designing HIV/AIDS programmes and messages.

2.4.2 SOUTH AFRICAN POPULATION
The previous sections discussed the African cultural background in general, giving some examples of the effect this may have on the HIV/AIDS pandemic in South Africa. However, South Africa is a diverse country with different ethnic groups. The next section takes a closer look at the demography of South Africa and its relation with the AIDS pandemic in South Africa.

2.4.2.1 Demography in relation with HIV/AIDS
As previously mentioned, South Africa has the largest number of HIV-infected people in the world. According to the CIA (2005), the estimated number of people living with HIV/AIDS in South Africa in 2003 was about 5.3 million people (out of a population of about 44 million). However, PLHA’s are not proportionally divided among the existing ethnic groups in South Africa. Black ethnic groups in South
Africa were more affected by the HIV/AIDS pandemic than the other ethnic groups, e.g. the white, Indian and coloured groups. According to the results presented in the study on the national prevalence of HIV in South Africa conducted by the NMF/HSRC (2002), the overall HIV prevalence by race in South Africa in 2002 was:

- Africans, 12.9%,
- Whites, 6.2%,
- Coloureds, 6.1%;
- Indians, 1.6%.

The geographical area and province of residence are also predictors of the HIV status of the population (NMF/HRSC 2002:56). 21.3% of the South African HIV-infected population lives in an urban informal area and 12.1% in the urban formal area (NMF/HSRC 2002). According to CIA (2005), the informal urban area has the highest prevalence of HIV compared to other locality types. Parker (2004) mentions that contextual factors such as poverty, unemployment and rapid urbanization mediate the risk of HIV infection. ‘Poverty and unemployment are related to sex for survival and rapid urbanization leads to informal urban settlements where social cohesion is low’ (Parker 2004:2). These factors disable volitional control over sexual activity, especially for females, and may contribute to a higher rate of HIV-infected persons. The Gauteng Province is an extended urban region where over 7 million people live. The Gauteng Province has one of the highest overall prevalence rates of HIV in South Africa, i.e. 14.7% of the total HIV-infected population in South Africa. The estimation is that by 2020, the population of the Gauteng Province will have grown to 20 million people (United Nations Human Settlements Programme, UN-HABITAT 2005). If HIV continues to spread as it does now, the Gauteng Province could face a serious health care crisis in the near future.

4 The HIV prevalence of South Africans of two years and older in this study was estimated at 11.4% which equals about 4.84 million HIV-infected South Africans.
Not only information about ethnicity and area of residence leads to better insight into the demography of South Africa; information about age in relation with sexual activity is also relevant.

2.4.2.2 Age

Austin (1995) explains that the mid-to-late adolescents (13 to 16, 16+ years old) are searching for their own identity, image and place in society. Schapink, Hema and Muaya (1997) state that adolescents from traditional African societies become physically mature at a young age. They may already be sexually active by the age of 13 to 14 years old.

Junger (1998) conducted research on adolescents and their risky behaviour in the Netherlands. He found that adolescents perform more risky behaviour than adults do. A possible explanation for this behaviour may be explained by the premise that adolescents think that risky behaviour is fun and exiting. Zuberi et al. (2004) conducted a study on HIV/AIDS stigma and human rights in the Hammanskraal community in the Gauteng Province in South Africa. They agree that adolescents underestimate the risks of certain forms of sexual behaviour, such as having sex without a condom. Adolescents do not see themselves as being at risk of HIV. Zuberi et al. (2004) state also that young people generally have the attitude to live life to the fullest. They do not think about the future as in forty years to come, but rather as next week and are therefore not preoccupied with the risks of unsafe sexual behaviour (Zuberi et al. 2004:26). Schapink et al. (1997) state that adolescents become physically mature at a young age, but their mental, emotional, and social skills are not developed enough to understand or perform safe sexual behaviour. This could explain why adolescents do not see themselves as being at risk of HIV/AIDS and therefore have unprotected sex. In addition, Perloff (2001) also claims that adolescents underestimate their susceptibility towards HIV/AIDS. Perloff (2001) illustrates that the low perceived susceptibility of adolescents may have consequences for the content of the HIV/AIDS education messages. He suggests that a fear appeal messages that
focus on death in HIV/AIDS education, may not get the attention of adolescents, because to the adolescents death seems too far away. As a consequence, the message may not seem relevant to them.

Adolescents are not completely independent in searching for their identity, image and place in society. Austin (1995) explains that parents, family, peers, and mass media still heavily influence adolescents. However, Schapink et al. (1997) argue that in most traditional societies the young children do not have a long childhood. At a young age, they often have the same responsibilities as adults, such as working and taking care of their brothers and sisters. Nevertheless, as Aggleton and Campbell (2000) state, parents play an important role in the life of their children. During the period that adolescents grow up, they are influenced by the parents' or other adult family/community members' values, ideas, beliefs and knowledge. In some countries in sub-Saharan Africa, adults have tried to deny adolescents access to information about sex because they fear that it will negatively influence the moral values of the adolescents (Aggleton & Rivers 1999).

The study by the NMF/HSRC (2002:8) states that in general, ‘South African HIV/AIDS campaigns have placed a strong emphasis on sexual risk and youth’. Research is mainly focused on adolescents and not on adults. However, as previously mentioned, adults influence their children in many ways. It is relevant to collect more data about the ideas and beliefs of the adults on risky behaviour regarding HIV/AIDS, and how they react to HIV/AIDS education and prevention material.

2.4.3 PURPOSE OF THIS STUDY

A theoretical framework is an important tool for the development of adequate HIV/AIDS education material. The literature discussed in this chapter concerned four central components, i.e. fear appeal (with in particular the EPPM), stigma (with in particular external stigma), narratives and the African cultural background. While a lot of research has been conducted on each of these components separately, there is
little knowledge about the interplay of these components in HIV/AIDS education material. Therefore, the purpose of this study is to investigate “to what extent the use of fear appeal messages in HIV/AIDS education material, among black adolescents and black adults with a lower socio-economic status in South Africa, leads to external stigmatisation of HIV/AIDS-infected people and to what extent this stigmatising behaviour differs between these adolescents and adults”. 
CHAPTER 3

METHOD
3  METHOD

In this chapter, the method that was used to examine the research question will be elaborated.

3.1  INTRODUCTION

This research was based on a 2 x 2 experimental design with text version and age group acting as the factors. The experimental group consisted of 140 participants (95 adolescents and 45 adults) who were presented with text version 1 (high threat and high efficacy or HTHE message). The control group consisted of 140 participants (100 adolescents and 40 adults) who were presented with text version 2 (low threat and high efficacy or LTHE message). More information on the text messages used (text version 1 and 2) is set out in section 6.4. After participants had read their respective text versions, they were asked to fill out a questionnaire, more on which is detailed in section 3.5.

3.2  PARTICIPANTS

A total of 280 participants took part in the research. 140 participants were presented with text version 1 and 140 participants were presented with text version 2 (see Table 1). All participants were black and came from either a township or a rural village.

<table>
<thead>
<tr>
<th>Age</th>
<th>Text version</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent</td>
<td>Text version 1, HTHE</td>
<td>95</td>
</tr>
<tr>
<td></td>
<td>Text version 2, LTHE</td>
<td>100</td>
</tr>
<tr>
<td>Adult</td>
<td>Text version 1, HTHE</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>Text version 2, LTHE</td>
<td>40</td>
</tr>
<tr>
<td><strong>Total population</strong></td>
<td></td>
<td><strong>280</strong></td>
</tr>
</tbody>
</table>

After reading the text messages, the participants were asked to complete a questionnaire. 11 questionnaires were insufficiently completed and could not be interpreted. After excluding these questionnaires, 269 questionnaires remained (see
Table 2 shows that 269 questionnaires were analysed. Out of those 269 questionnaires, 185 questionnaires were completed by adolescents and 84 questionnaires were completed by adults. 86.5% of the adolescents were black students at the Samafco high school \((N = 160)\) and 13.5% were black students at the Gatang high school \((N = 25)\). Both schools are situated in extension 4, Mamelodi East, which is a township of Pretoria, Gauteng Province, South Africa. The age of the adolescents varied from 14 to 20 years, with an average age of 16.7 years. 56% of the adolescents were female \((N = 104)\) and 44% were male \((N = 81)\). 48% of the adolescents received text version 1 \((N = 89)\) and 52% received text version 2 \((N = 96)\). After reading their respective text versions, they all completed the same questionnaire.

The second age group consisted of 84 black adults coming from Mamelodi \((N = 26)\), Soshanguve \((N = 11)\), Mpumalanga \((N = 16)\) and the city centre of Pretoria \((N = 31)\). The average age of the adults was 38.8 (ranging from 35 to 50 years of age).
Approximately equal numbers of participants received either text version 1 (52%, \(N = 133\)) or text version 2 (48%, \(N = 136\)), once again followed by an identical questionnaire. 43% of the adults were male (\(N = 36\)) and 57% were female (\(N = 48\)).

### 3.3 MATERIALS

For the purpose of this research, two different versions of a text suitable for a HIV/AIDS education brochure were developed, both in English. The difference between the two text versions was that text version 1 focused on a high level of threat and text version 2 on a low level of threat. Both text versions included the same high efficacy text message. Thus, each text version started with a manipulated message part which was either high or low threat, followed by an identical high efficacy message. The high efficacy part of the message, which was included in both text versions, is presented below. This narrative is a co-experiential illness narrative, as discussed in section 2.3.2.2.

**High efficacy text message**

_To everyone who is HIV-negative, please stay that way._

**Hello,**

_A lot of persons in South Africa are infected by HIV/AIDS. My partner and I talked to each other about this situation in our country. It is a big thing. We also talked to each other about our own health. We decided that we did not want to be at risk for HIV/AIDS. We decided to have safe sex. What is safe sex?_

_First of all, no sex is safe sex. So, we could say no to sex, but of course we are not going to do that our entire life. We decided to use condoms. Condoms prevent you from getting infected with HIV when you are having sex with your partner. Condoms are available in a lot of places in your community and you can get them for free. You should know that these free condoms protect you as much as condoms that you can buy in a store. Many people think that using a condom makes the sex bad. It is not true. We are happy together and most of all, we do not have to worry about getting infected!_

_Then, we decided to stay faithful to each other. Staying faithful to each other means that you are not sleeping around with other people._

\(^5\) Beforehand, an equal amount of questionnaires with text version 1 and text version 2 were shuffled and these were then handed out.
At the end, it is easy to protect yourself from getting infected with HIV/AIDS. The use of just one condom each time you have sex, is enough to protect you from getting HIV/AIDS. Talk to your partner about it, like we did. And another thing, be careful with sleeping around, stay faithful to your partner. It might just save your life!

Now it is your turn to think... are you being safe?

Mahlatsi

The high threat message part, which was included in text version 1, is set out below. This high threat message was an autobiographical illness narrative, as previously discussed in chapter 2.

High threat message

Hello,

I am Lerato and I would like to share my story with you.

My partner and I were once very close. But we have done something stupid. One night we experimented and some time after we "did it" my partner told me some bad news: my partner was HIV-positive. I was so angry and scared at the same time. How could my partner do that to me? I knew that I had to get myself tested to find out if I would be HIV-positive too. So, I went to a clinic, but they told me to come back in about 3 months, because it was not yet possible to see if I would be HIV-positive. For 3 months I was living in fear: was I or was I not infected with HIV? Was I going to die...? Then the day came that I returned to the clinic to get myself tested. The lady who took the test said that I needed to wait for 20 minutes and then I would get the results. These 20 minutes were the worst 20 minutes of my life. I was thinking: what if I am HIV-positive?! The thoughts were driving me crazy! Then the lady returned with the results. She looked at me and gave me the scary news: I was HIV-positive...

I stood up and left the clinic, everything outside suddenly looked different. I was scared. I could not go home and face my family. What would people think of me? I walked around and I started to think... Why...?

Since then, things have changed. I do not feel the same anymore. A lot of times I feel very sick and tired. I have this rash on my skin that I cannot hide. I know that there is no cure. I know I will die too young. I know I can have no dreams of a bright future, all because of this disease, HIV/AIDS. And the scariest thing is that it can happen to YOU too.

Lerato

Mahlatsi and Lerato are both names that can be used for women as well as men in South Africa. The names were specifically chosen to ensure that the story can be interpreted as either a male or a female telling the story, thus preventing potential differences in identification with characters on grounds of biological sex by the audience.
Finally, the low threat text message, which was included in text version 1, is set out below. General information about HIV/AIDS was supplied here by presenting facts such as the cause of the disease and its consequences.

Low threat message

In South Africa many people live with HIV/AIDS. But what is HIV/AIDS and what is the difference between HIV and AIDS?

HIV is a virus that is spread through the mixing of blood, semen or vaginal secretions. (Semen is the bodily fluid that comes out of the penis; vaginal secretions are any fluids in the vagina). Being HIV-infected means that you are carrying the virus and can infect other people. AIDS is a later stage where the infected person becomes ill.

How is HIV/AIDS being spread in South Africa?

1. In South Africa HIV is mostly spread through unprotected sex. Sex means that the man puts his penis into the vagina or anus of his partner. Unprotected means that it is unsafe. So, unprotected sexual intercourse means that people have sex without using protection, like a condom.

2. A woman who is HIV-infected can also pass HIV to her baby. The mother can pass HIV to her baby when she is pregnant or when she breastfeeds her baby.

3. Drug users who share needles can be infected by HIV too. In this case blood of an HIV-infected person stays behind on the needle and can infect a healthy person when he/she puts the same needle into his/her own body.

Prevention is the only way to stop HIV/AIDS. And prevention is really simple. The next story is told by a happy couple that wants to share their experience with you. They explain why it is so simple to prevent getting infected by HIV/AIDS. Read the story and see how normal people, just like you, take control of their own life. They show you how to take your future in your own hands and to take control of your future. Love your life and make the most of it!

Text version 1 (HTHE text message) included two photographs. Photograph 1, which is shown below, corresponded with the high threat message part of version 1. It was a photograph of an adolescent lying in bed (ill, with a skin rash on the face) and an adult looking very concerned. It was difficult to determine from the photograph whether the teenager was a boy or a girl. This was done on purpose to prevent differences in identification with the subject in the picture and to prevent participants from becoming biased in respect of gender. Both photographs were printed in grey-
scale to rule out effects attributable to colour. Photograph 2, which is also reproduced below, reflected the high efficacy text message and represented a happy couple full of confidence.

Photograph 1 accompanied HT text message in text version 1

Photograph 2 accompanied HE text message in text version 1 and 2

Text version 1 was drawn up in line with the guidelines for a successful fear appeal derived from the EPPM (high threat and high efficacy message). Text version 2 was intended to differ from text version 1 on the level of perceived threat (low threat message). A scary photograph was used with the intention to increase the severity/fear effect in the high threat message. In order to create a balance between the high threat and high efficacy text message parts in text version 1, a photograph was also used for the high efficacy message part. The same high efficacy message, with the same photograph was also included in text version 2. However, the low threat message in text version 2 was not accompanied by a photograph. This caused a methodological problem that will be discussed in section 5.2.1. The reason for not using a photograph for the low threat message was that this message was supposed to be perceived as neutral as possible by the recipient. This means that the low threat message part was not supposed to evoke fear or to emphasize the perceived efficacy, to create a clear distinction only on the level of perceived threat between the two text versions. The presence of a photograph might influence the recipient in a certain unpredictable way. Moreover, the results of the second pretest (discussed in section 3.4 below), as expected showed a clear distinction on the level of perceived threat.
between the participants who read text version 1 (M=2.25) and the participants who read text version 2 (M=4.00). Therefore, this material that included only two photographs was used in the actual research.

### 3.4 Pretests

Two pretests were conducted. The pretests served three purposes: firstly, to improve the quality of the texts and the statements in the questionnaire. Secondly, the pretests served to detect potential shortcomings in, for instance, the readability of the message parts as well as statements in the questionnaire. Thirdly, the pretests served as a manipulation check to detect if there was indeed a difference in the respondents' reported level of perceived fear between the two text versions, i.e. text version 1 (HTHE text message) should lead to stronger feelings of fear and discomfort than text version 2 (LTHE text message). The participants were first asked to read the instructions and then the allocated text versions. After that, they were asked to complete the questionnaire. The participants were requested to mark the words, phrases or sections in the message parts, as well as statements in the questionnaire that were not clear to them. Next, they were asked to write down why they did not understand these parts and how this could be improved in their opinion.

In the first pretest ten adolescents participated (five girls and five boys, ages varying from 14 to 19 years) and also four adults (two women and two men, ages varying from 35 to 45 years old). All were black South Africans from Mamelodi. Seven participants completed text version 1, the other seven completed text version 2. The outcome of this pretest showed that the perceived level of fear evoked by text version 1 was not sufficient (i.e. mean score for participants who read text version 1 was M>2.5, which should have been M≤2.5). Furthermore, some terms and definitions were not clear to the participants.

After adjustments were made according to the outcome of the first pretest, a second
The pretest was conducted in the same way as the first one. In this second pretest ten adolescents participated (different from the participants of the first pretest). All were black South Africans from Mamelodi (five girls and five boys; ages varying from 14 to 19 years old). Five participants received text version 1, the other five received text version 2. The results are presented below in table 3 and 4.

Table 3. Outcome text version 1 (second pretest)

<table>
<thead>
<tr>
<th>Statement</th>
<th>I completely agree</th>
<th>I agree</th>
<th>I am not sure / do not know</th>
<th>I disagree</th>
<th>I completely disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confused</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Scared</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Different</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Uncomfortable</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>11</td>
<td>1</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

The mean score on the total of four statements was 2.25.

Table 4. Outcome text version 2 (second pretest)

<table>
<thead>
<tr>
<th>Statement</th>
<th>I completely agree</th>
<th>I agree</th>
<th>I am not sure / do not know</th>
<th>I disagree</th>
<th>I completely disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confused</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Scared</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Different</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Uncomfortable</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td>5</td>
</tr>
</tbody>
</table>

The mean score on the total of four statements was 4.00.

In spite of the four participants who read text version 2 (see table 4) and who agreed that they felt different after reading the text, the overall outcomes regarding statements used in the questionnaire of the second pretest showed that these statements were now appropriate for actual research. Two statements were added (to the questionnaire to gain more information about the level of threat (i.e. “I felt shocked after reading the text” and “I felt afraid after reading the text”).

Furthermore, the participants were asked to respond to the statements that measured to what extent the text messages were clearly written and understandable, and whether the story was perceived as an authentic story. All participants agreed that the
story was interesting, informative, useful, real, believable, convincing, clearly written, easy and not boring to read. The participants also indicated that they understood the story and took it seriously. Next, the participants were asked to mark the statements in the questionnaire that were difficult to read or not clear. The participants indicated that they understood the statements and that they did not have problems understanding the statements in the questionnaire. The structure and the content of the questionnaire will be discussed in the following section.

3.5 Measures

The questionnaires were constructed as follows. First of all, they included general instructions that served as a guide to completing the questionnaire. After that, the two text messages followed: a HTHE text message (text version 1) or a LTHE text message (text version 2), as set out in section 3.3. The text versions were followed by a list of statements that had to be rated by the participant. This list of statements consisted of four parts:

1. statements relating to an evaluation of the text messages, including an evaluation of the content of the message, writing style, level of fear and level of authenticity.
2. statements relating to the variables of the EPPM, i.e. perceived severity, perceived susceptibility, perceived response efficacy and perceived self-efficacy,
3. statements relating to the indicators of external stigma, i.e. avoidance, rejection, moral judgement, stigma by association, unwillingness to invest in PLHA's, discrimination and abuse, and
4. general questions to collect demographic information.

For the rating of the statements in the first three parts of the list of statements a five-point Likert-type response format was used to assess participants' perceptions for each item, where "M ≤ 2.49" equals I agree, "M ≥ 2.5 and M ≤ 3.5" equal I do not know/I am not sure and "M ≥ 3.5" equals I disagree. In addition, the first part of the list of statements (evaluation of the text messages) included one open question. Each of
these four parts is discussed in more detail in the following subsections by means of some general comments as well as measurements of the internal consistency of each variable. The internal consistency was measured by Cronbach's alpha. The internal consistency of a variable was considered to be acceptable when Cronbach's alpha ≥ .70. An example of the full questionnaire can be found in Appendix D.

3.5.1 EVALUATION OF THE TEXT MESSAGES

The evaluation of the text messages was measured by asking the participants to respond on five-point Likert scales to the statements concerning the variables content of the message, the writing style, the level of perceived fear and the level of authenticity. Question 20 was an open question that served to give participants the opportunity to express their personal thoughts and feelings. Statements 4, 6, 9 and 10 were reversed7 before conducting the calculations. They read as follows:

- The story has got nothing to do with my life,
- I think the story is boring to read,
- I wanted to laugh after reading the story, and,
- I think the story is too long.

3.5.1.1 Content of the message

How the content of the message was evaluated, was measured by asking the participants to rate five statements, namely whether the text messages they had read were informative, too long, interesting, useful and convincing. The answers were given on five-point Likert scales (where “1” equals I completely agree and “5” equals I completely disagree). The statements used here were similar to those used in the research by Gommers (2004). Evaluation of the results showed that the internal consistency was not good (Cronbach's alpha = .3701; when the statement too long was deleted Cronbach's alpha = .4033). In view of the unsatisfactory internal consistency as indicated by Cronbach's alpha, it was decided that one statement would be regarded as representing the evaluation of the variable content of the

---

7 Statements needed to be reversed if “1” equalled I completely disagree in stead of I completely agree and “5” equalled I completely agree in stead of I completely disagree.
message. The statement that was considered to be both representative for the variable at stake and relatively easy to understand was *I think the story is informative*.

### 3.5.1.2 Writing style

The evaluation of writing style was measured by asking the participants to rate four statements, namely whether the text messages they had read were *clearly written*, *boring to read*, *easy to read* and *understandable*. The answers were given on five-point Likert scales (where “1” equals *I completely agree* and “5” equals *I completely disagree*). These items were also derived from the research of Gommers (2004). Internal consistency was moderate (Cronbach’s alpha = .5814; when the statement *clearly written* was deleted, Cronbach’s alpha = .6914). In view of the unsatisfactory Cronbach’s alpha, it was decided that one statement would be regarded as representing the variable writing style. The statement that was considered to be both representative for the variable at stake and relatively easy to understand, was *the story was easy to read*.

### 3.5.1.3 Level of fear

The level of fear was measured by having participants rate six fear-related statements after reading the text messages, namely *I felt different, confused, scared, uncomfortable, shocked* and *afraid after reading the text*, on the five-point Likert scales from “1” equals *I completely agree* and “5” equals *I completely disagree*. These adjectives were derived from the diagnostic scale to predict risk behaviours as devised by Witte, Cameron, McKeon and Berkowitz (1996). Internal consistency was not good (Cronbach’s alpha = .6358; when the statement *different* was deleted, Cronbach’s alpha = .6527). In view of the unsatisfactory Cronbach’s alpha, it was decided that one statement would be regarded as representing the variable level of fear. The statements that were considered to be both representative for the variable at stake and relatively easy to understand, were *I felt scared after reading the message* and *I was afraid after reading the message*. However, the second statement was not
pretested whereas the first statement was. Therefore, I felt scared after reading the message was regarded as representing the variable level of fear.

3.5.1.4 Perceived authenticity of the message

The evaluation of the perceived authenticity of the message was measured by asking the participants to rate four statements. The first two statements were used to determine whether the text messages respondents had read were believable and real. The answers to these two statements were given on five-point Likert scales (where “1” equals I completely agree and “5” equals I completely disagree). The two statements used were based on similar statements used in Gommers’ questionnaire (2004). The two other statements tested whether or not the story would affect the life of the participant and whether or not the text made the participant laugh. The statement that evaluated whether or not the story would affect the participant’s life was derived from a questionnaire developed by Witte (1996). The statement that evaluated whether or not the message made the participant laugh was based on my own experience of an audience ridiculing the suffering of an AIDS patient. Internal consistency was not good (Cronbach’s alpha = .2607; when the statement wanted to laugh was deleted, Cronbach’s alpha = .4269). In view of the unsatisfactory Cronbach’s alpha, it was decided that one statement would be regarded as representing the variable level of authenticity. The statement that was considered to be both representative for the variable at stake and relatively easy to understand, was the story seems real to me.

3.5.2 THE COMPONENTS OF THE EPPM

As explained in section 2.1, the EPPM states that when the recipient of a fear appeal perceives a certain level of threat (perceived severity + perceived susceptibility) he or she becomes motivated to begin the second appraisal, perceived efficacy (perceived response efficacy + perceived self-efficacy). As a consequence, a person can cope with the threat in two ways, he or she can control the danger or control their fear of the threat. However, the danger and fear control process modes of respondents were
not measured in this study. This topic will discussed in more detail in section 5.2.2. Below, the statements that reflected the variables (perceived susceptibility, perceived severity, perceived self-efficacy and perceived response efficacy) of the EPPM model will be discussed.

3.5.2.1 Perceived severity

Perceived severity was measured by asking the participants to respond to the following three statements:

37. I believe that HIV/AIDS is a serious health problem.
38. I believe that HIV/AIDS is a real danger to my health.
39. HIV/AIDS is a real danger to my community.

The first two statements were based on the statements used in Witte’s questionnaire (1996). The last one was based on my own finding from conversations with people from townships who told me that AIDS affects their entire community. Internal consistency was not acceptable before deleting a statement (Cronbach’s alpha = .6751). After deleting statement 37 the internal consistency was acceptable (Cronbach’s alpha = .7543). In view of the acceptable Cronbach’s alpha when deleting statement 37, it was decided that the mean scores per participant for the statements 38 and 39 together would be regarded as representing the variable perceived severity.

3.5.2.2 Perceived susceptibility

Perceived susceptibility was measured by asking the participants to respond to the following four statements:

33. My sexual lifestyle puts me at risk for HIV/AIDS.
34. It is possible that I have HIV/AIDS.
35. I may have had sex with someone who was at risk for HIV/AIDS.
36. I am at risk for HIV/AIDS.
The statements testing perceived susceptibility were based on the statements used in the perceived susceptibility measurement scale of CHIPTS. Internal consistency was not acceptable (Cronbach’s alpha = .5726). In view of the unsatisfactory Cronbach’s alpha, it was decided that one statement would be regarded as representing the variable ‘perceived susceptibility’. The statement that was considered to be both representative for the variable at stake and relatively easy to understand, was it is possible that I have HIV/AIDS.

3.5.2.3 Perceived response efficacy

The third EPPM component was measured by asking the participant to respond to the following eight statements:

25. Using a condom every time I have sex is effective in preventing HIV/AIDS (i).
26. Being faithful to my partner is effective in preventing HIV/AIDS (ii).
27. Praying to God will protect me from getting HIV/AIDS (iii).
28. Only having sex with people I know well from my community, will protect me from getting HIV/AIDS (iv).
29. It is better to use more than one condom each time I have sex with someone, because when one condom breaks, there is still at least one more to protect us (i).
30. If my partner and I stay faithful to each other, we protect ourselves from being at risk for HIV/AIDS (ii).
31. Praying to God and living a good life according to Him will protect me from getting HIV/AIDS (iii).
32. I can trust the people I know well. So having sex with them is safe, because they would never give me HIV/AIDS (iv).

Statement 25 was based on the perceived response efficacy statements originating from the scale to predict risk behaviour: Development and validation of a diagnostic scale (Witte 1996). Statement 26, 27, 30 and 32 were based on statements used in Ehlers’ questionnaire (2004). Statements 28, 29 and 31 were created from the researcher’s own perspective. The Cronbach’s alpha showed that the internal
consistency was not acceptable (Cronbach’s alpha = .4560; when statement 32 was deleted, Cronbach’s alpha = .5311). In view of the unsatisfactory Cronbach’s alpha, it was decided to divide perceived response efficacy into four categories:

1. the use of a condom during sexual intercourse;
2. staying faithful to one’s partner;
3. praying to God; and,
4. having sex only with people you know, as an effective way to prevent oneself from HIV infection.

The statements, which were considered to be both representative for the categories at stake and relatively easy to understand, were:

1. Using a condom every time I have sex is effective in preventing HIV/AIDS;
2. Being faithful to my partner is effective in preventing HIV/AIDS;
3. Praying to God will protect me from getting HIV/AIDS, and,
4. I can trust the people I know well. So having sex with them is safe, because they would never give me HIV/AIDS.

3.5.2.4 Perceived self-efficacy

The first EPPM component, perceived self-efficacy, was measured by asking the participants to respond to the following four statements:

21. If my partner wants me to have unprotected sex, I would probably do it.
22. If my partner wants me to join in unprotected sex and I would say that we need to be safer, we would have safer sex instead.
23. If my partner wants me to have unprotected sex and I would make an excuse to use a condom, we would still have unprotected sex.
24. If a sexual partner does not want to use a condom, we would have sex without using a condom.
The statements testing perceived self-efficacy were based on the statements used in the perceived self-efficacy measurement scale of CHIPTS. Statement 21, 23 and 24 were reversed. Internal consistency was not acceptable (Cronbach’s alpha = .4683; when statement 22 was deleted, Cronbach’s alpha = .6239). In view of the unsatisfactory Cronbach’s alpha, it was decided that one statement would be regarded as representing the variable perceived self-efficacy. The statement that was considered to be both representative for the variable at stake and relatively easy to understand, was if my partner wants me to have unprotected sex, I would probably do it.

3.5.3 THE INDICATORS OF EXTERNAL STIGMA

The third part of the questionnaire measured the external stigma components according to the indicators of Siyam’Kela (2003) as previously discussed in subsection 3.3.1. The statements used to measure each component are set out below. In view of an unsatisfactory Cronbach’s alpha (α ≤ .70), it was decided that one statement would be regarded as representing each variable at stake, which was considered to be both representative and relatively easy to understand.

3.5.3.1 Avoidance

The first indicator of external stigma, avoidance, was measured by asking the participants to respond to the following six statements:

40. I would be afraid to kiss someone on the mouth who has HIV/AIDS.
41. I feel uncomfortable shaking hands with someone who has HIV/AIDS.
42. If a close friend or relative gets HIV/AIDS, I would be nice to him/her and do the things we always did.
43. I would eat the soup that has been prepared by a person with HIV/AIDS.
44. I would be afraid to hug someone with HIV/AIDS.
45. I think it is wrong to allow an HIV-infected person into the supermarket.

Statements 42 and 43 were reversed. Internal consistency was not acceptable (Cronbach’s alpha = .6392). Deleting a statement did not improve the internal consistency. In view of the unsatisfactory Cronbach’s alpha, it was decided that one statement would be regarded as representing the variable avoidance. This statement that was considered to be both representative for the variable at stake and relatively easy to understand, was *I feel uncomfortable shaking hands with someone who has HIV/AIDS.*

3.5.3.2 Rejection

The next indicator of external stigma, rejection, was measured by asking the participants to respond to the following two statements:

46. *If a close friend or relative gets HIV/AIDS, the relationship/friendship between us would change.*

47. *I would feel bad if a person with HIV/AIDS would visit our home.*

Internal consistency was not acceptable (Cronbach’s alpha = .5835). In view of the unsatisfactory Cronbach’s alpha, it was decided that one statement would be regarded as representing the variable rejection. The statement that was considered to be both representative for the variable at stake and as relatively easy to understand, was *I would feel bad if a person with HIV/AIDS would visit our home.*

3.5.3.3 Moral judgement

A further indicator of external stigma, moral judgement, was measured by asking the participants to respond to the following three statements:

48. *People who got infected with HIV/AIDS through prostitution or by sleeping around, have got what they deserve.*

49. *God punishes people with HIV/AIDS when they have sex outside marriage or outside a steady relationship.*

50. *People who do not use a condom when they have sex deserve to be infected by HIV/AIDS*
Internal consistency was not good (Cronbach’s alpha = .6127). Deleting a statement did not improve the internal consistency. In view of the unsatisfactory Cronbach’s alpha, it was decided that one statement would be regarded as representing the variable moral judgement. The statement that was considered both representative for the variable at stake and relatively easy to understand, was people who got infected with HIV/AIDS through prostitution or by sleeping around, have got what they deserve.

3.5.3.4 Stigma by association

The next indicator, stigma by association, was measured by asking the participants to respond to the following four statements:

51. I can see if someone has HIV/AIDS.

52. If I hear someone has TB (tuberculosis), I think that he/she has HIV/AIDS.

55. If I see someone with a skin rash on his/her face, I think he/she must have HIV/AIDS.

54. People who work with HIV/AIDS patients will probably have HIV/AIDS too.

Internal consistency was not acceptable (Cronbach’s alpha = .6479; when statement “51” was deleted, Cronbach’s alpha = .6778). In view of the unsatisfactory Cronbach’s alpha, it was decided that one statement would be regarded as representing the variable stigma by association. The statement that was considered to be both representative for the variable at stake and relatively easy to understand, was if I see someone with a skin rash on his/her face, I think he/she must have HIV/AIDS.

3.5.3.5 Unwillingness to invest in PLHA’s

Another indicator, unwillingness to invest in PLHA’s, was measured by asking the participants to respond to the following two statements:

55. It is useless for employers to give training to someone with HIV/AIDS

56. It is a waste of money to give a better job to someone with HIV/AIDS.
Internal consistency was not acceptable (Cronbach’s alpha = .6354). In view of the unsatisfactory Cronbach’s alpha, it was decided that one statement would be regarded as representing the variable *unwillingness to invest in PLHA’s*. The statement that was considered both representative for the variable at stake and relatively easy to understand, was *it is useless for employers to give training to someone with HIV/AIDS*.

### 3.5.3.6 Discrimination

The indicator *discrimination* was measured by asking the participants to respond to the following two statements:

57. *Women who are HIV-positive should be allowed to have children.*
58. *People with HIV/AIDS have the right to be helped by the police.*

Both statements 57 and 58 needed to be reversed. The internal consistency was not acceptable (Cronbach’s alpha = .5835). In view of the unsatisfactory Cronbach’s alpha, it was decided that one statement would be regarded as representing the variable *discrimination*. The statement that was considered both representative for the variable at stake and relatively easy to understand, was *
women who are HIV-positive should be allowed to have children.*

### 3.5.3.7 Abuse

The final indicator of external stigma, *abuse*, was measured by asking the participants to respond to the following two statements:

59. *Sometimes it is OK if I would hit a person with HIV/AIDS.*
60. *Sometimes it is OK to swear at a person with HIV/AIDS or call him/her names.*

Internal consistency was not acceptable (Cronbach’s alpha = .5633). In view of the unsatisfactory Cronbach’s alpha, it was decided that one statement would be regarded as representing the variable *abuse*. The statement that was considered to be both representative for the variable at stake and relatively easy to understand, was
sometimes it is OK to swear at a person with HIV/AIDS or call him/her names.

3.5.4 DEMOGRAPHIC INFORMATION

Demographic information was obtained by asking the participants to supply information about their gender, age, religion, type of structure in which they were living, years of education completed, employment status, ethnic background, nationality and also sexual activity. They were also asked if they had ever taken an HIV test. If so, they were asked when the most recent test had been taken and what the result had been. For the complete list of questions and the answer possibilities, see Appendix D. The questions asked are set out below:

61. Age (in years)
62. Gender
63. Nationality
64. Do you have a partner?
65. Have you ever had sex with someone?
66. Have you ever taken an HIV test? If not, go to question 69.
67. When did you take an HIV test? Or when did you take your last HIV test, if you have taken more than one?
68. Were you... (positive, negative or do not want to say)?
69. Which of the following population groups do you consider yourself to be part of?
70. What language do you usually speak at home?
71. Where do you live at present?
72. In what type of structure / building do you live at present?
73. Are you a member of the following religions, or do you share the beliefs of any of the following?
74. At present... (needed to indicate if they worked, studied part-time / full time or were looking for work.
75. Which is the highest school grade you have passed?

Question 61 and 63 were open questions. Regarding the other questions, the participants had to choose one of the options supplied as their answer.
3.6 Procedure

For a white ‘Western’ student it turned out to be virtually impossible to go to townships and expect people to help with research about HIV/AIDS. This is why the researchers worked together with local people from the community who functioned as ‘cultural brokers’ (in total three cultural brokers participated). The cultural brokers introduced the researcher into their township and assisted in approaching people to ask them to participate in the research. The cultural brokers were paid a small fee for their efforts.

The data were collected on different days. The data from 160 adolescents were collected on 2 June 2005 in the morning, at their school (Samafco High school in Mamelodi East, a township of Pretoria). This group of adolescents was divided into five classes of approximately 35 students; each class was seated in a classroom. The teacher (who left during the session) asked the students to complete the questionnaire as sincerely as possible. Three persons remained in the classroom during the experiment, including the cultural broker who hailed from the same area as the adolescents. Then the researcher, together with the cultural broker, explained the background to the research, and how to complete the questionnaire. Everyone who was approached participated and no difficulties were encountered. Afterwards, the students received lollypops and they could keep the pen they had used to complete the questionnaire. An additional 25 questionnaires were completed by the adolescents of the Gatang High school in Mamelodi East on 16 July. The same procedure for collecting the data was followed as with the students of the Samafco High school.

The data from the 84 adults were collected in two Pretoria townships (Mamelodi and Soshanguve), in a rural area in Mpumalanga and in the city centre of Pretoria in the church community called ‘The Assembly of God’. Apart from these adults, there were also about 150 adults (housekeepers and gardeners working for the University of Pretoria, coming from poor townships) who could have been approached to
participate, but they were refused permission by their supervisor to participate at all, even outside working hours.

The 84 adults who properly completed the questionnaire were approached individually with the request to participate in the research. Each adult was informed of the background to the research and he or she was told how to complete the questionnaire. The participants from the church community completed their questionnaire after the service. The adults from Mamelodi and Soshanguve were asked to complete the questionnaire after working hours or after the service of their church. They were allowed to take the questionnaire home to complete it there. In agreement with those participants, the questionnaire was then collected at a certain time. In Mpumalanga the questionnaires were completed under supervision of a cultural broker.

Each participant took about 20-30 minutes to complete the questionnaire. The text versions were distributed randomly. Pupils from the Samafco High school who were in between classes on 2 June were approached and all these adolescents in the classroom completed the questionnaire. The same goes for the pupils from the Gatang High school on 16 July. The adult participants were approached by a cultural broker after a church service or at another social gathering outside of working hours. Adults were chosen at random. Beforehand, two equal numbered piles of questionnaires (of which one pile consisted of questionnaires with text version 1 and the other pile with text version 2) were mixed up and brought to one pile and then handed out to the participants.

With exception of the adolescents at the Samafco High school, who received lollypops, the participants were not promised or given any rewards for their efforts. They were only allowed to keep the pen.
CHAPTER 4

RESULTS
4 RESULTS

This chapter presents the results of the experimental research described in Chapter 3. It is divided into four sections of which the first three sections mirror the first three sections of the questionnaire namely evaluation of the message, the components of the Extended Parallel Process Model (EPPM) and the indicators of external stigma. Each of these three sections included several variables. With the data collected in each section, univariate analyses of variance were carried out to investigate possible interaction effects and main effects of age group and text version on the dependent variables. The outcome of each univariate analysis of variance carried out (consisting of mean scores, where “M≤2.49” equals I agree with the statement, “M≥2.5 and M≤3.5” equals I do not know/I am not sure and “M≥3.51” equals I disagree with the statement) is presented in a table. It is briefly discussed how the results can be interpreted.

In the fourth section of this chapter, the relation between fear and external stigma was analysed by means of a correlation analysis. In addition, the correlation between the indicators of external stigma, and participants who scored high on level of fear and low on perceived efficacy was analysed. These results are presented in a table. More overall conclusions will be discussed in chapter 5.

4.1 EVALUATION OF THE MESSAGE

The statements presented in the section of the questionnaire entitled evaluation of the message, served to verify how the participants perceived the stories they read. This was measured by four variables, i.e. content of the message, writing style, level of fear and the level of authenticity.

A univariate analysis of variance was carried out to investigate possible interaction effects and main effects of text version and age group on the evaluation of the variable content of the message. No significant interaction effects were found. In addition,
there were no significant main effects. This implies that the mean scores found regarding evaluation of the content of the message did not significantly differ between adolescents and adults, or between participants who read text version 1 and participants who read text version 2. The mean score of the total group of participants on a five-point scale was $M=1.89$, which shows that the participants perceived the story as informative regarding evaluation of the content of the message. The results are presented in table 5.

Table 5. Outcomes univariate analysis of variance for the evaluation of the content of the message in relation with age group and text version

<table>
<thead>
<tr>
<th></th>
<th>Adolescents</th>
<th>Adults</th>
<th>Total</th>
<th>Main effect age group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Text version 1</strong></td>
<td>M= 2.07, SD= 1.020</td>
<td>M= 1.64, SD= .917</td>
<td>M= 1.92, SD= 1.005</td>
<td>NS (p=.071)</td>
</tr>
<tr>
<td><strong>Text version 2</strong></td>
<td>M= 1.86, SD= .866</td>
<td>M= 1.85, SD= .893</td>
<td>M= 1.86, SD= .871</td>
<td>NS (p=.965)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>M= 1.96, SD= .946</td>
<td>M= 1.74, SD= .907</td>
<td>M= 1.89, SD= .938</td>
<td>No interaction effect (p=.091)</td>
</tr>
</tbody>
</table>

The univariate analysis of variance carried out regarding the evaluation of writing style, did not reveal significant interaction effects. In addition, there were no significant main effects. This implies that the mean scores found regarding evaluation of the writing style did not significantly differ between adolescents and adults, or between participants who read text version 1 and participants who read text version 2. The mean score of the total group of participants on a five-point scale ($M=1.67$) shows that the participants thought that the story was easy to read regarding evaluation of the writing style. The results are presented in table 6.
Table 6. Outcomes univariate analysis of variance for the evaluation of the writing style in relation with age group and text version

<table>
<thead>
<tr>
<th></th>
<th>Adolescents</th>
<th>Adults</th>
<th>Total</th>
<th>Main effect age group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Text version 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M= 1.79,</td>
<td>M= 1.45,</td>
<td>M= 1.68,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SD= .910</td>
<td>SD= .820</td>
<td>SD= .892</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Text version 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M= 1.68,</td>
<td>M= 1.65,</td>
<td>M= 1.67,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SD= .968</td>
<td>SD= .864</td>
<td>SD= .935</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M= 1.73,</td>
<td>M= 1.55,</td>
<td>M= 1.67,</td>
<td></td>
<td>NS (p=.136)</td>
</tr>
<tr>
<td>SD= .940</td>
<td>SD= .842</td>
<td>SD= .913</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Main effect text version</strong></td>
<td>NS (p=.720)</td>
<td>No interaction effect: (p=.205)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NS: not significant (α=.05)

A univariate analysis of variance was carried out to investigate possible interaction effects and main effects of age group and text version on the variable level of fear. No significant interaction effects were found. In addition, there were no significant main effects. This implies that the mean scores found in respect of level of fear did not significantly differ between adolescents and adults, or between participants who read text version 1 and participants who read text version 2. As such, both age group and text version did not affect how participants rated their level of fear. In general, the mean score of the total group of participants on a five-point scale (M=3.29) shows that they did not know if they felt scared after reading the text. The results are presented in table 7.

Table 7. Outcomes univariate analysis of variance for level of fear in relation with age group and text version

<table>
<thead>
<tr>
<th></th>
<th>Adolescents</th>
<th>Adults</th>
<th>Total</th>
<th>Main effect age group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Text version 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M= 3.11,</td>
<td>M= 3.25,</td>
<td>M= 3.16,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SD= 1.457</td>
<td>SD= 1.314</td>
<td>SD= 1.408</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Text version 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M= 3.25,</td>
<td>M= 3.83,</td>
<td>M= 3.42,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SD= 1.473</td>
<td>SD= 1.130</td>
<td>SD= 1.401</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M= 3.18,</td>
<td>M= 3.52,</td>
<td>M= 3.29,</td>
<td></td>
<td>Not significant</td>
</tr>
<tr>
<td>SD= 1.463</td>
<td>SD= 1.256</td>
<td>SD= 1.408</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Main effect text version</strong></td>
<td>Not significant</td>
<td>No interaction effect: (p=.253)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NS: not significant (α=.05)
The univariate analysis of variance carried out regarding *perceived authenticity* did not reveal significant interaction effects. In addition, there were also no significant main effects, which implies that the mean scores found in respect of perceived authenticity did not significantly differ between adolescents and adults, or between participants who read text version 1 and participants who read text version 2. The mean score of the total group of participants (M=1.91) shows that the participants perceived the text messages as authentic. The results are presented in table 8.

Table 8. Outcomes univariate analysis of variance for level of *perceived authenticity* in relation with age group and text version

<table>
<thead>
<tr>
<th></th>
<th>Adolescents</th>
<th>Adults</th>
<th>Total</th>
<th>Main effect age group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Text version 1</strong></td>
<td>M= 1.79, SD= 1.082</td>
<td>M= 1.70, SD= 1.069</td>
<td>M= 1.76, SD= 1.074</td>
<td></td>
</tr>
<tr>
<td><strong>Text version 2</strong></td>
<td>M= 2.14, SD= 1.236</td>
<td>M= 1.85, SD= 1.027</td>
<td>M= 2.05, SD= 1.182</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>M= 1.97, SD= 1.174</td>
<td>M= 1.77, SD= 1.045</td>
<td>M= 1.91, SD= 1.137</td>
<td>NS (p=.218)</td>
</tr>
<tr>
<td><strong>Main effect text version</strong></td>
<td>NS (p=.098)</td>
<td>No interaction effect: (p=.495)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NS: not significant (α=.05)

In summary, no significant interaction effects of age group and text version were found on any of the variables of the first section, i.e. *evaluation of the message*. This means that there was also no significant main effect of text version on *level of fear*, which is in contrast with what may have been expected from the results of the second pretest.

### 4.2 The components of the EPPM

The second part of the questionnaire served to test the predictions deduced from the EPPM. Therefore, four variables were tested (i.e. *perceived severity, perceived susceptibility, perceived response efficacy* and *perceived self-efficacy*).
A univariate analysis of variance was carried out to investigate possible interaction effects and main effects of text version and age group on the variable *perceived severity*. No significant interaction effects or main effects were found. This implies that the mean scores found regarding perceived severity did not significantly differ between adolescents and adults, and between participants who read text version 1 and participants who read text version 2. In general, the mean score of the total group of participants (M=1.82) implies that the participants believed that HIV/AIDS is a threat to their community and to their own health. The results are presented in table 9.

Table 9. Outcomes univariate analysis of variance for *perceived severity* in relation with age group and text version

<table>
<thead>
<tr>
<th></th>
<th>Adolescents</th>
<th>Adults</th>
<th>Total</th>
<th>Main effect age group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Text version 1</strong></td>
<td>M=1.93, SD=1.148</td>
<td>M=1.76, SD=.991</td>
<td>M=1.87, SD=1.079</td>
<td>NS (p=.413)</td>
</tr>
<tr>
<td><strong>Text version 2</strong></td>
<td>M=1.79, SD=1.125</td>
<td>M=1.72, SD=1.011</td>
<td>M=1.77, SD=1.090</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>M=1.86, SD=1.135</td>
<td>M=1.74, SD=.995</td>
<td>M=1.82, SD=1.093</td>
<td>NS (p=.545)</td>
</tr>
</tbody>
</table>

NS: not significant (α=.05)

The univariate analysis of variance carried out to investigate possible interaction effects and main effects of text version and age group on the variable *perceived susceptibility*, did not reveal significant interaction effects. In addition, there were no significant main effects, which implies that the mean scores found regarding perceived susceptibility did not significantly differ between adolescents and adults, or between participants who read text version 1 and participants who read text version 2. In general, the mean score of the total group of participants (M=3.35) implies that the participants were not sure whether they were susceptible to HIV/AIDS. The results are presented in table 10.
Table 10. Outcomes univariate analysis of variance for perceived susceptibility in relation with age group and text version

<table>
<thead>
<tr>
<th></th>
<th>Adolescents</th>
<th>Adults</th>
<th>Total</th>
<th>Main effect age group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Text version 1</strong></td>
<td>M= 3.17, SD= 1.432</td>
<td>M= 3.68, SD= 1.394</td>
<td>M= 3.34, SD= 1.435</td>
<td></td>
</tr>
<tr>
<td><strong>Text version 2</strong></td>
<td>M= 3.32, SD= 1.354</td>
<td>M= 3.49, SD= 1.335</td>
<td>M= 3.37, SD= 1.345</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>M= 3.25, SD= 1.390</td>
<td>M= 3.59, SD= 1.362</td>
<td>M= 3.35, SD= 1.388</td>
<td>NS (p=.065)</td>
</tr>
</tbody>
</table>

*Main effect text version* NS (p=.901) *No interaction effect: (p=.351)*

NS: not significant (α=.05)

The third variable was perceived response efficacy. This variable was divided into four subgroups, i.e. condom use, staying faithful to one’s partner, praying to God and having sex only with someone you know as effective responses in protecting oneself from HIV infection.

A univariate analysis of variance was carried out to investigate possible interaction effects and main effects of text version and age group on the sub-variable condom use. No significant interaction effects were found. In addition, there were no significant main effects, which implies that the mean scores found regarding sub-variable condom use did not significantly differ between adolescents and adults, or between participants who read text version 1 and participants who read text version 2. In general, the participants believe that the use of a condom is effective in preventing oneself from HIV infection (M=2.32). The results are presented in table 11.
Table 11. Outcomes univariate analysis of variance for perceived response efficacy - condom use in relation with age group and text version

<table>
<thead>
<tr>
<th></th>
<th>Adolescents</th>
<th>Adults</th>
<th>Total</th>
<th>Main effect age group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Text version 1</strong></td>
<td>M= 2.41, SD= 1.384</td>
<td>M= 2.05, SD= 1.346</td>
<td>M= 2.28, SD= 1.377</td>
<td></td>
</tr>
<tr>
<td><strong>Text version 2</strong></td>
<td>M= 2.43, SD= 1.420</td>
<td>M= 2.18, SD= 1.189</td>
<td>M= 2.36, SD= 1.357</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>M= 2.42, SD= 1.399</td>
<td>M= 2.11, SD= 1.269</td>
<td>M= 2.32, SD= 1.365</td>
<td>NS (p=.094)</td>
</tr>
</tbody>
</table>

**Main effect text version** | NS (p=.671) |

NS: not significant (α=.05)

The univariate analysis of variance carried out on the second sub-variable of the perceived response efficacy, namely staying faithful to one’s partner did not reveal significant interaction effects. However, the univariate analysis of variance revealed one significant main effect of age group on the sub-variable staying faithful to one’s partner: F(1,261)=8.78; p<.01; η²=.033. The mean score of the adults on the statement staying faithful to one’s partner is effective in protecting oneself from HIV infection was significantly higher (M=1.88, SD=1.196) than the mean score of the adolescents (M=2.41, SD=1.378). No significant main effect was found of text version on the sub-variable staying faithful to one’s partner. In other words, in contrast to text version, the age of the participants did have a significant statistical main effect on their response to the statement measuring the second sub-variable of perceived response-efficacy. As such, age did affect how the participants perceived staying faithful to one’s partner as an effective way to prevent oneself from HIV infection. The mean score of the total group of participants shows that, in general, the participants believe that staying faithful to one’s partner is effective in preventing oneself from HIV infection (M=2.24). The results are presented in table 12.
Table 12. Outcomes univariate analysis of variance for perceived response-efficacy-staying faithful to one's partner in relation with age group and text version

<table>
<thead>
<tr>
<th></th>
<th>Adolescents</th>
<th>Adults</th>
<th>Total</th>
<th>Main effect age group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Text version 1</strong></td>
<td>M= 2.28, SD= 1.289</td>
<td>M= 1.82, SD= 1.206</td>
<td>M= 2.12, SD= 1.276</td>
<td></td>
</tr>
<tr>
<td><strong>Text version 2</strong></td>
<td>M= 2.53, SD= 1.450</td>
<td>M= 1.95, SD= 1.197</td>
<td>M= 2.36, SD= 1.401</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>M= 2.41, SD= 1.378</td>
<td>M= 1.88, SD = 1.196</td>
<td>M= 2.24, SD= 1.344</td>
<td>Significant p&lt;.01; η²=.033</td>
</tr>
</tbody>
</table>

**Main effect text version** NS (p=.280) No interaction effect: (p=.742)

NS: not significant (α=.05)

The univariate analysis of variance carried out on the third sub-variable of the perceived response efficacy, praying to God, did not reveal a significant interaction effect of age group and text version on the sub-variable praying to God. However, one significant main effect was found in respect of the age group on the sub-variable praying to God: F(1,264)=5.51; p<.05; η²=.020. This implies that the mean score of the adolescents on the statement praying to God is effective in protecting oneself from HIV infection was significantly higher (M=2.24, SD=1.413) than the mean score of the adults (M=2.66, SD=1.413). No significant main effect of text version on the sub-variable praying to God was found. In other words, in contrast to text version, the age of the participants did have a significant statistical main effect on their responses to the statement measuring the third sub-variable of perceived response-efficacy. As such, age did affect how they perceived praying to God as an effective way to prevent oneself from HIV infection. The results are presented in table 13.
A univariate analysis of variance was carried out to investigate possible interaction effects and main effects of text version and age group on the fourth sub-variable *having sex only with someone you know*. No significant interaction effects were found. One significant main effect was found of the age group on the sub-variable *having sex only with someone you know*: $F(1,263)=10.41; \ p<.001; \ \eta^2=.038$. This implies that the mean score of the adolescents on the statement *having sex only with someone you know is effective in protecting oneself from HIV infection* was significantly higher ($M=4.05$, $SD=1.244$) than the mean score of the adults ($M=4.55$, $SD=.877$). No significant main effect of text version on the sub-variable having sex only with someone you know was found. In other words, in contrast to text version, the age of the participants did have a significant statistical main effect on their responses to the statement measuring the fourth sub-variable of perceived response-efficacy. As such, age did affect how the participants perceived having sex only with someone you know as an effective way to prevent oneself from HIV infection. In general, both adolescents and adults do not believe that having sex with only someone you know is effective in preventing oneself from HIV infection ($M=4.20$). The results are presented in table 14.
Table 14. Outcomes univariate analysis of variance for perceived response-efficacy - having sex with only someone you know in relation with age group and text version

<table>
<thead>
<tr>
<th></th>
<th>Adolescents</th>
<th>Adults</th>
<th>Total</th>
<th>Main effect age group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Text version 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M= 4.17,</td>
<td>M= 4.67,</td>
<td>M= 4.33,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SD= 1.100</td>
<td>SD= .715</td>
<td>SD= 1.016</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Text version 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M= 3.94,</td>
<td>M= 4.41,</td>
<td>M= 4.07,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SD= 1.360</td>
<td>SD= 1.019</td>
<td>SD= 1.285</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M= 4.05,</td>
<td>M= 4.55,</td>
<td>M= 4.20,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SD= 1.244</td>
<td>SD= .877</td>
<td>SD= 1.165</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Main effect text version</strong></td>
<td>NS (p=.104)</td>
<td>No interaction effect: (p= .913)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NS: not significant (α=.05)

In summary, three significant main effects were found of age group on three subvariables of perceived response efficacy, i.e. staying faithful to one’s partner, praying to God and having sex only with someone you know.

A univariate analysis of variance was carried out to investigate possible interaction effects and main effects of text version and age group on the variable perceived self-efficacy. No significant interaction effects were found. However, a significant main effect was found in respect of text version on the variable perceived self-efficacy: $F(1,258)=7.77$, $p<.01$; $\eta^2=.006$. This implies that the mean score of the participants who read text version 1 ($M= 1.63$, $SD= 1.065$) was significantly higher than the mean score of the participants who read text version 2 ($M= 1.99$, $SD= 1.328$) regarding perceived self-efficacy. No significant main effect was found of age group on perceived self-efficacy. In other words, the age of the participants did not have a significant effect on their responses to the statement measuring the variable perceived self-efficacy, and as such, age did not affect how the participants perceived themselves as able to perform the recommended behaviour to avert the threat of HIV/AIDS. In general, the mean score of the total group of participants shows that the participants believed that they would be able to use a condom during sexual intercourse to prevent HIV infection ($M=1.81$). The results are presented in table 15.
Table 15. Outcomes univariate analysis of variance for perceived self-efficacy in relation with age group and text version

<table>
<thead>
<tr>
<th></th>
<th>Adolescents</th>
<th>Adults</th>
<th>Total</th>
<th>Main effect age group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Text version 1</strong></td>
<td>M= 1.66, SD= 1.047</td>
<td>M= 1.57, SD= 1.108</td>
<td>M= 1.63, SD= 1.065</td>
<td></td>
</tr>
<tr>
<td><strong>Text version 2</strong></td>
<td>M= 1.89, SD= 1.281</td>
<td>M= 2.23, SD= 1.423</td>
<td>M= 1.99, SD= 1.328</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>M= 1.78, SD= 1.177</td>
<td>M= 1.83, SD= 1.301</td>
<td>M= 1.81, SD= 1.216</td>
<td>NS (p=.447)</td>
</tr>
</tbody>
</table>

Main effect text version: Significant p<.01; η² = .006
No interaction effect: (p=.178)

NS: not significant (α=.05)

In conclusion, no significant interaction effects were found of text version and age group on the variables deduced from the EPPM. However, four significant main effects were found: three significant main effects of age group were found on three subvariables of perceived response efficacy, i.e. staying faithful to one’s partner, praying to God and having sex only with someone you know and one other significant main effect was found regarding text version on the variable perceived self-efficacy. The significant main effect of age group on the sub-variable staying faithful to one’s partner shows that adults, in general, were more convinced of the effectiveness of staying faithful to one’s partner to prevent HIV infection than adolescents were. Furthermore, on average, the adolescents had more faith in praying to God as an effective way to prevent oneself from HIV infection than the adults had. In general, the adults were unsure about its effectiveness. Having sex only with someone you know was not considered to be effective in preventing oneself from HIV infection, but the significant main effect of age group on this variable shows that the adults were more convinced of its ineffectiveness than the adolescents were. The final significant main effect of text version on perceived self-efficacy shows that the participants who read text version 1 scored higher on this variable than the participants who read text version 2.
4.3 THE INDICATORS OF EXTERNAL STIGMA

This section presents the results of the univariate analysis of variance regarding the indicators of external stigma. As mentioned before, the indicators of external stigma are: avoidance, rejection, moral judgement, stigma by association, unwillingness to invest in PLHA's, discrimination and abuse. Univariate analyses of variance were carried out to investigate possible significant interaction effects and main effects of text version and age group on each of the indicators of external stigma.

The univariate test of variance did not reveal any significant interaction effects of text version and age group on the indicator avoidance. However, a significant main effect of text version was found on avoidance: $F(1,262)=4.81; p<.05; \eta^2=.018$. The univariate test of variance also revealed a significant main effect of age group on avoidance: $F(1,262)=9.17; p<.01; \eta^2=.034$. The first main effect implies that the mean score of the participants who read text version 1 was significantly higher ($M=3.88$, $SD=1.409$) than the mean score of the participants who read text version 2 ($M=3.38$, $SD=1.565$). The second main effect implies that the mean score of the adolescents regarding this indicator was significantly higher ($M=3.44$, $SD=1.578$) than the mean score of the adults ($M=4.05$, $SD=1.248$). As such, both age group and text version affected the extent to which participants would feel uncomfortable when shaking hands with a PLHA. The results are presented in table 16.

Table 16. Outcomes univariate analysis of variance for avoidance in relation with age group and text version

<table>
<thead>
<tr>
<th></th>
<th>Adolescents</th>
<th>Adults</th>
<th>Total</th>
<th>Main effect age group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Text version 1</strong></td>
<td>M= 3.73, SD= 1.506</td>
<td>M= 4.18, SD= 1.147</td>
<td>M= 3.88, SD= 1.409</td>
<td></td>
</tr>
</tbody>
</table>
| **Text version 2** | M= 3.17, SD= 1.604 | M= 3.90, SD= 1.353 | M= 3.38, SD= 1.565 | Significant $p<.01; \eta^2=.034$
| **Total**       | M= 3.44, SD= 1.578 | M= 4.05, SD= 1.248 | M= 3.63, SD= 1.507 | 
| **Main effect text version** | Significant $p<.05; \eta^2=.018$ | | | No interaction effect: $(p=.479)$

NS: not significant ($\alpha=.05$)
A univariate analysis of variance was carried out to investigate possible interaction effects and main effects of text version and age group on the indicator *rejection*. No significant interaction effects were found. However, one significant main effect of age group was found on rejection: $F(1,262)=5.28; p<.05; \eta^2=.020$. This implies that the mean score of the adolescents on this indicator was significantly higher ($M=3.98$, $SD=1.418$) than the mean score of the adults ($M=4.37$, $SD=.946$). As such, the age of the participants affected the extent to which they would feel bad if a PLHA would visit their house. No significant main effect of text version was found on the indicator rejection. The results are presented in table 17.

Table 17. Outcomes univariate analysis of variance for rejection in relation with age group and text version

<table>
<thead>
<tr>
<th></th>
<th>Adolescents</th>
<th>Adults</th>
<th>Total</th>
<th>Main effect age group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Text version 1</strong></td>
<td>M= 3.99, SD= 1,418</td>
<td>M= 4.55, SD= 820</td>
<td>M= 4.17, SD= 1.276</td>
<td></td>
</tr>
<tr>
<td><strong>Text version 2</strong></td>
<td>M= 3.97, SD= 1,348</td>
<td>M= 4.18, SD= 1.048</td>
<td>M= 4.03, SD= 1.267</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>M= 3.98, SD= 1.379</td>
<td>M= 4.37, SD= 946</td>
<td>M= 4.10, SD= 1.271</td>
<td></td>
</tr>
<tr>
<td><strong>Main effect text version</strong></td>
<td>NS (p=.248)</td>
<td>No interaction effect: (p=.302)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NS: not significant ($\alpha=.05$)

A univariate analysis of variance was carried out to investigate possible interaction effects and main effects of text version and age group on the indicator *moral judgement*. No significant interaction effects were found. However, one significant main effect of age group was found on moral judgement: $F(1,264)=24.18; p<.001; \eta^2=.084$. This result implies that the mean score of the adolescents regarding this indicator was significantly higher ($M=2.72$, $SD=1.362$) than the mean score of the adults ($M=3.61$, $SD=1.360$). As such, the age of the participants affected the extent to which they would think that PLHA’s who contracted HIV/AIDS through prostitution or by sleeping around received what they deserved. No significant main effect of text version was found on the indicator moral judgement. The results are presented in table 18.
Table 18. Outcomes univariate analysis of variance for moral judgement in relation with age group and text version

<table>
<thead>
<tr>
<th></th>
<th>Adolescents</th>
<th>Adults</th>
<th>Total</th>
<th>Main effect age group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Text version 1</strong></td>
<td>M= 2.65, SD= 1.298</td>
<td>M= 3.82, SD= 1.386</td>
<td>M= 3.04, SD= 1.432</td>
<td></td>
</tr>
<tr>
<td><strong>Text version 2</strong></td>
<td>M= 2.78, SD= 1.423</td>
<td>M= 3.38, SD= 1.310</td>
<td>M= 2.96, SD= 1.414</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>M= 2.72, SD= 1.362</td>
<td>M= 3.61, SD= 1.360</td>
<td>M= 3.00, SD= 1.42</td>
<td>Significant p&lt;.001; η²=.084</td>
</tr>
</tbody>
</table>

Main effect text version NS (p=.399) No interaction effect. (p=.119)

NS: not significant (α=.05)

A univariate analysis of variance was carried out to investigate possible interaction effects and main effects of text version and age group on the indicator stigma by association. No significant interaction effects were found. One significant main effect of age group was found on stigma by association: F(1,264)=4.26; p<.05; η²=.016. This implies that the mean score of the adolescents regarding stigma by association was significantly higher (M=3.83, SD=1.268) than the mean score of the adults (M=4.15, SD=1.070). As such, the age of the participants affected the extent to which they would think that someone with a skin rash on his/her face is HIV-infected. No significant main effect of text version was found on stigma by association. The results are presented in table 19.

Table 19. Outcomes univariate analysis of variance for stigma by association in relation with age group and text version

<table>
<thead>
<tr>
<th></th>
<th>Adolescents</th>
<th>Adults</th>
<th>Total</th>
<th>Main effect age group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Text version 1</strong></td>
<td>M= 3.80, SD= 1.208</td>
<td>M= 4.14, SD= 1.133</td>
<td>M= 3.91, SD= 1.190</td>
<td></td>
</tr>
<tr>
<td><strong>Text version 2</strong></td>
<td>M= 3.85, SD= 1.329</td>
<td>M= 4.18, SD= 1.010</td>
<td>M= 3.95, SD= 1.248</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>M= 3.83, SD= 1.268</td>
<td>M= 4.15, SD= 1.070</td>
<td>M= 3.93, SD= 1.217</td>
<td>Significant p&lt;.05; η²=.016</td>
</tr>
</tbody>
</table>

Main effect text version NS (p=.770) No interaction effect. (p=.960)

NS: not significant (α=.05)
A univariate analysis of variance was carried out to investigate possible interaction effects and main effects of text version and age group on the indicator *unwillingness to invest in PLHA's*. No significant interaction effects were found. In addition, there were no significant main effects, which implies that the mean scores found regarding the indicator unwillingness to invest in PLHA’s did not significantly differ between adolescents and adults, or between participants who read text version 1 and participants who read text version 2. In general, the participants do not believe that it is useless for employers to give training to someone with HIV/AIDS (M=3.82). The results are presented in table 20.

Table 20. Outcomes univariate analysis of variance for *unwillingness to invest in PLHA's* in relation with age group and text version

<table>
<thead>
<tr>
<th></th>
<th>Adolescents</th>
<th>Adults</th>
<th>Total</th>
<th>Main effect age group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Text version 1</strong></td>
<td>M= 3.90,</td>
<td>M= 3.91,</td>
<td>M= 3.90,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SD= 1.223</td>
<td>SD= 1.428</td>
<td>SD= 1.289</td>
<td></td>
</tr>
<tr>
<td><strong>Text version 2</strong></td>
<td>M= 3.69,</td>
<td>M= 3.83,</td>
<td>M= 3.73,</td>
<td>NS (p=.678)</td>
</tr>
<tr>
<td></td>
<td>SD= 1.474</td>
<td>SD= 1.279</td>
<td>SD= 1.415</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>M= 3.79,</td>
<td>M= 3.87,</td>
<td>M= 3.82,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SD= 1.359</td>
<td>SD= 1.351</td>
<td>SD= 1.354</td>
<td></td>
</tr>
<tr>
<td><strong>Main effect text version</strong></td>
<td>NS (p=.419)</td>
<td></td>
<td></td>
<td>No interaction effect</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(p=.734)</td>
</tr>
</tbody>
</table>

NS: not significant (α=.05)

A univariate analysis of variance was carried out to investigate possible interaction effects and main effects of text version and age group on the indicator *discrimination*. No significant interaction effects were found. In addition, there were also no significant main effects, which implies that the mean scores found regarding the indicator discrimination did not significantly differ between adolescents and adults, or between participants who read text version 1 and participants who read text version 2. In general, the participants are not sure whether HIV-infected woman should be allowed to have children. The results are presented in table 21.
Table 21. Outcomes univariate analysis of variance for discrimination in relation with age group and text version

<table>
<thead>
<tr>
<th></th>
<th>Adolescents</th>
<th>Adults</th>
<th>Total</th>
<th>Main effect age group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Text version 1</strong></td>
<td>M= 2.90, SD= 1.398</td>
<td>M= 3.07, SD= 1.265</td>
<td>M= 2.95, SD= 1.352</td>
<td>NS (p=.119)</td>
</tr>
<tr>
<td><strong>Text version 2</strong></td>
<td>M= 3.04, SD= 1.351</td>
<td>M= 3.43, SD= 1.259</td>
<td>M= 3.16, SD= 1.331</td>
<td>NS (p=.157)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>M= 2.97, SD= 1.372</td>
<td>M= 3.24, SD= 1.267</td>
<td>M= 3.06, SD= 1.343</td>
<td>No interaction effect: (p=.552)</td>
</tr>
</tbody>
</table>

NS: not significant (α=.05)

The univariate test of variance did not reveal significant interaction effects of age group and text version on the indicator abuse. However, one significant main effect of age group was found on this indicator: $F(1,262)=21.09; p<.001; \eta^2=.074$. This implies that the mean score of the adolescents regarding abuse was significantly higher (M=3.68, SD=1.374) than the mean score of the adults (M=4.45, SD=1.034). As such, the age of the participants affected the extent to which they would think that it is correct to swear at PLHA's. No significant main effect of text version was found on the indicator abuse. The results are presented in table 22.

Table 22. Outcomes univariate analysis of variance for abuse in relation with age group and text version

<table>
<thead>
<tr>
<th></th>
<th>Adolescents</th>
<th>Adults</th>
<th>Total</th>
<th>Main effect age group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Text version 1</strong></td>
<td>M= 3.55, SD= 1.454</td>
<td>M= 4.48, SD= 1.045</td>
<td>M= 3.86, SD= 1.399</td>
<td>Significant: P&lt;.001; $\eta^2=.074$</td>
</tr>
<tr>
<td><strong>Text version 2</strong></td>
<td>M= 3.81, SD= 1.289</td>
<td>M= 4.42, SD= 1.035</td>
<td>M= 3.99, SD= 1.248</td>
<td>NS (p=.532)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>M= 3.68, SD= 1.374</td>
<td>M= 4.45, SD= 1.034</td>
<td>M= 3.92, SD= 1.324</td>
<td>No interaction effect: (p=.351)</td>
</tr>
</tbody>
</table>

NS: not significant (α=.05)

In conclusion, no significant interaction effects were found. Six significant main effects were found on the external stigma indicators. Of those six significant main
effects, one main effect of text version was found on the indicator avoidance, and five main effects of age group were found on the indicators avoidance, rejection, moral judgement, stigma by association and abuse. This outcome can be interpreted as follows. The participants who read text version 2 scored significantly higher on avoidance than the participants who read text version 1. Furthermore, the five significant main effects found regarding the five indicators, show that the adolescents scored significantly higher on all those five indicators (i.e. avoidance, rejection, moral judgement, stigma by association and abuse) than the adults did. No main effects were found on the indicators unwillingness to invest in PLHA's and discrimination.

The previous discussed results presented the effects of text version and age group on the variables included in the sections, evaluation of the message, the components of the Extended Parallel Process Model (EPPM) and the indicators of external stigma. The presumed relation between fear and external stigma was analysed by means of a correlation analysis. The results are presented in the next section.

4.4 CORRELATION BETWEEN FEAR AND EXTERNAL STIGMA

To analyse the relation between fear and external stigma, a correlation analysis was conducted on each stigma indicator in relation with the variable level of fear. The outcomes of the correlation analyses carried out are presented in table 23 – 29.

Table 23 shows that the correlation analysis did not reveal a significant positive correlation between avoidance and level of fear. As such, the level of fear was not related to the way participants would feel when shaking hands with a PLHA.

Table 23. Correlation between avoidance and level of fear

<table>
<thead>
<tr>
<th>I felt scared after reading the story</th>
<th>I feel uncomfortable shaking hands with someone who has HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt scared after reading the story</td>
<td>1</td>
</tr>
<tr>
<td>I feel uncomfortable shaking hands</td>
<td>1</td>
</tr>
<tr>
<td>with someone who has HIV/AIDS</td>
<td>.115</td>
</tr>
</tbody>
</table>

Note: *p<.05; **p<.01; ***p<.001. In case of no asterisks: no correlation.
The correlation analysis revealed a significant positive correlation between rejection and level of fear \((r = 0.132, p < 0.05)\). This implies that the higher the level of fear is, the more participants would feel bad if a PLHA would visit their home. The outcome is presented in table 24.

Table 24. Correlation between rejection and level of fear

<table>
<thead>
<tr>
<th>I felt scared after reading the story</th>
<th>I would feel bad if a person with HIV/AIDS would visit our home.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt scared after reading the story</td>
<td>1</td>
</tr>
<tr>
<td>I would feel bad if a person with</td>
<td>.132*</td>
</tr>
<tr>
<td>HIV/AIDS would visit our home.</td>
<td></td>
</tr>
</tbody>
</table>

Note: *: \(p < 0.05\); **: \(p < 0.01\); ***: \(p < 0.001\). In case of no asterisks, no correlation.

The correlation analysis revealed a significant positive correlation between moral judgement and level of fear \((r = 0.193, p < 0.001)\). This implies that the higher the level of fear is, the more participants would think that people who got infected with HIV/AIDS through prostitution or by sleeping around, have got what they deserve. The outcome is presented in table 25.

Table 25. Correlation between moral judgement and level of fear

<table>
<thead>
<tr>
<th>I felt scared after reading the story</th>
<th>People who got infected with HIV/AIDS through prostitution or by sleeping around, have got what they deserve.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt scared after reading the story</td>
<td>1</td>
</tr>
<tr>
<td>People who got infected with HIV/AIDS through prostitution or by sleeping around, have got what they deserve.</td>
<td>0.193***</td>
</tr>
</tbody>
</table>

Note: *: \(p < 0.05\); **: \(p < 0.01\); ***: \(p < 0.001\). In case of no asterisks, no correlation.

The correlation analysis revealed a significant positive correlation between stigma by association and level of fear \((r = 0.250, p < 0.001)\). This implies that the higher the level of fear is, the more participants would believe that someone has HIV/AIDS when that person has a skin rash on his/her face. The outcome is presented in table 26.
Table 26. Correlation between stigma by association and level of fear

<table>
<thead>
<tr>
<th>I felt scared after reading the story</th>
<th>If I see someone with a skin rash on his/her face, I think he/she must have HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt scared after reading the story</td>
<td>1</td>
</tr>
<tr>
<td>If I see someone with a skin rash on his/her face, I think he/she must have HIV/AIDS</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: *p<.05; **p<.01; ***p<.001. In case of no asterisks, no correlation.

Table 27 shows that the correlation analysis did not reveal a significant correlation between unwillingness to invest in PLHA’s and level of fear. As such, the level of fear was not related to the way participants think about the use of giving training to PLHA’s. The outcome is presented in table 27.

Table 27. Correlation between unwillingness to invest in PLHA’s and level of fear

<table>
<thead>
<tr>
<th>I felt scared after reading the story</th>
<th>It is useless for employers to give training to someone with HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt scared after reading the story</td>
<td>1</td>
</tr>
<tr>
<td>It is useless for employers to give training to someone with HIV/AIDS</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: *p<.05; **p<.01; ***p<.001. In case of no asterisks, no correlation.

Table 28 shows that the correlation analysis did not reveal a significant correlation between discrimination and level of fear. As such, the level of fear was not related to the indicator discrimination. The outcome is presented in table 28.

Table 28. Correlation between discrimination and level of fear

<table>
<thead>
<tr>
<th>I felt scared after reading the story</th>
<th>Women who are HIV-positive should not be allowed to have children</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt scared after reading the story</td>
<td>034</td>
</tr>
<tr>
<td>Women who are HIV-positive should not be allowed to have children</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: *p<.05; **p<.01; ***p<.001. In case of no asterisks, no correlation.

The correlation analysis revealed a significant positive correlation between abuse and level of fear (r = .237, p < .001). This implies that the higher the level of fear is, the
more participants think that verbal abuse towards PLHA's is okay. The outcome is presented in table 29.

Table 29. Correlation between abuse and level of fear

<table>
<thead>
<tr>
<th>I felt scared after reading the story</th>
<th>Sometimes it is OK to swear at a person with HIV/AIDS or call him/her names</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt scared after reading the story</td>
<td>1</td>
</tr>
<tr>
<td>Sometimes it is OK to swear at a person with HIV/AIDS or call him/her names</td>
<td>.237***</td>
</tr>
</tbody>
</table>

Note: *p<.05; **p<.01; ***p<.001. In case of no asterisks, no correlation.

In summary, four significant correlations were found between level of fear and four indicators of external stigma, i.e. rejection, moral judgement, stigma by association and abuse.

Next, as discussed in sub-section 2.2.2, it is presumed that especially people with a high level of fear of HIV/AIDS and a low level of perceived efficacy may turn to stigmatising behaviour towards PLHA’s. In addition to the concept of the fear control process in the EPPM (which states that these people with a high level of fear and low perceived efficacy exhibit fear control modes of coping) the relation between the level of fear and stigmatising behaviour for participants who enter the fear control process needed to be analysed. However, in this study the fear or danger control mode of the participants was not measured. This methodological problem will be further discussed in section 5.2.3. Instead, participants who scored high on level of fear (i.e. level of fear ≤ 2.49) and low on perceived efficacy (i.e. P.E. ≥ 3.5) were selected. Of the 269 participants, only nine of them corresponded to this profile of scoring high on the level of fear and low on perceived efficacy. Correlation analyses were conducted on each stigma indicator and the level of fear. The results are presented in table 30 - 36.

Table 30 shows that the correlation analysis did not reveal a correlation between avoidance and the level of fear. As such, regarding the participants with a high level of fear and low perceived efficacy, the level of fear was not related to the way the
participants would feel when shaking hands with someone who has HIV/AIDS.

Table 30. Correlation between avoidance and level of fear.

<table>
<thead>
<tr>
<th></th>
<th>I felt scared after reading the story</th>
<th>I feel uncomfortable shaking hands with someone who has HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt scared</td>
<td>1</td>
<td>-.100</td>
</tr>
<tr>
<td>after reading the story</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel uncomfortable</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>shaking hands with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>someone who has HIV/AIDS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: *: p<.05; **: p<.01; ***: p<.001. In case of no asterisks, no correlation.

Table 31 shows that the correlation analysis did not reveal a correlation between level of fear and rejection. As such, regarding the participants with a high level of fear and low perceived efficacy, the level of fear was not related to the way they would feel when a PLHA would visit their home.

Table 31. Correlation between rejection and level of fear.

<table>
<thead>
<tr>
<th></th>
<th>I felt scared after reading the story</th>
<th>I would feel bad if a person with HIV/AIDS would visit our home.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt scared after reading the story</td>
<td>1</td>
<td>-.189</td>
</tr>
<tr>
<td>I would feel bad if a person with HIV/AIDS would visit our home.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: *: p<.05; **: p<.01; ***: p<.001. In case of no asterisks, no correlation.

The correlation analysis revealed a significant negative correlation between moral judgement and the level of fear (r = -0.839, p < .01). This result implies that the higher the level of fear is, the less likely these participants (with a high level of fear and low perceived efficacy) believe that people who got infected with HIV/AIDS through prostitution or by sleeping around, have got what they deserve. The outcome is presented in table 32.

Table 32. Correlation between moral judgement and level of fear.

<table>
<thead>
<tr>
<th></th>
<th>I felt scared after reading the story</th>
<th>People who got infected with HIV/AIDS through prostitution or by sleeping around, have got what they deserve.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt scared after reading the story</td>
<td>1</td>
<td>-0.839**</td>
</tr>
<tr>
<td>People who got infected with HIV/AIDS through prostitution or by sleeping around, have got what they deserve.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: *: p<.05; **: p<.01; ***: p<.001. In case of no asterisks, no correlation.
Table 33 shows that the correlation analysis did not reveal a correlation between \textit{stigma by association} and the \textit{level of fear}. As such, regarding the participants with a high level of fear and low perceived efficacy, the level of fear was not related to the way they thought about someone with a skin rash on his/her face.

### Table 33. Correlation between \textit{stigma by association} and \textit{level of fear}.

<table>
<thead>
<tr>
<th></th>
<th>I felt scared after reading the story</th>
<th>If I see someone with a skin rash on his/her face, I think he/she must have HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt scared after reading the story</td>
<td>1</td>
<td>-.460</td>
</tr>
<tr>
<td>If I see someone with a skin rash on his/her face, I think he/she must have HIV/AIDS</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Note: *: p<.05; **: p<.01; ***p<.001. In case of no asterisks, no correlation.

Table 34 shows that the correlation analysis did not reveal a correlation between \textit{unwillingness to invest in PLHA's} and the high \textit{level of fear}. As such, regarding the participants with a high level of fear and low perceived efficacy, the level of fear was not related to the way they thought about the use for employers to give training to PLHA's.

### Table 34. Correlation between \textit{unwillingness to invest in PLHA’s} and \textit{level of fear}.

<table>
<thead>
<tr>
<th></th>
<th>I felt scared after reading the story</th>
<th>It is useless for employers to give training to someone with HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt scared after reading the story</td>
<td>1</td>
<td>.378</td>
</tr>
<tr>
<td>It is useless for employers to give training to someone with HIV/AIDS</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Note: *: p<.05; **: p<.01; ***p<.001. In case of no asterisks, no correlation.

Table 35 shows that the correlation analysis did not reveal a correlation between \textit{discrimination} and the \textit{level of fear}. As such, regarding the participants with a high level of fear and low perceived efficacy, the level of fear was not related to the way they thought about women with HIV and those women then having children and potentially passing HIV on to their new borns.
Table 35. Correlation between discrimination and level of fear.

<table>
<thead>
<tr>
<th></th>
<th>I felt scared after reading the story</th>
<th>Women who are HIV-positive should not be allowed to have children</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt scared after reading the story</td>
<td>1</td>
<td>.060</td>
</tr>
<tr>
<td>Women who are HIV-positive should not be allowed to have children</td>
<td>.060</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: *: p < .05; **: p < .01; ***: p < .001. In case of no asterisks, no correlation.

Table 36 shows that the correlation analysis did not reveal a correlation between abuse and the level of fear. As such, regarding the participants with a high level of fear and low perceived efficacy, the level of fear was not related to the way they thought about verbal abuse.

Table 36. Correlation between abuse and level of fear.

<table>
<thead>
<tr>
<th></th>
<th>I felt scared after reading the story</th>
<th>Sometimes it is OK to swear at a person with HIV/AIDS or call him/her names</th>
</tr>
</thead>
<tbody>
<tr>
<td>I felt scared after reading the story</td>
<td>1</td>
<td>.213</td>
</tr>
<tr>
<td>Sometimes it is OK to swear at a person with HIV/AIDS or call him/her names</td>
<td>.213</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: *: p < .05; **: p < .01; ***: p < .001. In case of no asterisks, no correlation.

In summary, the correlation analyses carried out only revealed one significant correlation (which proved to be negative) between the indicator moral judgement and the level of fear.

The results discussed in this chapter will be elaborated in the next chapter, in which the overall conclusions, discussion and recommendations will be presented.
CHAPTER 5

CONCLUSIONS, DISCUSSION AND RECOMMENDATIONS
5 CONCLUSIONS, DISCUSSION AND RECOMMENDATIONS

The aim of the experimental research undertaken was to examine whether the use of a fear appeal in HIV/AIDS education material would cause black adolescents and black adults with a lower socio-economic status in South Africa to display stigmatising behaviour towards people living with HIV/AIDS. This chapter sets out the conclusions based on the results discussed in the previous chapter. Furthermore, this chapter offers some points of discussion regarding this experimental research and a number of recommendations for further research.

5.1 CONCLUSIONS

The conclusions are presented in four sections. The first three sections mirror the first three sections of the questionnaire, namely the evaluation of the message, the components of the Extended Parallel Process Model (EPPM) and the indicators of external stigma. The fourth section discusses the relation between fear and external stigma.

5.1.1 THE EVALUATION OF THE MESSAGE

In general, the participants thought that the text messages used in this experimental research were easy to read, informative and authentic. The perceived authenticity of a narrative is an important factor in captivating the reader. A narrative that captivates its readers may result in the readers changing their attitude and beliefs (Green 2002). As most of the participants perceived the narratives as being authentic, it can be said that the text messages used in this study may have captivated the participants, thereby hopefully resulting in the participants changing their beliefs and attitude.

In contrast to what might have been expected from the results of the second pretest, the high threat text message did not have a significant influence on the level of fear of the participants. Basically, text version 1 (which contained the high threat message) failed to evoke a high level of fear among the participants who read this text version. Text version 2 (which contained a low threat message) also failed, because
participants reading this version should not have perceived any threat. This may be explained by the high level of fear that was already experienced before reading the text messages by the participants who read text version 2. It may also be possible that the participant’s emotions of fear were repressed by his/her fear control mechanisms, such as denial. On average, the participants of both text versions were not sure whether they felt scared after reading their text messages. The methodological implications related to this outcome will be discussed in section 5.2.1.

5.1.2 THE COMPONENTS OF THE EPPM

The results of the research showed that on average, the participants do not know if they are susceptible to HIV/AIDS. The rather low score of perceived susceptibility might be interpreted to mean that the participants do not want to know whether or not they are susceptible to HIV/AIDS. This premise may be caused by the fear of HIV infection, and the potential consequence of being stigmatised as a result. The high score on perceived severity reflects this fear of HIV infection, i.e. the participants mostly perceived HIV/AIDS as a threat to their community and to their own health.

The results also showed that most of the participants perceived their self-efficacy as high regarding HIV-prevention. They claimed that they would use a condom during sexual intercourse. Of the four recommended responses to prevent HIV infection, the participants considered two responses to be effective, i.e. using a condom and staying faithful to one’s partner. Especially the adults were, on average, convinced about the effectiveness of staying faithful to one’s partner.

In general, the adolescent participants believed that praying to God was effective while the adult participants were not sure about the effectiveness of this method. Having faith in God and believing that He will protect someone from HIV infection when living according to His rules, corresponds to the theory explaining the cause of illness by means of the level of macro-cosmos as discussed in section 2.4.1.1. However, this perspective on HIV-prevention is a reason for concern. People should
rather relate the cause of HIV/AIDS to their own actions instead of explaining it by means of supernatural or external forces. In respect of the fourth sub-variable of response efficacy (having sex only with someone you know), both age groups generally do not believe that having sex only with people you know is effective in protecting oneself from HIV infection.

5.1.3 THE INDICATORS OF EXTERNAL STIGMA

The results of the study show that, in general, the participants' responses did not reveal stigmatising behaviour towards PLHA's. The conclusions based on the results of the univariate analysis of variance are listed below. These are that, the participants generally believe that:

- they would not feel bad when shaking hands with someone who has HIV/AIDS (avoidance);
- they would not feel bad when a person with HIV/AIDS would visit their home (rejection);
- they would not believe that people who have become infected with HIV/AIDS through prostitution or by sleeping around, have received what they deserve (moral judgement);
- they would not suspect that a person with a skin rash on his or her face to have HIV/AIDS (stigma by association);
- it is not useless for employers to give training to someone with HIV/AIDS (unwillingness to invest in PLHA's);
- they would not know whether an HIV-infected woman should be allowed to have children (discrimination), and,
- that it is not correct to swear sometimes at a person with HIV/AIDS or call him/her names (abuse).

Even though the participants' responses did not reveal external stigma, the significant higher mean scores of the adolescents on five indicators of external stigma indicate that adolescents are generally more inclined than adults to stigmatise PLHA's. This
may be explained by the premise that adults are more aware of what is *morally accepted* in society. Adults may also consider themselves to be a role model for children in society and therefore feel more obliged to give the *right answer* than the adolescents would be. As explained in section 2.4.2.1.1, adolescents are physically mature at a young age, but their mental, social and emotional skills are not yet sufficiently developed to be able to understand the consequences of unsafe sexual behaviour. In addition, because of their underdeveloped skills to understand certain aspects of life, they may be less aware of the consequences of stigma. As a result, they may score higher on the external indicators of stigma than adults would.

It is remarkable that the results of the study reveal no stigmatising behaviour, only a slightly higher inclination among adolescents to stigmatise. This may be caused by the moderate level of fear of the participants, taking the presumed relation between fear and stigma into account, which is explained in the next section.

5.1.4 RELATION BETWEEN FEAR AND EXTERNAL STIGMA

According to Dijker and Koomen (1996), fear is one of the factors that causes people to stigmatise PLHA’s. The outcome of the correlation analyses revealed a significant correlation between the level of fear and four indicators of external stigma: rejection, moral judgement, stigma by association, and abuse. In other words, there is a positive relation between fear and external stigma, which implies the higher the recipient's level of fear, the more likely they are to stigmatise PLHA’s. This relation found in the correlation analyses supports the theory of Dijker and Koomen (1996). However, the univariate analysis of variance carried out on each of the seven indicators of external stigma did not reveal stigmatising behaviour towards PLHA’s, as concluded in the previous section. In addition, the low scores on the indicators of external stigma may be explained by the moderate level of fear, taking the positive relation between fear and stigma into account. Because the participants did not show stigmatising behaviour in this study, the theory of Dijker and Koomen stating that fear causes people to stigmatise PLHA’s, cannot be completely supported.
The theory of the EPPM states that people who are completely preoccupied by their fear of, for example, HIV/AIDS and who do not believe that they are able to avert the threat of this disease (low perceived efficacy) will end up in the fear control mode. Their perceived threat of HIV/AIDS exceeds their perceived efficacy to prevent HIV infection. As explained in section 2.2, it is presumed that especially these people, with their high level of fear of HIV/AIDS and low level of perceived efficacy to prevent HIV infection, can be considered a target group that would stigmatise PLHA's. Stigmatising behaviour is considered a psychological defense mechanism to control one's anxiety.

The assumption that people who end up in the fear control mode are likely to stigmatise PLHA's had to be analysed by means of a correlation analysis between the level of fear and the indicators of external stigma. However, whether respondents were in danger or fear control mode was not measured in this study. To solve this problem, the participants with a high level of fear and low perceived efficacy were selected to represent the group who would be expected to enter the fear control process. This methodological problem regarding the danger and fear control mode will be discussed in section 5.2.2.

No significant positive correlations were found between the indicators of external stigma and the level of fear of the participants with a high level of fear and low level of perceived efficacy. Therefore, the results of this study cannot support the premise that participants with a high level of fear and a low level of perceived self-efficacy are more likely to stigmatise PLHA's. However, the small number of participants who perceived their level of fear as high and their self-efficacy as low (N = 9), caused a methodological problem regarding the interpretation of the results. This methodological problem will be discussed in section 5.2.3.

In short, it can be concluded that the use of fear appeals in the HIV/AIDS education text messages tested in this research did not cause the black adolescent and adult
participants with a lower socio-economic status in South Africa to display stigmatising behaviour towards PLHA's. However, the results did show a positive relation among all participants between fear and four indicators of external stigma, which implies that the higher the level of fear was, the more people would perform external stigmatising behaviour. Furthermore, the age of the participants did appear to have an effect on the extent of stigmatising behaviour, i.e. adolescents were more inclined to stigmatise PLHA's than the adults were. In the next section, some points of discussion are set out.

5.2 DISCUSSION

Due to the relatively small sample size and the fact that the data were collected mainly in the surroundings of Pretoria, the results of this study obviously cannot be said to apply to all poor black communities in South Africa. Caution should be exercised in applying the study results to other geographic regions and demographic groups. Although the findings of the study are no more than indicative, they may provide useful insights into the possible effects of fear-based HIV/AIDS messages on people in black communities with a lower socio-economic background in South Africa. Apart from the fact that the results of this research cannot be applied to all poor black communities in South Africa, there are three other points of discussion, namely the effect of the text versions, the relation between fear and external stigma and the problems regarding the procedure.

5.2.1 DISCUSSION REGARDING THE EFFECT OF THE TEXT VERSIONS

In this study, text version 1 did not appear to have an effect on the level of fear, or on the perceived severity or the perceived susceptibility (i.e. perceived threat). It can be questioned whether the use of text messages in HIV/AIDS education has any effect on changing a person's attitude or behaviour towards a more HIV-preventative behaviour. There are signs among South Africans of some resistance to the threat of HIV/AIDS that may have been caused by an overload of written HIV/AIDS education material, such as HIV/AIDS brochures, leaflets etc. A possible
consequence of this resistance may be that fear of HIV/AIDS can no longer be evoked by means of written text messages about HIV/AIDS.

There are two methodological implications that arose out of the use of the different text versions. Firstly, as previously discussed in section 3.3, the low threat text message was not accompanied by a photograph while the high threat and high efficacy text messages were. As a consequence, the balance between the two text versions was interrupted because of the lack of this one photograph. This caused a methodological problem, which negatively affected the validity of the interpretation of the results. The second methodological implication is that there was only one type of each text version used in this study. According to Meuffels and Van den Bergh (2005), if research shows text messages to have no effect (with only one type of text material), this does not mean that text messages in general do not have any effect at all. Perhaps another text message could have had an effect. Therefore, based on the method used in this study where only one type of each text version was used, it cannot be concluded that text messages do not have any effect on the level of fear or perceived threat.

5.2.2 DISCUSSION REGARDING THE RELATION BETWEEN FEAR AND EXTERNAL STIGMA

This study did not measure whether participants were exhibiting danger or fear control modes of coping. Therefore, it was not possible to analyse whether the difference in text versions led to different coping modes. However, this study did attempt to analyse the relation between people with a high reported level of fear and a low level of perceived efficacy, and their manifestations of external stigma. Of the 269 participants, only nine participants corresponded to the profile of showing a high score on the reported level of fear and a low score on perceived self-efficacy. This small number of participants caused a methodological problem, i.e. with such a small number of participants a very high correlation has to be found before the correlation can be deemed significant. This high correlation was not found in this study. The small number of participants also affected the validity of the conclusions, i.e. due to
the small number of participants, the conclusions cannot be said to apply in general to
the target groups used in this study. A reason for this small number of participants
may be that the participants did experience fear but were reluctant to admit it.
However, another reason may be that the participants did not experience fear because
of resistance towards fear appeals relating to HIV/AIDS, as discussed in the previous
section.

5.2.3 DISCUSSION REGARDING PROBLEMS WITH THE PROCEDURE
In general, the adolescent participants were relatively easy to find with the help of a
teacher or another member from certain school. However, it is not clear whether all
the adolescent participants completed the questionnaire of their own volition. If they
experienced some pressure to participate, this may have influenced their precision or
good faith in completing the questionnaire. The adult participants were more difficult
to find and to persuade to take part in a study concerning HIV/AIDS. As previously
mentioned, this may have been related to the sensitivity surrounding HIV/AIDS. In
addition, many negative reactions also seemed to derive from the existing fatigue in
respect of HIV/AIDS campaigns and research. Specifically, in conversations with
adults it became clear that the lack of any progress regarding the HIV/AIDS
pandemic in the last couple of years and an overload of HIV/AIDS information had
caused fatigue among people regarding the HIV/AIDS issue. This may have made
participants less focused on, or less critical towards, the statements set out in the
study’s questionnaire. The fact that the researcher’s cultural background differed
from that of the participants on aspects such as age, ethnicity and sometimes
biological sex, while asking questions about private matters, may also have
influenced the people’s attitude towards this research. To reduce this problem,
cultural brokers were used to persuade people to participate in this study.

5.3 RECOMMENDATIONS
Having completed this study, a number of recommendations for further research are
set out:
I. A study should be set up to measure which mode of coping a participant enters after reading certain text messages, i.e. the danger or the fear control process. In addition, the research should measure the level of fear before and after participants read a high threat text message so as to be able to verify any difference in level of fear created by such a message.

II. The text versions should only differ from each other in respect of the manipulated text message or message part in order to exclude methodological problems that negatively affect the validity of the results’ interpretation. In other words, where one non-manipulated text message or message part includes a photograph in text version 1, the other identical non-manipulated text message or message part in the other text version(s) must also include the exact same photograph.

III. More than one type of each text version will have to be used in order to exclude the methodological implications discussed in section 5.2.1 above.

IV. Furthermore, it is highly recommended to use cultural brokers when the experimental research concerns participants with a cultural background that differs from that of the researcher.

Finally, further research is needed to assess the relationship between fear appeals in HIV/AIDS education material and external stigma along with the audience’s cultural background.

5.4 Final Thoughts

Based on the results of this experimental research, it can be concluded that the use of fear appeals in HIV/AIDS education messages does not cause black adolescents and adults with a lower socio-economic status in South Africa, to display stigmatising behaviour towards people living with HIV/AIDS. Adolescents in this group are more inclined to stigmatise PLHA’s than adults are. However, there is a positive relation between fear and external stigma. Therefore, the designers of HIV/AIDS education
material (which use fear appeals to create fear among its readers) should take into account that readers with a high level of fear are more likely to stigmatise PLHA’s. This is undoubtedly not the intention of the designers and it is therefore important that those producing HIV/AIDS education material do not automatically opt for the use of fear appeals without considering the possibility that in doing so they may contribute to a tendency of stigmatisation of PLHA’s in the target group.
LIST OF REFERENCES


Siyam’Kela (2003d). *The policy project. Literature review.* Pretoria: Centre for the study of AIDS at the University of Pretoria.


**WEBSITES:**


15-03-2005.

APPENDIX A

INTRODUCTION

QUESTIONNAIRE
Good day,

We would like you to take part in a research project carried out by the department of Business Communication at the University of Nijmegen in Holland. In this research, we would like to hear what you think about written information on HIV/AIDS. The information that you give us will be used to make better education material.

How does it work? We would like YOU TO READ A STORY AND THEN ANSWER a few questions to see what you think or feel about some things. After reading the question you mark the answer which you think is OK. For example:

<table>
<thead>
<tr>
<th>I like to play soccer</th>
<th>I completely agree</th>
<th>I mostly agree</th>
<th>I do not know/ I am not sure</th>
<th>I mostly disagree</th>
<th>I completely disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>O</td>
<td>X</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

You can not give wrong answers! Just be HONEST and your answer will be ok. It will take 30 minutes of your time to read the text and answer all the questions. YOU CAN WRITE DOWN THE ANSWERS IN THIS BOOKLET. NO-ONE WILL KNOW WHAT YOU HAVE ANSWERED, BECAUSE YOU DO NOT HAVE TO WRITE YOUR NAME ON THE BOOKLET. NO-ONE will be allowed to see your answers. Perhaps you find some words difficult in this list with questions. You can look them up in this scheme.

<table>
<thead>
<tr>
<th>Unprotected sex/ unsafe sex</th>
<th>Sex without a condom, full penetration without a condom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protected sex/ safe sex</td>
<td>Sex with a condom, sex without penetration, no sex at all; hugging and kissing</td>
</tr>
</tbody>
</table>

WE ARE REALLY HAPPY THAT YOU WANT TO HELP US by ANSWERING THE QUESTIONS. But if AT ANY TIME you would like to stop with ANSWERING, that is OK. You can just tell us so and your booklet will be destroyed.

Thank you for your help and your time!

Rafaëla Feddes
APPENDIX B

TEXT VERSION 1 (HTHE)
Hello,

I am Lerato and I would like to share my story with you. My partner and I were once very close. But we have done something stupid. One night we experimented and some time after we "did it" my partner told me some bad news: my partner was HIV-positive. I was so angry and scared at the same time. How could my partner do that to me? I knew that I had to get myself tested to find out if I would be HIV-positive too. So, I went to a clinic, but they told me to come back in about 3 months, because it was not yet possible to see if I would be HIV-positive. For 3 months I was living in fear: was I or was I not infected with HIV? Was I going to die...? Then the day came that I returned to the clinic to get myself tested. The lady who took the test said that I needed to wait for 20 minutes and then I would get the results. These 20 minutes were the worst 20 minutes of my life. I was thinking: what if I am HIV-positive? The thoughts were driving me crazy! Then the lady returned with the results. She looked at me and gave me the scary news: I was HIV-positive...

I stood up and left the clinic, everything outside suddenly looked different. I was scared. I could not go home and face my family. What would people think of me? I walked around and I started to think...Why...?

Since then, things have changed. I do not feel the same anymore. A lot of times I feel very sick and tired. I have this rash on my skin that I can not hide. I know that there is no cure. I know I will die too young. I know I can have no dreams of a bright future, all because of this disease, HIV/AIDS. And the scariest thing is that it can happen to YOU too.

Lerato

To everyone who is HIV-negative, please stay that way.

Hello,

A lot of persons in South Africa are infected by HIV/AIDS. My partner and I talked to each other about this situation in our country. It is a big thing. We also talked to each other about our own health. We decided that we did not want to be at risk for HIV/AIDS. We decided to have safe sex. What is safe sex?

First of all, no sex is safe sex. So, we could say no to sex, but of course we are not going to do that our entire life. We decided to use condoms. Condoms prevent you from getting infected with HIV when you are having sex with your partner. Condoms are available in a lot of places in your community and you can get them for free. You should know that these free condoms protect you as much as condoms that you can buy in a store. Many people think that using a condom makes the sex bad. It is not true. We are happy together and most of all, we do not have to worry about getting infected!

Then, we decided to stay faithful to each other. Staying faithful to each other means that you are not sleeping around with other people. At the end, it is easy to protect yourself from getting infected with HIV/AIDS. The use of just one condom each time you have sex, is enough to protect you from getting HIV/AIDS. Talk to your partner about it, like we did. And another thing, be careful with sleeping around, stay faithful to your partner. It might just save your life!

Now it is your turn to think... Are you being safe?

Mahlatsi
APPENDIX C

TEXT VERSION 2 (L THE)
In South Africa many people live with HIV/AIDS. But what is HIV/AIDS and what is the difference between HIV and AIDS?

HIV is a virus that is spread through the mixing of blood, semen or vaginal secretions. (Semen is the bodily fluid that comes out of the penis; vaginal secretions are any fluids in the vagina. Being HIV-infected means that you are carrying the virus and can infect other people. AIDS is a later stage where the infected person becomes ill.

How is HIV/AIDS being spread in South Africa?

1. In South Africa HIV is mostly spread through unprotected sex. Sex means that the man puts his penis into the vagina or anus of his partner. Unprotected means that it is unsafe. So, unprotected sexual intercourse means that people have sex without using protection, like a condom.

2. A woman who is HIV-infected can also pass HIV to her baby. The mother can pass HIV to her baby when she is pregnant or when she breastfeeds her baby.

3. Drug users who share needles can be infected by HIV too. In this case blood of an HIV-infected person stays behind on the needle and can infect a healthy person when he/she puts the same needle into his/her own body.

Prevention is the only way to stop HIV/AIDS. And prevention is really simple. The next story is told by a happy couple that wants to share their experience with you. They explain why it is so simple to prevent getting infected by HIV/AIDS. Read the story and see how normal people, just like you, take control of their own life. They show you how to take your future in your own hands and to take control of your future. Love your life and make the most of it!

To everyone who is HIV-negative, please stay that way.

Hello,

A lot of persons in South Africa are infected by HIV/AIDS. We talked to each other about this situation in our country. It is a big thing. We also talked to each other about our own health. We decided that we do not want to be at risk for HIV/AIDS. We decided to have safe sex. What is safe sex?

First of all, no sex is safe sex. So, we could say no to sex, but of course we are not going to do that our entire life. We decided to use condoms. Condoms prevent you from getting infected with HIV when you are having sex with your partner. Condoms are available in a lot of places in your community and you can get them for free. You should know that these free condoms protect you as much as condoms that you can buy in a store. Many people think that using a condom makes the sex bad. It is not true. We are happy together and most of all, we do not have to worry about getting infected!

Then, we decided to stay faithful to each other. Staying faithful to each other means that you are not sleeping around with other people. At the end, it is easy to protect yourself from getting infected with HIV/AIDS. The use of just one condom each time you have sex, is enough to protect you from getting HIV/AIDS. Talk to your partner about it, like we did. And another thing, be careful with sleeping around, stay faithful to your partner. It might just save your life!

Now it is your turn to think... Are you being safe?

Mahlatsi
APPENDIX D

QUESTIONNAIRE
**THE SHADOW OF FEAR**

---

WE WOULD LIKE TO HEAR WHAT YOU THINK OF THE STORY YOU HAVE READ AND HOW YOU FEEL ABOUT IT

<table>
<thead>
<tr>
<th>A</th>
<th>Statement</th>
<th>I completely agree</th>
<th>I mostly agree</th>
<th>I do not know/I am not sure</th>
<th>I mostly disagree</th>
<th>I completely disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 1</td>
<td>I think that the story is clearly written.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>A 2</td>
<td>I think the story is informative.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>A 3</td>
<td>I felt different after reading the story.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>A 4</td>
<td>The story has nothing to do with my life.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>A 5</td>
<td>I felt confused when I read the story.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>A 6</td>
<td>I think the story is boring to read.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>A 7</td>
<td>I think the story is believable.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>A 8</td>
<td>I felt scared after reading the story.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>A 9</td>
<td>I wanted to laugh after reading the story.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>A10</td>
<td>I think that the story is too long.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>A11</td>
<td>I think the story is interesting.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>A12</td>
<td>I felt uncomfortable when I read the story.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>A13</td>
<td>I think the story is useful.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>A14</td>
<td>The story seems real to me.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>A15</td>
<td>I think the story is convincing.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>A16</td>
<td>I think the story is easy to read.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>A17</td>
<td>I clearly understand the story.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>A18</td>
<td>I was shocked after reading the story.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>A19</td>
<td>I was afraid when I read the story</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

A 20 | Do you have anything to say or questions about the story? Please write them down here:  

...........................................................................................................................................................  
...........................................................................................................................................................  
...........................................................................................................................................................

ON THE NEXT PAGE WE WOULD LIKE TO ASK YOU SOME OTHER QUESTIONS
<table>
<thead>
<tr>
<th>Statement</th>
<th>I completely agree</th>
<th>Mostly agree</th>
<th>I do not know/I am not sure</th>
<th>Mostly disagree</th>
<th>I completely disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>If my partner wants me to have unprotected sex, I would probably do it.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>If my partner wants me to join in unprotected sex and I would say that we need to be safer, we would have safer sex instead.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>If my partner wants me to have unprotected sex and I would make an excuse to use a condom, we would still have unprotected sex.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>If a sexual partner does not want to use a condom, we would have sex without using a condom.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Using a condom every time I have sex is effective in preventing HIV/AIDS.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Being faithful to my partner is effective in preventing HIV/AIDS.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Praying to God will protect me from getting HIV/AIDS.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Only having sex with people I know well from my community, will protect me from getting HIV/AIDS.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>It is better to use more than one condom each time I have sex with someone, because when one condom breaks, there is still at least one more to protect us.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>If my partner and I stay faithful to each other, we protect ourselves from being at risk for HIV/AIDS.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Praying to God and living a good life according to Him will protect me from getting HIV/AIDS.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I can trust the people I know well. So having sex with them is safe, because they would never give me HIV/AIDS.</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
B33c  My sexual lifestyle puts me at risk for HIV/AIDS.
I completely agree I mostly agree I do not know/I am not sure I mostly disagree I completely disagree
O    O    O    O    O

B34c  It is possible that I have HIV/AIDS.
O    O    O    O    O

B35c  I may have had sex with someone who was at risk for HIV/AIDS.
O    O    O    O    O

B36c  I am at risk for HIV/AIDS.
O    O    O    O    O

B37d  I believe that HIV/AIDS is a serious health problem.
O    O    O    O    O

B38d  I believe that HIV/AIDS is a real danger to my health.
O    O    O    O    O

B39d  HIV/AIDS is a real danger to my community.
O    O    O    O    O

C40a  I would be afraid to kiss someone on the mouth who has HIV/AIDS
O    O    O    O    O

C41a  I feel uncomfortable shaking hands with someone who has HIV/AIDS.
O    O    O    O    O

C42a  If a close friend or relative gets HIV/AIDS, I would be nice to him/her and do the things we always did.
O    O    O    O    O

C43a  I would eat the soup that has been prepared by a person with HIV/AIDS
O    O    O    O    O

C44a  I would be afraid to hug someone with HIV/AIDS.
O    O    O    O    O

C45a  I think it is wrong to allow an HIV-infected person into the supermarket.
O    O    O    O    O

C46b  If a close friend or relative gets HIV/AIDS, the relationship/friendship between us would change.
O    O    O    O    O

C47b  I would feel bad if a person with HIV/AIDS would visit our home.
O    O    O    O    O
<table>
<thead>
<tr>
<th>ID</th>
<th>Statement</th>
<th>Agree</th>
<th>Mostly Agree</th>
<th>Not Know/Not Sure</th>
<th>Mostly Disagree</th>
<th>Completely Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>C48c</td>
<td>People who got infected with HIV/AIDS through prostitution or by sleeping around, have got what they deserve.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>C49c</td>
<td>God punishes people with HIV/AIDS when they have sex outside marriage or outside a steady relationship.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>C50c</td>
<td>People who do not use a condom when they have sex deserve to be infected by HIV/AIDS.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>C51d</td>
<td>I can see if someone has HIV/AIDS.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>C52d</td>
<td>If I hear someone has TB (tuberculosis), I think that he/she has HIV/AIDS.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>C53d</td>
<td>If I see someone with a skin rash on his/her face, I think he/she must have HIV/AIDS.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>C54d</td>
<td>People who work with HIV/AIDS patients will probably have HIV/AIDS too.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>C55e</td>
<td>It is useless for employers to give training to someone with HIV/AIDS.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>C56e</td>
<td>It is a waste of money to give a better job to someone with HIV/AIDS.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>C57f</td>
<td>Women who are HIV-positive should be allowed to have children.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>C58f</td>
<td>People with HIV/AIDS have the right to be helped by the police.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>C59g</td>
<td>Sometimes it is OK if I would hit a person with HIV/AIDS.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>C60g</td>
<td>Sometimes it is OK to swear at a person with HIV/AIDS or call him/her names.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>
FINALLY, WE WOULD LIKE SOME PERSONAL INFORMATION FROM YOU.
YOU DO NOT HAVE TO GIVE YOUR NAME.

D61 Age (in years): ...........................................

D62 Gender: Male ○ Female ○

D63 Nationality (from which country are you?): .............................................................

D64 Do you have a partner? Yes ○ No ○

D65 Have you ever had sex with someone? Yes ○ No ○

D66 Have you ever taken an HIV test? Yes ○ No ○ If no, go to question D69

D67 When did you take an HIV test? Or when did you take your last HIV test, if you have taken more than one?
This week ○ 1-4 weeks ago ○ 1-3 months ago ○ 3-6 months ago ○ longer ago ○

D68 Were you: positive ○ negative ○ I don’t want to say ○

D69 Which of the following population groups do you consider yourself to be part of?
African ○ White ○ Indian ○ Coloured ○ I don’t want to say ○

D70 What language do you usually speak at home?
English ○ isNdebele ○
Sesotho sa Leboa ○ isiSwati ○
Sesotho ○ Setswana ○
Tshivenda ○ Afrikaans ○
isaXhosa ○ Other ○ (please specify: ............................)

D71 Where do you live at present?
Rural area ○ Urban area ○

D72 In what type of structure / building do you live at present?
Squatter camp house/shack ○ Township house ○
Suburban house ○ Flat ○
Farmhouse ○ Hostel ○
Other ○ (please specify: .............................)
FINALLY, WE WOULD LIKE SOME PERSONAL INFORMATION FROM YOU. 
YOU DO NOT HAVE TO GIVE YOUR NAME.

D61 Age (in years): ...........................................

D62 Gender: Male ○ Female ○

D63 Nationality (from which country are you?): ...............................................................  

D64 Do you have a partner? Yes ○ No ○

D65 Have you ever had sex with someone? Yes ○ No ○

D66 Have you ever taken an HIV test? Yes ○ No ○ If no, go to question D69

D67 When did you take an HIV test? Or when did you take your last HIV test, if you have taken more than one?
This week ○ 1-4 weeks ago ○ 1-3 months ago ○ 3-6 months ago ○ longer ago ○

D68 Were you…: positive ○ negative ○ I don’t want to say ○

D69 Which of the following population groups do you consider yourself to be part of?
African ○ White ○ Indian ○ Coloured ○ I don’t want to say ○

D70 What language do you usually speak at home?
English ○ isiNdebele ○
Sesotho sa Leboa ○ isiSwati ○
Sesotho ○ Setswana ○
Tshisivenda ○ Afrikaans ○
isiXhosa ○ Other ○ (please specify: ...................................)

D71 Where do you live at present?
Rural area ○ Urban area ○

D72 In what type of structure / building do you live at present?
Squatter camp house/shack ○ Township house ○
Suburban house ○ Flat ○
Farmhouse ○ Hostel ○
Other ○ (please specify: .................................)
D73 Are you a member of the following religions, or do you share the beliefs of any of the following?

- Do not support any religion
- Islam
- Any African Church
- Roman Catholic Church
- ZCC
- Jewish faith
- Anglican Church
- Buddhism
- Pentecostal Church
- Hinduism
- Other Christian church (please specify: ......................................)
- Other religion (please specify: ......................................)

D74 At present……:

- I go to school full-time
- I go to an educational institution other than school (full-time)
- I go to school part-time
- I go to an educational institution other than school (part-time)
- I am looking for work (jobless)
- I work full-time
- I work part-time
- I stay at home to look after my family
- Other (please specify: ......................................)

D75 Which is the highest school grade you have passed?

- Grade 7 (standard 5) or lower
- Grade 8 (standard 6)
- Grade 9 (standard 7)
- Grade 10 (standard 8)
- Grade 11 (standard 9)
- Grade 12 (standard 10 /matric) or higher

You have now FINISHED completing this list with questions. Thank you so much!!!
APPENDIX E

DEFINITION APPENDIX
<table>
<thead>
<tr>
<th><strong>DEFINITION</strong></th>
<th><strong>EXPLANATION IN THE CONTEXT OF HIV/AIDS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abuse</strong></td>
<td>One of the manifestations of external stigma according to Siyam’Kela (2003) in which verbal or physical violence against PLHA’s is showed as a reaction of a person’s disapproval and rejection towards PLHA’s.</td>
</tr>
<tr>
<td><strong>Affection</strong></td>
<td>Emotions, feelings.</td>
</tr>
<tr>
<td><strong>AIDS</strong></td>
<td>Acquired Immune Deficiency Syndrome. AIDS is the end stage of HIV infection. At this stage various diseases attack the weakened body.</td>
</tr>
<tr>
<td><strong>Antilocution</strong></td>
<td>This the first level of Allport’s (1954) manifestations of stigma, (1954) referring to people who talk about the stereotypes of PLHA’s and its prejudices.</td>
</tr>
<tr>
<td><strong>Avoidance</strong></td>
<td>This is the second level of Allport’s (1954) manifestations of stigma, referring to avoiding any social interaction with the stigmatized. It is also one of the manifestations of external stigma according to Siyam’Kela (2003) in which people avoid PLHA’s, because of the fear of transmission or the perception that PLHA’s are dirty and immoral.</td>
</tr>
<tr>
<td><strong>Cognition</strong></td>
<td>The mental action or process of acquiring knowledge and understanding through thought and experience.</td>
</tr>
<tr>
<td><strong>Danger control coping</strong></td>
<td>The process of adapting the recommended behaviour.</td>
</tr>
<tr>
<td><strong>Danger control mode/process</strong></td>
<td>A cognitive process eliciting protection motivation that occurs when one believes he or she is able to effectively avert a significant and relevant threat through self-protective changes. When in danger control, people think of strategies to avert a threat (Witte 1998:429).</td>
</tr>
<tr>
<td><strong>Danger control responses</strong></td>
<td>Belief, attitude, intention, and behaviour changes in accordance with a message’s recommendations (Witte 1998:429).</td>
</tr>
<tr>
<td><strong>Discrimination</strong></td>
<td>This the third level of Allport’s manifestations of stigma, (1954) referring to people who can discredit and discriminate the stigmatized individual. It concerns unjust or prejudicial treatment of different categories of people, especially on the grounds of race, age or sex. It is also one of the manifestations of external stigma (Siyam’Kela 2003) in which PLHA’s experience an unequal treatment because they are HIV-positive, such as insurance companies and financial institutions that deny PLHA’s access to their services.</td>
</tr>
</tbody>
</table>
**Efficacy**


**Extermination**

This is the fifth level of Allport’s (1954) manifestations of stigma. It is the most severe manifestation of stigma, such as murder and lynching.

**External stigma**

One of the two categories of stigma according to Siyam’Kela (2003) characterised by actual experiences of domination, oppression, the exercise of power or control, harassment, categorising, accusation, punishment, blame, exclusion, ridicule or resentment.

**Fear**

Fear is an internal emotional reaction composed of psychological and physiological dimensions that may be aroused when a serious and personally relevant threat is perceived (Witte 1998:429).

**Fear appeal**

A persuasive message that arouses fear by outlining the negative consequences that occur if a certain action is not taken (Witte 2001:2).

**Fear control coping**

The process of being preoccupied on loosing ones fear.

**Fear control mode / process**

An emotional process eliciting defensive motivation that occurs when people are faced with a significant and relevant threat, but believe themselves to be unable to perform a recommended response and/or they believe the response to be ineffective. The high levels of fear caused by this condition produce defensive motivation resulting in coping responses that reduce fear and prevent danger control responses from occurring (Witte 1998:429).

**Fear control responses**

Coping responses that diminish fear such as defensive avoidance, denial, and reactance, including issue and message derogation and perceived manipulative intent (Witte 1998:429).

**HIV**

Human Immuno-deficiency Virus. HIV is the virus that causes AIDS. HIV attacks the immune system and weakens it.

**Internal stigma**

One of the two categories of stigma according to Siyam’Kela (2003) referring to a way to protect oneself from the evil and the harsh world around him/her.

**Message-acceptance**

The outcome of the danger control process: accepting the message.
Message-rejection

The outcome of the fear control process: rejecting the message.

Moral judgement

One of the manifestations of external stigma according to Siyam’Kela (2003) in which people judge PLHA’s for their immoral beliefs and immoral lifestyle and therefore got punished with HIV. It involves viewing PLHA’s as either guilty or innocent in terms of how they contracted HIV.

Narrative

A story that reflects a certain experience of the author. It judges the actions taken by the character in the story in order to make ‘sense of the social world’ (Hydén 1997:49).

Perceived self-efficacy

Thoughts or cognitions of a person about ones ability to perform the recommended behaviour: e.g., I believe that I will always use a condom during sexual intercourse.

Perceived response efficacy

Thoughts or cognitions of a person about the effectiveness of the recommended response to prevent the threat: e.g., I believe that using a condom prevents me from HIV infection.

Perceived efficacy

Thoughts or cognitions about its underlying dimension, response efficacy and self-efficacy (Witte 1998:429).

Perceived severity

Beliefs about the significance or magnitude of the threat: e.g., AIDS leads to death (Witte 1998:429).

Perceived susceptibility

A set of beliefs about one’s risk of experiencing the threat: e.g., I am at risk for HIV/AIDS because I do not use a condom (Witte 1998:429).

Perceived threat

Perceived threat is composed of two underlying dimensions, perceived severity and perceived susceptibility (Witte 1998:429).

Physical attack

This the fourth level of Allport’s (1954) manifestations of stigma, referring to intimidation, threat and violence used against the stigmatized.

PLHA

Person living with HIV/AIDS.

Rejection

One of the manifestations of external stigma according to Siyam’Kela (2003) in which someone may reject PLHA’s because he or she thinks that PLHA’s got what they deserve, because of their immoral lifestyle.

Response efficacy

Beliefs about the effectiveness of the recommended response to avert the threat: e.g., Using a condom consistently will prevent my getting HIV/AIDS (Witte 1998:429).
Self-efficacy: Beliefs about one’s ability to perform the recommended response to avert the threat: e.g., I am able to use a condom consistently to prevent my getting HIV/AIDS (Witte 1998:429).

Severity: The magnitude of the threat.

Susceptibility: The vulnerability of a person towards the threat.

Stigma: A process in which an individual is being discredited significantly in the eyes of others. Within a particular culture or setting, certain attributes are seized upon and defined by others as discreditable or unworthy (UNAIDS 2002:8).

Stigma by association: One of the manifestations of external stigma according to Siyam’Kela (2003) in which someone who is associated with PLHA’s is being stigmatized, because of certain medical conditions, being personally related to a PLHA’s or because he or she belongs to a group that is vulnerable to becoming HIV infection.

Threat: A threat is a danger or harm that exists in the environment whether we know it or not. Perceived threat is cognitions or thoughts about that danger or harm. Perceived threat is comprised of two underlying dimensions, severity and susceptibility (Witte 1998:429).

Unwillingness to invest in PLHA: One of the manifestations of external stigma according to Siyam’Kela in which a PLHA is stigmatized because of a commonly held belief/attitude that investing in PLHA’s in the workplace is a waste of money, because PLHA’s are not as productive as healthy people and will die sooner.