Social Representation of AIDS among Zambian Adolescents

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Abstract
This study explores shared thinking about HIV/AIDS among Zambian adolescents. With high numbers affected, the question is how this group represents its risk. Social representations of the origin, spread and risk of HIV/AIDS were gleaned via 60 semi-structured interviews with urban 15 to 20 year olds. A systematic analysis revealed a shared picture: AIDS was linked to the West, God and teenage girls; its spread lay beyond the control of adolescent boys and men; and the personal sense of vulnerability was low. The results are discussed in light of their corroboration of the finding that social representations of danger can be identity protective, yet also system justifying. The potential transfer of such findings to psychological theory and to health campaigns is considered.

Keywords
blaming ‘the Other’, females as vectors of disease, HIV/AIDS, identity and power, social representations

COMPETING INTERESTS: None declared.

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This study explores the ways in which Zambian adolescents make sense of the HIV/AIDS epidemic, utilizing the social representations approach. In the early years of the AIDS epidemic, social representations research discerned an identity protective process at work in lay explanations of AIDS. This was expressed in associating AIDS with ‘the Other’, namely foreigners, out-groups and deviant practices (Joffe, 1996, 1999).

This study aims to investigate the social representations of AIDS among Zambian adolescents with a view to examining whether or not the identity protective response dominates in a context where AIDS is pervasive and ‘close-to-home’. It would be of theoretical value, as well as of use to those attempting to curtail the spread of HIV, to establish whether the pattern of distancing discerned in the early years of the epidemic occurs when the disease is widespread.

Background

Sub-Saharan Africa is the region worst affected by HIV/AIDS in the world (UNAIDS, 2002). An estimated 28.5 million Africans were living with HIV by the end of 2001. By that time, a further 19.2 million had already died of AIDS there, three times the number of AIDS-related deaths in the rest of the world. Sub-Saharan Africa is home to close to 90 per cent of the world’s young people living with HIV/AIDS, and almost 80 per cent of the world’s AIDS orphans.

Zambia is undoubtedly one of the countries most severely affected by the epidemic, with a national HIV prevalence rate of approximately 21.5 per cent (UNAIDS, 2002). The most recently available Zambian Ministry of Health (ZMH) figures state that the prevalence rate is 28 per cent in urban areas and almost 14 per cent in rural areas (ZMH, 1999). The risk of contracting HIV is highest in the youngest age groups (ZMH, 1999). The social and economic pressure on adolescents, particularly girls, to become sexually active at an early age, and to have multiple partners, plays a major role in this (Feldman, O’Hara, Babii, Chitalu, & Lu, 1997). Furthermore, condoms are only used frequently by a fifth of sexually active 15 to 19 year olds (Magnani, Karim, Weiss, Bond, Lemba, & Morgan, 2002). Therefore, the chances of transmission of HIV, once it has entered this social network, are high.

The majority of Zambians are highly familiar with the problem of AIDS. Magnani et al. (2002) found that virtually all of their survey respondents had heard of AIDS, believed it existed and believed that a person could get AIDS via sexual intercourse. Abstinence and condom use were cited as the two key methods to prevent transmission. Yet there is a major gap between such knowledge and practice, as the low condom use figures demonstrate.

This gap presents itself in a context in which AIDS-related deaths in early adulthood are an accepted part of Zambian life with 70 per cent of adults knowing someone who has died of AIDS (ZMH, 1999). Yet Feldman et al. (1997) found that while many Zambians were very worried about contracting AIDS in a general sense, they believed that their personal chances of contracting it were ‘none’ or ‘very small’. These findings indicate that people who have direct experience of others with AIDS and worry about its effects on their community, do not perceive themselves as personally at risk. Magnani et al. (2002) corroborate this finding.

While a strand of the optimistic bias (OB) tradition predicts the strong sense of personal invulnerability to HIV/AIDS within networks highly affected by it (e.g. Taylor, Kemeny, Aspinwall, Schneider, Rodriguez, & Herbert, 1992), the OB model does not capture what constellations of thought and feeling underpin the sense that the disease is serious but does not threaten the self. The social representations approach is chosen for its ability to tap such constellations, and its attention to the broader context that prevents young people from choosing abstention and condom use.

The social representations approach

A ‘social representation’ refers to a widely held common sense, such as westerners linking AIDS to Africa, and the thoughts and images that surround the links. Although not restricted to the health risk sphere, the social representations approach is particularly useful for it since it has a particular concern with the way in which new ideas and events, confronting the public, are integrated (see Hewstone & Augoustinos,
1998). Therefore, AIDS formed a focus within this rubric in the 1980s and 1990s when it was still a relatively new phenomenon (see Joffe, 1996; Markova & Wilkie, 1987; Paez & Echebarria, 1989; Paez, Echebarria, Valencia, Romo, San Juan, & Vergara, 1991).

In the early 1990s, when the epidemic was imminent but prevalence was still low, Joffe (1996) found that a key pattern of thinking in her samples of differing nationalities was to link AIDS to groups with which they did not identify. Such groups, in turn, were associated with ‘perverse’ practices, including aberrant sexuality and tribal rituals. Whatever their own identity, respondents chose ‘Others’ to whom such deviance was ascribed.

This study also showed that dis-empowered groups in the countries studied viewed themselves as both affected by and liable for AIDS. Therefore, not all groups were afforded the same level of identity protection via social representation. This interplay of identity and power, and its manifestation in social representations, has been understudied. Similarly, little research has been carried out to explore contemporary social representations of AIDS and their continuities and discontinuities with the earlier work. This study addresses these gaps. In order to do so, a number of dynamics specific to Zambian ‘common sense’ must be considered.

Social scientists have demonstrated that certain widespread beliefs about the causes of traditional diseases manifest in the representation of AIDS. For the Tonga people of Zambia, AIDS results from importing western practices: people leave rural areas to live in towns, visit prostitutes and no longer follow traditions and old moral codes (Gausset, 2001; Mogensen, 1995). In particular, AIDS is associated with kahungo, a traditional disease caused by being in contact (not necessarily sexually) with a woman who has miscarried (Mogensen, 1997). Such a woman is considered impure and must undergo a period of seclusion and ritual cleansing (Gausset, 2001). Men can contract kahungo without knowing that the moral code has been violated. They are therefore considered the innocent party. Thus, the responsibility to follow the prescribed rules falls on women.

Another traditional disease, Nchilaombe, has also become associated with AIDS. This is a Goba term and refers to a disease caused by teenage girls having sexual intercourse, especially with older married men (Bond & Ndubani, 1997). While premarital sex is frowned upon, especially for females, it is common. The 2000 Zambian Sexual Behaviour Survey (ZCSO, 2002) found that 49 per cent of males and 60 per cent of females between the ages of 15 and 20 were sexually active and the median age of first sex was 18.5 for males and 17.6 for females. Furthermore, the figure for females, in particular, is probably an underestimation since stigma is likely to lead to under-reporting.

The way in which AIDS is linked with the two traditional diseases, in Zambian thinking, fits with the social representational process of anchoring (see Moscovici, 1984). When new phenomena are assimilated they are interpreted in light of those already understood. In using the old to understand the new, existing values, norms and power relations are brought forward from the past and are thereby maintained. Via anchoring AIDS to kahungo and nchilaombe the concept of disease as punishment is perpetuated. Furthermore, the representation of the newer disease as the woman’s fault is also likely to carry forward.

The inferior position of women in Zambia is well documented, and social representations of AIDS are likely to reflect and perpetuate this power differential. Females are taught to be obedient and submissive to males from early childhood, in rural and urban areas alike. Sexually, women are expected to please their partners, sometimes at the expense of their own pleasure and well-being. This includes never refusing sex with husbands, regardless of the number of partners he has or his non-willingness to use condoms, and even if he is suspected of having HIV or other sexually transmitted diseases (ZMH, 1999). The dominance of male interests and lack of assertiveness of women are key determinants of women’s high AIDS risk, both within and outside marriage.

Prior to marriage, socio-economic pressures place female adolescents in one of the highest at-risk groups for HIV infection in Zambia (Feldman et al., 1997). Young women in the 15–19-year-old age group are five times more likely to be infected than males in the same age
group (ZMH, 1999). The differing infection rates have been partly attributed to the transmission of HIV from older men to younger women (ZMH, 1999), associated with the ‘sugar daddy’ phenomenon: older men having sex with younger women from deprived backgrounds in exchange for money or gifts.

A further factor that must be considered in conceptualizing the way that Zambian youths respond to the epidemic is that religion is important for most Zambian adolescents (see Feldman et al., 1997). Christian churches have played an important role in promoting fidelity in marriage and in strongly discouraging premarital sex. Christian leaders argue that fidelity and abstinence should render condoms irrelevant, making Zambians reluctant to use them (Godfrey-Faussett, Baggaley, Scott, & Sichone, 1994). However, being affiliated with the Christian religion is not significantly associated with abstinence but is significantly associated with diminished condom use in Zambia (Magnani et al., 2002). When compared with those of no, or other religions, Protestant and Catholic youth are less likely to have used condoms either during their last sexual encounter or consistently with their most recent partner. It seems that while the Church’s anti-condom message impacts on young people, its call to abstinence does not. This spreads HIV.

The present study examines the social representations of AIDS among urban adolescents, considering how the array of factors that colour identity in Zambia manifest in such representations. Given the fact that the risk of HIV/AIDS is higher for those living in urban areas in Zambia, it is surprising that much of the research has been carried out in more rural areas (see, for exceptions, Feldman et al., 1997; Magnani et al., 2002). Zambian adolescents’ common sense is of theoretical importance in that a society where the inferior position of women and girls is so apparent offers a useful context in which to explore how identity and power manifest in social representations. Furthermore, ecologically valid psychological studies can inform effective campaigns which have the potential to reach those not yet entrenched in their unsafe sexual habits.

Aims of the study
The broad aim of this study is to explore the ways in which Zambian adolescents conceptualize HIV/AIDS. A particular objective is to ascertain whether these adolescents distance their identities from risk, in accordance with earlier findings, or not. In this light, the study sets out to develop an understanding of the ways in which Zambian adolescents represent:
1. The origin of HIV/AIDS.
2. The spread of HIV/AIDS.
3. Personal risk of HIV/AIDS.

Method
Participants
Sixty Zambian adolescents were recruited by randomly selecting students attending senior classes 10, 11, and 12 in the three largest co-educational, government schools in Ndola, Zambia’s second largest city. Ten male and 10 female students were randomly selected from the senior classes in each school. If the selected student did not wish to participate, then another student from the same class, and of the same gender, was randomly selected. Only three people who were invited to participate declined. The sample included an equal number of males and females and their ages ranged from 15 to 20 (mean of 17.3 years). In Zambia, admission to public secondary school is highly competitive. Less than 30 per cent of those who take the test to enter the first year there (grade 8) pass (Baggaley, Sulwe, Chilala, & Mashambe, 1999) and only 15 per cent of those who take the test to enter grade 10 pass (Feldman et al., 1997). Thus people take these tests repeatedly. This accounts for the scatter of ages across senior years.

Half of the respondents described themselves as Catholic, 19 as Protestant, five as ‘other’, three as ‘none’ and three participants did not state their religion. The vast majority (n = 58) attended a place of religion two or more times per month.

Out of the total sample only one respondent did not know a person or people with AIDS or who had died of AIDS. Over half (n = 31) of the adolescents had lived with someone with AIDS or who had died of AIDS. Over half (n = 35) of the adolescents had relatives, 14 had friends,
three had acquaintances and seven knew ‘others’ with AIDS or who had died of AIDS. Seventeen respondents stated that they were sexually active, 42 that they were not and one did not answer the question.

Procedure and measures
The study utilizes a combination of interviews and questionnaires to ascertain how the adolescents make sense of AIDS. While interviews can address issues of meaning, anonymous questionnaires are more acceptable to respondents when revealing issues of a sensitive nature, such as sexual practices (see Dockrell & Joffe, 1992). When self-administered, such questionnaires can diminish the embarrassment and self-presentation effects that can pervade face-to-face encounters. Furthermore, the use of two methods in accessing a phenomenon provides a form of triangulation, which enhances the validity of the findings (see Flick, 1992).

Interview
A semi-structured interview lasting between 20–30 minutes was conducted with each participant in English. Questions were open-ended and as non-directive as possible to facilitate the production of the respondent’s meaning frame. The interview, designed to elicit respondent’s understandings or representations of AIDS, ascertained answers to the following questions, among others: Could you talk to me about the origin of AIDS? Could you talk to me about the spread of AIDS? Could you talk to me about your own sense of risk?

Prior to the interview participants were informed that there were no right or wrong answers; their ideas on the various issues were being explored and assured that the interview was anonymous and confidential. Key questions and the explanation of what the interview entailed were held constant across the interviews to ensure comparability. All the interviews were conducted in a quiet room on the premises of the schools and were audio-recorded with the consent of the respondent.

Questionnaire
Following the interview, respondents were asked to complete a questionnaire. This ascertained, in addition to demographic details, whether participants were sexually active, and perceived themselves to be at risk. A question drawn from Weinstein’s (1987) comparative optimism scale was included to gauge perceived relative risk. A question pertaining to the origin of AIDS was also included as the researchers envisaged that the European origin of the interviewer (a white woman raised in Zambia) might inhibit responses that located origin in the West.

Analysis
A systematic, thematic analysis (see Joffe & Yardley, 2003) of interview data was conducted. This demonstrates the typicality of particular ideas alongside their substance, and also their distribution within subgroups of a purposive sample.

Interviews were transcribed and a coding frame developed by examining the full set of transcriptions. Categories were derived to systematize the content. Having operationalized what content should be coded under each category, a second researcher checked reliability by coding 20 per cent of the interviews. In 92 per cent of cases, the same codes were given to excerpts. In order to respond to the limited number of differences, the category was operationalized more carefully in the coding frame. Subsequently, the entire set of interviews was coded anew using the computer package ATLAS-ti (see Dey, 1993 for a description).

The questionnaire data were used predominantly for descriptive statistics (analysed in SPSS) concerning participants, but also for their gauge of optimistic bias and for answers to the question about the origin of AIDS.

This article will focus on the themes most prevalent across the sample as a whole, as well as on themes specific to gender subgroups. Prevalent thinking is taken as an indication of the more consensual, socially circulating aspects of the social representation. Quotations have been selected to illustrate such themes. Limitations of space prevent the full set from being cited, but the proportion of texts that contain similar quotations is noted. An appendix for each section contains the frequencies and percentages of occurrence of the categories that appear in the interviews.

Results
Results are reported in sections that indicate the main issues mentioned concerning the origin,
spread and personal risk of AIDS. While the focus is upon the interview data, the questionnaire data are reported at two junctures. Each section contains a figure that depicts the ideas most frequently mentioned in the interviews. These are arranged in a hierarchical order with the most prevalent themes situated at a higher position. This is followed by an articulation of the substance of each theme, which includes an indication of the proportion of the sample who verbalized it. Gender variations are mentioned when the substance and prevalence of what each gender says are noticeably different. Other differences, such as between Catholics and Protestants were examined, but no detectable differences were found.

The origin of AIDS

The way in which the origin of AIDS is conceptualized by the adolescents is illustrated in Fig. 1.

When asked about the origin of AIDS in the questionnaire, almost two-thirds of the participants attribute it to the West. In relation to this question in the interview, two-fifths of the respondents explicitly state that they believe AIDS originates in the West (see Appendix 1). AIDS is seen to result from practices that are ‘perverse’ or ‘deviant’ and intentionally committed by westerners. The most prevalent practice is bestiality, but anal sex is also mentioned.

The quotation below illustrates a process whereby ‘perverse’ practices are attributed to westerners:

There were some people I think in the United States . . . who felt more about sex and then they went and slept with some monkeys . . . then those monkeys were said to have . . . certain diseases and those diseases were passed on to those people and those people went around to sleep again with other human beings . . . they transferred that virus . . . So you find that when that virus was passed within the United States, where it is said to have originated from, it was passed to people around the world until it spread into Africa.

(Male aged 19)
The excerpt tells a story in which AIDS originates in an animal on a foreign continent and reaches Africa by way of animal–human sexual contact. Almost double as many male participants, as opposed to female, associate the origin of AIDS with bestiality. In addition, only male interviewees mention anal sex, another instance of western deviance:

AIDS came from homosexuals. It’s like the friction between the two people caused the virus. Though people think that AIDS came from the black man, it actually came from the white men in USA, I think New York. Yeah, so I think basically it came from abroad, USA, that’s what I think about it. (Male aged 16)

This adolescent’s recognition and direct refutation of theories that associate AIDS, black people and Africa is also found among other respondents. In total, five respondents mention knowledge of the theory that AIDS originated in Africa. All refute it. No one in the sample places the origin of AIDS in Africa.

The other practice linked with the western origin of AIDS, by over a quarter of the sample, is science or experimentation:

It was made in a lab by a scientist and the only people who make things in labs are those from Europe, their minds are very sharp and they can make something and then it will come here. So I think it came from there because the doctors from here were very surprised to see that someone from here had that disease. (Female aged 17)

Occasionally, science is spoken of with reference to bestiality (with regards to experimenters testing the effects of mating animals with humans) and also to God. Almost a third of the respondents view AIDS as a direct punishment from God for people’s immoral behaviour. This involves, in particular, having sexual relationships before, and outside of, marriage:

I think that AIDS came from God…I just thought of maybe if I put something there, to make people come back to their senses…People…are having relationships outside marriage, and things like not being frank in marriages. Like you are married and then you go out and you have relationships and when you are young, you are not even married and you have sex outside marriage, that sort of thing. (Male aged 17)

Discussion of the origin of AIDS findings

Corroborating earlier findings (e.g. Joffe, 1996, 1999), this Zambian sample distances HIV/AIDS from a number of its identities. AIDS’ association with ‘the Other’ is evident in the representation of its western, non-African origin, and in the perverse sexual and scientific practices that occur ‘out there’. It is also manifest in placing AIDS’ origin in God’s punishment for immorality, associated with the sexually wayward ‘Other’, by this church-going sample. Set against a national context in which AIDS is omnipresent, the social representation that origin resides in the West and the non-God fearing is identity protective for this sample. This aspect of the representation comforts those who propagate it by leaving them unscathed by the danger.

The spread of HIV/AIDS in Zambia

A discuss talk about the spread of HIV/AIDS within Zambia can be divided into ‘groups linked to the spread’, and ‘factors influencing the spread’ (see Figs 2 and 3). The two are treated separately for conceptual clarity, but the overlap is striking and speaks to how central groups are in the adolescents’ representations of AIDS.

Groups linked to the spread

A key shared idea, expressed in the vast majority of the interviews, is that adolescents play a major role in the spread of AIDS (see Appendix 2). Yet, three-quarters of the sample attribute this specifically to the behaviour of
Girls. Girls’ interaction with sugar daddies, in particular, forms a focus for over half of the sample. It is not the sugar daddies, but the girls, who are regarded as the vectors of the virus, as these accounts illustrate:

The boys, the most way they get HIV/AIDS it’s from the girls here at school . . . because these girls they sleep with big people, elder people [sugar daddies] and the elder people are HIV positive, so we are likely to get it from them. (Male aged 19)

The sugar daddies are those who like getting schoolgirls. Those are also at high risk of getting AIDS and when they get those schoolgirls, they get infected and in turn infect their wives. (Male aged 18)

While the majority of the sample attributes the spread of HIV/AIDS to adolescent girls, a large minority also states that adolescent boys play a role. In contrast to the detailed consensus regarding the way in which girls are vectors of HIV, the male role tends to be loosely specified:

Us boys . . . we are also much involved in this sexual spread of AIDS. (Male aged 18)

Adolescent girls tend to be implicated by the vast majority of both the females and the males in the sample, while minorities of both genders implicate adolescent boys. Thus the girls, in particular, have a strong tendency to implicate themselves.

In addition to the dominant theme of AIDS being spread by the adolescent or ‘youth’ group, over half of the sample see prostitutes as the vectors of AIDS:

You see when going [out] we never planned that we would be with these prostitutes, so we never prepared ourselves, like to have condoms. So you see, these girls, just like forced us to have sex with them and, in fact, they were even older than us, you see. (Male aged 19)
Those sex workers they are the ones who spread AIDS. (Male aged 18)

Female prostitutes and female adolescents are strikingly present in the shared representations of the spread of AIDS in this sample. Alongside these group-based notions of spread, a large number of factors are linked to the spread of HIV/AIDS.

Factors influencing the spread

The most prevalent non-group explanation concerning the spread is that knowledge of HIV/AIDS is ignored:

Most of our friends here, they know that... the transmission of AIDS is in these ways or that, then they just ignore it as if they don't know that it is there... They know quite alright that AIDS is transmitted through maybe having sex with a girl or boy, and using already used razor blades, they just pretend that they don't know how it is contracted and transmitted. (Male aged 17)

The implication that peers with full knowledge of routes of transmission choose to ignore it, is quite different from that of HIV/AIDS spreading due to lack of knowledge, a factor mentioned by just a third of the sample: ‘I think that AIDS is spreading too much because many people, they don’t know how AIDS is. They don’t have that knowledge, they are not educated about this disease’ (Male aged 18).

The second most prevalent non-group theme concerning the spread is poverty, mentioned by two-thirds of the sample:

... though there’s adequate information you know, poverty is the major thing of AIDS. You know someone can know that AIDS kills, AIDS is a dangerous disease, but if there’s poverty... she can be forced to sell herself... whereby you know she’s being infected with the disease. (Male aged 18)

... you find that there is a situation whereby you’ve been going out without food for five days. You can’t find anything to eat and there comes a man for example ‘I love you girl I want to have sex with you, I can give you a 5000 K wacha [73 pence] you can go and buy...’ and you have been going for five days
without food, you really accept that because, you know, hunger is not a thing to play with. (Male aged 19)

The gender issue is inextricably linked to poverty, since it strongly associated with girls who exchange sex for money.

Young women not only spread HIV/AIDS due to poverty, but owing to their love of money, according to a large minority of the sample. While the poverty theme refers to needing money, this refers to a want of money, as the quotation below illustrates:

... some girls come from rich families where there is a lot of money but they still feel that they have to go out with sugar daddies so that they can get more money, as if they are not satisfied with the money that they have at home. (Female aged 16)

The third most common factor implicated in the spread of AIDS, with almost two-thirds of the sample referring to it, is a lack of control over sexual desire:

Because scientifically a man thinks of sex after 10 minutes, let's say five to 15 minutes. So when he is thinking of sex, he has to have it. (Female aged 17)

Males are almost twice as likely to mention the lack of control over desire theme, when compared with the females in the sample. The biologically based drive is seen to be exacerbated by a range of external elements.

Places where one drinks or takes drugs, generally called 'disco houses', are implicated as an important external element that promotes a loss of control over desire. Males are over three times more likely to mention drinking places compared to females:

... when those people go to bars, some drink a lot of beer such that they can't control themselves and then ... when those sexual feelings come, they'll unfortunately go to a prostitute and then have sex without even knowing what they are doing ... because they are being controlled by the beer which they drink from those bars. (Male aged 16)

For a fifth of the adolescents the western clothing worn by girls, such as miniskirts, slit skirts and tight garments, also feed the male lack of control over desire, their helplessness in the face of an attractive girl, and thereby encourage the spread of HIV. Males are over three times more likely than females to mention the theme of female dressing:

... the girls are also contributing to the thing of the spreading of HIV by wearing miniskirts ... the girls are very attractive at this time. So you find, that if they add more by wearing miniskirts then, I don't think, men or boys would help it, staying out from that. (Male aged 19)

... they [girls] have to be advised to be dressed well with long skirts because the thing is boys, in some way they are not supposed to be blamed if I can call it in that way because if girls can dress in that way, you find that boys cannot help themselves. It's nature, they have to be attracted to that ... (Male aged 19)

The final element seen to exacerbate lack of control over desire is modern day film. This is mentioned exclusively by the males in the sample, with the exception of one female, cited below:

... the films which are brought on these televisions, the way they are, or the way they are presented, they are like some sort of danger to the youth ... You know at a certain age, when a youth is growing, anything that comes in, the youth will take it and use it. (Female aged 19)

Related to the above-mentioned external elements that control male desire, almost half of the respondents state that peer pressure plays a role in the spread of HIV. The only discernible specific idea concerning the impact of peer pressure on HIV rates is that a third of those mentioning it link it to males being pressurized into having a lot of sexual partners, to signal their adequacy as men:

... boys mostly they change partners like that ... people just think that if you don't do it, you are not a man, you are a chicken ... it's from peer pressure those people who are involved ... and maybe you try to resist, you try to convince them about it, you find that they bring all sorts of comments like that. They say 'you are afraid, you are not a man,
you are afraid of these things’ . . . (Male aged 17)

. . . they [boys] keep on doing it just because they want to tell their friends that he’s man enough and stuff like that. (Female aged 17)

Immorality and sin is a further factor, mentioned by well over a third of the participants, seen to play a role in the spread of HIV in Zambia by both genders. A gain, the theme refers to AIDS as punishment for engagement in adultery and fornication.

Finally, over a third of respondents feel that the spread of AIDS is caused by vindictive behaviour. This is ascribed to those who are already ill and to prostitutes:

prostitutes won’t use condoms because for example she noticed that she contracted the HIV disease . . . Maybe that person could want others to have the, you know, the pain she’s going through so as a result she will decide to sleep with other men so that the virus can be spread. (Male aged 16)

Discussion of the spread of AIDS in Zambia findings The group-based identity protective process evident in ‘The origin of HIV/AIDS’ section is not all pervasive. The adolescents, half of them female, implicate female adolescents, primarily, in the spread of HIV in Zambia. If not their poverty, then their love of money leads them to use sugar daddies and thereby spread HIV; if they are not undermining male control over sexual desire by way of provocative (western) clothing, then drugs/alcohol, the media and/or peer pressure step in to undermine it. Females, be they adolescents or prostitutes, lead men into unsafe sex, thereby spreading HIV. In particular, female sexuality is represented as active, and serving non-sexual ends (having sex to allay poverty, to get extra pocket money or vindictively to spread HIV) and juxtaposed to the pervasive representation, primarily propagated by the males themselves, that men lack control over their desire and, therefore, inadvertently play a role in the spread of HIV. Male identity is protected, while female identity is disparaged, in this complex aspect of the social representation of AIDS in Zambia.

Personal sense of risk Questionnaire data pertaining to the question of comparative personal risk of contracting HIV/AIDS reveal optimistic bias for almost three-quarters of the participants. This portion of the sample feels its chances of contracting HIV or AIDS are below average, with the vast majority feeling that it is ‘much below average’. Nine respondents feel their chances are ‘average’, whereas only eight feel their chances are above average.

In the course of the interviews, and casting light on this questionnaire item, the vast majority of the respondents explicitly state that they do not feel personally at risk of contracting HIV/AIDS, for reasons illustrated in the Fig. 4.

The lack of a personal sense of risk in this sample is attributed, by two-thirds of the respondents (see Appendix 3), to abstaining from sex, following God’s commandments:

No I don’t feel at risk because one: I obey God; two: I fear God with all of my heart and soul and with all my mind . . . since I was born until now I haven’t indulged myself in these things. (Female aged 16)

Having knowledge concerning how HIV/AIDS is transmitted is the other factor associated with the low sense of personal risk, mentioned by almost a quarter of the sample:

I don’t feel at risk because I know how you can contract HIV. (Male aged 20)

When there is recognition of potential risk, it is attributed to circumstances over which respondents currently have no control or intentional involvement. Nine respondents think they could contract it through the behaviour of a future partner:

I feel at risk because when I look around I feel like every girl you meet, its like she’s been there. Y eah, she has been there so it really can be that I’m also at risk because I might get somebody who has don that before and maybe she is infected as the symptoms can take time to come out. (Male aged 17)

This external attribution is even more salient in the eight respondents who feel that they would contract it only by mistake, for instance by using contaminated instruments:
Discussion of the personal sense of risk
While female adolescents, as a group, are implicated by the sample in the spread of HIV (see section on 'The spread of HIV/AIDS in Zambia' above), at a personal level, both the females and males feel 'not me' in relation to the personal risk of contracting HIV. Abstaining from sex according to God’s commandment and being knowledgeable are cited as protection against personal risk. The sense of low personal HIV risk corroborates Feldman et al.’s (1997) and Magnani et al.’s (2002) findings concerning Zambian youth.

Concluding discussion
The data reveal that simultaneous to their self- and group protective role, social representations can serve an ideological function. This finding is continuous with previous social representational research in the AIDS sphere (e.g. Joffe, 1996), but the current study sheds additional light on the complexity of the motivations that inform social representation, and links the ideological motivation with the anchoring process.

The ideas of higher status groups dominate the social representation of AIDS in Zambia, often working against the best interests of disadvantaged groups. This is instanced, primarily, in the representation of teenage girls as the vectors of AIDS in their interactions with sugar daddies and male adolescents. As men with financial resources in a capitalist, patriarchal society, responsibility is deflected away from the sugar daddies. The pervasive social order feeds the social representation that blames girls for the AIDS epidemic.

This process is analogous to what Jost and Banaji (1994) term the 'system justification' function of stereotyping, a process whereby widespread ideas are used to justify existing status hierarchies or the division of social roles. The Zambian study casts light on how such 'widespread ideas', which are essentially social
representations, perpetuate a social order in which adolescent boys and men are constructed as the ‘innocent’ parties, in the spread of HIV. It advances theory by demonstrating that the stereotyping and social representations literatures can complement one another, and by providing further evidence for the workings of the interplay of identity and power issues in talk about disease.

In addition, the social representation of AIDS constructed by the Zambian adolescents casts light on their health concepts. In the Zambian context, AIDS is infused with issues of blame and punishment, anchored in conceptualizations of more traditional illnesses. Therefore, a number of illnesses are associated with behaving badly in the Zambian context, leaving health as the reward for being morally ‘good’. Bearing in mind this conceptualization of illness, it is not surprising that Zambian adolescents muster a rich representation to distance themselves, particularly if they are male, from AIDS.

In line with the devaluing of women in Zambian society, and perpetuating conceptualizations of the two traditional diseases kahungo and nchilaombe, females form the repository of culpability and immorality. This sheds light on the workings of the social representational anchoring process, particularly insofar as it perpetuates existing values, norms and power relations. Thus anchoring and system justification are intertwined. Even though adolescent boys have sex with their female counterparts and with prostitutes, they tend to be represented—by adolescent boys and girls alike—as entities who can be threatened by danger but who do not generate it, as they have been traditionally. This is in keeping with the male sexual drive discourse, also found in the West (see Hollway, 1989), which centres on the proposition that men are driven by the biological necessity to seek out sex. It relies on the more general claim that sex is ‘natural’ for men and not socially mediated. Men’s right to control this sphere, paradoxically, is borne of their lack of control over their sexual drives.

When linked to the AIDS sphere in Zambia, this legitimates existing social arrangements, perpetuating the disadvantaged position of women. The data convey the extent to which disease is a key vehicle through which societies express who is to be valued, and who derogated.

The significance of the social representations approach comes into focus in these findings. By studying widespread beliefs in themselves, without attempting to test whether a single process drives them (e.g. optimistic bias), one foregrounds the complex nature of meaning making.

On a methodological note, only 28 per cent of the sample claim that they have ever had sex. Thus their current sense of low personal risk may be consistent with their practices. However, if the self-reported sexual behaviour were accurate, the sample would be surprisingly atypical. As stated, the Zambian Sexual Behaviour Survey indicates that over half of people in the 15–20 age range are sexually active. Furthermore, existing statistics obtained from each of the three schools involved in this study indicate that, on average, 48 per cent of students between the ages of 15 and 20 are sexually active (Bukanga, 2001). Since people in this age range were selected at random from these schools for the present study it seems unlikely that the reported incidence of sexual activity is accurate.

Possible under-reporting may result from fear of censure for admitting to sexual activity, stemming from the Church’s call for abstinence. Future studies in contexts where the Church prevails might consider the following. As pupils emerge from most of the schools used in this study, they are confronted with walls painted with slogans such as ‘abstinence is the way’, ‘keep your virginity’, ‘you only have it once’. Yet directly across the road from the schools are areas filled with bars. The interviewer observed older men approaching the schoolgirls, some of whom had just participated in interviews for this study. The possible mismatch between what is said in interviews and this observation warrants further, systematic study, possibly of a participant observational nature.

The social representations approach can be criticized from a number of vantage points. For Hollway and Jefferson (2000), the fragmentation of narratives that a systematic, thematic analysis involves, strips the data of their richness. From a wholly different angle, a more positivist psychology bemoans the non-predictive approach to data (e.g. see Fife-Shaw, 1997), which a proper science demands. Furthermore, there are tensions within the social representations field itself, concerning
which conceptualizations and methods are most appropriate. However, the current study has borne in mind Silverman’s (2001) proposal that the quality of any framework rests in its appropriateness for addressing the particular research questions under investigation, as well as in the interpretation it allows.

Shifting from theoretical and methodological issues, to those pertaining to the relevance of this study to AIDS prevention, the social representation that emerges points to the difficulty of bringing the adolescents to an awareness of the need for personal action. The data reflect a sense of powerlessness: boys are powerless in the face of their sexual drives and peer pressure, and girls in the face of their need and want of money. Such powerlessness compromises the active stance involved in the choice to abstain.

The highly successful Swiss AIDS campaign assumes that adolescents are sexually active but that promotion of consistent condom use will protect them from HIV. This simple assumption, and its translation into a message stripped of morality and the complex meanings of HIV, has made for the most effective campaign in Europe, many of which have contained far more moralistic messages. While Zambian health campaigns are obviously embedded in a different cultural context, to which its messages must show sensitivity and relevance, the triumph of a non-moralistic campaign over its more moralistic counterparts must be taken seriously, in the face of AIDS’ devastation of Zambia.

**Notes**

1. This article draws exclusively on English language research in this area.
2. The transmission of HIV and AIDS in Zambia is almost entirely accounted for by heterosexual contact and mother to child transmission (ZMOH, 1999).

**References**


**Appendix 1: Origin of AIDS (frequency and percentage of responses in interviews)**

<table>
<thead>
<tr>
<th>Origin</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>US</td>
<td>8 (13.3%)</td>
<td>4 (6.7%)</td>
<td>12 (20%)</td>
</tr>
<tr>
<td>Europe</td>
<td>7 (11.7%)</td>
<td>4 (6.7%)</td>
<td>11 (18.3%)</td>
</tr>
<tr>
<td>Australia</td>
<td>0</td>
<td>1 (1.7%)</td>
<td>1 (1.7%)</td>
</tr>
<tr>
<td>Not Africa</td>
<td>4 (6.7%)</td>
<td>1 (1.7%)</td>
<td>5 (8.3%)</td>
</tr>
<tr>
<td>Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bestiality</td>
<td>14 (23.3%)</td>
<td>8 (13.3%)</td>
<td>22 (36.7%)</td>
</tr>
<tr>
<td>Science</td>
<td>8 (13.3%)</td>
<td>8 (13.3%)</td>
<td>16 (26.7%)</td>
</tr>
<tr>
<td>Anal sex</td>
<td>5 (8.3%)</td>
<td>0</td>
<td>5 (8.3%)</td>
</tr>
<tr>
<td>God/morality</td>
<td>11 (18.3%)</td>
<td>7 (11.7%)</td>
<td>18 (30%)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3 (5%)</td>
<td>5 (8.3%)</td>
<td>8 (13.3%)</td>
</tr>
</tbody>
</table>

*The total percentage for each theme refers to the proportion of the 60 respondents who mentioned that category. In many cases participants make more than one type of response, thus the total percentage often adds up to more than 100%*
Appendix 2: Spread of AIDS in Zambia (frequency and percentage of responses in interviews)

<table>
<thead>
<tr>
<th>Spread</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Groups</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent girls</td>
<td>21 (35%)</td>
<td>24 (40%)</td>
<td>45 (75%)</td>
</tr>
<tr>
<td>Prostitutes</td>
<td>17 (28.3%)</td>
<td>16 (26.7%)</td>
<td>33 (55%)</td>
</tr>
<tr>
<td>Sugar daddies</td>
<td>14 (23.3%)</td>
<td>17 (28.3%)</td>
<td>31 (51.7%)</td>
</tr>
<tr>
<td>Adolescent boys</td>
<td>15 (25%)</td>
<td>10 (16.7%)</td>
<td>25 (41.7%)</td>
</tr>
<tr>
<td><strong>Factors</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ignore knowledge</td>
<td>27 (45%)</td>
<td>24 (40%)</td>
<td>51 (85%)</td>
</tr>
<tr>
<td>Lack of knowledge</td>
<td>15 (25%)</td>
<td>5 (8.3%)</td>
<td>20 (33.3%)</td>
</tr>
<tr>
<td>Resource</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poverty</td>
<td>22 (36.7%)</td>
<td>18 (30%)</td>
<td>40 (66.7%)</td>
</tr>
<tr>
<td>Love of money</td>
<td>10 (16.7%)</td>
<td>14 (23.3%)</td>
<td>24 (40%)</td>
</tr>
<tr>
<td>Personal control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modern day disco houses</td>
<td>13 (21.7%)</td>
<td>14 (23.3%)</td>
<td>27 (43.3%)</td>
</tr>
<tr>
<td>Modern day dressing</td>
<td>10 (16.7%)</td>
<td>3 (5%)</td>
<td>13 (21.7%)</td>
</tr>
<tr>
<td>Modern day film</td>
<td>7 (11.7%)</td>
<td>1 (1.7%)</td>
<td>8 (13.3%)</td>
</tr>
<tr>
<td>Peer pressure</td>
<td>15 (25%)</td>
<td>14 (23.3%)</td>
<td>29 (48.3%)</td>
</tr>
<tr>
<td>Multiple partners</td>
<td>9 (15%)</td>
<td>10 (16.7%)</td>
<td>19 (31.7%)</td>
</tr>
<tr>
<td><strong>Morbidity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immortality/sin</td>
<td>14 (23.3%)</td>
<td>11 (18.3%)</td>
<td>25 (41.7%)</td>
</tr>
<tr>
<td>Inductive behaviour</td>
<td>8 (13.3%)</td>
<td>13 (21.7%)</td>
<td>21 (35%)</td>
</tr>
</tbody>
</table>

Appendix 3: Personal risk of contracting AIDS (frequency and percentage of responses in interviews)

<table>
<thead>
<tr>
<th>Personal risk</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abstains/obey God</td>
<td>19 (31.7%)</td>
<td>21 (35%)</td>
<td>40 (66.7%)</td>
</tr>
<tr>
<td>Has knowledge</td>
<td>8 (13.3%)</td>
<td>6 (10%)</td>
<td>14 (23.3%)</td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future partner</td>
<td>5 (8.3%)</td>
<td>4 (6.7%)</td>
<td>9 (15%)</td>
</tr>
<tr>
<td>Instruments</td>
<td>4 (6.7%)</td>
<td>4 (6.7%)</td>
<td>8 (13.3%)</td>
</tr>
</tbody>
</table>


