Research project:

Stigmatization, Knowledge and Erroneous Beliefs about AIDS Influencing Social Cognitions and Condom Use among Adolescents in the Dominican Republic

Report of
Bachelor assignment

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Preface

About one year ago, Dorieke and I started talking about doing part of our study in a foreign country, after doing some research about the different countries and possibilities we came across the minor International Management, it was also possible to combine this minor with your bachelor project. This seemed perfect to us, we would be in a foreign country for a longer period, but there wouldn't be too much delay with school. We decided to go to the Dominican Republic and do research about cultural variables and their influence on condom use and social cognitions about condom use. After a lot of preparations, like getting a visa, arranging housing etc. but also doing extensive research about the Dominican Republic and its culture, we left The Netherlands on February 10, we would not return until June 8.We had a wonderful time on the Dominican Republic, we studied Spanish, met a lot of local people, went to every part of the country and basically had a lot of fun.

But it was not always easy, we had a research to do too. Especially beginning in a country as warm and nice as the Dominican Republic was hard and you do have to get used to the fact that everything is going a lot slower and even the simplest of things can take a long time. But other than this, there were no major obstacles. This was in part because of our good preparation even though we were the first psychology students going abroad, we have to thank our supervisors, Dr. Henk Boer and Dr. Sirp de Boer for this. Without their advice, help and support before departure we would not nearly be as well prepared as we were. Dr. Henk Boer especially helped us with the research project, he provided related articles and literature and helped us formulate the research questions and goals. Dr. Sirp de Boer helped us with preparing for the big cultural differences between The Netherlands and the Dominican Republic. But also after departure and return they kept giving comments and advice, which helped things run more smoothly and improved our research.

Of course we also want to thank all the Dominican people that participated in our research or helped us in some way or another. They were all very friendly and helpful. A special thanks to Steven and Monique from the El Colibri Hotel, they were the Dutch owners of the hotel where we stayed for a long time. They made us feel right at home in the Dominican Republic and showed us around in the first couple of weeks.

Summary

This research covers the influence of social cognitions about condom use, stigmatization towards people with AIDS, knowledge about AIDS and erroneous beliefs surrounding AIDS and their influence on condom use among adolescents in the Dominican Republic. The research was conducted by using a questionnaire consisting of items which measure social cognitions based on the Theory of Planned Behavior and the Protection Motivation Theory. Stigmatization is measured by questions measuring emotional reactions to people with AIDS, blaming of people with AIDS, distance to people with AIDS, societal stigmatization to people with AIDS and feeling of repulsion towards people with AIDS. Knowledge and erroneous beliefs are measured by using 'true' or 'false' questions about AIDS and about erroneous beliefs. Condom use is measured by three questions covering the condom use last time had sex, condom use in the last year and the average percentage of condom use.

Research group and method
The questionnaire was conducted on different schools throughout the country, also a small portion of the adolescents were acquired on the beach of Sosua. The purpose of the research and an explanation on how to fill in the questionnaires were provided and everybody was assured of their anonymity.

Results
209 respondents participated in the research of which 85 (41%) males, 93 (45%) females and 31 (15%) unknown. The mean age of the respondents is 18. The results can be divided into 4 areas (social cognitions, stigmatization, knowledge and erroneous beliefs)

Social cognitions about condom use and intentions to use condoms
People with higher social norms and motion to comply and a higher response efficacy intend to use condoms more. Surprisingly there is no connection between intention to use condoms and condom use. But people with better attitudes surrounding condoms do use more condoms in last year and last time they had sex. Also surprisingly the opposite is true for perceived behavioural control, the higher the perceived control about using condoms is, the less the actual condom use in the last year or last time.

Stigmatization towards people with AIDS
There is stigmatization among the adolescents in the Dominican Republic and there is not really a difference between males and females. People who score higher on stigmatization think AIDS is more severe, but their self-efficacy is less.
People who score higher on emotional reactions, distancing from the self and attitudes to societal measures and repulsion also score higher on perceived behavioural control. The people that score high on emotional reactions and distancing from the self also show a higher severity score.
Whereas lower emotional reactions, lower blaming and less repulsion suggests better attitude towards condoms.
Low distancing from the self scores indicate a high response efficacy and a high vulnerability. A low attitude towards societal measures also indicates a high vulnerability. And finally people with more feelings of repulsion are less self efficient using condoms.

Knowledge and erroneous beliefs about HIV/AIDS
The knowledge among adolescents is fairly good, women's knowledge is slightly better than men's. There is no connection between knowledge and condom use. But surprisingly people who have good social norms surrounding condoms have less knowledge about AIDS.
80% of the Dominican adolescents believes in at least one myth surrounding AIDS, males have slightly more myths than females. The most common myth is that AIDS can be transmitted by mosquito's.
People who have less erroneous beliefs/myths have a better attitude about condoms, a higher response efficacy and a high vulnerability score.

1 Introduction

1.1 Background

The Dominican Republic is a beautiful island in the Caribbean. The country is a very popular destination for tourists, mainly because of the Caribbean atmosphere and all the wonderful beaches. However, there are also a lot of problems in the Dominican Republic. The country is a developing country, and this becomes very obvious when you take a look at some statistics. According to the Human Development Report (2003), more than 28% of the people are living below the national poverty line. Over 5% of the children under the age of 5 are underweight and 26% of all people are undernourished. Almost 15% does not survive to age 40. The percentage of people that does not have sustainable access to an improved water source is 14%. 16% of all adults are illiterate. Only 60% of all people have sustainable access to affordable essential drugs. These are only a few statistics that show that the country still faces many problems.

One of the major problems that the country is facing is the HIV prevalence rate. Together, the Dominican Republic and the neighboring country Haiti account for 85% of HIV/AIDS cases in the Caribbean. According to the US Agency for International Development, the adult HIV prevalence in the Dominican Republic is 2,5%. The prevalence for the population most at risk is 4,7%. It is estimated that over 130,000 people (adults and children) are living with HIV/AIDS. However, the Dominican Republic's National Program for the control of HIV/AIDS fears that as many as 170,000 people may be infected with HIV/AIDS. Almost 5,000 children under the age of 15 are infected with HIV/AIDS. 7,800 Adults and children have died since the beginning of the epidemic, and 33,000 children have lost their mother or both parents to AIDS.

Men constitute 64% of all reported AIDS cases; women represent 36%. Young people, ages 15 to 24 years, account for 22 percent of AIDS cases, which implies they were infected with HIV in early adolescence. Of those, 52% are men and 48% are women.

These numbers are important to us, because our research has to do with HIV/AIDS and the factors that influence condom use.

1.2 Research project

We combined our bachelor thesis with the Minor International Management. The bachelor thesis consists of a research. We studied the psychological factors that play a role in the condom use among adolescents. We want to see if machismo, marianismo, erroneous beliefs and stigmatization influence the condom use among adolescents in the Dominican Republic. Dorieke will be focusing on machismo and marianismo and Jostan will be focusing on and stigmatization towards people with HIV/AIDS and knowledge and erroneous beliefs/myths about HIV/AIDS. We used a Spanish measurement instrument, a questionnaire. Most of the items in the questionnaire have been used before and have proven to be valid. In the next chapter, we will provide more information about the questionnaire.

Once we were in the Dominican Republic, we had to check if the questionnaire needed to be adjusted. Although it is a Spanish questionnaire, it was possible that some words or sentences had to be changed because the Spanish spoken in the Dominican Republic is somewhat different from regular Spanish. It was also possible that we would discover other erroneous beliefs once we were there. If that happened, we could have created some new items about these erroneous beliefs. Once the questionnaire was ready, we started looking for adolescents (ages 14-21). We traveled around and visited different areas because it is possible that, for instance, erroneous beliefs can be present in one specific area of the country. The goal was to receive at least 200 filled out questionnaires. We visited schools looking for respondents.

Once we had enough data, we entered the data into the statistical analyzing software SPSS. Next, we started analyzing the data. We focused on finding out if there were any significant correlations between the cultural variables we had measured and the social cognitions about condom use and the actual condom use.

The objectives of the research for the bachelor thesis are:

1. To find an answer to the research questions (these will be discussed in section 2.3)
2. Establish the value and usefulness of the Spanish measurement instrument
3. To do a research of a certain academic level of difficulty

1.3 Context

There is a complete other culture in the Dominican Republic than in The Netherlands. By doing the research in the Dominican Republic we learned to understand certain aspects of this culture a little bit better.

Aspects of the Dominican Republic that were of importance for us and for our research were:

- Language; the official language in the Dominican Republic is Spanish. In the tourist places some people speak English too, but mostly it's just Spanish, so it was important for us to know at least enough Spanish to get around. This also implicated that our questionnaire has to be in Spanish
- Location; the Dominican Republic is not a very big country, but there are very big differences, there are places with a lot of tourists and almost no tourist, there are beaches, mountains, cities, rural areas, rainforests, swamps etc. The location of where the research takes place might affect the results, so it's important to do research in more places.
- Education; since for the most part we went to schools to acquire or respondents, it's important to know what the education is like in the Dominican Republic. Education in the Dominican is compulsory and free for children from 7-14, but they do still have to buy their school uniform etc. themselves. This means that for our age group (14-22) education is no longer compulsory, so there might be a group that we don't reach by going to schools, probably the most poor and problematic group.
- Economics; the Dominican Republic is a relatively poor country with big differences between the rich and the poor, this usually implies crime (robberies). So we had to watch out for this.
- Haitians are usually the most poor people in the Dominican Republic, they usually concentrate in certain areas of the country. The AIDS problem in Haiti is much bigger than in the Dominican Republic, so you might expect different answers from Haitians than from Dominicans.

  Also, tourism is one of the major incomes in the Dominican Republic and especially in the coastal areas there are a lot of tourists, the Dominican Republic is also known for sex tourism. People that live in places with a lot of tourists or with a lot of sex tourism, may have different attitudes and opinions than the other people in the Dominican Republic.
- Time; the time experience is very different in the Dominican Republic. In the Netherlands everything happens on time and 'time is money'. In the Dominican Republic on the other hand, the people don't care too much about time. It's normal for them to be an hour late. Things also go a lot slower in the Dominican, partly this is also because of the weather, it's just too hot to work hard all the time and partly because some things are just a lot less efficient than in the Western countries. You have to be prepared for this, or else a lot of frustration awaits you..

1.4 Problem identification & formulation

The number of HIV infections in the Dominican Republic is stabilizing to some degree; this could be the result of successful national AIDS prevention and control strategies. Nevertheless, the country continues to struggle with a high incidence of HIV transmission, particularly among young people. The government of the Dominican Republic has therefore committed to develop a sex education program to target adolescents. It has also committed to implement a national policy to promote and distribute condoms to vulnerable people. This is certainly necessary because the condom use among adolescents raises some concerns. According to the Human Development Report (2003), the condom use among women is only 12%; among men this is 48%. In order to reduce HIV prevalence, condom use has to be increased, especially among adolescents, since many people seem to get infected in early

adolescence.
There has been a lot of research about social cognitions and their influence on condom use. But this has never been done on the Dominican Republic. This is important because there are cultural variables influencing social cognitions about condom use, so you can not use the results from 1 country and expect them to be the same in another country. This is important because a lot of HIV/AIDS prevention and education that is being done right now on the Dominican Republic is straight from the USA, but because the culture in the Dominican Republic is very different then the USA it might not work as well.
The cultural influences that are going to be investigated are: machismo/marianismo, stigmatization towards people with HIV/AIDS and knowledge and erroneous beliefs/myths about HIV/AIDS.
The results might help improve HIV/AIDS prevention and education programs.

1.5 Research questions

The main research question is:
Do stigmas and erroneous beliefs exist among adolescents in the Dominican Republic, to what extent and how do stigmas and erroneous beliefs influence social cognitions and condom use?

Other research questions are:
-How much knowledge about HIV/AIDS do adolescents in the Dominican Republic have?
-Are there erroneous beliefs about HIV/AIDS among adolescents in the Dominican Republic?
-Are there HIV/AIDS-related stigmas among adolescents in the Dominican Republic?
-Does the amount of knowledge influence social cognitions about condom and/or condom use?
-Do stigmas influence social cognitions about condoms and/or condom use?
-Do erroneous beliefs influence social cognitions about condoms and/or condom use?
-Do machismo, marianismo, knowledge, erroneous beliefs and stigma's influence each other?

Dorieke Kuijper's main research question is:
Do machismo and marianismo exist among adolescents in the Dominican Republic, to what extent and how do machismo and marianismo influence the social cognitions and condom use?

1.6 Research strategy: questionnaire

The research was done by means of a questionnaire. A questionnaire was used because this holds a couple of advantages:

- It's easily expressed in numbers
- It's relatively quick
- There were a lot of items available already

Most of the items in this survey have been used before in other research and proved to be valid. All of those items were put together in one questionnaire, then some items were removed and some items were added. Most of the items were also already translated into Spanish, but some were not. We translated these items in the Dominican Republic with the help of a Spanish teacher. After this, there was a pretest to see if all items were understandable. More information about the questionnaire will be given in chapter 3.2
The research was conducted among adolescents, because most people that get infected with AIDS are in their early adulthood or in adolescence. HIV/AIDS prevention and education is also the most effective in adolescence, so these are the reasons we chose for a research among adolescence.
To get a good idea of the cultural variables and the social cognitions about condom use in the Dominican Republic as a whole and not just in a certain part of the Dominican Republic, the research was done in different parts of the country, in the city, in tourist areas (the coast), inland and near the border with Haiti.
The goal was to have at least 200 respondents. After collecting all the data, the data was entered into SPSS and analyzed. In chapter 4 the results from this analysis will be showed.

1,7 Structure of report

In this chapter, the background, the research, the context in which the research will be done, the problem identification and the research strategy were discussed.
Section 2.1 is about the different health models that explain sexual behaviour by using social cognitions. Section 2.2 gender roles are discussed briefly, for more information about gender roles see the research of Dorieke Kuijpers. In 2.3 stigmatization towards people with HIV/AIDS and the different kinds of stigmatization are discussed, followed by an explanation about knowledge and erroneous beliefs about HIV/AIDS in 2.4. Chapter 2 is closed by the expectations that were formulated before the research.
In the third chapter the methodology will be described, started by 3.1 which gives some information about the respondents and where they were acquired, then in 3.2 there is a detailed discussion about the questionnaire that was used. Chapter 3 is concluded by 3.3 which tells the procedures that were followed in acquiring respondents.
In chapter 4 we start with a description of the respondents and their sexual behavior in 4.1, then section 4.2 which focuses on the descriptive statistics of social cognitions, stigmatization and knowledge and erroneous beliefs/myths, followed in 4.3 with the correlations between the different factors, then the last section 4.4 describes the regression and shows if the determinants are proximal or distal.
In the chapter 5 the conclusions that can be drawn from the results will be given, first in 5.1.1 the conclusions about the social cognitions and condom use, then in 5.1.2 the conclusions about stigmatization and the influence on social cognitions and condom use and then in 5.1.3 the conclusions from knowledge and erroneous beliefs/myth about HIV/AIDS and their influence on social cognitions and condom use, finally in 5.1.4 an answer to the main research question will be given.
Section 5.2.1 and 5.2.2 consists of the personal reflections about the research, 5.2.1 is about in what way the research objectives are reached and 5.2.2. is about what I would do different in a next research and what I would advise to other people that want to do something similar. And finally in section 5.3 are the recommendations

2 Social cognitions, stigmatization and knowledge about AIDS

Several researches have shown that social cognitions are a good predictor of intention to use condoms and condom use. However it is not known if this applies in all cultures and in what extend culture influences social cognitions.

2.1 Social cognitions

The Theory of Planned Behaviour deals with social cognitions. This theory has proven to be a good theory in explaining condom use (Marin, Gomez, Tschann & Gregorich, 1997 and Albarracin, Fishbein, Johnson & Muellerleile, 2001). These two researches both indicate the same thing; social norms, attitudes, perceived control and self efficacy lead to an intention to use condoms and this intention predicts the actual condom use.
In this context, the Protection Motivation Theory (Rogers, 1983) can also be used. According to this theory the intention to protect yourself against certain risk factors (in this case HIV/AIDS) depends on 4 factors:

1. The perceived severity of the threat
2. The perceived vulnerability
3. The perceived efficacy of the recommended behaviour
4. The perceived self-efficacy (level of trust in your own capabilities to perform the recommended preventive behaviours

2.2 Gender roles

Cultural variables can also play a big role in condom use and other risky sexual behaviour. Marin, Gomez, Tschann & Gregorich (1997) concluded that there are some cultural variables that can predict condom use. Their research shows that machismo influences the social cognitions related to condom use.
A part of the machismo/marianismo construct consists of traditional gender roles and inequality between men and women.
For instance, more machistic (men) or more marianistic (women) people think that women should enter into marriage as a virgin more often than less machistic/marianisic people (Gupta, 2002)
In the Dominican culture, there is a lot of machismo and marianismo. Because of this, many people have social expectations that dictate women to be faithful (and basically tell men it is ok not to be faithful). Furthermore, women are often found guilty for introducing HIV into the relationship. 'It is easier to forgive a man who has AIDS, than to forgive a woman, men are supposed to have sex outside of their marriage'. Women who get HIV/AIDS from their husband often blame themselves too, because they think their husband would not have cheated when they would have been a better wife (*Human Right Watch, 2004)*

2.3 Stigmatization

The part about gender roles shows that stigmatization of people with AIDS is very alive in the Dominican Republic. Because of this stigmatization, many women are afraid that it will be known that they are infected with HIV/AIDS. This fear is not completely unrealistic, because there is a law that requires you that you have to tell your sexual partners that you are HIV-positive. Women are more often (involuntary) tested for HIV/AIDS, because they often have or want to have jobs (e.g. in tourism) where it is obligatory to do a HIV-test to get the job.
Research (Brown, Macintyre & Trujillo, 2003) shows that stigmatization has a negative influence on the prevention of HIV/AIDS. A stigma means that a person (or a group) has an unwanted attribute, and because of that attribute his status in society is lowered. Society labels this person or group as different or bad. Stigmatization is a dynamic process that originates in the idea that somebody crossed the line concerning certain shared attitudes, beliefs and values. According to Bos, Kok & Dijker (2001), there are three factors that influence the stigmatization of HIV/AIDS:

1. Perceived contagiousness
2. Perceived responsibility

3. Negative attitudes about groups associated with AIDS (homosexuals, drug addicts)

Another research (Boer & Emons, 2004) shows that emotions also play an important role in stigmatization, these emotions are:

1. Fear for the people with HIV/AIDS
2. Anger towards the people with HIV/AIDS (strongly associated with perceived responsibility.
3. Pity for the people with HIV/AIDS

Fear and anger increase the stigmatization, while pity lowers it. Another emotional reaction that plays a role in stigmatization is repulsion. People who stigmatize more, protect themselves less against HIV/AIDS. This may seem odd at first, but by stigmatizing they take a certain distance from the victims. 'They are very different from me, they sleep with everyone and that is why they have AIDS, I do not so I will not get it. Stigmatization also has a negative effect on people who already have HIV/AIDS because they are less likely to take the test and/or get a treatment (and may pass it on unknowingly) because they are afraid of the reaction of others (Kalichman & Simabyi, 2004). In this context, there are two kinds of stigmas: 'felt stigmas' and 'enacted stigmas'. Felt stigma is the real or imagined fear of societal attitudes and potential discrimination. Enacted stigma is the real discrimination of someone with HIV/AIDS.

So in short stigmatization can be divided into 5 subgroups:

- Emotional reactions (anger, pity etc.)
- Blaming (responsibility)
- Distancing (for example is it acceptable that your neighbor has AIDS?)
- Attitudes to societal measures (to what extent people with AIDS are allowed to participate in society)
- Repulsion (Kalichman & Simbayi, 2004)

2.4 Knowledge and erroneous beliefs/myths

Another cultural variable is the knowledge and myths about HIV/AIDS. People expect that there is a strong connection between knowledge about HIV/AIDS and erroneous beliefs/myths about HIV/AIDS, however research shows the contrary. People who have the full and correct knowledge about HIV/AIDS may still believe in some myths. It is not enough to just give information about HIV/AIDS, the erroneous beliefs have to be fought actively too. For this reason it is important to know what the erroneous beliefs/myths are in a certain place. There are several myths in the Dominican Republic
about AIDS, but it is unknown which ones exactly.

Boer & Emons (2004) state that erroneous beliefs/myths about HIV/AIDS can be divided into two types of myths. These are:

1. Myths about the transmission of HIV/AIDS (e.g. HIV/AIDS is transmitted by mosquitoes)
2. Myths about AIDS itself, the progression (e.g. you can see it if someone has HIV)

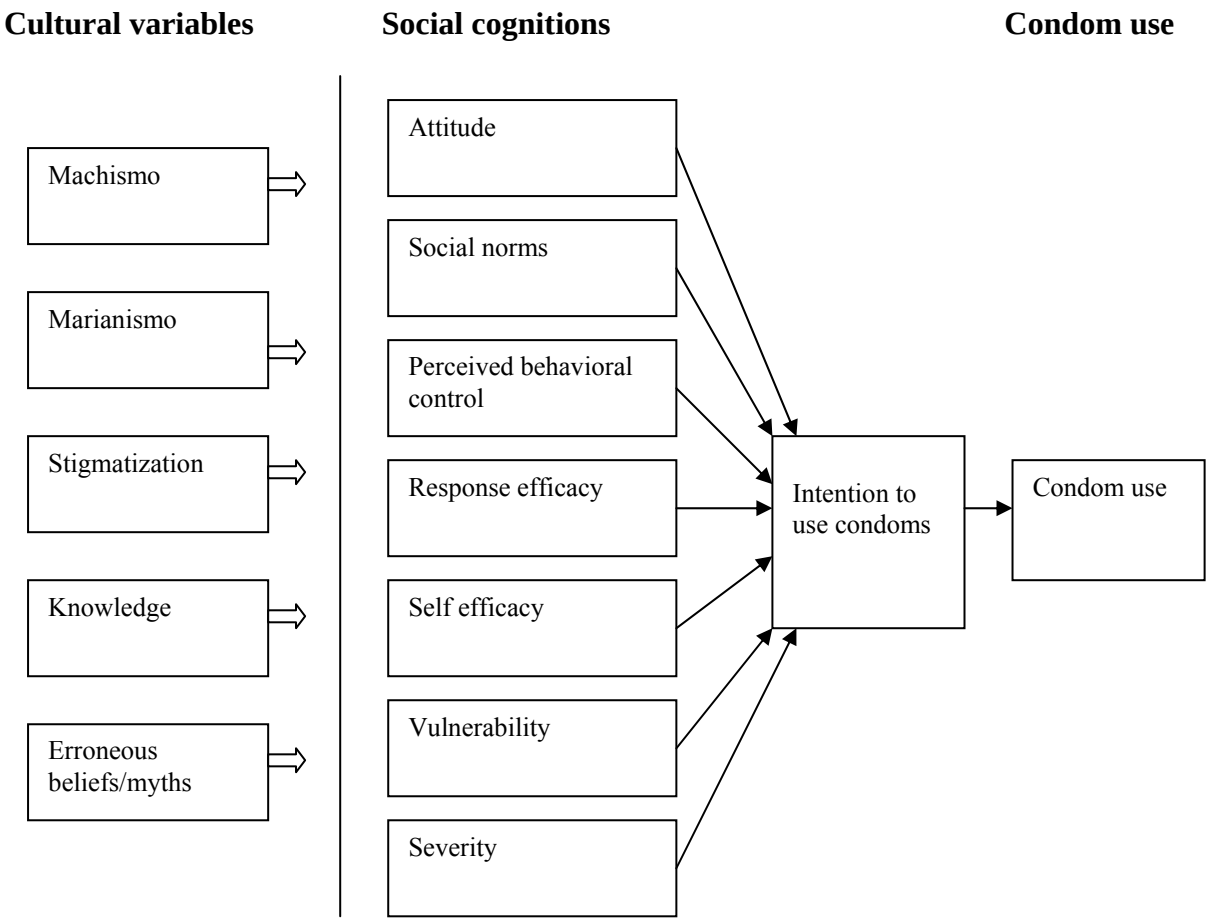
Myths are strongly associated with knowledge about HIV/AIDS. However, there is a difference, because someone who has the full and correct knowledge about AIDS may still believe in some myths. It is not enough to just give information about AIDS, the myths have to be fought actively too. For this reason it is important to know what the myths are in a particular place.

2.5 Expectations

Based on available literature there were some expectations abut the outcomes of the research, the expectations were:

- There is stigmatization among adolescents in the Dominican Republic
- Stigmatization has a negative affect on the social cognitions and condom use
- The knowledge about HIV/AIDS in the Dominican Republic is quite good
- There are some erroneous beliefs, but not a lot.
- Knowledge has a positive influence on social cognitions and condom use
- Erroneous beliefs have a negative influence on social cognitions and condom use
- Stigmatization, knowledge and erroneous beliefs are distal determinants and the social cognitions

A model from the expectations follows below. The cultural variables do influence intentions to use condoms, but only indirectly, because the cultural variables influence the social cognitions and they on their turn influence the social cognitions.



3 Methods

3.1 Respondents

In total there were 209 respondents involved in the research. All of them were adolescents in the age of 14 to 22. 149 respondents were students who were approached in public high schools or a university, the other 60 respondents were acquired on the beach of Sosua (their educational status is unknown).

The first 60 respondents were acquired on the beach of Sosua because all schools were closed due to a two-week long national holiday. Sosua is a small town on the north coast of the Dominican Republic and it is very touristic. Many Dominican families from all over the country and from all levels of society came to Sosua beach during the holidays. There were also people from Haiti, most of them worked on the beach. The educational level of the respondents approached on the beach is probably the same or lower than the educational level of the students.
Most respondents were acquired in schools. During a visit to a public school in Sosua, 29 respondents were acquired. The school in Sosua is a big school compared to other schools, there were more than 1000 students. Questionnaires were handed out in two classrooms.
Another 17 students were acquired on a public school in Cabarete, a town near Sosua. This school was much smaller than the one in Sosua. During a second visit to the school in the evening, there were about 30 students being taught in two classrooms. However, not all students were in the right age group. There were many people who were to old to fill out questionnaires (25-40 years old). This was because the classes given in the evening were for people who once dropped out of school and wanted to get their diploma.
Puerto Plata is a big city located on the north coast of the Dominican Republic. In Puerto Plata, students were approached on a military school. This too was a public school, but most of the students were children of militarists. The school was much more strict than the other schools visited. Other than that, the school was the same as the others. The principal of the school didn't want to disturb all students. Therefore, 5 students out of every classroom were asked to go to an empty classroom. In total, 25 students were acquired on this military school.
18 respondents were acquired on the university of Santiago, the second biggest country in the Dominican Republic. The city is located more inland. The educational level of the university students is higher than those in public high schools. Students from different studies filled out questionnaires.
Moca is also located more inland. The town is less developed than the towns located on the north coast. The school in Moca was very small, less than 150 students. During a visit to this school, 12 students in one classroom were acquired to fill out questionnaires.
In Las Terrenas, 17 adolescents were acquired, also on a public high school. Las Terrenas is a town in the east of the Dominican Republic. The school was quite big. Most of the students here did not live in Las Terrenas, but in other smaller towns around Las Terrenas. The students were all acquired in one classroom.
Finally, 31 respondents were acquired in a town called Dajabon. This is a town very close to the Haitian border, in the west of the Dominican Republic. There were many Haitian students at this public high school. Students, both Haitians and Dominicans, were approached in two classrooms

3.2 Questionnaire

In order to conduct the research, a Spanish questionnaire was used. Most of the items have been used before in a research about HIV-preventive behaviour in Peru (Eva Rom, 2004). The questionnaire consisted of 101 items. Items 1-41 covered the different aspects of social cognitions. Items 42-64 covered the seven aspects of stigmatisation. Items 65- 77 covered machismo and items 78-83 covered marianismo. The last 18 items covered knowledge about HIV/AIDS and myths.
Most of the items have been used before in Peru and were therefore already translated into Spanish. However, since the Spanish in the Dominican Republic could be different from the Spanish in Peru, the items were checked by a Dominican professor who teaches Spanish and English. The same professor also helped translate the remaining items. Once everything was translated and checked, the

questionnaire was read by several Dominicans to see if everything was clear to them. This seemed to be the case.

3.2.1 Social cognitions

The first part of the questionnaire consists of questions measuring the social cognitions, these are the social cognitions from the Theory of Planned Behavior and the Protection Motivation Theory.
Question 1-13 are about attitude towards condoms, these include questions such as 'Condoms make sex less romantic', condoms reduce my sexual pleasure', condoms make sex complicated etc. The reliability of the attitude scale is 0,71, no questions are deleted.
Question 14-25 are about social norms and motion to comply, these include questions such as 'My friends think it's important to use condoms' and 'The opinion of my friends matter to me'. The reliability for social norms is 0,80. In order to reach this reliability 2 questions are deleted. Question 25 and 26 ('The catholic church forbids condom use' and 'The opinion of the catholic church matters to me)
Question 26-28 covers perceived behavioral control, this was measured by asking 'The use of condoms is totally up to me' and 'I have a lot of personal control about the use of condoms. The reliability of this scale is 0,47 after deleting item 28 (Using condoms is outside my personal control)
Then the response efficacy is measured by question 29-31, question were asked like 'Using condoms protects me against HIV/AIDS and using condoms protects me against other STD's'. The reliability is 0,80 and no questions were deleted.
Self efficacy is measured by question 32-38, these include questions such as 'I think using condoms is difficult' and 'My partner will get mad when I propose to use condoms'. The reliability of the self efficacy scale is 0,68 after deleting question 36 (I'm capable of talking with my partner about save sex)
Question 39-41 measures the intentions to use condoms, this scale contains questions such as 'I will always use condoms in the future' and 'I will not have sexual relationships if there's no possibility of using condoms'. The reliability here is 0,76.
Next is vulnerability covering questions 42-44, questions include 'When I don't use condoms, the risk of getting infected with AIDS is high' and 'When I don't use condoms the risk of contracting other STD's is high'. The reliability is 0,80 and there were no items deleted.
Then there is the severity scale which is measured by questions 45-47 'If I get infected with AIDS I will get in socially isolated' and 'If I get infected with AIDS I will get depressed. 1 item was deleted (If I get infected with AIDS I won't be able to fulfill my obligations) after that the reliability was 0,74

3.2.2 Stigmatization

The stigmatization is measured by question 48-64 and is divided in 5 subgroups.
The first group is emotional, this covers the questions 48-50 and has statements such as 'When I think about people with AIDS I feel angry' and 'When I think about people with AIDS I feel fear'. One question was removed (When I think about people with AIDS I feel pity) and after this the reliability was 0,61
Then question 51-54 measures blame and includes some questions as 'The people that got AIDS by sex or drugs have gotten what they deserve' and 'Most people with AIDS are responsible for their sickness' No questions were removed and the reliability is 0,52
Question 55-56 cover distance, this was measured by stating 'I don't want anyone with AIDS living in my street' and 'I don't want to be friends with anyone who has AIDS'. The reliability is 0,53.
The societal subgroup was measured by question 57-58; 'People with AIDS shouldn't be accepted in any job' and 'It is safe for people with AIDS to work with children'. The reliability is low with 0,16.
Finally repulsion is measured by question 59-64 with statements like 'Most of the people with AIDS are stupid' and 'Most of the people with AIDS are cursed'. One question (63) was deleted (People with AIDS do not need to feel guilty). After that the reliability was 0,75.
The reliability of the total stigmatization scale is 0,59

3.3.3 Knowledge and erroneous beliefs/myths

5 question cover the knowledge about AIDS (91,92,93,94 and 100). The knowledge about AIDS is tested with questions like 'A pregnant woman can give AIDS to her baby' and then the people could

answer yes or no to these statements. Another question was ‘There is a cure for AIDS’. It was not possible to make a knowledge scale (reliability was 0,02)
There were 13 statements to see if people had any erroneous beliefs or myths, they could only answer yes or no to every statement. Questions measuring erroneous beliefs were 84-90, 95-99 and 101. The statements included ‘Mosquito’s can transmit AIDS’ and ‘AIDS can be transmitted by toiletseats and ‘You can get AIDS by kissing’. The reliability of the erroneous beliefs/myths scale is 0,53

3.3 Procedures

The first 60 respondents were acquired on the beach in Sosua. People were approached personally and they were asked how old they were to check if they were in the right age group. If this was the case, a short explanation about the research followed. Next, people were asked if they wanted to fill out a questionnaire. The respondents who were willing to do this were given a pen and a questionnaire and were told where they could hand in the completed questionnaires. They were also told that they had to fill out the questionnaires by themselves, without discussing with others.
Most respondents were acquired on public high-schools. The procedures that were followed at these schools were almost always the same. The schools were visited on a Monday, in the afternoon. The principal of the school, or in some cases a teacher, was approached. An introduction and a short explanation about the research would follow. They responded positive in all cases and gave permission to conduct the research. At most schools (5 out of 6), the older students had classes in the evening, around 6 p.m. Therefore, an appointment would be made to come back in the evening, sometimes another day of the week. In all cases a teacher was appointed to go to one or several classrooms to explain about the questionnaire, while they questionnaires were handed out to the students. The teacher also answered any questions that the students had. When the students were finished they could hand in the questionnaires by putting it in a box.
The procedures on the university were a little different. During the second visit to the university of Santiago, a teacher gave his permission. However, no teacher was appointed to assist and no classrooms could be disturbed. The students were therefore approached outside the building of the university, most of them during their break.
All respondents were told that the answers were anonymous and that the data would be handled confidentially. Also, the students were told that there were no right or wrong answers because it was their opinion that counted, and that they could only fill out one answer per item.
The overall response rate was quite good (88,9%). The worst response rate was found on the university of Santiago. Here, 18 out of 27 students agreed to fill out a questionnaire (66,7%). Some students did not want to fill out the questionnaires, they said they did not have any time or had to go to classes. On the beach, 60 out of 72 people filled out a questionnaire (83,3%). The best response rate was found in the high schools, 131 out of 136 respondents completed a questionnaire (96,3%).

3,4 Data analysis

After all data was collected, the statistical software program SPSS 12.01 was used to analyze the data. First of all, all variables were coded, for instance 1 is male and 2 is female. Then, all data was entered in the computer program.
After this was done, some items had to be recoded. The following items were recoded: 36, 58, 63, 66, 68, 72, 76 and 77.
Also, the items about the social norms and the motion to comply were recoded in a special way. The items about the social norms were recoded first, the scores 1 to 5 became –2 to 2. The scores on the items about the motion to comply remained the same, 1 to 5. Then, the scores on the items about social norms were multiplied by the scores of the items about the motion to comply.
Below in table 1 a short summary of the reliabilities of the different scales.

Table 1
Scales and their reliabilities

Scale	**Reliability**
Attitudes toward condoms (items 1 to 13)	0,71
Social norms and motion to comply (items 14 to 23)	0,80
Perceived behavioural control (items 26 and 27)	0,47
Response efficacy (items 29, 30 and 31)	0,80
Self efficacy (items 32 to 35, 37 and 38)	0,68
Intentions to use condoms (items 39, 40 and 41)	0,76
Vulnerability (items 42, 43 and 44)	0,80
Severity (items 45 and 46)	0,74
Emotional reactions (items 48 and 49)	0,61
Blaming (items 51 to 54)	0,52
Distancing (items 55 and 56)	0,53
Attitude to societal measures (items 57 and 58)	0,16
Repulsion (items 59 to 62 and 64)	0,75
Machismo (items 65, 67, 69, 70, 71, 75, 76 and 77)	0,60
Marianismo (items 78 to 83)	0,64
Erroneous beliefs/myths (items 84-90, 95-99 and 101	0,53
Knowledge (91-94 and 100)	n/a

4 Results

4.1 Respondents

Table 2 shows some statistics about the respondents. The numbers show that the group of respondents is quite varied.

Table 2
Description of the respondents

variables	(n=209)
Age	
Mean	18 years
Median	18 years
Min.	14 years
Max.	22 years
Gender	
Male	85 (41%)
Female	93 (45%)
Unknown	31 (15%)
Relationship	
Yes	101 (48%)
No	78 (37%)
Unknown	30 (14%)
Schools	
High school in Sosua	29 (14%)
High school in Cabarete	17 (8%)
High school in Puerto Plata	25 (12%)
High school in Moca	12 (6%)
High school in Las Terrenas	17 (8%)
High school in Dajabon	31 (15%)
University of Santiago	18 (9%)
Sosua beach	60 (29%)

As you can see from the table there is quite a big number of respondents that did not want to tell their gender or their relationship status. This might indicate a fear for identification. Also the number of people with a relationship is quite high.

Table 3 contains numbers that tell something about the sexual behaviour of the respondents.

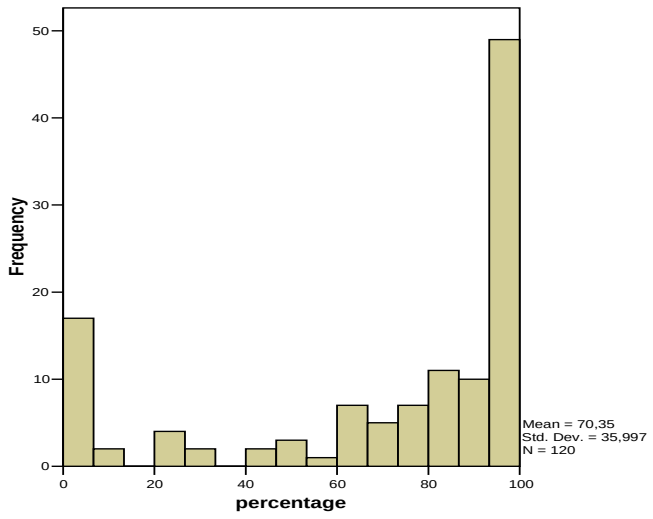
Table 3
Sexual behaviour of the respondents

Variables	**(n=209)**		
	Total	**Male**	**Female**
Sexually active	123 (59%)	69 (81%)	52 (56%)
Estimated condom use in %	70%	70%	70%
Used condom last time			
Yes	81 (66%)	54 (78%)	25 (48%)
No	42 (34%)	15 (22%)	27 (52%)
Used condom last year			
Never	17 (14%)	6 (9%)	11 (21%)
Sometimes	20 (16%)	11 (16%)	9 (17%)
Often	33 (27%)	19 (28%)	14 (27%)
Always	49 (40%)	30 (43%)	17 (33%)

The majority (59%) of the respondents are sexually active. There are more males sexually active then there are females. The estimated condom use is almost equal for males and females, around 70 percent, which is very high. But it is strange to see that even though the estimated condom use is equal for men and women, but if you look at condom use last time and last year men show a much greater condom use.
More than 3 quarters of the males claim to have used a condom the last time they had sex, while not even half of females claim the same. When you look at the condom use last year you get the same results, almost one quarter (21%) of the women admit to have never used a condom in the last 12 months against only one in ten men (9%). A lot more men (43%) say they always used a condom in the last 12 months than the women (only 33%) The 'often' and 'sometimes' answers are the same for men and women.

Graph 1 shows the distribution of the condom use (the estimated percentages) among the respondents.

Graph 1
Distribution of condom use



The graph shows that a lot of respondents say they always use a condom, and also a lot of people say they never use a condom (but not nearly as much as the always group). There is only a relatively small group that give answers anywhere between 0 and 100%. But if you look at the table where the question was asked in terms of 'never', 'sometimes', 'often' and 'never' then you see 43% uses condoms somewhere in between.

4.2 Stigmatization

Table 4 contains numbers about the stigmatisation.

Table 4
Descriptives of stigmatization (score 1-5)

Variables	Male	Female
Mean score stigmatisation	2,9	2,8
Std.	0,6	0,6
Min.	1,3	1,6
Max.	5	4,4

The mean score on the stigmatization scale is slightly higher among males than among females, but there is no big difference. What's interesting though is the maximum score on stigmatization for males, this is the most you can get. You can also see there is a really big difference between individuals, some almost have no stigmatization and others have a lot.

4.3 Knowledge and erroneous beliefs/myths

Table 5 shows the knowledge questions about AIDS and the the percentage of correct answers for both males and females.

Table 5
Percentage correct for each knowledge question about AIDS

Knowledge questions	Total	Male	Female
93 Somebody who looks healthy can be infected with HIV	91	89	91
94 A pregnant woman can infect her baby with HIV/AIDS	89	94	86
100 There is a cure for AIDS	89	83	94
91 Aids is caused by HIV	86	86	83
92 Somebody who is infected with HIV has to get AIDS within 3 months	49	39	58

As you can see from table 15, most of the question are answered quite good and there is no big difference between males and females. Except for question 92, not even half gave a correct answer and males scored much worse on this question than females.

Graph 2 shows the distribution of correct answers on the knowledge question for males and females. Around 40% of all the females answered all the questions correct, whereas only 20% of the males answered all the questions correct. Most people have either 5 or 4 questions correct, but still around 1 in 5 answers 2 or more question incorrect.

Graph 2
Distribution of total correct answers for both males and females

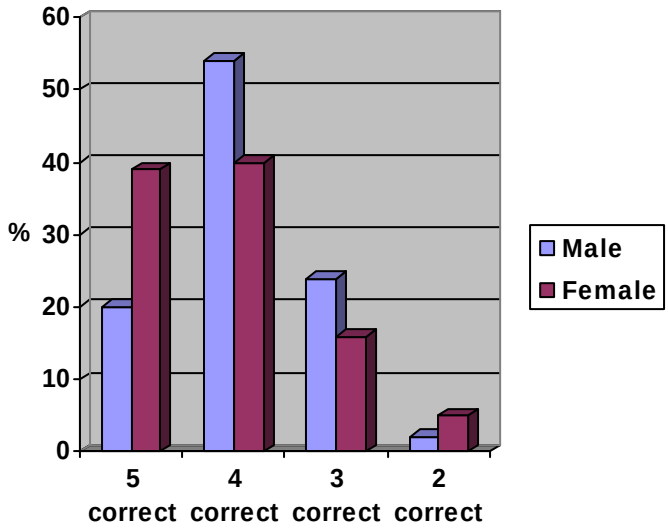


Table 6 shows the percentage of the people that belief in a certain myth

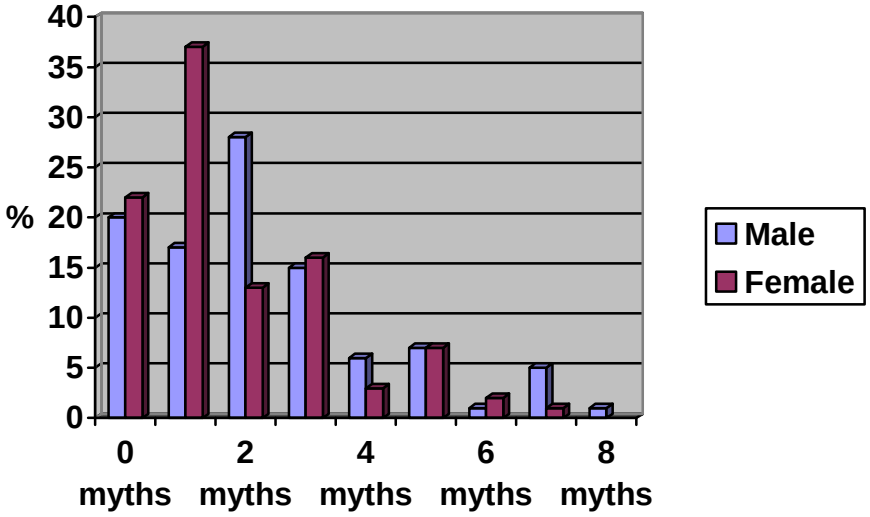
Table 6
Believes in a certain myth (N=209)

Erroneous beliefs/myths	**Total (N=209)**		**Male (N=84)**		**Female (N=93)**	
	%	**n**	**%**	**n**	**%**	**n**
90 Mosquitos can transmit HIV	44	88	52	44	38	35
95 Women can infect men, but men cant infect women	31	62	24	20	36	33
98 A person has to have multiple sexual companions to be infected	28	56	24	20	30	28
99 You can get rid of AIDS by sleeping with a virgin	19	37	25	21	13	12
96 AIDS can be transmitted by kissing	18	36	17	14	17	16
97 You can get infected with AIDS by sharing a kitchen	16	31	24	20	9	8
89 HIV can be transmitted by toilet seats	14	28	18	15	13	12
101 You can get AIDS by sharing a glass with someone who has AIDS	13	25	22	18	4	4
88 HIV can be transmitted through a swimming pool	5	10	8	7	3	3
85 HIV can be transmitted by sharing of cigarets	5	10	6	5	5	5
86 HIV can be transmitted by hugging a person that has AIDS	4	8	1	1	4	4
84 HIV can be transmitted by coughing and sneezing	3	5	5	2	3	3
87 HIV can be transmitted through air	2	4	1	1	1	1

Table 6 shows that especially the myth that mosquitos can spread AIDS is widely held, more than half of the men belief in this myth and almost 40% of the women, other myths that a lot of people belief in are that women can infect men, but men cant infect women, especially women belief this. And that somebody has to have multiple sexual companions to have AIDS. Myths that especially men belief in are that you can get rid of AIDS by sleeping with a virgin, that you can get AIDS by sharing a glass and by sharing a kitchen, especially for the last 2 women have much lower numbers.

Graph 3 shows the distribution of people that believes in myths.

Graph 3
Distribution of belief in myths



You can see in graph 4 that only 20% of all the people don't believe in myths at all, that means that 80% at least has one myth about AIDS or it's transmission. You can also see that women belief a little bit less in myths, but there isn't a big difference.

4.3 Correlations between social cognitions and cultural variables

4.3.1 Social cognitions

Table 7 shows the correlations between the different subgroups of the social cognitions and the intentions to use condoms.
Table 7
Correlation between social cognitions and intentions

Social cognitions	***Intentions***
Attitudes	0,03
Social norms	0,38**
Perceived behavioural control	0,11
Response efficacy	0,27**
Self efficacy	0,12

***Correlation is significant at the 0,01 level*

The numbers show that there are two significant correlations. There is a significant positive correlation between the social norms and the intentions to use condoms. There is also a significant positive correlation between the response efficacy and the intentions. This means that the better the social norms are regarding condom use, the better are the intentions to use condom, the same goes for self efficacy.

Table 8 shows the correlations between the social cognitions and the items about condom use.

Table 8
Correlations between the social cognitions and condom use

Variables	Percentage	Last time	Last year
Attitude	0,18	0,27**	0,28**
Social norms	0,13	-0,01	0,06
Perceived behavioral control	-0,15	-0,19*	-0,16*
Response efficacy	0,16	-0,05	0,03
Self efficacy	0,17	0,11	0,06
Intention to use condoms	0,12	0,06	0,01

** Correlation is significant at he 0,05 level*
*** Correlation is significant at the 0,01 level*

You can see from table 9 that attitude correlates positively with condom uses last time and condom uses last year, this means the better the attitudes are for condom use the more likely it is somebody used a condom last year and last time.
Strangely there is another correlation, a negative one, this one is not to be expected it is between perceived behavioral control and condom used last time and last year. This means that the more somebody thinks the use of condoms is within his control the less likely it is somebody used a condom last time and last year.
There appear to be no significant correlations between intentions and condom use.

4.3.2 Stigmatization
Table 9 contains the correlations between the variables mentioned in the Protection Motivation Theory and stigmatization

Table 9
Correlations between stigmatization and the different aspects of social cognitions

Variables	Stigmatization total	Stigmatization males	Stigmatization females
Response efficacy	-0,07	-0,07	-0,13
Self efficacy	-0,18*	-0,11	-0,12
Vulnerability	-0,06	-0,02	-0,03
Severity	0,18	0,10	0,30*
Attitude	-0,27**	-0,21	-0,32*
Social norms	0,03	0,03	0,11
Perceived behav.	0,23**	0,30**	0,33**

**Correlation is significant at 0,05 level*
*** Correlation is significant at 0,01 level*

In table 9 you can see that there is a significant negative correlation between stigmatization and self efficacy, which means the the higher the total score on stigmatization the lower the self efficacy is.
Also there is a positive correlation between stigmatization and severity, this means that people who stigmatize more think AIDS is more severe. Surprisingly though there is also a positive correlation between stigmatization and perceived behavioral control, the higher the score on stigmatization the more the behavior is perceived to be under own control.
From the table you can also conclude that for girls stigmatization plays a big role for severity, attitude (negatively) and perceived behavioral control. Stigmatization plays a role in self efficacy for both male and females, but is only significant when male and females are mixed together, because then the sample is bigger. For males stigmatization only plays a significant role for perceived behavioral control.

Table 10 shows the correlations between the different aspects of the stigmatization scale (emotional reacties, blaming, distancing, repulsion and attitude to societal measures and the social cognitions (attitude, social norms, perceived behavioral control, response efficacy, self efficacy, vulnerability and

severity)

Table 10
Correlations between the different aspects of stigmatization and the social cognitions

Variables	**Emotional reactions**	**Blaming**	**Distancing of the self**	**Repulsion**	**Attitude to societal measures**	**Stigma scale**
Attitude	-0,19*	-0,20*	-0,13	-0,22**	-0,02	-0,27**
Social norms	0,13	-0,10	-0,06	0,05	0,03	0,03
Perceived behavioral control	0,15*	0,13	0,14*	0,14*	0,18*	0,23**
Response efficacy	-0,04	-0,11	-0,25**	0,04	0,18	-0,07
Self efficacy	0,20	-0,04	0,12	-0,27**	0,09	-0,18*
Vulnerability	0,06	-0,01	-0,24*	-0,06	-0,21**	-0,06
Severity	0,29*	-0,01	0,17*	0,14	0,10	0,18

** Correlation is significant at 0,05 level*
*** Correlation is significant at 0,01 level*

As you can see from table 10 the strongest (negative) correlation is between repulsion and self efficacy, this means that the stronger the repulsion is towards people with AIDS, the lower the self efficacy is for using condoms. Another strong correlation is between distancing and response efficacy, this is also a negative correlation, this means that the more people feel they need to keep a distance between them and people with AIDS, the less they believe condoms really help protect against HIV/AIDS. There is also a strong relation between repulsion and attitude, this is a negative correlation, which means the more repulsion they feel towards people with HIV/AIDS, the worse their attitudes are about condoms. In short you can say that different aspects of stigmatization influence different social cognitions. Stigmatization does not have any correlations with social norms, but it does correlate strongly with distancing of the self, repulsion and emotional reactions You can also see in table 10 that there is a positive correlation between emotional reactions and severity, this implies that the stronger the (negative) emotional reactions (fear and anger) are towards people with HIV/AIDS, the more they think HIV/AIDS is severe. What is remarkable though is the negative correlation between distancing of the self and vulnerability and the negative correlation between attitude to societal measures and vulnerability, because these 2 correlations mean that the more they want to keep a distance between them and people with AIDS and the more they feel society has to take measures that stop people from participating in society the less vulnerable they feel. You would expect the opposite. What is also remarkable is that every aspects of stigmatization (except blaming) correlates positively with perceived behavioral control, but a negative correlation would be expected.

Table 11 shows the correlations between the different subgroups of the stigmatization scale and the intentions to use condoms.

Table 11
Correlation between intentions to use condoms and stigmatization

Stigmatization	***Intentions to use condoms***
Emotional reactions	0,21**
Blaming	0,01
Distancing from self	-0,07
Attitudes to societal measures	-0,04
Repulsion	0,03

***Correlation is significant at 0,01 level*

There is a positive significant correlation between emotional reactions and the intentions to use condoms, which means the stronger the emotional reactions (anger, fear) the more they are inclined to

use condoms

Table 12 contains correlations between the 3 items about the estimated condom use and the different aspects of the stigmatization scale. There appears to be no significant relation between these variables. There is also no correlation between condom use and the stigmatization scale as a whole.

Table 12
Correlation between condom use and stigmatization

Variables	***Percentage***	***Last time***	***Last year***
Emotional reactions	-0,07	-0,06	-0,09
Blaming	-0,07	-0,02	0,04
Distancing	-0,11	-0,09	-0,13
Attitudes to societal measures	-0,05	0,04	0,01
Repulsion	-0,01	-0,07	-0,03

4.3.3 Knowledge and erroneous beliefs/myths about HIV/AIDS

Table 13 shows the correlations between knowledge and the different subgroups of the social cognitions scale.

Table 13
Correlations between knowledge and social cognitions

Social cognitions	**Knowledge**		
	Total (N=200)	**Male (N=84)**	**Female (N=93)**
Attitudes	-0,00	-0,02	-0,06
Social norms	-0,21**	-0,12	-0,25*
Perceived	-0,12	0,02	-0,21*
Response efficacy	0,01	0,03	-0,02
Self efficacy	0,12	0,06	0,14
Vulnerability	0,13	0,24*	0,03
Severity	0,12	0,21	0,09

**Correlation is significant at the 0,05 level*
*** Correlation is significant at the 0,01 level*

There is one significant negative correlation between knowledge and social norms This is remarkable, because this means the higher somebody's knowledge about HIV/AIDS, the lower the social norms are surrounding condom use. Interestingly you see different correlations for males and females. For males there is one positive correlation with knowledge and vulnerability which means the higher somebody's knowledge the more vulnerable they feel. For females knowledge has two negative correlations; one with social norms and one with perceived behavioral control.

Table 14 shows the correlations between knowledge and condom use. It shows that there are no significant relations between knowledge and condom use..

Table 14
Correlations between condom use and knowledge

Condom use	**Knowledge**
Percentage	-0,00
Last time	0,05
Last year	0,02
Intention	0,01

Table 15 shows the correlations between erroneous beliefs and the different subgroups of the social cognition.

Table 15
Correlations between erroneous beliefs and social cognitions

Social cognitions	**Erroneous beliefs**
Attitudes	-0,31**
Social norms	-0,12
Perceived	-0,06
Response efficacy	-0,32**
Self efficacy	-0,25**
Vulnerability	-0,19**
Severity	0,06
Intentions	-0,17*

** Correlation is significant at 0,05 level*
*** Correlation is significant at 0,01 level*

In table 15 you see that there is a significant negative relation between erroneous beliefs and attitudes, which means the more erroneous beliefs people are holding, the worse the attitudes about condom use. The same goes for response efficacy and self efficacy, the more erroneous beliefs people hold, the less people feel using condom is efficient in preventing AIDS and the less they are able to use Also note the negative correlation between erroneous beliefs and vulnerability, the more erroneous beliefs somebody has, the less vulnerable they feel.
There is also an important negative correlation between erroneous beliefs and intentions to use condoms, which means, the more erroneous beliefs people have the less they intend to use condoms.

The numbers in table 16 show that there are no significant correlations between erroneous beliefs and the different items about condom use.

Table 16
Correlations between condom use and erroneous beliefs

Condom use	***Erroneous beliefs***
Percentage	-0,04
Last time	0,01
Last year	-0,02

4.4 Regression analysis

Table 17 shows the regression analysis with the social cognitions from the theory of planned behavior

Table 17
Regression with the Theory of Planned behavior

Variables	**Beta model 1**	**Beta model 2**
Emotional reactions	0,28**	0,22*
Blaming	0,04	0,06
Distancing	-0,15	0,05
Attitudes to societal measures	-0,07	-0,12
Repulsion	0,24*	0,15
Knowledge	-0,03	-0,02
Erroneous beliefs	-0,27**	-0,07
Attitudes		-0,04
Social norms		0,30**
Perceived behavioral control		-0,11
Response efficacy		0,30**
Self efficacy		-0,04
R square	0,21	0,37

** Correlation is significant at 0,05 level*
*** Correlation is significant at 0,01 level*

You can see from table 17 that the coefficients from the cultural variables are bigger in model 1 than in model 2, which means that the cultural variables are probably working indirect through the social cognitions and do not have a direct influence on intentions to use condoms.
Social norms and response efficacy have the biggest influence on intentions to use condoms and the cultural variables that influence condom use (or the social cognitions about condom use) are emotional reactions, repulsion and erroneous beliefs. But surprisingly emotional reactions and repulsion have a positive correlation with intention to use condoms.
Using only the cultural variables in this model explains 21% of the results, using also the social cognitions from the theory of planned behavior explains 37% of the results.

Table 18 shows the regression analysis with the social cognitions from the protection-motivation theory

Table 18
Regression with the Protection-Motivation Theory

Variables	**Beta model 1**	**Beta model 2**
Emotional reactions	0,19*	0,15*
Blaming	0,06	0,02
Distancing	-0,11	0,00
Attitudes to societal measures	-0,03	0,00
Repulsion	0,21*	0,14*
Knowledge	-0,04	-0,07
Erroneous beliefs	-0,22*	-0,11
Response efficacy		0,15
Self efficacy		0,03
Vulnerability		0,35**
Severity		0,02
R square	0,14	0,30

** Correlation is significant at 0,05 level*
*** Correlation is significant at 0,01 level*

You can see from table 18 that the same cultural variables play a role here as in the theory of planned behavior, again the coefficients are smaller in model 2 than in model, which means that the determinants are distal. Vulnerability is the biggest factor using the protection motivation theory.
With this model you can explain 14% of the outcomes using only the cultural variables and 30% also using the social cognitions from the protection-motivation theory. This is a little bit lower than with the theory of planned behavior, but not much.

Table 19 shows the regression analysis with the social cognitions from the theory of planned behavior and protection-motivation theory

Table 19
Regression using both the Theory of Planned Behavior and Protection-Motivation Theory

Variables	**Beta model 1**	**Beta model 2**
Emotional reactions	0,25*	0,21*
Blaming	0,05	0,02
Distancing	-0,15	0,02
Attitudes to societal measures	-0,07	-0,05
Repulsion	0,27*	0,22*
Knowledge	-0,04	-0,03
Erroneous beliefs	-0,24*	-0,03
Attitudes		-0,06
Social norms		0,24**
Perceived behavioral control		-0,18
Response efficacy		0,14
Self efficacy		-0,09
Vulnerability		0,44**
Severity		0,01
R square	0,20	0,50

** Correlation is significant at 0,05 level*
*** Correlation is significant at 0,01 level*

You can see from table 19, that again the cultural variables; emotional reactions, repulsion and erroneous beliefs play a distal role in predicting intention to use condoms, whereas emotional reaction and repulsion also still appear to play a proximal role when you include all the social cognitions. But social norms and vulnerability have the biggest influence. The higher the social norms regarding condom use and the more you think you are vulnerable to HIV/AIDS the more you are inclined to using condoms.
Using only the cultural variables 20% of the outcomes are explained, using the cultural variables and all the social cognitions from both theories 50% of the outcome is explained. This is a very high number.

5 Conclusion

5.1 Conclusions

5.1.1 Social cognitions

From the theory of planned behaviour we expected to find that the social cognitions (attitude, social norms and motion to comply, perceived behavioural control, response efficacy and self efficacy) would lead to intention to use condom, this intention would predict the condom use. This turns out to be only partly true.

- Intentions to use condoms have no correlation with the actual condom use
- Here is a strong connection between social norms and motion to comply and intentions to use condoms
- There is also a positive connection between response efficacy and intention to use condoms.
- A positive correlation is found between attitude and used condom last time and last year
- A negative correlation is found between perceived behavioural control and used condom last time and last year

The reason why there is no connection between intentions to use condoms and the actual condom use is maybe because a lot of people in the Dominican Republic are not really good with numbers, for example the percentage question could be too difficult for a lot of people, also another reason could be that people didn't answer honestly to the condom questions.
As expected social norms and motion to comply and response efficacy do influence intentions to use condoms, there was also a relation between perceived behavioural control and self efficacy and intentions to use condoms, but this relation was not significant. Why there is no relation found between attitude and intentions to use condoms is not known.
However even though there were no correlations between intentions to use condoms and the condom use, there were relations between some aspects of the social cognitions (attitude and perceived behavioural control) and used a condom last time and last year. This is strange because these cognitions are supposed to have an indirect influence on condom use through intentions, but in this case they don't influence intentions and intentions don't influence condom use.
The positive correlation between condom use and attitude is exactly what should be expected, because the better people think about condoms the more they use condoms, this is logical and according to the Theory of Planned Behavior. But there is another connection a negative one, that cant be explained using the Theory of Planned Behavior, this theory predicts that the more people perceive the use of condoms within their control the more people use condoms (indirectly through intentions), but here the results show that the more people perceive the use of condoms within their control, the less they actually use it. It's not clear why.

From the analysis of the regression it seems that especially vulnerability and social norms play an important role in the prediction of intention to use condoms.

5.1.2 Stigmatization

From the results can be concluded that there indeed is stigmatization in the Dominican Republic under adolescents. There are not a lot of differences between males and females, but there are big differences individually.
To explain stigmatization both the Protection Motivation Theory and the Theory of Planned behaviour were used. The idea was that stigmatization would influence the social cognitions from one or both theories. This indeed seems to be the case. But stigmatization predicts in no way the use of condoms or the intentions to use condoms.
The overall stigmatization score correlates positively with severity and negatively with self efficacy.
Both fit in the theory, because the more you think you posses the abilities the prevent AIDS, the less you feel the need to stigmatize. On the other hand the more severe you think about AIDS, the more

scared you are of the disease and the more likely you are to stigmatize. This correlation with severity is especially strong among women.

The results also show that different social cognitions influence different aspects of stigmatization

- Repulsion has a negative correlation with self efficacy
- Distancing from the self has a negative correlations with response efficacy.
- Distancing from the self and attitude to societal measures have a negative correlation with vulnerability.
- Emotional reactions and distancing have a negative correlation with severity.

This is all in the line of expectation, except for the vulnerability correlation, this is exactly the opposite of what would be expected. For now an explanation can not be given.

When the Theory of Planned behaviour is used, stigmatization has a negative correlation with attitude and self efficacy and a positive correlation with perceived behavioural control.
The negative correlations are what should be expected, but the positive correlation with perceived behavioural control is exactly the opposite of what should be expected, just as with the negative correlation between perceived behavioural control and condom use, this can not really be explained.
With the Theory of Planned behaviour the different aspects of stigmatization influence the different aspects of the social cognitions.

- Emotional reactions have a negative correlation with attitude and a positive correlation with perceived behavioural control.
- Blaming has a negative correlation with attitude
- Distancing from the self has a negative correlation with response efficacy and a positive correlation with perceived behavioural control
- Attitude to societal measures has a positive correlation with perceived behavioural control.
- Repulsion has negative correlations with attitude and self efficacy and a positive correlation with perceived behavioural control.

Again the perceived behavioural control correlation can not be explained, but all other correlations are according to the theory.

This is all according to the expectation, except for the relation with perceived behavioural control. What is not according the expectations is the results from the regression analysis however. According to this the higher the emotional reactions and repulsions are, the higher the intentions to use condoms, but stigmatization does have a negative effect on the social cognitions.

5.1.3 Knowledge and erroneous beliefs/myths

The adolescents in the Dominican Republic have a fairly good knowledge about AIDS, the only question that a lot of people did not answer correctly was the question about if somebody got AIDS three months after getting infected with HIV. On all the other questions they did good. Women have a slightly better knowledge about AIDS than do men, but there is no big difference. Knowledge does not influence condom use or the intentions to use condoms. Using the Theory of Planned Behaviour and Protection Motivation Theory to explain knowledge there are 2 significant correlations

- There is a negative correlation knowledge between social norms and motion to comply
- With only males there are no correlations
- With only females there are 2 negative correlations; with social norms and motion to comply and perceived behavioural control.

These correlations are surprising, because this means the better the knowledge about HIV/AIDS the

wors the social norms are surrounding condoms The negative correlation between perceived behavioural control is also unexplained. But it should be noted here that it was not possible to make a knowledge scale, probably because there is no underlying concept, so this could be a reason of the strange correlations

Only 20% of the questioned Dominican adolescents do not believe in any myth surrounding AIDS, this means that 80% beliefs in 1 or more myths. This is quite a lot. Men do seem to have a little more erroneous beliefs, but again there is no big difference. There is a difference between the sexes in what kind of myths they believe. The most common erroneous belief is that you can AIDS from mosquito's, closely followed by the myth that women can give AIDS to men, but men can not give AIDS to women. Also a lot of people think that somebody has to have multiple sexual partners before he can get AIDS. Men especially seem to believe that they can get rid of AIDS by sleeping with a virgin and that they can get AIDS by sharing a kitchen with somebody who has AIDS or by drinking from the same glass.

With the social cognitions from the Theory of Planned behaviour and the Protection Motivation Theory four correlations are found

- Negative correlations between number of erroneous beliefs and attitude, response efficacy, self efficacy and vulnerability

The first three correlations are exactly what should be expected from the theories, the correlation between vulnerability and erroneous beliefs is a little bit more complicated because it can work both ways. In this case it seems that the more vulnerable somebody feels, the less erroneous beliefs he has, maybe because he's looking for right information because he is feeling so vulnerable.
There is no correlation between number of erroneous beliefs and condom or intentions to use condoms.

There are a couple of drawbacks about this research, first of all, no causal connections are tested, the results are just correlations and do not say anything about the directions of these correlations.
Second of all, the data was received by questionnaires, people had to fill in their opinion about a certain matter, but they could easily lie, because they want to give the answers that are socially acceptable, especially with a research with so many personal aspects such as sex.
Thirdly a number of people did not fill out the complete questionnaire or skipped certain questions, it is unknown why they did this, a possible reason is fear of identification, or because they felt that the questions were too personal, so this may have influenced the results.
Fourth, most of the respondents we got by going to schools, the drawback about this tactic is that all the adolescents who do not go to school are cut out. And this could be the most interesting group, because they are probably the poorest and have the most problems with AIDS and using condoms.
Another problem often heard was that 'Dominican people are not really used to deal with numbers', this could especially be a problem for the percentage question, a lot of people said a lot of Dominican people do not even understand the question and will fill out just any number or nothing.
Also there were some problems with the reliabilities of the different aspects of stigmatization, only the repulsion scale had a good reliability (0,75). For knowledge it was not possible to make, this means that it has no underlying concept, which makes is difficult to correlate it.

The expectation was that knowledge would have a positive influence on social cognitions and condom use, this turned out to be not true, as a matter of fact, knowledge does not do much at all.
Also there were a lot more erroneous beliefs than were expected, but the negative influence on social cognitions and condom use turned out to be true.

5.1.5 Main question
The main question was:
'Do stigmas and erroneous beliefs exist among adolescents in the Dominican Republic, to what extent and how do stigmas and erroneous beliefs influence social cognitions and condom use?'

The answer to this question is, yes stigmas and erroneous beliefs do exist among adolescents in the Dominican Republic, in greater extents then was expected. Erroneous beliefs and stigmas have a negative correlation with social cognitions.

The model that was used seems to work, although it is questionable if emotional reactions and repulsion only play a distal role, because the correlations in the regression analysis did drop a little when the social cognitions were added to the model, but not so much and they stayed significant.
The big factors in predicting intention to use condoms are vulnerability and social norms (and motion to comply) surrounding condom use.

5.2 Reflections

5.2.1Research project objectives

I think I succeeded in reaching all the research objectives.

Objective 1: To find an answer to the research questions
Through the research and the data analysis I came to a conclusion. See the report for all the answers on the research questions

Objective 2 Establish the value and usefulness of the Spanish measurement instrument
The Spanish measurement instrument proved to be useful, the results showed that also in the Dominican Republic the same social cognitions predict the intentions to use condoms and condom use. But care should always be given in translating the Spanish into the Spanish that people speak in a particular country, because there can be big differences. Although educated people will understand the normal Spanish less educated people sometimes have difficulty understanding Spanish from other countries, because the frequency of using certain words is different in the different countries. Also less educated people speak much more street Spanish (which may even be different from town to town) and this could be completely different from the normal Spanish.
Also, certain aspects for example machismo that the questionnaire measures may be different from country to country. For example when you go to 2 different Spanish speaking countries that both score quite high on machismo, you may find that one country scores very high on a certain part of machismo (family is the first responsibility of a man) and very low on another part of machismo (a woman needs to stay in the house), while in the other country it's the other way around. So machismo is not just one thing, it can be different from culture to culture.
Also, especially the erroneous beliefs part should be specifically fitted for the specific country you are going to, because it's no use to mention erroneous beliefs that nobody believes in. So it's important to find what kind of myths are a live in the region you are going to.

Objective 3: To do a research of a certain academic level of difficulty
I think we did do a research with a level of academic difficulty, this report is a result of that. Because we did everything step by step and prepared ourselves very well, there were not too much problems with the research itself, there were however some minor problems with executing the research, for example the electricity. Sometimes we were working on the laptop and then the electricity would go. If you were lucky you could work for an hour more or something with the battery, but then you had to wait, until the electricity got back, which you would never know when that would happen, it could be back in 5 minutes, it could be back in 3 days. This was really frustrating sometimes and certainly delayed work Also things that are easily accessible in The Netherlands, are not so accessible in the Dominican Republic (a copy machine or a printer). But these were problems easily overcome, although it did take some extra time.

5.2.2 Research process

I learned a lot from doing the research and I think it has certainly reached an academic level of difficulty. We started out with doing research about the subject. Then we decided to use two health

models; the theory of planned behavior and the protection motivation theory. Based on these theories we formulated research questions and expectations. Then we focused on creating a good questionnaire to get all the data we needed.
In the Dominican Republic we tried to get a varied sample of respondents by traveling to different parts of the country, instead of just staying in one place. After this we entered the data in SPSS and analyzed it. Through all of this we had regular feedback from our teachers, so we could change and/or improve certain things if necessary.
If I look back now, I would do few things different. But there are some things.

1. Have everything ready before you leave. Our preparation of the research in the Dominican Republic was very good, we had almost everything ready. Except for the questionnaire, we still had to translate some items into Spanish and change a couple of very small things, next time I would definitely finish this before I leave, because it is so much easier to do these kind of things in Holland. Over there you have to look for a computer with internet, sometimes they don't have Word, but Works (or just only Wordpad) which would change the layout all the time. It's just much easier to have everything ready.
2. Set goals and stick to them. When we arrived in the Dominican Republic it was just our little paradise. We had said to ourselves that first we could take a vacation for 2 weeks in which we did not have to work on school. But after those 2 weeks, it was hard to start and everyday we said, ahh well, we can start tomorrow'. But this made starting only more difficult. Finally we did start and then everything went well. But starting was hard, so next time I will just start on the day that was planned, no excuses accepted.
3. One other thing that was difficult, was that we had no supervision in the Dominican Republic, this was no problem for the research itself, but we did not have to do anything (see point 2), there was no company that we had to work for. We could just do anything we wanted. Of course this had its good points too, but next time I would, if it's possible, be connected with some kind of organization that I have to check into at least once a week.

5.3 Recommendations

Future research should focus on making more reliable stigmatization scales, except for repulsion, the reliability of the stigmatization scale were not very good.
Also in a next research there should be more knowledge questions, in this research there were only 5. The 13 questions about erroneous beliefs showed that some erroneous beliefs are very common, other ones nobody really believes. But it should be noted, that the questionnaire could be missing some important erroneous beliefs, so there might be more. For better programs for prevention of HIV/AIDS people should actively fight these erroneous beliefs.
Future research could also focus on developing questions that measure the condom use well, there are some question that measure condom use, but these are not always very reliable.
This research shows that cultural variables (machismo/marianismo, stigmatization and knowledge and erroneous beliefs about HIV/AIDS) do have an influence on the social cognitions about condom use, intentions to use condoms and condom use, more research is needed to translate these results into creating better HIV/AIDS programs.

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Annex 1: Questionnaire Spanish

	Completa-mente en desacuerdo	En desacuerdo	Neutral	De acuerdo	Completa-mente de acuerdo
1. Tener relaciones sexuales usando condón es menos romántico	1	2	3	4	5
2. Tener relaciones sexuales usando condón es menos agradable	1	2	3	4	5
3. Usar condones es una interrupción fastidiosa	1	2	3	4	5
4. Usar condones reduce el placer sexual de mi pareja	1	2	3	4	5
5. Usar condones reduce mi placer sexual	1	2	3	4	5
6. Es difícil planear por adelantado el uso de condones	1	2	3	4	5
7. Usar condones evoca resistencia de parte de mi pareja	1	2	3	4	5
8. Usar condones hace el sexo complicado	1	2	3	4	5
9. Usar condones hace el sexo embarazoso	1	2	3	4	5
10. Usar condones puede hacer que mi pareja piense que tengo SIDA	1	2	3	4	5
11. Usar condones puede hacer que mi pareja piense que me acuesto con varias personas	1	2	3	4	5
12. Proponer el uso de condones, puede hacer que mi pareja piense que yo no confío en él/ella	1	2	3	4	5
13. Usar condones me da la sensación de ser menos hombre/mujer	1	2	3	4	5
14. Mi pareja actual piensa que deberíamos usar condones	1	2	3	4	5
15. La opinión de mi pareja actual es importante para mí	1	2	3	4	5

	Completa-mente en desacuerdo	En desacuerdo	Neutral	De acuerdo	Completa-mente de acuerdo
16. Mis amigos piensan que debería usar condones	1	2	3	4	5
17. La opinión de mis amigos es importante para mí	1	2	3	4	5
18. Mi doctor me recomendaría el uso de condones	1	2	3	4	5
19. La opinión de mi doctor es importante para mí	1	2	3	4	5
20. Mis padres piensan que debería usar condones	1	2	3	4	5
21. La opinión de mis padres es importante para mí	1	2	3	4	5
22. Las campañas de salud recomiendan el uso de condones	1	2	3	4	5
23. Las opiniones expresadas en las campañas de salud son importantes para mí	1	2	3	4	5
24. La iglesia católica prohibe el uso de condones	1	2	3	4	5
25. La opinión de la iglesia católica es importante para mí	1	2	3	4	5
26. Usar o no condones depende totalmente de mí	1	2	3	4	5
27. Tengo mucho control personal sobre el uso de condones	1	2	3	4	5
28. Usar condones esta más allá de mi control personal	1	2	3	4	5
29. Usar condones me protege del contagio con HIV	1	2	3	4	5
30. Usar condones me protege contra otras ETS	1	2	3	4	5
31. Usar condones me protege de embarazos no deseados	1	2	3	4	5
32. Es difícil para mi hablar acerca de condones	1	2	3	4	5
33. Sería difícil para mi interrumpir el sexo para colocarse un condón	1	2	3	4	5
34. Pienso que usar condones es difícil	1	2	3	4	5
35. Pienso quelos condones son costosos	1	2	3	4	5
36. Soy capaz de hablar con mi pareja acerca del sexo seguro	1	2	3	4	5

	Completa-mente en desacuerdo	En desacuerdo	Neutral	De acuerdo	Completa-mente de acuerdo
37. Tengo miedo de darle una mala impresión a mi pareja al sugerir el uso de condones	1	2	3	4	5
38. Mi pareja se enfadaría si yo propusiese usar condón	1	2	3	4	5
39. En el futuro, siempre usaré condones	1	2	3	4	5
40. En el futuro, no tendré relaciones sexuales si no hay la posibilidad de usar condones	1	2	3	4	5
41. En el futuro, exigiré usar condones, aunque mi pareja no lo quiera	1	2	3	4	5
42. Si no uso condones, corro un alto riesgo de contagiarme con el VIH/SIDA	1	2	3	4	5
43. Si no uso condones, corro un alto riesgo de contagiarme con otras ETS (Enfermedades de Transmision Sexual)	1	2	3	4	5
44. Si no uso condones, la posibilidat de infectarme con el VIH/SIDA es alta	1	2	3	4	5
45. Si me infecto con el VIH o si me da SIDA, seria aislado socialmente	1	2	3	4	5
46. Si me infecto con el VIH o si me da SIDA, entraria en un estado depresivo	1	2	3	4	5
47. Si me infecto con el VIH o si me da SIDA, no seria capaz de cumplir con mis obligaciones	1	2	3	4	5
48. Cuando yo pienso en la gente con VIH/SIDA algunas veces me siento con ira.	1	2	3	4	5
49. Cuando yo pienso en la gente con VIH/SIDA algunas veces me siento con miedo	1	2	3	4	5
50. Cuando yo pienso en la gente con VIH/SIDA algunas veces me siento con lástima.	1	2	3	4	5
51. La contracción de SIDA por transfusión de sangre es su propio error	1	2	3	4	5
52. La mayoría de la gente con VIH/SIDA no se preocupa si ellos infectan otras personas	1	2	3	4	5
53. La gente infectada de SIDA por sexo o drogas tiene lo que merece	1	2	3	4	5
54. La mayoría de la gente con SIDA es responsable de su enfermedad	1	2	3	4	5

	Completa-mente en desacuerdo	**En desacuerdo**	**Neutral**	**De acuerdo**	**Completa-mente de acuerdo**
55. Yo no quiero que alguien con VIH/SIDA esté en mi camino	1	2	3	4	5
56. Yo no quiero ser amigo de alguien infectado de VIH/SIDA	1	2	3	4	5
57. La gente infectada de VIH/SIDA debiera ser aceptado en ningún trabajo	1	2	3	4	5
58. Es seguro para la gente infectada de VIH/SIDA trabajar con niños	1	2	3	4	5
59. La mayoría de la gente infectada de VIH/SIDA es deshonesta	1	2	3	4	5
60. La mayoría de la gente infectada de VIH/SIDA es maldita	1	2	3	4	5
61. La mayoría de la gente infectada de VIH/SIDA no es confiable	1	2	3	4	5
62. La mayoría de la gente infectada de VIH/SIDA debiera estar avergonzada	1	2	3	4	5
63. La gente infectada de VIH/SIDA no tiene que sentirse culpable	1	2	3	4	5
64. La mayoría de la gente que llega a ser infectada es débil y tonta	1	2	3	4	5
65. Un hombre no debe mostrar sus emociones	1	2	3	4	5
66. Es mejor para un hombre ser inteligente que ser fuerte	1	2	3	4	5
67. Una mujer debería votar de acuerdo a lo que quiera su marido	1	2	3	4	5
68. Mujeres deberían estar interesadas en la política	1	2	3	4	5
69. El marido debería tomar todas las decisiones importantes	1	2	3	4	5
70. Es mejor para un hombre dar ordenes que recibirlas	1	2	3	4	5
71. Un hombre necesita tener hijos para ser hombre de verdad	1	2	3	4	5
72. Es mejor para un hombre pedir ayuda para tareas difíciles	1	2	3	4	5
73. Es importante para un hombre ser respetado por las demás personas	1	2	3	4	5

	Completa-mente en desacuerdo	**En desacuerdo**	**Neutral**	**De acuerdo**	**Completa-mente de acuerdo**
74. La principal responsabilidad de un hombre es su familia	1	2	3	4	5
75. Es importante para un hombre conservar sus creencias	1	2	3	4	5
76. Un hombre debería compartir los quehaceres de la casa con su mujer	1	2	3	4	5
77. Decisiones de la casa deberían hacerse en conjunto	1	2	3	4	5
78. ¿ Piensas que es peligroso para una mujer saber tanto o más que un hombre acerca del sexo?	1	2	3	4	5
79. ¿ Piensas que un mujer debe pagar las consecuencias al coquetear con un hombre?	1	2	3	4	5
80. ¿Piensas que un hombre muestra menos respeto por una mujer si le habla acerca del sexo?	1	2	3	4	5
81. ¿Piensas que tener experiencias sexuales antes del matrimonio es más importante para un hombre que para una mujer?	1	2	3	4	5
82. ¿Piensas que es importante que una mujer sea virgen antes el matrimonio?	1	2	3	4	5
83. ¿Piensas que es dañino para un hombre ser excitado sexualmente y no eyacular?	1	2	3	4	5

marcar con un círculo la respuesta correcta	**SI**	**NO**
84. El HIV puede trasmitirse al toser y estornudar	1	2
85. El HIV se puede trasmitir al compartir cigarrillos	1	2
86. El HIV se puede trasmitir al abrazar a una persona que esté infectada	1	2
87. El HIV puede ser transmitido a través del aire	1	2
88. El HIV puede ser transmitido a través de una piscina	1	2
89. El HIV puede ser transmitido a través de los asientos del inodoro	1	2
90. Mosquitos pueden transmitir el HIV	1	2
91. El SIDA es causado por el HIV	1	2
92. A alguien que ha sido infectado con el HIV, le dará SIDA dentro de tres meses	1	2
93. Alguien que parezca tener buena salud puede estar infectado con el HIV	1	2
94. Una mujer embarazada puede infectar a su criatura	1	2
95. Las mujeres pueden infectar a los hombres, pero los hombres no pueden infectar a las mujeres	1	2
96. El SIDA es expandido por besos	1	2
97. Una persona puede ser infectada si comparte una cocina con alguien que esté infectado	1	2
98. Una persona tiene que tener diferentes compañeros para ser infectada	1	2
99. Una persona puede desembarazarse de VIH/SIDA si se acuesta con una virgen	1	2
100. Hay una cura pare el VIH/SIDA	1	2
101. Una persona puede ser infectada de VIH/SIDA si toma del mismo vaso de otra persona infectada	1	2

¿Cuántos años tienes? …… años

Cual es su sexo □ masculine □ femenino

¿Tienes pareja fija? □ si □ no

¿Que porcentaje de veces considera usted que usa el condón?…….. porcentaje

La ultima vez que tuviste relaciones sexuales, usaste un condón?
□ si □ no □ no aplicable / nunca he tenido sexo

¿Cuántas veces has usado condones en los últimos 12 meses?
□ siempre □ casi siempre □ a veces □ nunca □ no aplicable / nunca he tenido sexo

Annex 2: Questionnaire English

	Completly disagree	Disagree	Neutral	Agree	Completly
1. Having a sexual relation with condoms is less romantic	1	2	3	4	5
2. Having sexual relations with condoms is less pleasurable	1	2	3	4	5
3. Using condoms is an annoying interruption	1	2	3	4	5
4. Using condoms reduces the sexual pleassure of my partner	1	2	3	4	5
5. Using condoms reduces my sexual pleasure	1	2	3	4	5
6. It's difficult to plan the use of condoms	1	2	3	4	5
7. Using condoms evokes resistance from my partner	1	2	3	4	5
8. Using condoms makes sex difficult	1	2	3	4	5
9. Using condoms makes sex embarrasing	1	2	3	4	5
10. Using condoms makes my partner think that I have AIDS	1	2	3	4	5
11. Using condoms may make my partner think that I sleep with several people	1	2	3	4	5
12. Propose using condoms make my partner think that I dont trust him/her	1	2	3	4	5
13. Using condoms makes me feel like less of a man/woman	1	2	3	4	5
14. My current partner thinks that we should use condoms	1	2	3	4	5
15. The opinion of my partner matters to me	1	2	3	4	5

	Completly disagree	Disagree	Neutral	Agree	Completely agree
16. My friends think that I should use condoms	1	2	3	4	5
17. The opinion of my friends are important to me	1	2	3	4	5
18. My doctor recommends using condoms	1	2	3	4	5
19. The opinion of my doctor matters to me	1	2	3	4	5
20. My parents think I should use condoms	1	2	3	4	5
21. The opinion of my parents matters to me	1	2	3	4	5
22. Health campaigns recommend using condoms	1	2	3	4	5
23. The opinions expressed health campaigns are important to me	1	2	3	4	5
24. The catholic church prohibites condom use	1	2	3	4	5
25. The opinion of the catholic church is important to me	1	2	3	4	5
26. The use or not use of condoms is totally up to me	1	2	3	4	5
27. I have a lot of personal control about the use of condoms	1	2	3	4	5
28. The use of condoms is outside of my personal control	1	2	3	4	5
29. Using condoms protects me against getting infected with HIV.	1	2	3	4	5
30. Using condoms protects me against other STD's	1	2	3	4	5
31. Using condoms protects me against unwanted pregnancy	1	2	3	4	5
32. It's difficult for me to talk about condoms	1	2	3	4	5
33. It would be difficult for me to stop sex to put on a condom	1	2	3	4	5
34. I think using condoms is difficult	1	2	3	4	5
35. I think condoms are expensive	1	2	3	4	5
36. I'm capable of talking with my partner about safe sex	1	2	3	4	5

	Completely disagree	Disagree	Neutral	Agree	Completely agree
37. I'm afraid of giving a bad impression to my partner when I suggest the use of condoms	1	2	3	4	5
38. My partner will get angry when I propose to use condoms	1	2	3	4	5
39. In the future, I will always use condoms	1	2	3	4	5
40. In the future, I will not have sexual relations, when there is not the possibility of using condoms	1	2	3	4	5
41. In the future I will demand using condoms, even if my partner doesn't want to	1	2	3	4	5
42. If I don't use condoms I run a high risk of getting infected with HIV	1	2	3	4	5
43. If I don't use condoms I run a high risk of getting infected with other STD's	1	2	3	4	5
44. If I don't use condoms the possibility of getting infected with HIV is high	1	2	3	4	5
45. If I get infected with HIV/AIDS, I'm going to be socially isolated	1	2	3	4	5
46.If I get infected with HIV/AIDS, I'm going to be depressed	1	2	3	4	5
47. If I get infected with HIV/AIDS, I won't be able to fullfill my obligations	1	2	3	4	5
48. When I think about people with HIV/AIDS I feel angry	1	2	3	4	5
49. When I think about people with HIV/AIDS I feel fear	1	2	3	4	5
50. When I think about people with HIV/AIDS I feel pity	1	2	3	4	5
51. Getting HIV/AIDS by a blood transfusion is your own fault	1	2	3	4	5
52. The majority of the people with HIV/AIDS don't care if they infect other people	1	2	3	4	5
53. The people that are infected with HIV/AIDS because of drug use, have gotten what they deserved	1	2	3	4	5
54. They majority of the people with HIV/AIDS are responsible for their sickness	1	2	3	4	5

	Completey disagree	Disagree	Neutral	Agree	Completely agree
55. I don't want anybody with HIV/AIDS living in my neighbourhood	1	2	3	4	5
56. I don't want to be friends with anybody that has HIV/AIDS	1	2	3	4	5
57. People infected with HIV/AIDS shouldn't be accepted in any job	1	2	3	4	5
58. It's safe for people with HIV/AIDS to work with children	1	2	3	4	5
59. The majority of people with HIV/AIDS are dishonest	1	2	3	4	5
60. The majority of the people with HIV/AIDS are cursed	1	2	3	4	5
61. The majority of the people with Hiv/AIDS aren't trustworthy	1	2	3	4	5
62. The majority of the people with HIV/AIDS should be ashamed of themselves	1	2	3	4	5
63. The people infected with HIV/AIDS shouldn't feel guilty	1	2	3	4	5
64. The majority of the people infected with HIV/AIDS or foolish and stupid	1	2	3	4	5
65. A man shouldn't show his emotions	1	2	3	4	5
66. It's better for a man to be intelligent than to be strong	1	2	3	4	5
67. A wife should vote as her husbands wants her too	1	2	3	4	5
68. Women should be interested in politics	1	2	3	4	5
69. The husband should take the important decisions	1	2	3	4	5
70. It's better for a man to give orders, then to take them	1	2	3	4	5
71. A man needs to have children to be a real man.	1	2	3	4	5
72. It's better for a man to ask for help with difficult tasks	1	2	3	4	5
73. It's important for a man to be respected by a lot of people	1	2	3	4	5

	Completely disagree	Disagree	Neutral	Agree	Completely agree
74. The first responsibility of a man is his family	1	2	3	4	5
75. It's important for a man to stick with his beliefs	1	2	3	4	5
76. A man should help with the household	1	2	3	4	5
77. Decions about the house should be made together	1	2	3	4	5
78. Do you think it's dangerous for a woman to know enough or more than a man about sex?	1	2	3	4	5
79. Do you think a woman should pay the consequenses for flirting with a man?	1	2	3	4	5
80. Do you think a man shows less respect to a woman when he starts talking to her about sex?	1	2	3	4	5
81. Do you think it's more important for a man to have sexual experience before marriage then for a woman?	1	2	3	4	5
82. Do you think it's important for a woman to be a virgin when she marries?	1	2	3	4	5
83. Do you think it's dangerous for a man to get excited and not ejaculate	1	2	3	4	5

marcar con un círculo la respuesta correcta	**Yes**	**NO**
84. HIV is transmitted by sneezing and coughing	1	2
85. HIV can be transmitted by sharing cigarets	1	2
86. You can get HIV by hugging a person that is infected	1	2
87. HIV can be transmitted by air	1	2
88. HIV can be transmitted by a pool	1	2
89. You can get HIV from a toilet seat	1	2
90. Mosquitos can transmit HIV	1	2
91. AIDS is caused by HIV	1	2
92. When somebody gets infected with HIV, he gets AIDS within 3 months	1	2
93. Somebody who looks healthy can be infected with HIV/AIDS	1	2
94. A pregnant woman can infect her baby	1	2
95. Women can infect men with HIV/AIDS, but men can't infect women	1	2
96. AIDS is transmitted by kissing	1	2
97. A person can get infected with HIV/AIDS when he shares a kitchen with someone who has HIV/AIDS	1	2
98. Somebody has to have different sexual partners to be infected with HIV/AIDS	1	2
99. You can get rid of HIV/AIDS by sleeping with a virgin	1	2
100. There is a cure for AIDS	1	2
101. Somebody can get HIV/AIDS by drink from the same glass as somebody who has HIV/AIDS	1	2

How old are you …… years

What's your sex? □ male □ female

Do you have a partner? □ yes □ no

What's the percentage you had sex that you used a condom…….. percentage

Did you use a condom the last time you had sex?
□ yes □ no □ not aplicable / never had sex

How many times did you use a condom in the last 12 months?
□ Always □ Almost always □ Sometimes □ Never □ not aplicable / never had sexo

Annex 3: Country background

Geography

The Dominican Republic is located in the Caribbean. It covers two-thirds of the island of Hispaniola, between the Caribbean Sea and the North Atlantic Ocean. Hispaniola is the second largest island in the Caribbean (the largest is Cuba). The other country on the island of Hispaniola is Haiti. Haiti covers the western part of the island; the Dominican Republic covers the eastern part. The Dominican Republic covers 48,730 square kilometres (48,380 sq km land and 350 sq km water). The only border is the border with Haiti (275 kilometre).

There are rugged highlands and mountains with fertile valleys interspersed. The mountains and valleys of the Dominican Republic divide the country into the northern, the central, and the south-western regions.

The northern region, bordering the Atlantic Ocean, consists of the Atlantic coastal plain, the Cordillera Septentrional (or Northern Mountain Range), the Valle del Cibao (Cibao Valley), and the Samaná Peninsula. The central region is dominated by the Cordillera Central (Central Range); it runs eastward from the Haitian border and turns southward at the Valle de Constanza (or Constanza Valley) to end in the Caribbean Sea. The south-western region lies south of the Valle de San Juan. It encompasses the Sierra de Neiba, which extends 100 kilometres from the Haitian border to the Yaque del Sur River.

The lowest point in the Dominican Republic is Lago Enriquillo (-46 meters) and the highest point is Pico Duarte (3,175 meters). There are many rivers in the Dominican Republic. The most significant rivers include the Jimani River, Rio Yaque del Norte, Rio Jamao del Norte, Rio Isabela and the Ozames River. The Dominicans themselves say that there are 43,330 (small) beaches. There are a lot of small islands along the coast.

The country has some national resources, like nickel, bauxite, gold and silver. There is one big natural hazard, the island of Hispaniola lies in the middle of the hurricane belt and is subjected to severe storms from June to October.

The climate in the Dominican Republic is tropical maritime, there is little seasonal variation in temperature but there is great seasonal variation in the rainfall.

Santo Domingo is the capital city. This city is situated on the southern portion of the island. Santo Domingo is located directly on the coast, and therefore it is a major centre of seaport activity. The second largest city is Santiago. Santiago is closer to the mountainous areas to the north.

History

The earliest known inhabitants of the Dominican Republic reached the island around the year 2600BC. They came from South America. They were primarily nomadic hunter-gatherers who used stone tools and left little behind. A second group, often referred to as the Salanoids or ancient Arawaks, landed on Hispaniola around 250BC. The group spread throughout the Caribbean.

In the year 700, the Taino's (which means friendly people) occupied the Dominican Republic. They specialized in fishing, worship, art and farming. An estimated 400,000 of them lived on the island of Hispaniola when Christopher Columbus arrived in December 1492. People on other islands had told Columbus that there was gold to be found there. Columbus called the island Hispaniola, which means little Spain.

Columbus went to the Dominican Republic a second time in 1493, and he established the first Spanish colony on the north shore. His brother Bartolome stayed there to govern. He later

moved to what is now Santo Domingo. The headquarters of the Spanish Empire were set up in Santo Domingo and the city flourished. The Taino's were set to work. Because of the cruel working conditions and the European diseases the number of Taino people declined very fast. Much of the original culture was lost. Spain's influence began to decline in the late 1600's and the western part of Hispaniola, Haiti, was taken over by France.
The Spanish, French, British and Haitians continued to battle for control of eastern Hispaniola. This lasted until 1844, when Juan Pablo Duarte helped establish the Dominican Republic as an independent nation. The poorly armed Dominican population fought the Spanish troops very well. On march 3, 1865, the queen of Spain annulled all claims to the island. Part of the reason was also that the gold ran out.
The war against the colonials left the country badly damaged. The urban infrastructure and the agrarian economy were bad. The United States saw the damage in the Dominican Republic as an opportunity for expansion. In 1916, the US troops moved in. However, when it became clear that the German's weren't going to attack the Panama Canal (as was assumed) the Dominican Republic became strategically less important. In 1924, the US left the island. This is when president Horacio Vasquez stepped up. He built roads and schools, he initiated irrigations projects and the economy was doing better.
In 1930, the dictator Rafael Trujillo took over. He forced Vasquez to resign. Trujillo was a dictator and repression, murder and torture were very common. However, he kept building and the economy was doing very well. Trujillo was assassinated in 1960 and Joaquin Balaguer took over as president. He served seven terms, until the mid 1990's. His opponents often said that his electoral victories were a result of fraud.

Politics

The Dominican government is a representative democracy. In 1994, the Dominican Republic has taken on a new constitution. The government is divided into three branches: executive, legislative and judicial. The executive branch is represented by the president and his cabinet. The legislative branch is represented by a two house system of senators and deputies. The judicial branch is represented by a national judicial council. The president is democratically elected and holds one term for four years and he can be re-elected. The president appoints a cabinet of ministers to handle certain affairs. The president is the official head of state and is commander in chief of the armed forces. The democratically elected legislative branch consists of the congress, which is split between the Senate and Chamber of Deputies. There are 30 seats in the Senate, and senators are elected for four years. The country has 30 provinces and each province has one senator. The members of the Chamber of Deputies are also elected to a four year term. Each member represents 50,000 people. As the population changes, the number of deputies changes to reflect the new population levels. The judicial branch consists of a national judicial council. It has the responsibility to appoint judges independently from the political process. The system of law is Civil Law. This means that judges hear and decide cases, and not juries.
The Dominican government has proven to be quite stable. From 1982 until 2004, the country has had 5 presidents. These presidents and their cabinets have all completed (at least) the four year term. There have not been any major problems of conflicts that could indicate instability. However, according to the US Department of State, there are some threats to the democratic stability.
The problems mentioned are narcotics trafficking, extradition, money laundering, corruption, illegal migration and alien smuggling.
Especially the corruption causes many problems. In 2003 and 2004 there was an increase in the perceived corruption in the Dominican Republic. CPI scores relate to perceptions of the

degree of corruption as seen by business people and country analysts. It ranges between 0 (highly corrupt) and 10 (highly clean). The CPI score for the Dominican Republic is 2.9 (2004). The confidence range (which provides a range of possible values of the CPI) is 2.4-3.3. There were 6 surveys used that assessed the country's performance. The CPI score for the Dominican Republic is very low compared to The Netherlands (CPI=8.7). The CPI score is also lower than in other Caribbean islands, e.g. Cuba (CPI=3.7) and Jamaica (CPI=3.3). This means that the Dominican Republic is probably more corrupt than other surrounding islands and the country is very corrupt in comparison to countries in Western Europe.
The bureaucracy is another political problem. Its large ministries, autonomous agencies, and public corporations make the Dominican government by far the largest employer in the country. The ineffectual civil service used to leave employees subject to turnovers whenever there was a change of government. The government used to be known for giving out government positions in return for personal and political loyalty and service. Government workers formed unions in an effort to protect themselves. However, the civil service laws were very old, so the unions were not very effective and they still aren't. There is still a lot of patronage and corruption, so the public service is neither effective nor responsive. Over the last years, there have been made various efforts to change this. However, politicians often hesitate to change the system because the corruption and patronage is what helped them get their power. For the same reason, they often resist the privatisation of the many inefficient state-owned enterprises. There have been a few bureaucracy related improvements, but it remains a serious problem.
An indicator for the human rights is the status of major international human rights instruments. The Dominican Republic has ratified these conventions, except for one; this is the convention against torture and other cruel, inhuman or degrading treatment or punishment (1994). There are some serious problems in the Dominican Republic concerning the human rights. The police committed extra judicial killings. The police, and also the military, have tortured, beat and otherwise abused prisoners and detainees. The authorities rarely prosecute these abusers. The police sometimes use excessive forces to end demonstrations. The conditions in the prisons are very bad. The police arbitrarily arrested and detained suspects and their relatives. The pre-trial detention is often very long and sometimes there are long delays in trials. The authority often doesn't respect privacy rights and the police sometimes enter private homes without judicial orders. Members of the President's security force mistreated journalists, and journalists at times practiced self-censorship. The Government expelled Haitian and Dominican-Haitian migrants with force. Other serious problems concerning human rights are: violence and discrimination against women, prostitution (including child prostitution), abuse of children, discrimination against persons with disabilities, discrimination against and abuse of Haitian migrants and their descendants and child labour. There are reports of forced labour. Workers on the sugar plantations and mills often work in unsafe conditions. Given the many problems, there is a lot of work to be done in the area of human rights.

The employment rights in the Dominican Republic are quite good, compared to other developing countries. The status of the employment rights can be measured by the status of fundamental labour rights conventions. The following conventions are ratified:

-Freedom of association and collective bargaining (conventions 87 and 98),
-Elimination of forced and compulsory labour (conventions 29 and 105),
-Elimination of discrimination in respect of employment and occupation (conventions

100 and 111)
-Abolition of child labour (conventions 138 and 182)

All of the fundamental conventions are ratified; this indicates that the employment rights are quite good in the Dominican Republic. However, there are some problems.
Child labour has been reported in the Dominican Republic and the working conditions are sometimes unsafe.
The diplomatic activities of the Dominican Republic are concentrated on the Caribbean, Latin America, the United States and Western Europe. The relations with the neighbouring country Haiti have never been extensive. This is the result of many cultural divergences and the bad history between the countries. However, the relations have been improving since the accession of the two countries to the Lome Agreements. There has been a long-standing issue of illegal immigration of Haitians in the Dominican Republic (an estimated 650,000 immigrants). In order to settle this issue, the two countries have now established a bilateral commission. The countries are now trying to develop more interaction so that they can work together and solve problems. The Dominican Republic and Cuba recently established consular relations, and there is contact in fields such as commerce, culture and sports. The Dominican Republic also developed relations with other Caribbean countries; they joined the CARIFORUM and the Association of Caribbean States (ACS). They also signed free trade agreements with Central America (in 1999) and with the CARICOM (in 2000). The Dominican Republic, nonetheless, still remains one of the most protectionist trade regime in the area. The most important international relationship is probably the one with the United States; the Dominican Republic depends on the US, mostly economical, but also political and strategically. The US has a strong interest in a democratic, stable and economically healthy Dominican Republic, this is because of the proximity to the US and other Caribbean countries, and because the Dominican Republic's economy is the largest Caribbean economy. The economic links with the US have been strengthened through the Caribbean Basin Initiative (CBI). The relations between the Dominican Republic and the European Union are good and still developing. The commercial relations with EU members have been progressing. The EU is now the second largest commercial partner after the United States. France, Germany, Italy, the Netherlands, Spain and the United Kingdom have permanent diplomatic representations in Santo Domingo. The Dominican Republic is a very active party in the EU-ACP relations. The trade between the EU and the Dominican Republic is expanding.

Economics

The Dominican Republic is a developing country. This becomes very clear after looking at some economical numbers. The following table gives an impression of the FDI inflows and outflows.

Table 1: FDI inflows and outflows (million US$)

CYear	Inflows	Outflows
1995	414,3	15
1996	96,5	14
1997	420,6	1
1998	669,8	1

1999	1337,8	6
2000	953	3

(Source: World Bank website, 2001)

The inflows are much higher than the outflows; this is not uncommon for developing countries. The outflows have been decreasing since 1995, except for 1999 en 2000. The inflows are not very stable.
The unemployment rates in the Dominican Republic are very high. The table below consists of the unemployment rates (percentages) between 1991 and 1997.

Table 2: unemployment rates

Year	Total Population	Male	Female
1991	19,6	12,5	33,0
1992	20,3	11,7	34,5
1993	19,9	11,4	34,8
1994	16,0	10,0	26,9
1995	15,8	10,2	26,2
1996	16,7	10,8	27,7
1997	15,9	9,5	28,7

(Source: www.earthtrends.com)

Today, according to several sources, the unemployment rate is about 16%. The unemployment rates for females are a lot higher than for males, this is very common in Caribbean countries. Until 1997, the employment rates seem to be dropping steadily, but over the last few years, the rate has not been improving.
The following table consist of some numbers about the GDP trends.

Table 4: GDP trends

GDP (US$ billions), 2001	21,1
GDP (PPP US$ billions), 2001	59,7
GDP per capita (US$), 2001	2494
GDP per capita (PPP US$), 2001	7020
GDP per capita annual growth rate (%), 1975-2001	1,8
GDP per capita annual growth rate (%), 1990-2001	4,2
GDP per capita, highest value (PPP US$), 1975-2001	7020
GDP per capita, year of highest value	2001

(Source: Human Development Report 2003)

The GDP trends are developing in a positive direction.
The next table gives an impression of the structure of trades.

Table 5: import and export

Imports of goods and services (as % of GDP), 1990	44
Imports of goods and services (as % of GDP), 2001	32
Export of goods and services (as % of GDP), 1990	34
Export of goods and services (as % of GDP), 2001	24

(Source: Human Development Report 2003)

Both the import and the export have been dropping since 1990.
The table below gives an impression of the inequality in income.

Table 6: Inequality in income

Share of income or consumption (%)-Poorest 10%	2,1
Share of income or consumption (%)-Poorest 20%	5,1
Share of income or consumption (%)-Richest 20%	53,3
Share of income or consumption (%)-Richest 10%	37,9
Inequality measures- Ratio of richest 10% to poorest 10%	17,7
Inequality measures- Ratio of richest 20% to poorest 20%	10,5

(Source: Human Development Report 2003)

The table shows much inequality in income. The richest 20 percent get over 50% of the income.

All of these numbers show that the economy is far from optimal and that it needs a lot of improvement.

Socio-cultural

The total population in the Dominican Republic is 8,5 million. It is estimated that this number will increase to 10,1 million in 2015. The annual growth rate is 2,0 % (1975-2001). This number is expected to decrease to 1,3 %. The urban population is 66,0%. 33% of all inhabitants is under the age of 15, 4,5% is over 65. It is expected that, over the next 10 years, the number of people over 65 will increase and the number of people younger than 15 will decrease. The total fertility rate per woman is 2,7.
According to the WHO, the life expectancy at birth for both sexes is 68 years. For males, this is 64,9 and for females this number is 71,5. The life expectancy index is 0,70. This is lower than the overall index for Latin America and the Caribbean, which is 0,75. In the Netherlands, the index is 0,89
The education index is based on the adult literacy rate and the combined primary, secondary and tertiary gross enrolment ratio. The education index for the Dominican Republic is 0,81.This is low compared to the Netherlands (index=0,99). The index is also low compared to the index for Latin America and the Caribbean (index=0,86).
The GDP per capita in the Dominican Republic is 7,020. This is slightly lower than the GDP per capita for Latin America and the Caribbean (7,050).
The GDP per capita rank minus the HDI rank is –26.
An indicator for longevity is the chance of not surviving to age 60. The probability at birth of not surviving to age 60 is 27.1%. This is very low compared to the Netherlands (8,7%). The

probability at birth of not surviving to age 40 is 14,6%. In the Netherlands this number is a lot lower, 2,1%.
The only known number about knowledge is the illiteracy rate. The adult illiteracy rate is 16,0%. This means that 16% of all people aged 15 years and older is illiterate. This number is higher than in other Caribbean countries like Cuba (3,2%) and Jamaica (12,7%). However, the number is much lower than in Haiti (49,2%).
In the Dominican Republic, 67% of the people have access to improved sanitation. 86% of the total population has sustainable access to an improved water source. 20% live below the national poverty line. 50-79% has sustainable access to affordable essential drugs.
Next to these numbers, there are many other socio-cultural aspects, for instance the aesthetics, such as music. Music is an important part of the Dominican culture. The most popular form of music and dance in the Dominican Republic is called *Merengue*. The sound combines a mixture of African and European elements. This is the music you'll see the Dominican people dancing to in bars, and listening, as well as singing to, in their cars, businesses and homes. The other national music, especially popular in the countryside or more rural regions of the Dominican Republic, is *Bachata*. The lyrics in this music are mostly about life in the country and relationships between men and women. Baseball is another part of the culture. The USA brought the game of baseball to Cuba in the mid-1860's and Cuban immigrants spread the game throughout the Caribbean, which included the Dominican Republic. Dominicans embraced the sport very quickly and began organizing teams and tournaments. By the 1920's Dominican teams were competing against other Caribbean countries and teams in North America.
The attitudes and beliefs in the Dominican Republic are different from the ones in the Netherlands. For instance, the attitude towards time and promptness is very different. In the US and Western Europe, time is very important and the people are usually very prompt and punctual. In the Dominican Republic, it seems that time is less important. People are more relaxed and don't always show up on time. There is a *mañana* attitude. "*Mañana"* means "tomorrow", but in the Dominican Republic it means "sometime in the next few days". This attitude towards time is very common in most Caribbean countries, but also in South America, Spain and other countries.
The majority of the people of the Dominican Republic are Christian, with over 90% of those claiming Roman Catholicism as their religion. Dominican Catholicism is a mix of Roman Catholic traditions and African-rooted religions/ceremonies, or Santeria, and is widespread in the Dominican Republic. There are some small Protestant, Seventh Day Adventist, Baptist, Mormon and Jewish communities throughout the Dominican Republic as well.
The official language in the Dominican Republic is Spanish. Most people involved in tourism understand and speak at least some English, if not other major tourism-related languages, such as German and French. The Spanish that is spoken in the Dominican Republic is somewhat different from the Spanish spoken in Spain. For instance, there are some African words in the Dominican Republic, and the accents are also different. A French dialect is heard along the Haitian frontier.
The societal organization in the Dominican Republic is mostly based on family. This also includes extended family. Members of a family spend a lot of time together and everyone feels responsibility for their family. The relationship between religions are good.

Conclusions

There is a complete other culture in the Dominican Republic than in The Netherlands. By doing our research in the Dominican Republic we are hopefully going to understand certain aspects of this culture a little bit better. But before we begin it is also important to have some knowledge of the setting in which we are going to conduct our research. Therefore we will

now point out all the things that are important for us. We have to pay a lot of attention to these points in order to understand the culture and adapt well to the culture.
The first point is the language. Language is a very important part of any culture, by which big things and small things are said. In the Dominican Republic, Spanish is the main language. But just speaking and understanding Spanish isn't enough, because language can sometimes be a very tricky thing.
Someone can say something, but in a particular culture it can be something completely different then its actual meaning. Like 'mañana': when someone says he's going to do it 'mañana' he doesn't mean he's going to do it tomorrow, but he means he's going to do it tomorrow or the day after or the day after that (in the next couple of days). In addition, there are many typical Dominican sayings and words that don't exist in other Spanish-speaking countries. Among them there are many African words.
To master, or try to master this aspect of the culture we both did a short Spanish course in The Netherlands. Additionally, we are going to follow an intensive Spanish course (for four weeks) in the Dominican Republic. During this course, we hope to learn a bit more about the Dominican Spanish language. Unfortunately, we probably don not have enough time to learn to speak and understand the language perfectly. We will therefore also try to improve our Dominican Spanish by having a lot of contact with the locals. When we improve our Spanish, it will probably become a lot easier to have conversations with the locals and to get to know the Dominican culture better.
That brings us to the second and third point: the way that people interact with each other and the interaction between men and women. Of course we are going to experience this for ourselves when we have contact with the local men and women, but are we going to experience a difference in the way that a Dutch man approaches us and how a Dominican man approaches us? If we believe the stories, Dominican men are much more aggressive and the only thing that can hold them off is a wedding ring. We plan to be a bit careful, and of course very polite and friendly, when interacting with local people. It is probably best to spent some time just watching how local people interact with each other, on the streets, in the supermarket, on the beach etc.
Another important aspect of the culture is its history. We want to get to know the Dominican history by visiting museums, but also by visiting Santo Domingo for a couple of days, which was the first European city on the western hemisphere. There are a lot of colonial buildings in Santo Domingo and the city also contains a lot of history.
Music and dance plays a very important role in the daily lives of the Dominican people. We want to know more about this, for instance what the differences are compared to music in the Netherlands. To get to know the most popular music in the Dominican Republic, merengue, we are going to take a couple of merengue dancing lessons.
Another point of attention is the education of children. What do the parents teach their children? What values are important in a family? We also want to know more about the formal education. At what age do they start going to school? What are the rules in school? Is it formal? Do they wear uniforms? May a teacher hit a child? To answer some of these questions we can visit a school and look at the rules that are enforced in school. We can also talk to teachers and ask if they want to tell us more about the school.
What is happening in the house between the parents and their children is a little bit harder to observe, but we can look at how people respond and relate to children in public.
For our research, it is important to know more about the sexual education in the Dominican Republic. Do they receive sexual education from their family? Friends? Teachers? And at what age does the education start? Is it factual or are many things 'made up' or omitted?
We can find this out by looking at some books about sexual education. We can also go to some organisations that deal with sexual education, maybe they can give us more information

about the problems they are facing and what they are doing to reduce the problems. When we are searching for adolescents to fill out the questionnaires for our research, we can try to have some conversations with them. If they are willing, we can ask them a bit more about their sexual education.
A couple of question concerning our research is the attitude of the Dominicans toward sex. Some important questions are: is there a difference in attitudes between men and women? At what age is it acceptable to have sex? What do people think about teen pregnancies? These kinds of questions may also be answered by visiting organisations that deal with these kinds of questions. And again, we will try to talk to (young) people about this.
Last, but not least, we want to get to know the country better by travelling to different parts of the Dominican Republic, the beach, the rural areas, the cities etc. This way we can find out if there are a lot of differences between people living in the city and people living in the rural areas.