

**GENDER-BASED KNOWLEGDE, ATTITUDES AND PERCEPTIONS OF STUDENTS
TOWARDS THE “ABC” HIV PREVENTION STRATEGY; A CASE STUDY OF UNIVERSITY
OF VENDA, LIMPOPO PROVINCE, SOUTH AFRICA**

BY

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Research dissertation

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Declaration

I, Mkhabisi Jabuli, declare that this research thesis is my original work and has not been submitted for any degree at any other university or institution. The thesis does not contain other persons' writing unless specifically acknowledged and referenced accordingly.

Signed..... Date:

Abstract

Extensive resources and information are available on HIV/AIDS, but there remain disparities between what is known and actual behavior, particularly among students at tertiary institutions. A lot has been done to create HIV awareness and prevent further infections among male and female students in Higher Education Institutions of South Africa. Despite the availability of information, awareness education and campaigns, free condoms and treatment, the HIV infections continue to increase in South Africa especially amongst the youth. The aim of the study was to investigate the knowledge, attitudes, and perceptions of male and female students at the University of Venda towards the “ABC” strategy for HIV prevention, and how these consequently influence their sexual behavior. Data was obtained from 32 students using a semi-structured questionnaire. A non-probability, haphazard sampling technique was used to randomly select the participants. Descriptive statistics and thematic analysis were used for data analysis. The study findings contend that knowledge of HIV and its prevention measures always translates to positive sexual behaviour, as university students were found to be knowledgeable enough, but their attitudes and sexual behaviour were found not to be consistent enough. The researcher recommends future researchers to focus on the factors that hinder sexual abstinence, fidelity in sexual relationships, and condom use amongst Higher Education students, towards creating safer environments for them.

Key words: HIV/AIDS, gender, knowledge, ABC prevention method, attitudes, perceptions, sexual behavior.

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Dedications

I dedicate this full dissertation to my family, the Jabuli family, and all its extended members for everything they have done to shape me to who I am today, may God bless us in this life and the next. This study is also dedicated to all Univen graduated, current, and future students, and whoever else is reading it at any moment in life, I hope you find in it whatever it is you seek.

List of acronyms

HIV- Human Immuno Deficiency Virus

AIDS- Acquired Immuno Deficiency Syndrome

ABC- Abstain, Be-faithful, Condomise

HEIs- Higher Education Institutions

HEISA-Higher Education Institutions South Africa

ART- Anti-Retroviral Treatment

MC- Male Circumcision

Chapter 1: Introduction and Background

1.1 Introduction

HIV/AIDS is one of the biggest challenges facing the world today, directly and indirectly, affecting men and women of different social eminences and race differently. It poses a serious threat to humans because the methods of treatment are generally ill-defined and complete cures are nonexistent (UNAIDS, 2015). There were approximately 36, 9 million people living with HIV globally in 2014 and tens of millions of people have died of AIDS-related causes since the beginning of the epidemic. In 2014 alone, up to 1, 2 million people died of AIDS (UNAIDS, 2015). New HIV infections globally have declined by 35% since 2000 and deaths have seen a 42% decrease since 2004, due in part to Anti-retroviral treatment (ART) scale-up. However, HIV is still a major cause of death worldwide and the number one cause in Africa, and there has been about 2, 0 million new infections globally in 2015 alone (UNAIDS, 2015).

This pandemic is seen as resurgent in South Africa after years of decline, with as many as 80,000 people dying of the disease every year. From a peak of 18% infected in 1992, South Africa's

“ABC” strategy helped slash rates to 6,4% in 2005. However, according to the Human Science Research Council (HSRC) National HIV Prevalence, Incidence and Behaviour Survey that was released in April 2014, the rates had crept up to 10,6% in 2008, and further up to 12,2% in 2012 and remained the same in 2014. Women aged between 30 and 34 and males aged 35-39 had the highest infection rates: 36% of females and 28% of males in these respective age groups contracted HIV.

HIV and AIDS stand as some of the main challenges faced by educational institutions in the world, with the power relations that exist between males and female putting females at a greater risk of infection and effect. This cannot be overlooked or ignored in the context of Higher Education Institutions in South Africa (HEISA). They constitute a growing problem that could be having a crippling effect on the functions and operations of higher education institutions in African nations.

Researchers, policymakers, and programmers have long recognized that gender plays a role in vulnerability to HIV/AIDS and its impacts in every region in the world. Gender refers to socially defined and learned male and female behaviours that shape the opportunities that one is offered in life, the roles one may play and the kinds of relationships that one has. It is distinct from sex,

which is a biologically determined and fixed set of characteristics for men and women. It is also distinct from - though closely linked to - sexuality, which is the “social construction of a biological drive” that is defined by how, why, and with whom one has sex (Rao Gupta, 2000). The inequalities between men and women that are created and reinforced by gender roles typically leave women especially vulnerable to HIV infection and its impacts, but it is also important to recognize that gender roles affect men’s vulnerability as well.

This study was aimed at exploring Univen male and female students’ knowledge, attitudes and perceptions of the Abstain, Be Faithful and Condomise (ABC) strategy for HIV prevention, with a view of understanding male and female students’ responses to the pandemic in Higher Education Institutions (HEIs).

1.2 Background of the study

The United States of America (USA) is the greatest national funder of the HIV epidemic globally, yet it is still facing a major ongoing epidemic itself, with a prevalence rate of 0,4% - 0,9% as of 2012. More than 1.2 million people in the USA are living with HIV and almost 1 in 8 (12,8%) are unaware of their infection (UNAIDS, 2014). By race, blacks/ African Americans face the most severe burden of HIV in the USA.

Many adolescents and young adults engage in sexual intercourse, often times with multiple sex partners and without using condoms. In 2007, 47.8% of high school students in the U.S. reported having had sexual intercourse (Eaton, Kann, & Kinchen, 2007:8), with 7.1% reporting having had sexual intercourse for the first time before age 13. Although most adolescents do not have concurrent sex partners at any given point in time, the number of sex partners cumulates over time. Specifically, among high school seniors in 2007, approximately 22.4% reported having had sex with at least four different sex partners (Eaton, et al., 2007). Moreover, among sexually active adolescents, only 61.5% reported using a condom the last time they had sexual intercourse (Eaton, et al., 2007). In spite of the fact that many adolescents have used condoms at some time during an episode of sexual intercourse, comparatively few report using them every time they have sex (Moore, Driscoll, & Lindberg, 1998). Thus, adolescents engage in sexual behaviors that place them at risk for acquiring STIs, including HIV.

Approximately 25.8 million people were living with HIV in Sub-Saharan Africa in 2014, which is 70% of the global prevalence. In the same year, there were estimated 1.5 million new HIV

infections and 1.1 million AIDS-related deaths. Southern Africa is the worst affected region and is widely regarded as the epicentre of the global HIV epidemic (UNAIDS, 2014). Swaziland has the highest HIV prevalence of any country worldwide (27.4%) while South Africa has the highest number of new HIV infections worldwide (HSRC, 2014). As many as 1.8 million people in the country now live with HIV and a million children have been orphaned after their parents died of AIDS. HIV prevalence in Western and Eastern Africa is low to moderate, ranging from 0.5% in Senegal to 6% in Kenya (UNAIDS, 2014).

HIV remains a considerable challenge facing the South African community today. It does not only affect the health of individuals, it impacts households, communities, and the development and economic growth of the nation. It is estimated that the current HIV prevalence rate in South Africa is at 12.2% (HSRC, 2014). Provincial prevalence rates are as follows; KwaZulu Natal (KZN) 16,9%, Mpumalanga (MP) 14,1%, Free State (FS) 14%, North West (NW) 31,3%, Gauteng Province (GP) 12,4%, Eastern Cape (EC) 11,6%, Limpopo Province (LP) 9,2%, Northern Cape (NC) 7,4%, and Western Cape (WC) 6,0% (HSRC, 2014).

In 2014 alone, a 1,2million people died of AIDS globally (UNAIDS, 2015). In 2010, approximately 280 000 South Africans died of HIV/AIDS. In the decade up to 2010, between 42% and 47% of all deaths among South Africans were HIV/AIDS related (Statistics South Africa (STATSSA), 2010). According to the Human Science Research Council (HSRC), prevalence of HIV among South Africans over the age of 20 has increased (Setswe & Zuma, 2013). The increase in HIV prevalence rates amongst South Africans 20 years and above raises a concern as to the prevalence rate of the pandemic in similar age group within Higher Education Institutions (HEIs). Tertiary education represents a time for sexual exploration and freedom for many young people. Many students become sexually more active as they move to urban settings away from their homes and enter a developmental phase during which experimentation and risk-taking with a variety of sexual practices seem appealing. Unfortunately, this sexual exploration and freedom can result in students contracting HIV (Thompson-Robinson, Richter, Shegog, Weaver, Sellers, & Brown, 2013).

Higher Education Institutions are a replication of a larger society consisting of academic and administrative staff, including students that reside and study within the institution. The history, the nature and the shape of the epidemic reveals itself as an intellectual challenge and therefore, absolutely part of the “core function” of a higher education institution. The core element of HIV/AIDS strategies in higher education institutions in the SADC is to generate,

collect, transmit and expand AIDS-relevant knowledge, wisdom, understanding, and practice as part of institutionalized and mainstreamed response to the epidemic which pervades institutional structures while also operating in synergy with national and regional policies. The unique infrastructure of HEIs allows for greater interaction between students, academics, administrative staff and external stakeholders. “University campuses constitute a potentially fertile environment for the spread of HIV/AIDS. They bring together, in close physical proximity devoid of systematic supervision, a large number of young adults at their peak years of sexual activity and experimentation. Combined with the ready availability of alcohol and perhaps drugs, together with divergent levels of economic resources, these circumstances create a very high risk environment from an HIV/AIDS perspective” (Saint, 2012). However, HIV prevalence is substantially lower in HEI communities than among the general population in South Africa (HEIAIDS, 2010).

These interactions pose both a challenge and an opportunity to the management of HIV/AIDS. The challenges arise in the maintenance of low HIV/AIDS prevalence within the university; this is often influenced by the nature and sexual behaviour of students. The opportunity lies in the possibility for such a workplace to participate in building the capacity of trained personnel who can drive local economies, support civil society, teach children, lead effective governments and make decisions that affect society and address national issues (Higher Education South Africa (HESA), 2013). The potential risks to students at HEIs, according to Phaswana-Mafuya, (2011) are heightened by the liberal atmosphere characterized by HEI campus cultures, which is open to activities and life-styles that may facilitate the spread of HIV/AIDS. The HEIs are not only teaching institutions. Largely, the role of the universities is also in research and the dissemination of findings. Therefore, HEIs have the dual role of protecting the health of the student as well as carrying out research that increases the understanding of the pandemic.

It is crucial for universities to provide intellectual leadership, to challenge assumptions about the epidemic, society, sexuality and identity and to create new understandings of HIV/AIDS and the contexts in which it is developing. In the past, higher education institutions were able to respond effectively and creatively to societal injustices, notably a rich history of opposition to apartheid in the SADC. This active engagement and critique, however, has been largely absent in terms of HIV/AIDS in the tertiary education sector. Nevertheless, the complex social phenomenon of HIV/AIDS offers a new critical lens through which long-standing, seemingly intractable social

issues such as discrimination, class, gender, power, poverty and social change can be understood and challenged.

The “ABC” approach to HIV prevention is defined as follows;

“A” stands for Abstaining from sex, “B” stands for Being faithful (fidelity), and “C” stands for Condom use. The ABC approach employs population-specific interventions that emphasize abstinence for youth and other unmarried persons, including delay of sexual debut; mutual faithfulness (sometimes measured as reduction in number of sexual partners) for sexually active adults; and correct and consistent use of condoms by those whose behaviour places them at risk for transmitting or becoming infected with HIV (Weller, 2011). The ABC-plus approach is an HIV prevention approach that emphasizes ABC behaviours and addresses the effects of gender, poverty, violence, stigma, and discrimination on sexual behaviour. In order for the ABC approach to be successful in reducing HIV prevalence within a population, “plus” elements such as increased gender equality and decreased stigma and discrimination have to be present as well.

The ABC approach has been the subject of much attention and controversy in recent years, as it has become the policy of the largest AIDS relief plan in the history of the pandemic. In January 2003, the United States pledged \$15 billion to global AIDS under the President’s Emergency Plan for AIDS Relief (PEPFAR). The U.S. Agency for International Development (USAID) had recently adopted the ABC approach as the model of HIV prevention for generalized epidemics, using Uganda’s success as a model. In 2003, PEPFAR also adopted the ABC approach. The first

PEPFAR prevention strategy document to be released announced that “risk elimination” would be the “cornerstone” of prevention under PEPFAR. Risk elimination, also called risk avoidance, refers to sexual abstinence and to mutual fidelity between two uninfected sex partners. Risk reduction, on the other hand, refers to strategies such as condom usage that reduce but do not eliminate the risk of sexual transmission (Green & Herling, 2007). PEPFAR, through the ABC approach, would combat AIDS both ways (The Office of the U.S. Global AIDS Coordinator (OGAC), 2005). From a peak of 18% infected with HIV in 1992, South Africa’s “ABC” strategy helped slash rates to 6, 4% by 2005. However, by 2012 up to 2014, the rates had crept back up to 12, 2%. This study will, therefore investigate the University of Venda (Univen) male and female students’ responses to this approach as far sexual behaviour is concerned.

A study on the prevalence of risky sexual behaviours amongst undergraduate students in Jigjiga University in Ethiopia by Mudzusi & Asgedom (2013) revealed that 70.53% of respondents were sexually experienced. Majority (54.8%) of the sexually experienced respondents were sexually active within 3 months of the study. Up to 30.14% of sexually experienced respondents have had sex with a person other than their current partner in the past 12 months. Only 59.6% of the sexually experienced respondents used condom in their most recent sexual engagement. The findings of this study showed that university students are involved in sexual behaviours that may increase their risk of contracting HIV infection.

The same study findings revealed that prevalence of sexual risky behaviours such as premarital sex, early sexual debut, multiple sexual partnerships including commercial sex was high. This suggests that undergraduate students at Jigjiga University were vulnerable to risky sexual behaviours. Prevalence of condom use among those sexually active respondents was low. This suggested that many respondents did not adopt safe sexual practices. A considerable number of respondents engaged in sex with older partners particularly for material and financial benefits. Such sexual practices may increase their risk of contracting STIs, including HIV. The prevalence of substance use during sexual activity was high. This fact exposes respondents to risky sexual behaviours such as unprotected sex as substance abuse affect the thinking capacity regarding use of precautionary measures when engaging into sexual practices. Most of the respondents did not discuss sexual matters with their sexual partners or with their parents. This makes it difficult to negotiate safer sex practices. This was also reflected in their lack of awareness on safe sex practices such as being faithful and condom use. The majority of sexually active respondents seemed to have initiated sex when they entered college. This fact may show that college students are more prone to early sexual initiation due to increased freedom from parental protection and guidance. These findings mean that students at Jigjiga University are engaging in high risky sexual behaviours that may lead some of them to be infected with HIV before they graduate from the university (Mudzusi & Asgedom, 2013). The findings were comparable to most of the studies conducted in Ethiopia and other countries.

As a result of their societal roles, women and girls face a number of unique challenges that affect their ability to protect themselves from HIV/AIDS and its overwhelming effects. This is evidenced by the disproportionate impact of the epidemic on women, especially in Sub-Saharan Africa, where the “feminization” of AIDS is most visible. In this region, for every HIV-positive young man (15-24 years) there are three HIV positive young women (Mudzusi & Asgedom).

Social norms about female sexuality make it very difficult for women and girls around the world to protect themselves from HIV infection. Women and girls are often encouraged to remain uninformed about sexual matters and/or remain sexually passive. Traditional norms of virginity for unmarried girls impede young women's freedom to seek important sexual health information, including knowledge about HIV risk. Women often have limited access to sexual health information and services because of a misguided fear that it will encourage sexual activity. In addition, in order to preserve their virginity, many young women engage in alternative sexual behaviours, such as anal sex, which can increase their risk of acquiring HIV (Rao Gupta, 2000). The expectations for sexual passivity in women, along with the priority given to male sexual pleasure, also makes it difficult for women to be an equal partner in deciding the terms of sexual activity, including negotiating safer sex practices.

Societal expectations of men and boys also have an impact on male vulnerability to HIV/AIDS. Social norms about masculinity often assume that men are knowledgeable and experienced when it comes to sexual issues. This can have the negative effect of preventing men from seeking sexual health information or admitting their lack of knowledge about HIV risk reduction. Such norms cause myths about HIV/AIDS to persist (such as the myth that one can be "cured" by having sex with a virgin). Masculinity norms can also pressure men to have multiple sexual partners, which contradicts HIV/AIDS prevention messages about fidelity, delaying onset of sexual activity in young people, or reducing the number of sexual partners (Rao Gupta, 2000).

The archetypal image of the strong, virile, aggressive male also contributes to widespread homophobia, leaving men who have sex with men to struggle with fear and stigma. This can often compel men who have sex with men to keep their sexual behaviour secret and avoid accessing services or seeking information that can help them adopt behaviours to protect themselves and their sexual partners (whether male or female) from HIV transmission. In regions where homosexuality is criminalized, the vulnerability of men who have sex with men and their sexual partners is even greater (Devries, Mak, García-Moreno & Petzold, 2013).

A lot has been done to create HIV awareness and prevent further infections among students in HEIs in South Africa. Univen has organized and hosted remarkable informative awareness campaigns that the researcher has personally witnessed. Amongst others are the Scrutinize, Lovelife and Zazi campaigns that have been conducted right within the university campus. The university also has a VCT facility where students and staff can get tested and counseled

regularly. Peer educators are also available with their door-to-door campaigns wherein they distribute free condoms and mobilize students to go for HIV screening and counseling.

The Zazi campaign mentioned in the preceding paragraph dealt mainly with female students' situations in HIV and AIDS. The campaign engaged young women and men on issues of gender violence, preventing unplanned pregnancies, HIV and sugar daddies. It also advocates for women to have greater access to key services, to help stop new HIV infections, to minimize unwanted pregnancies and to prevent mother-to-child transmission of HIV. Furthermore, it advocates for healthy lifestyles and early detection and management of chronic diseases (Nendila, 2013).

Study findings by Jabuli (2013) revealed that the levels of knowledge in young people about HIV and sexual matters were very high. It also revealed that young people know about condom use as prevention against unwanted pregnancies and HIV as well as other STIs. This suggested that young South Africans at HEIs are well informed about sexual matters and the ways of preventing pregnancy and STIs. The study also revealed that there is a gap that exists between young people's knowledge about HIV/AIDS and actual safe sexual behavior, as the influence of such aspects as alcohol abuse were pointed out, as well as the general negative attitudes towards condom use (Jabuli, 2013).

Thereby, students continue engaging in risky sexual behaviours. From the current researcher's observation and experience, the environment in which students at Univen live in, as well as personal attitudes, both contribute a lot in exposing them to risky sexual behaviour. Access to alcohol and drugs, lack of student funding (for some students, especially the female students), a desperation to protect long-term relationships, lack of in-campus accommodation, and cohabitation all add up to an environment that influences students to engage in transactional sex and, or unprotected sex. Findings from research by Jabuli (2013) have revealed that regardless of their availability, free government issued condoms are disliked by students for a number of reasons (Jabuli, 2013). HIV education programs must provide opportunities for students to develop positive behaviours and to practice interpersonal and social skills such as decision making, and communication.

In a national survey on knowledge, attitude, behaviour, and practices conducted by HEAIDS during 2008-2009 among 21 HEIs in South Africa, Univen obtained the following HIV prevalence

rates; students (3.3%), academics (1.1%), administrative staff (5.6%) and service staff (10.0%), (Univen, 2010).

According to HIV/AIDS unit records, Univen distributed 109 700 male and 554 female free condoms in campus in 2010, of which less than 6 000 students stayed in campus officially. It is yet disturbing that in the same year, 293 students consulted the HIV/AIDS unit in request of emergency contraceptive tablets, popularly known as the morning-after pills (Mudzusi, 2011). This implies that besides the availability of free condoms, male and female students still engage in unprotected sex. This study will thus determine if students' attitudes and perceptions towards the behavioural elements of the ABC strategy for HIV prevention are the ones discouraging them from safe sexual practices. The following section will discuss the statement of problem.

1.3 Problem statement

The impact of HIV and AIDS is so vast to the extent that no segment of society can claim to have escaped its impact (Karim, Abdool & Baxter, 2008). Since there is no known cure for HIV and AIDS yet, prevention and control is still all the world can do regarding the epidemic. National governments, Non-Governmental Organisations (NGOs), Faith Based Organisation (FBOs) and other private organisations sponsor campaigns to create awareness and prevent new infections all over the world today. In South Africa, awareness is created through the media, education, cultural arrangements, parental talk, religious organizations, community gatherings, and the use role models. At Univen, as it has already been mentioned, awareness campaigns are conducted for the sake of the Univen community, for example the "Lovelife" and "Zazi" campaigns. The university's VCT facility and the peer education structure also have a great deal informing students about HIV reproductive health related issues.

We see awareness campaigns being conducted on many university campuses; it is also known that the majority of students are well informed and knowledgeable about HIV and ways of prevention. It is, however, sadly true that new HIV infections still occur amongst student populations, although there has been a reduction in the rates lately. The occurrence of new infections leaves one asking; are awareness campaigns effective enough in changing students' sexual behaviour? Do these campaigns address students' unique and varying personal situations and conditions like socio-economic status, gender, backgrounds and attitudes when promoting certain sexual behaviours? It is thus important for this study to evaluate the effects of

the “ABC” strategy on Univen male and female students’ sexual behaviour. The next section focuses on the purpose of the study.

1.4 Purpose of the study

The purpose of this study was to investigate Univen male and female students’ knowledge, attitudes and perceptions towards abstinence, being faithful to one sexual partner, and condom use, as HIV prevention measures.

1.5 Study aim

The aim of this study was to investigate Univen students’ knowledge, attitudes and perceptions towards the “ABC” strategy for HIV prevention, and how these consequently affect their sexual behaviour.

1.6 Study objectives

The study is intended to realize these objectives:

- To scrutinize the level of male and female students’ knowledge about the “ABC” method as a prevention strategy.
- To describe the role of gender relations on the adoption of the behavioural elements of the “ABC” strategy for HIV prevention by male and female students.
- To investigate male and female students’ perceptions and attitudes towards the behavioural elements of the “ABC” strategy for HIV prevention, and how existing power relations between genders may influence these.
- To determine male and female students’ responsiveness to HIV/AIDS awareness campaigns and health services rendered to them by health promoters on campus.

1.7 Research questions

These questions have been formulated to help achieve the research objectives:

- What is the level of male and female students’ knowledge about the “ABC” method as a prevention strategy?

- What is the role of gender relations on the adoption of the “ABC” strategy for HIV prevention by male and female students?
- How do gender power relations affect male and female students’ perceptions and attitudes towards the behavioural elements of the “ABC” strategy for HIV prevention?
- What is the extent of male and female students’ responsiveness to HIV/AIDS awareness campaigns and health services rendered to them by health promoters on campus?

1.8 Significance of the study

The study will be of benefit to any government department, NGOs, FBOs, and individuals in the fight against HIV and AIDS; the study findings may help the above-mentioned organisations in HIV-related policy formulation, budget and funding decisions, and intervention processes. Furthermore, the study will benefit the Univen campus health authorities and campaigners in evaluating how their own awareness campaigns that are in place affect male and female students’ behaviour. Any organization fighting the pandemic through the promotion of the “ABC” behaviours will also benefit from the findings of this study. Through the findings of this study, the “ABC” strategy may be improved by covering any gaps that may be left open in it.

1.9 Definitions of operational terms

1.9.1 HIV

This stands for Human Immune Virus. HIV is the virus that causes AIDS (WHO, 2015).

1.9.2 AIDS

AIDS is an infectious disease caused by the human immune virus (HIV). The virus affects and destroys the immune system and the people become more prone to opportunistic infections and other conditions (Lindsey, 2001).

1.9.3 “ABC” strategy

According to Kanabus and Noble (2007) UNAIDS definition of “ABC” strategy is, Abstinence or delaying first sex. Being safer by being faithful to one partner or by reducing the number of sexual partners. Correct and consistent use of condoms for sexually active young people, couples in which one partner is HIV positive, sex workers and their clients and anyone engaging in sexual activity with partners who may have been at risk of HIV exposure.

For the purpose of this study “ABC” will mean:

- **Abstinence:** Complete avoidance of sexual contact.
- **Being faithful:** Having only one sexual partner, or being in a marital and monogamous relationship
- **Condom-use:** Correct and consistent use of condom.

1.9.4 Attitude

This refers to one’s way of thinking and behaving, Oxford dictionary. 3rd Ed (2005). Attitudes are the established ways of responding to people and situations that have been learnt, based on the beliefs, values and assumptions (Kotelnikov, 2008).

1.9.5 Prevention

According to the Longman Dictionary of contemporary English (2012) prevention is stopping (something) happening or stop (someone) doing something. For the purpose of this study prevention (primary, secondary) in the context of HIV/AIDS, refers to activities designed to reduce the risk of becoming infected with HIV/AIDS (primary prevention) and the risk of transmitting the disease to others (secondary prevention).

1.9.6 Condom

A rubber covering worn by men or women on their sexual organs during sex, as a contraceptive and protection against STIs (Cleveland, 2011).

1.9.7 Awareness

Knowing; knowing that something exists and is important (Oxford Dictionary, 2015).

1.9.8 Epidemic

A large number of cases of a particular disease happening at the same time in a particular community (Oxford Dictionary, 2015).

1.9.9 Knowledge

Knowledge refers to familiarity with or the understanding of (Oxford Dictionary, 2015), in this context, the ABC method for HIV prevention, HIV and AIDS facts, information and the awareness of HIV and AIDS responses that are engaged at the University of Venda.

1.9.10 Perception

A perception is a mental impression by which a person regards, understands or interprets something (Oxford Dictionary, 2015). Thus, the mental impression of male and female students at Univen towards the HIV and AIDS response programmes will be assessed.

1.9.11 Gender

Gender refers to socially defined and learned male and female behaviours that shape the opportunities that one is offered in life, the roles one may play and the kinds of relationships that one has. It is distinct from sex, which is a biologically determined and fixed set of characteristics for men and women. It is also distinct from – though closely linked to – sexuality, which is the “social construction of a biological drive” that is defined by how, why, and with whom one has sex (Rao Gupta, 2000).

Chapter 2: Literature Review

2.1 Introduction

The purpose of this chapter is to introduce the literature reviewed on HIV and AIDS, the sexual behaviours of both male and female young people across the globe and in South Africa, as far as abstinence, faithfulness to one sexual partner, and the correct and consistent use of condoms during sex are concerned, in the prevention of HIV/AIDS, STIs and teenage or untimely pregnancies. A literature review involves the systematic identification, location, scrutiny and summary of written material that contains information in a specific research problem (Polit & Hungler, 2010). Polit and Hungler (2010) further state that the overall purpose of a research literature review is to assemble knowledge on a topic regarding what is known or what has been studied about the area and where knowledge gaps exist. A thorough literature review provides a foundation on which to base new knowledge.

2.2 The theoretical framework of the study (The health belief model)

As cited by Diteweg, Van-Oostwaard, Tempelman, Vermeer, Appels, Van der Schaaf & Maree, 2013, in order to develop effective HIV and AIDS prevention programmes, it is important to have accurate knowledge of how people behave in different situations. It is essential to know when and under what conditions people will be prepared to change their behaviour (Van Dyk, 2005).

Regardless of the availability of condoms in many countries of the world and the knowledge that young people have on the possible consequences of having both protected and unprotected sex, it is a disturbing truth that only a few young people still abstain from sex before marriage, with a part of them engaging in unprotected sex and having multiple sexual partners, of which some have and are facing the consequences. This could all but not totally be blamed on the attitudes that male and female young people have on the values of abstinence, faithfulness, and condom use, which influences them to act or behave accordingly, depending on their perceived behavioural control and the manner in which others will view the behaviour, especially the peers.

This could be supported using the theory of reasoned action by Ajzen and Fishbein which suggests that a person's behaviour is determined by their intention to perform a behaviour and that this is in turn, a function of their attitude toward the behaviour and their subjective norm, as well as their perceived behavioural control. Subjective norm refers to one's beliefs about how

people they care about will view the behaviour in question (Carter, 2009). The theory holds that only specific attitudes towards the behaviour in question can be expected to predict that behaviour. Perceived behavioural control refers to people's perceptions of their ability to perform a given behaviour (Ott, Adler, Millstein, Tschann & Ellen, 2002). The Health Belief Model (HBM), mother to the theory of reasoned action, is used in health promotion to design intervention and prevention programs (Shigemi, Shinji, Masamine, Masao & Susumu, 2007). The focus of the HBM is to assess health behaviour of individuals through examination of perceptions and attitudes someone may have towards disease and negative outcomes of certain actions. The HBM assumes that behaviour change occurs with the existence of three ideas at the same time:

- An individual recognizes that there is enough reason to make a health concern relevant. (perceived susceptibility and severity)
- That person understands he or she may be vulnerable to a disease or negative health outcome. (Perceived threat)
- Lastly the individual must realize that behaviour change can be beneficial and the benefits of that change will outweigh any costs of doing so. (Perceived benefits and barriers)

2.2.1 Application of the theory

The general rule in this theory is that, from within, an individual perceives susceptibility of disease (HIV for this study) in certain behaviour (sexual intercourse for this study), as well as the seriousness of the disease. The individual goes on to what is known as the perceived threat of the disease, which is when he/she considers the fact that he/she may actually be vulnerable to a disease as a result of his/her engagement in certain behaviour. At this stage, environmental factors, such as one's socio-economic status and pressure from friends, may add to threat of disease while cues to action, such as mass media campaigns, advice from others or the illness of a family member, may actually trigger a decision to change behaviour. Lastly, the individual may evaluate the perceived benefits to certain behaviour against the perceived barriers, and then act. At this last stage, an individual may choose to abstain, be faithful, or use a condom as preventive measures.

2.3 The 'ABC' strategy for HIV prevention

Abstinence, be faithful, use a condom, also known as the ABC strategy or abstinence-plus sex education, also known as abstinence-based sex education, is a sex education policy based on a combination of "risk avoidance" and harm reduction which modifies the approach of abstinence-only sex education by including education about the value of partner reduction safe sex and birth control methods. Abstinence-only sex education is strictly to promote the sexual abstinence until marriage, and does not teach about safe sex or contraceptives. The abstinence-based sex education program is meant to stress abstinence and include information on safe sex practices. In general terms, this strategy of sex education is a compromise between abstinence-only education and comprehensive sex education.

The ABC approach was developed in response to the growing epidemic of HIV/AIDS in Africa, and to prevent the spread of other sexually transmitted diseases. This approach has been credited by some with the falling numbers of those infected with AIDS in Uganda, Kenya and Zimbabwe, among others. From 1990 to 2001 the percentage of male and female Ugandans living with AIDS fell from 15% to 5%. This fall is believed to result from the employment of the ABC approach, especially reduction in the number of sex partners, called "Zero-Grazing" in Uganda (Murphy, et al., 2006).

Abstinence, be faithful, use a Condom consists of three components:

- Abstinence:

The ABC approach encourages young adults to delay "sexual debut" (age of first sexual intercourse), as used by Uganda, or to use abstinence until marriage, the most effective way to avoid HIV infection, as advocated as the ideal by Christianity and Islam. The program develops skills for practicing abstinence and encourages participants to adopt social norms that support abstinence.

- Be Faithful:

In addition to abstinence, the ABC approach encourages participants to eliminate casual or other concurrent sex partners and to practice fidelity within their marriages and other sexual relationships. This reduces exposure to HIV. In Uganda, between 1989 and 1995, President Museveni reported a 20% decline in casual sex partners, and an 11% decline in reported cases of HIV (Murphy, Greene, Margaret, Mihailovic, & Olupot-Olupot, 2006).

- Condom use:

The final component to the ABC approach is "correct and consistent condom use." While understanding the benefits of abstinence, participants are instructed how to apply and use a condom. This is an example of risk reduction during cases when risk elimination is not practiced. Students are also taught that condoms do not protect against all forms of sexually transmitted diseases.

2.3.1 Abstinence

The age at which teens in Sub-Saharan Africa typically initiate sex is surprisingly similar to that of teens in the United States and other developed countries. Although only a small proportion of teens have had sex by age 15, sexual experience is common by the late teen years. This differs for male and female teens. By their 20th birthday, roughly three in four young women and six in 10 young men in Sub-Saharan Africa have had intercourse. Adolescent sexual activity occurs both within and outside of marriage, with young women much more likely than young men to be married. Premarital sex, however, is common, even among females. Indeed, in most Sub-Saharan countries, one-third or more of women have had premarital sex by age 18 (National Research Council and Institute of Medicine, 2005).

A study by McCauley (2003), on the teachings of abstinence in schools in South Africa, Thailand, and Mexico, investigating whether abstinence messages were appropriate and effective, found that abstinence levels were 81% in South Africa. The reasons cited for abstaining from sex were that the individual was not ready, to protect his/her health and that friends were teasing him/her. Youth indicated that abstinence was a good choice because it protected against STDs and pregnancy (McCauley, 2003).

According to a study finding by Setswe & Zuma (2009), young South Africans have strong views on abstaining from sexual intercourse, as 83% says that it was possible not to have sex for as long as you can. A strong support for abstinence was shown by a 78,5% that said not having sex was the best way of HIV prevention. In total, 68,1% of male and female South African youths said that the media had a positive influence on encouraging abstinence 72,1% said role models could help them not to have sex, while 84,3% said that leadership and life skills workshops were helpful in encouraging them to abstain from sex. They also had strong views on and perceptions of remaining faithful to one partner (Setswe & Zuma, 2009).

Age at first sex is an important indicator of sexual risk, as it marks the onset of one's potential exposure to infection. Delaying the first sexual encounter can have a significant impact on the health and well-being of adolescents and on the progress of the HIV/AIDS epidemic in communities. In many of the countries hardest hit by HIV/AIDS, sexual activity begins early and prior to marriage. Surveys show that, on average, slightly more than 40% of women in Sub-Saharan Africa have had pre-marital sex before age 20; among young men, sex before marriage is even more common. A significant minority of male and female youths experience first sex before age 15 (Family Health International, 2002).

The 2005 Human Science Research Council (HSRC) survey in South Africa reviewed behavioural determinants of HIV/AIDS, and found the overall median age of first sex was 17 for male and female youth aged 15-24 in the study group. Research commissioned by the Nelson Mandela Children's Fund (NMCF) and conducted by Development Research Africa (DRA) focused on the sexual and reproductive behaviours of young people in the Goelama intervention areas and factors that may influence these behaviours (Horizons, 2004). The survey was conducted with nearly 5 000 youth from eight districts in three provinces in South Africa, Mpumalanga, Limpopo and KwaZulu-Natal. Forty five percent of youth respondents 12-20 years old reported having sex. Some of the findings showed that males initiate sex at an earlier age than females and are more likely to report more than one simultaneous sexual partner. The findings of this study proved that young people are sexually active (45%) in KwaZulu-Natal, which was the location for this study. Male and female students at the University of KwaZulu-Natal were therefore considered to form part of this young sexually active population.

The findings showed that young men and women in South Africa are not delaying sexual debut or practicing abstinence, limiting the number of sexual partners or ensuring the correct and consistent use of condoms. This questioned not only the factors that affect or encourage young peoples' sexual practices but the effectiveness of the ABC approach. A review of some of these statistics and the surveys conducted on young people's sexual practices showed that despite the increase in condom use, multiple partners was still common among young people, especially the male. This indicated that the ABC prevention strategy did not reflect young peoples' behavioural patterns, and therefore was not able to always offer solutions to the complexities of their sexual interactions. The HSRC survey confirmed young people as being sexually active and at risk despite all the ABC messages targeted at them.

Young people who have not had their sexual debut are encouraged to practice abstinence until they have established a lifelong monogamous relationship. For those youths who have initiated sexual activity, returning to abstinence is a primary message for prevention intervention.

Abstinence interventions encourage unmarried individuals to abstain from sexual activity as the best and only certain way to protect themselves from exposure to HIV and other STDs. Abstinence programs are particularly important for young people, as approximately half of all new infections occur in the 15-24-year-old age group (UNAIDS, 2004).

Abstinence is a viable strategy for some groups but not for others. Faith based organisations (FBOs), with a stronger history of involving themselves in the social, sexual and marital relationships between men and women were more credible in ensuring that their followers take seriously the strategy of abstinence. FBOs often deliver the message of faithfulness as a twin message alongside that of abstinence. The message of faithfulness, while somewhat less frequent, is targeted at married couples to encourage them to avoid the risks infidelity and the chance that infidelity can lead to infection (Liebowitz, 2004).

2.3.2 Being faithful/marital fidelity

Be faithful interventions encourage male and female individuals to practice fidelity in marriage and other sexual relationships as a critical way to reduce one's risk of exposure to HIV. Once a person begins to have sex, the fewer lifetime sexual partners he/she has, the lower the risk of contracting or spreading HIV and other STDs. Be faithful interventions promote:

- The elimination of casual sexual partnerships
- The development of skills for sustaining marital fidelity
- The importance of mutual faithfulness with an un-infected partner in reducing the transmission of HIV among individuals in long term sexual partnerships
- HIV counseling and testing with their partner for those couples who do not know their HIV status
- Endorsement of social and community norms supportive of refraining from sex outside marriage, partner reduction and marital fidelity, by using strategies that respect and respond to local cultural customs and norms and to the adoption of social and

community norms that denounce cross generational sex, transactional sex as well as rape, incest, and other forced sexual activities (Stoneburner & Low-Bear, 2004).

In the national South African population-based survey of 2005, 40% of male and 25% of female South African youths aged 15-24 reported having more than one concurrent sexual partner (Shisana, Rehle, Simbayi, Parker, Zuma, Bhana, Connolly, Jooste & Pillay, 2005).

Whilst traditional polygyny has declined in many African societies, men in present-day South Africa commonly engage in multiple and concurrent partnerships. This is done as much in the pursuit of social and individual validation as it is done in the pursuit of reproductive success, as male virility is often measured by how many sexual partners one has at any given time. Even though polygyny in contemporary South Africa is not the only norm prescribing husband-wife relations, the cultural heritage of polygyny continues to legitimize sex with multiple and concurrent partners and presents a challenge to HIV prevention. In southern Africa, including South Africa, sex with multiple and concurrent partners in the context of poor and inconsistent male condom usage has been identified as the key behavioural driver of HIV (Mah & Halperin, 2008).

2.3.3 Condom use

In a survey conducted by the Kaizer Family Foundation (KFF) and the South African Broadcasting Corporation (SABC), 60% of young male and female South Africans named HIV/AIDS as the most important issue or problem facing their age in South Africa and three quarters (75%) said they were personally concerned about becoming infected with HIV in the next ten years. HIV prevention campaigns targeting young people often encourage safe sex practices, such as condom use, as well as the distribution of condoms at no cost. Such campaigns, however, often have disappointing results, even in areas where condoms are widely available and awareness about STIs is high (Marston & King, 2006).

Informing male and female young people about HIV/AIDS, STIs, and teenage pregnancy equips them with the adequate knowledge to counter protect themselves from these pathologies. Where young people are knowledgeable about HIV/AIDS risks and prevention strategies, they change their behaviour in ways that reduce their vulnerability (Douthwaite & Sareoun, 2006). For example, in several countries, targeted education has led to delayed sexual debut and increased use of condoms resulting in a decrease in HIV prevalence in male and female young people. In Zambia, the knowledge about risks of pregnancy and HIV/AIDS resulted in a decline

in HIV/AIDS prevalence among young people aged 15 -19 years from 28% in 1993 to 15% in 1998. The decline was attributed to the delayed sexual initiation, reduced number of sexual partners and increased condom use (UNICEF, 2007).

Young Nigerian students who were given health education and a demonstration on the correct use of condoms showed an increase in condom use, a reduction in the mean number of sexual partners and increased HIV/AIDS knowledge (Fawole & Brieger, 1999). In a study on male and female adolescents' knowledge of "ABC" strategy in Kenya, half of the respondents demonstrated adequate knowledge of the meaning of abstinence and why it was important as an HIV prevention method. The knowledge regarding 'being faithful' and condom use was found to be inadequate (Kaiser Report, 2006). Another study on sexual abstinence behavior among youth by Koffi &

Kawahara (2008) revealed that females were more knowledgeable about 'being faithful' than males.

However, some authors go with the opinion that young people may have knowledge about HIV and condom use, yet they do not behave likewise. Although male and female young people may be knowledgeable about STIs, knowledge does not necessarily equate with behavioural changes, nor does it influence risk perception of STIs (Andersson-Ellstrom & Milsom, 2002). Condom use is inconsistent despite the awareness that condoms are effective in preventing transmission of STIs (James, Reddy, Taylor, & Jinabhai, 2004). Although some young people may have adequate knowledge about STIs, their perceptions of themselves as being at low risk increase their vulnerability to STI acquisition.

Despite high levels of knowledge of HIV/AIDS among young people, there is however a gap between knowledge and reported sexual behaviours (James, et al., 2004). Reports on sexual and reproductive health of young people in Botswana showed that most male and female young people have been exposed to information about many aspects of sexual and reproductive health, and yet male and female young people aged 15-19 and 20-24 years in Botswana still exhibit high HIV infection rates and that the principal mode of transmission of HIV is through unprotected heterosexual contact (WHO, 2005).

Together, these factors reveal the youth's inability to adopt and translate knowledge of HIV/AIDS risk and prevention programs into positive behavioural changes. They also signal the

need for policy on abstinence programs to seriously consider the context within which male and female young people's sexuality is expressed.

Studies on the HIV/AIDS related knowledge of young people in Botswana revealed high levels of knowledge. In a study on predictors of knowledge about HIV/AIDS among adolescents, it was found that most young people (63.1%) displayed adequate knowledge about HIV/AIDS (Fako, Kangara & Forcheh, 2010). Seboni (2001) cites the WHO/ University of Botswana study (2000) which states that there is high knowledge (HIV awareness of 95%) about HIV and other risky behaviours such as early initiation of sexual intercourse among adolescents in Botswana. However, this knowledge has been found to be incongruent with the actual practice of safe sex hence the high infection rates of HIV/AIDS among male and female young people in Botswana.

Knowledge alone about risky behaviour and HIV/AIDS transmission is not always enough because it does not necessarily translate into safe sexual behaviour. Aral & Douglas (2007) maintain that attitude and behaviour change are effective in curbing the spread of STI and HIV/AIDS. The goal of changing behaviours is to ultimately decrease the rate of disease transmission by means of correct and consistent condom use, delaying the initiation of sexual activity, mutual monogamy and decreasing the number of sexual partners.

Negative attitudes towards condom use in sub-Saharan Africa are often based on cultural factors, for example, the desire for children and female sexual compliance are often ways used by women to achieve economic status (Campbell, 2001). The use of condoms is believed to be unnatural, a tool used by men to prevent disease or children (Meyer-Weitz, et al., 1998). According to these authors, condom use is seen as a 'waste' of sperm and that this conflicts with the emphasis on fertility in African culture (Caldwell, et al., 1994). Such beliefs encourage people to engage in highrisk sexual behaviour and risk HIV infection in order to produce male offspring. Despite such beliefs, studies of condom usage continue to reveal that reported levels of condom use are high in South Africa (Shisana, et al., 2005).

2.3.3.1 Some reasons why young people do not use condoms

Below are some of the themes that other researchers in different nations came up with as reasons for non-condom use and attitudes that young people have toward condom use in general.

- *Contraception and 'safer' sex*

The terms safer sex and contraception are often used ambiguously and interchangeably, although they have differing meanings. Contraception refers to controlling of fertility to avoid pregnancy, while safer sex generally refers to precautionary actions taken to prevent the transmission of STIs (Anderson, et al., 2002). However, although meaning, purpose and preventative techniques differ between contraception and safer sex practices, safer sex is often equated with contraception and contraceptive use (Kirkman, Rosenthal & Smith, 1998). This ambiguity increases vulnerability to STIs because of the perception that the use of any contraceptive is a safer sex practice, including techniques that are non-barrier contraceptives, and hence do not protect against STIs (Kirkman, et al., 1998).

This ambiguity may be in part because of the fact that there is some overlap between contraception and safer sex, with condoms having some protective functions for both STIs and pregnancy. However, the most effective contraceptive, the oral contraceptive pill (OCP), has no efficacy in preventing STIs. Despite the epidemic proportions of STIs and extensive publicity campaigns, condom use is reported to be generally inconsistent, particularly among young people (Minkin & Wright 2005). Less than half of an Australian sample of sexually active respondents, aged 16–59 years, reported using a condom in the preceding 12-month period (de Visser, Smith,

Rissel, Richters, & Grulich, 2003). A Korean study of young sexually active university students found that only 10% of males and 8% of females reported consistent use of condoms. This low rate of condom use and multiple partners were associated with STI prevalence among the sample (Lee, Cho, Ha, Kim, Yoon, & Bae, 2005). Similarly, over half of an HIV-positive Taiwanese sample aged 21–65 years engaged in unprotected sexual intercourse and had a history of an additional STI (Chen, Wang, Chen, Yan, Tang, Lin, & Yen, 2006). Almost a quarter of a sample of predominantly young adults, recruited from an STI clinic, reported errors with condom use that could lead to greater exposure to STIs (Grimley, Annang, Houser & Chen, 2005).

There is some suggestion in the literature that condoms are more strongly associated with contraception rather than safer sex (Garside, Ayres, Owen, Pearson & Roizen, 2001, Flood, 2003), and this association could mean that young people may stop using condoms when other contraceptives are used. Darney, Callegari, Swift, Atkinson, & Robert (1999) found that their sample of adolescent females using a hormonal implant contraceptive were aware that the device did not protect against STIs; however, consistent condom users declined from 39% to

8% and those who hardly ever used condoms increased from 14% to 63% after a 2-year period, despite partner changes. Similarly, a longitudinal study of women (aged 13–46 years) using injectable contraception revealed that less than one-fifth of the sample used condoms consistently, despite their awareness that their injectable contraceptive offered no protection against STIs (SangiHaghpeykar, Poindexter & Bateman, 1997).

➤ *Condom use and romantic love*

The development and formation of romantic and sexual relations begin in the time span between adolescence and young adulthood (Regan, Durvasula, Howell, Ureno & Rea, 2004). Although romantic love among young people can have various meanings, it is generally characterized as having attributes such as trust, attraction, happiness and friendship. Within the context of romantic love, sexual relations can be guided by gender scripts, which equate sexual activity with trust, intimacy and commitment for young women, and with physical pleasure, particularly for young men. Safer sex and condom use can be hindered because condom use may imply mistrust, and unsafe sex is often seen as a declaration of one's love (Kirkman, et al., 1998). Within the romantic love discourse it is difficult to conceive that the person who holds the affection of another could possibly be a source of sexual infection.

The emotions and behaviors associated with romantic love can influence decision-making when it comes to practicing safer sex. In a study exploring the attitudes of safer sex and love among single-adult heterosexuals, it was found that safer sex was confounded by love (Rosenthal, Gifford & Moore, 1998). Women associated sexual activity with love, romance, and the potential formation of a relationship, while male participants expressed some similar views, they could also conceive of sexual activity as independent of love and romance (Rosenthal, et al., 1998). Women may sacrifice protective sex because of the perceived threat it poses to the development of a potential loving partnership (Rosenthal, et al., 1998). Men admitted to using the promise of romance to gain their sexual desires and disclosed a reluctance to use condoms, with some admitting that they refused condom use altogether, facing women with the choice of foregoing safer sex or jeopardizing a potentially satisfying romantic relationship (Rosenthal, et al., 1998). In this case, the clear disparity between how men and women view sexual intimacy feeds male desire; this places women's health at risk and suggests that women may place themselves at risk rather than face potential abandonment by an actual or potential romantic partner.

Condom use is dependent on relationship type, it decreases with: age, having a child, cohabitation, increased frequency of intercourse within a partnership and perceptions of a relationship as positive and monogamous (Critelli & Suire, 1998). Clearly, individuals perceive that they are not at risk of STIs based on the subjective assumption of monogamous partner behavior. However, monogamy is individually defined and can refer to serial monogamy. Findings by Critelli & Suire (1998) suggested that perceived trust, desire for intimacy, holding a relationship in positive regard, belief in monogamy within relationships and perceived low risk of STI acquisition, overrode concerns about STI risk.

The general image of condoms is not of something that contributes positively to an intimate relationship, but that the condom is an object that symbolically taints it. The condom is often associated with casual sexual encounters and infidelity, and thus can imply mistrust within a partnership (Kirkman, et al., 1998). Mistrust is not in keeping with the ideas and beliefs young people hold about romantic love. However, what is concerning is that it has been posited that the average time-frame for young women's relationships to progress from being treated as new to being considered established (marking the beginning of unsafe sexual practices) is 21 days (Fortenberry, Tu, Harezlak, Katz & Orr, 2002). With trust long being promoted as the basis for a healthy and loving relationship, women may be reluctant to initiate discussion about a partner's previous sexual exploits and safer sex, as it may be interpreted by their partner as mistrustful. Furthermore, women may be reluctant to broach the subject of safer sex because of their own previous sexual history, fearing judgment by their partner that parallels societal disapproval and labeling of sexually active women as promiscuous.

Judgments about sexual risk and condom use may be made based on appearance and other factors that can lead to decisions to engage in unsafe sex. However, subjective assessments determining a sexual partner's risk are often erroneous and can conflict with the sexual partner's actual-lived background. Skidmore & Hayter (2000) found that unprotected sexual encounters were influenced by the physical appearance of potential sexual partners and factors such as perceived knowledge and trust. Despite assertions that they would only have unprotected sexual encounters with partners they knew and trusted, many participants had engaged in unprotected sexual activity with casual partners (Skidmore & Hayter, 2000). Further, Stoner et al., (2003) found that individuals who had contracted an STI had underestimated the sexual risk of a partner. Hoffman & Cohen (1999) concluded that assessment of an individual's sexual riskiness was based on personal looks and characteristics, perceived trust, and disclosed

(rather than factual) information. These bases for assessment, as the authors suggested, reinforced sexual risk behavior because people assumed that their subjective assessment of partner risk was correct, particularly when previous avoidance of STIs had occurred despite engagement in unprotected sexual activity.

Although monogamy may be viewed as a 'safer' sex practice (James, et al., 2004), risk behavior still exists within 'exclusive relationships', depending on the behaviors of both partners (Lawrence, Eldridge, Reitman, Little, Shelby & Brasfield, 1998). Findings by Seal & Palmer-Seal (1996) suggested that women were more likely to perceive no STI risk from their male partners; however, information from the male partners was often contradictory and suggested that there was a degree of risk to the female partners. The authors concluded that personal perceptions are often inaccurate, particularly in reference to sexual risk and sexual history, STI history and relationship status (Seal & Palmer-Seal, 1996).

➤ *Perceived risk, knowledge and invulnerability*

Although young people, typically those under 25 years, have a high incidence of STIs (Dehne & Riedner, 2005), young people perceive themselves as being relatively invulnerable to STI acquisition. Owing to this perceived invulnerability, and the general concept of invincibility among young people, it is common for them to think that STIs happen to others rather than to themselves and they may frequently engage in sexual high-risk behaviors (WHO, 2004).

Although young people may be knowledgeable about STIs, knowledge does not necessarily equate with behavioral changes, nor does it influence risk perception of STIs (Andersson-Ellstrom

& Milsom, 2002). Condom use is inconsistent despite the awareness that condoms are effective in preventing transmission of STIs (James, et al., 2004). Similarly, another study found that consistent condom use only occurred in just over half a sample of sexually active young people (aged 14–20 years) (Trani, Gnisci, Nobile & Angelillo, 2005). From the findings of these studies, it could be asserted that, although some young people may have adequate knowledge about STIs, their perceptions of themselves as being at low risk increase their vulnerability to STI acquisition.

In a study which was focused on determining the perceived and actual knowledge of STIs among young women, Rouner & Lindsey (2006) found that the majority of women were confident of their knowledge about STIs but demonstrated little knowledge in relation to the

symptoms. Findings suggested that, although most of the women perceived their knowledge to be high, it was essentially limited to naming a few STIs, with HIV/AIDS being the most commonly named. Similarly, Garside, et al., (2001) in a study which examined the knowledge and attitudes of adolescents found that, although HIV was most commonly recognized as an STI, infections such as chlamydia were not. Participants had little knowledge about symptoms of STIs and often associated condoms with pregnancy prevention rather than protection against STIs. This association and low-perceived risk of STI acquisition hindered consistent condom use (Garside, et al., 2001).

➤ *Male resistance to condom use*

Clearly, despite the availability of condoms, there remain significant barriers to their use. Furthermore, it is well documented that, for a variety of reasons, men of all ages do not like to use them (Flood, 2003). The resistance by men in using condoms has the potential to impact substantially on women's sexual and reproductive health, particularly when STIs in women are often asymptomatic and therefore undetected until permanent damage to the reproductive organs has occurred (Commonwealth of Australia, 2005). Owing to the power inequality in sexual relationships, women remain ill-equipped to advocate their own sexual health; adolescent girls, in particular, reportedly find it easier to refuse sex than to initiate condom use (Harrison, Xaba & Kunene, 2001). The reluctance associated with condom use is complex and embedded in issues of gender and power relationships.

Attitudes to the use of condoms differ between the genders. Grady, Klepinger & Nelson-Wally (1999) found that both men and women ranked the condom highest as a way of preventing STIs (Grady, et al., 1999). Although pregnancy prevention was ranked the most important characteristic of contraception among the males and females, men ranked prevention of STIs higher than women. Similarly, the findings of a Russian study showed that the importance of condom use for females was pregnancy prevention, whereas for men it was STI prevention (Bobrova, Sergeev, Grechukhina & Kapiga, 2005). These findings could reflect the fact that women bear the major responsibility for the consequences of unwanted or unplanned pregnancy, the ramifications of which may be perceived as more long-lasting and life-changing than contracting a STI.

The issue of perceived sexual pleasure is central to the use of condoms regardless of whether the purpose of use is to protect against STIs, prevent conception, or both. It has been reported that males place greater value than women on sexual pleasure, with men asserting that condom

use interferes with sexual pleasure and intimacy. Thus, men have some resistance to condom use (de Visser, 2004) and may refuse to use condoms. In addition, men may assume birth-control is the responsibility of women, which further contributes to male resistance to condom use (Skidmore & Hayter, 2000).

➤ *Women, condoms and tainted love*

The method most effective for STI prevention, the male condom, is controlled by men (Wulff & Lalos, 2004). Men do not necessarily need to negotiate condom use, whereas women may have to initiate and negotiate in order for them to be used. Male resistance to condom use places the onus on young women to insist on their use, a stance that may pose difficulties for some women. Condom negotiation requires women to have high self-efficacy, perceived autonomy within the encounter, and acceptance of sexuality and effective communication skills (de Visser & Smith, 2001).

Women of all ages may find it difficult to successfully negotiate the use of condoms; however, young women and adolescents may find it even more difficult because of their age and probable inexperience in such negotiation (Dehne & Riedner, 2005). Strongly entrenched social and cultural norms that reinforce male dominance and female passivity within sexual encounters are likely to hinder women's ability to negotiate safer sexual practices. This power imbalance and inequality limits female assertiveness.

It has been reported that young women feel more positive towards condoms and are more committed to their use than men (de Bro, Campbell & Peplau, 1994). However, condom use is influenced by egalitarian partnerships with women's use of condoms being hindered by repressive relationship dynamics and gender attitudes. That is, in relationships in which women are typically viewed as subordinate to the male, women lack the power to assert condom use. Furthermore, successfully negotiating condom use can be hindered by women perceiving a negative reaction from partners, including fear of emotional or physical abuse.

The introduction of the female condom, as well as the development of other female controlled methods, have given women alternative contraceptive barrier options, and thus has the possibility to facilitate greater barrier protection and consistent condom use. The use of the female condom, however, is still reliant on relationship dynamics and partner negotiation (Artz, Macaluso, Brill, Kelaghan, Austin, Fleenor, Robey & Hook, 2000). It has been suggested that male condoms are more widely used and preferred in comparison to the female condom

(Ehrhardt, Exner, Hoffman, Silberman, Yingling, Adams-Skinner & Smart-Smith, 2002). The female condom is bulkier and more obtrusive than the male condom, it is relatively new, expensive, not widely available, and may be difficult to use (Artz, et al., 2000). Evidence suggests that male partner objection is the main factor for non-use of the female condom. Therefore, even when women endeavor to protect their reproductive health by initiating the use of a female condom, the power inequity of their sexual relationship negates its use. Apart from the reported reduction in tactile stimulation because of condom use in general (Flood, 2003), the female condom is also unsightly. The negative impact that its use potentially has on both tactile and visual sexual stimulation inevitably reduces the romantic aspect of sexual encounters.

The usefulness of the ABC approach, however, is highly debated. The three elements are interpreted differently by different actors and critics argue that often abstinence and faithfulness are unduly promoted over condoms and other measures such as education, female empowerment and making available modern antiviral drugs. For example, the U.S. President's Emergency Plan for AIDS Relief under President George W Bush has been criticized for seeming to prioritize "A" and "B" over "C" within its funding criteria. "C" activities may only be directed at "high-risk" groups, and not to the general population. However, donor funding has always been allocated overwhelmingly to condoms, reflecting clear US and European policy priorities (Bendavid & Bhattacharya, 2009).

Critics argue that in many countries women are frequently infected by their unfaithful husbands while being faithfully married, and thus women who follow the recommendations of ABC promoters face an increased risk of HIV infection. Condoms, needles, and negotiation is a proposed alternative approach as is Safer practices, Available medication, Voluntary testing & counseling and Empowerment through education (SAVE).

Critics furthermore allege that the strategy overlooks the epidemic's social, political, and economic causes and "vulnerable populations", e.g. sex workers and "those who lack the ability to negotiate safe sex" as well as risk groups such as homosexuals and intravenous drug users. However, most infections in Africa occur outside these vulnerable groups, and ABC was a US donor policy only for the "generalized" epidemics in Africa. Murphy et al., found that Uganda's ABC approach empowered women. "Remarkably, in the 2000–2001 Uganda Department of Health and Human Services (DHS), 91 percent of women said they could refuse sex with their husbands if they knew their husbands had STIs, a somewhat higher percentage than in several other African countries".

Critics also argue that using the word "abstinence," then teaching about safe sex and contraceptives, can be contradictory (Murphy, et al., 2006).

2.4 HIV/AIDS in higher and tertiary education institutions

According to Martin & Alexander (2002), South Africa was slow to react to the enormous threat posed by HIV/AIDS, especially as there was an awareness of the dangers that it presented from as early as 1985 (Whiteside & Sunter, 2000). The 1980s saw AIDS stigmatized as a 'gay plague' and a black disease, and it was ignored by an apartheid government that was fighting for its survival. This lethargic response to HIV/AIDS extended well beyond government, it correspondingly occurred in one particular domain of focus for this study, higher education. Due to a failure of institutional leadership and a slow movement by academics, very little happened in this domain until 1999 (Martin & Alexander, 2002).

From 8 to 9 November 1999, the Association of Commonwealth Universities (ACU) held an international seminar in Durban that addressed the consequences of the AIDS pandemic for the University sector. The event led to the circulation of a draft 'HIV/AIDS Policy for Staff and Students at Commonwealth Universities' (ACU, 1999). This policy document provides detailed advice rooted in developmental and ethical principles. It proposes that, for staff and students alike, there should be a firm commitment to oppose all forms of discrimination against HIV positive individuals; no requirements for compulsory testing; education about AIDS; and free and easily accessible condoms, counseling and medical support. It further suggests that universities have a responsibility to provide male staff with such gender-sensitization programs as will ensure that they are aware not only of the rights and vulnerabilities of women but also of the HIV/AIDS related implications of sexual abuse and violence (ACU, 1999).

Since the year 2000, a number of case studies on higher education institutions have been conducted, seeking to document the impact of HIV and AIDS on higher education institutions in Africa. The first series of such studies was commissioned in 2000 by the Association for the Development of Education in Africa (ADEA) Working Group on Higher Education (WGHE). At around the same time, the South African Universities Vice-Chancellors' Association (SAUVCA) also commissioned case studies involving universities in South Africa. Evidence from these studies began to demonstrate that HIV and AIDS were being experienced, to varying extents, in higher education institutions across Africa in the form of increased attrition among staff and students, increased medical expenses, increased absenteeism, and loss of morale among

students and staff. Most higher education institutions were found not to be engaged in any systematic impact or risk assessment, thus making it difficult to establish the magnitude of the HIV and AIDS problem and to project what the increasing attrition meant for higher education institutions in the future (Katahoire & Kirumira, 2008).

HIV and AIDS stand as some of the main challenges faced by educational institutions in the world. This cannot be overlooked or ignored in the context of South African Higher and Tertiary Education institutions. They constitute a growing problem that could be having a crippling effect on the functions and operations of higher education institutions in African nations, South Africa being the main concern for this study. The following are reasons why HIV/AIDS is of particular relevance to higher education.

- HIV/AIDS is a development issue, not just a health issue. AIDS is a problem that affects not just the health status, but the social, economic and psychological wellbeing of people and organizations too. If there is agreement on this fundamental principle, then institutional responses need to be formulated in a substantively different way to the way they are at present.
- HIV/AIDS affects not just individuals, but organizations and systems. The epidemic will have an effect on all the categories of people that make up a university community: students, academic staff, clerical and administrative staff, support staff and parents. These effects will manifest themselves in host of different ways. Illness, death, trauma, and reduced capacity to work and study will affect both students and staff. Institutions will lose students and staff through mortalities; illness and absenteeism will affect productivity. The pool of skills and knowledge that sustains organizations will be depleted and the loss of both staff and students may ultimately call into question the viability of the institution.
- HIV/AIDS affects human resource development. The life-blood of universities is the crop of students they enroll every year. These 18-30 year olds are amongst the most capable and promising members of all societies. They represent the future corps of the highly skilled base of any economy. They are also the age group at the highest risk of contracting the HIV-virus. Many may arrive at university already infected; others will become infected whilst at university, because of a range of factors which make higher education institutional environments a focal point of social and sexual interaction.

- Preventing the spread of HIV/AIDS and managing its impact requires knowledge. Simply put, universities are about teaching, learning and the generation of new knowledge. In a context where every aspect of society is being affected by the pandemic, the role of the university as a teaching institution which shapes the attitudes and practices of future decision-makers is critical. In the same vein, the university has at its core the responsibility of generating and disseminating new knowledge, which will affect its prospects of limiting and mitigating the effects of the pandemic. Universities have the capability of influencing policy and shaping the national development agenda: research can be mobilized as a decision-making tool, best practice can be advocated, and new standards can be set.
- A successful institutional and societal response to HIV/AIDS requires leadership. Lastly, universities play a role in the leadership of their communities. They represent and defend values which are essential in the fight against HIV/AIDS. These include openness, freedom of choice, the value of knowledge and a belief in the beneficial effects of social and economic progress.

In a study on the impact of HIV and AIDS on higher education institutions in Uganda (Katahoire & Kirumira, 2008), the following were pointed out as institutional problems perpetuated by the pandemic:

- Difficulties in replacing highly trained and experienced staff
- Prolonged illness and eventual death of academic staff had in some cases negatively affected students' performance
- Newly infected students reportedly reacted in different ways to their status. Below are the risky reactions pointed out:
 - Alcohol abuse
 - Indiscriminate sex with multiple partners
 - Withdrawal from social relations
 - University/college dropouts

From the findings of the same study, it was realized that, while HIV and AIDS prevention education was provided for male and female students in higher education institutions, there were hardly any such programmes for staff. Furthermore, the available programmes were not comprehensive and minimal effort had been made so far, at institutional level, to integrate HIV and AIDS into the teaching curricular. This may be due to lack of expertise, but may also reflect

the academic staff's attitude towards HIV and AIDS. If higher education institutions in Uganda are to rise to the multiple challenges posed by the epidemic, they must accept that their mandate now includes educating young people on the issue by teaching negotiation, conflict-resolution, critical thinking, decisionmaking, communication competencies, and other critical life skills in the curriculum and cocurricular activities in order to make informed-indeed, potentially lifesaving decisions.

Despite intensified HIV and AIDS education campaigns, unprotected sex is still reported to be a common practice in these institutions. Medical personnel from some institutions reaffirmed this when they reported incidences of unplanned pregnancies, abortions and sexually transmitted diseases (STDs) among students. Top administrators were reluctant to provide condoms for students lest they be perceived as condoning immoral behaviour. This, however, did not appear to deter students from engaging in sexual activity (SADC, 2006).

Tertiary education represents a time for sexual exploration and freedom for many young people. Many students become sexually more active as they move to urban settings away from their homes and enter a developmental phase during which experimentation and risk-taking with a variety of sexual practices seem appealing. Unfortunately this sexual exploration and freedom can result in students contracting HIV (Thompson-Robinson, et al., 2005). Statistical findings among male and female students predicting a 10% increase in the HIV infection rate of universities' undergraduates in only five years (Levine & Ross, 2002), as well as the possible inability of universities to cope with societies' demands for academically trained workers due to the effect of HIV and AIDS on students (Bridgraj, 2000), draw attention to new high-risk behavioral patterns among male and female students who are normally seldom targeted in HIV/AIDS prevention programs.

Social and economic realities have a direct impact on HIV/AIDS as well as the quality of life and potential success of university students, especially the female. Many students are forced to migrate to bigger towns to attend university, which affects their financial security and makes them more vulnerable to HIV. Female students who are economically and socially disadvantaged in particular, are at the highest risk for HIV infection because of the impoverished living conditions they are exposed to (Van den Berg & Van Rooyen, 2007). In addition, many students' bursaries are not dispersed until well into the academic year, creating an unstable economic situation (Southern African Regional Universities Association, 2009). For example here at Univen, the first days of a new academic year are usually marked by male and female

new students sleeping in office corridors queuing for registration and accommodation allocation. This puts the female young students at risk of being sexually exploited by senior male students who would already be comfortably occupying their rooms, especially those who are in the Student Representative Council (SRC) and post-graduate students.

South African literature makes it abundantly clear that financial status is a major HIV risk factor, often influenced by gender. A lower economic status adds to the problem of females having unwanted sexual relationships (Evian, 2003). It is true that 'sugar daddy' practices and prostitution occur in South African female student communities (Kelly, 2011). Money often plays a role in young women bargaining with older men for sexual favours. A regular practice in African and Western cultures is that of males presenting female sexual partners with gifts. These partners are seen as 'girlfriends' and not as 'prostitutes' (Delius & Walker, 2009). Female students sometimes regard sexual practices and their gender as a source from which to gain material and financial advantages. Sexual favours may vary on a continuum from rewards for meeting basic needs to sex for expensive items. The tendency of younger women to form relationships with men five to ten years their senior and to accept money or favours in return for sex increases the likelihood that they will be exposed to HIV (Chikore, 2000).

Sabone, Ntsayagae, Brown, Seboni, Mogobe & Sebege (2007) studied the perceptions of undergraduate male and female students not participating in HIV/AIDS prevention activities in Botswana. The findings showed that the students felt that abstinence could be a good way of preventing the spread of HIV/AIDS but they believed that it was not practical for them. Again the students reported that while being faithful to one's partner made sense, it was also not practical in a campus environment because of factors that included peer pressure and boredom. In the same study the students also indicated condom use rate was low among them as the decision making related to sex was male-dominated and that a female student would not even find out if the partner was using a condom or not. Another finding was that female students date older men from outside the university because of money so they exchange unprotected sex for money. This implies that although young people may be equipped with enough information and knowledge on HIV/ AIDS, its impact and ways of prevention, there are still other underlying factors that may always lead them to risky sexual behaviours.

The University of Venda has a policy on HIV/AIDS, which is applicable to all staff and registered male and female students. Its purpose is to enable management to set up projects and programs through the HIV/AIDS Unit, Student Counseling Bureau, and Campus Health and

Wellness Unit which combat the spread of HIV/AIDS. The policy statement reads that the University of Venda is committed to fighting the HIV/AIDS epidemic using the HIV/AIDS Unit as well as the Campus Health and Student Counseling Services Units as main drivers of the programs. It will, therefore, endeavour to protect the rights of all employees and students who are infected and affected by HIV and AIDS.

This is in line with the South African Higher Education and Training Department's policy statement on HIV/AIDS which reads; The Higher Education sector commits itself to responding to the challenges posed by the HIV and AIDS pandemic through all aspects of its core mission, teaching and learning, research and innovation, and community engagement, and to mitigate its impact on Higher Education Institutions and, correspondingly, on society as a whole.

HIV/AIDS Unit, the HIV/AIDS Committee, and the HIV/AIDS Coordinator, are structures and persons set up by the University to ensure that HIV/AIDS activities and programs are properly coordinated and managed. These are responsible for the implementation of the HIV/AIDS policy and related programs on campus (Manenzhe, 2009).

2.5 The sociological review of HIV/AIDS

According to the World Health Organization (2013), an estimated 34 million people are living with HIV globally, and several recent literature reviews examine the AIDS pandemic in various regions

(De Cock, et al., 2013), including sub-Saharan Africa, home to more than two-thirds of the world's HIV infections, and China (Hong & Li, 2009).

HIV prevention programs are interventions that aim to halt the transmission of HIV. They are implemented to either protect an individual and their community, or rolled out as public health policies. Initially, HIV prevention methods focused primarily on preventing the sexual transmission of HIV through behaviour change. For a number of years, the ABC Approach - "Abstinence, Be faithful, Use a Condom" was used in response to the growing epidemic in sub-Saharan Africa. However, by the mid-2000s, it became evident that effective HIV prevention required more than simply ABC and that interventions need to take into account underlying socio-cultural, economic, political, legal and other contextual factors. Indeed, as the complex nature of the global HIV epidemic has become clear, forms of 'combination prevention' have largely replaced ABC. Combination prevention advocates for a holistic approach whereby HIV

prevention is not a single intervention (such as condom distribution) but the simultaneous use of complementary behavioural, biomedical and structural prevention strategies. Combination prevention programs combine many different HIV prevention interventions into a single, all-inclusive program. Combination prevention includes a range of initiatives from condom promotion to blood screening, and legal reform. Combination prevention programs consider factors specific to each setting, e.g. levels of infrastructure, local culture and traditions as well as populations most affected by HIV. Combination prevention programs can be implemented at the individual, community and population levels. UNAIDS have called for combined approaches to HIV prevention to be scaled up, to reinvigorate the global response and make a sustained impact on global HIV incidence rates. UNAIDS defines combination prevention as: "rights-based, evidence-informed, and community-owned programs that use a mix of biomedical, behavioural, and structural interventions, prioritized to meet the current HIV prevention needs of particular individuals and communities, so as to have the greatest sustained impact on reducing new infections (UNAIDS, 2005).

HIV/AIDS is an epidemic of intersectional inequality fueled by racial, gender, class, and sexual inequities at the macro-structural, institutional, and micro-interpersonal levels. These inequalities shape the likelihood of exposure to the virus; the realities of living with HIV; and our medical, programmatic, political, and social-scientific responses.

Identities and statuses based on race, sexual orientation, class, gender, and other categories serve as organizing principles and help to determine how power is distributed, (im)balanced, maintained, and challenged (Watkins-Hayes, 2008). Various forms of inequality rendered through racism, sexism, class subordination, heterosexism, and other forms of exclusion intersect and interact with one another, creating what Collins (1990) calls interlocking systems of oppression. As individuals navigate their social worlds and encounter privileges or disadvantages by virtue of their various social group memberships, they affirm, acquiesce to, resist, or create alternatives to dominant ways of thinking and behaving.

Intersectionality is therefore a conceptual framework that acknowledges how multiple, simultaneous and structurally embedded social locations influence the life experiences, opportunities, investments, and constraints of individuals and groups (Collins, 2008).

Unlike many other illnesses, HIV has a particular cultural significance that obliges its carriers, and those most intimately involved in their lives, to grapple with weighty and contentious social

issues: sex, sexuality, drugs, class, race, gender, and inequality of exposure to harm. HIV/AIDS intersects with long-standing social hierarchies that seemingly render some groups more expendable than others. As such, HIV/AIDS is not only a medical epidemic but also a social and cultural test that pushes our views about difference and complex inequalities to center stage. The goal of an AIDS-free generation seems attainable in well-resourced countries like the United States, but almost impossible in under developed countries, and experts now publicly contemplate “the beginning of the end of AIDS.” However, President Obama’s statement as he unveiled a national HIV/AIDS strategy in America hinted at the vexing reality that social status continues to play a significant role in determining who is most at risk of infection, who is most likely to receive life-saving treatment, and how the epidemic disproportionately affects certain communities.

Not all sociologists have emphasized the cultural and structural dimensions of HIV. In his work on sexual narratives of Mexican gay and bisexual immigrant men in San Diego, Fontdevila (2009) focuses on the micro-level interactions that facilitate HIV transmission, emphasizing protective versus trusting frames during sexual encounters. Protective cooperative frames promote selfprotective barriers such as condom use, whereas trusting cooperative frames depend on trust, trustworthiness, and reciprocity of information about HIV status between sexual partners. Individuals often move between frames during sexual encounters, reacting to contextual cues and deciding in the moment whether to use condoms.

2.5.1 Gender issues relevant to HIV/AIDS

HIV affects men and women alike. Young women however, face a dual challenge. In addition to the threat of AIDS, mortality and morbidity related to pregnancy, delivery and unsafe abortion remain among the most significant risks to young women’s health.

The patriarchal social arrangements of African societies ultimately serve to submit power and privilege into the hands of men while simultaneously curtailing the autonomy of women. The gender dynamics that result from this system put women in South Africa at greater risk of HIV infection than their male counterparts. These inequalities have serious implications for choices that women are able to make in their lives, and provide a supportive backdrop for gender-based violence.

- In the first instance, it affects women’s capacity to decide with whom, when and how sexual intercourse takes place (Pettifor, Measham, Rees & Padian, 2004). Indeed, such

decisions are frequently constrained by coercion and violence in the women's relationships with men. Young girls are often coerced by older men, including male school teachers, into having their first sexual experience with them.

- Second, women are generally not socialized to initiate sexual activity. This task is normally considered to be part of a man's role (Varga, 2009).
- Third, men perceive themselves to be naturally superior to women and often consider it a cultural right to have multiple partners. Such behaviour is generally equated with notions of normative masculinity (Eaton, et al., 2003).
- Finally, women are commonly implicated for bringing HIV into a relationship while their male counterparts are culturally absolved of blame for the disease (Leclerc-Madlala, 2002).

Young people in Africa are much more likely to be living with HIV than adolescents in other regions around the world. Across Sub-Saharan Africa, HIV is spreading throughout the general population. Young women are more greatly affected than young men: An estimated 4.3% of women aged 15–24 in Sub-Saharan Africa are living with HIV, compared with 1.5% of men in that age-group. In some countries, the rates are much higher; 15% or more of young women in Botswana, South Africa, Swaziland and Zimbabwe are living with HIV (Gutmacher Institute, 2007). It is little wonder then that the Joint United Nations Programme on HIV/AIDS (UNAIDS) considers 15–24-year-olds to be the age-group "most threatened by AIDS" and "at the center of HIV vulnerability."

By far the predominant mode of HIV transmission in Sub-Saharan Africa is heterosexual intercourse, which also puts young women at risk of unplanned pregnancy. In Sub-Saharan Africa, the average birthrate is 143 per 1,000 women aged 15–19, well over twice the worldwide average of 65 per 1,000. Most births to teen mothers in Sub-Saharan Africa occur within marriage and are planned, but one in five teen pregnancies result in an unplanned birth. Across Africa, rates of unplanned births among teens vary widely, from a low of 11% in Niger to half or more of all adolescent births in Gabon, Ghana, Lesotho, Namibia, South Africa and Togo (Gutmacher Institute, 2007).

An unplanned pregnancy can be an emotionally wrenching experience for any woman, and it can be especially frightening for an unmarried adolescent, who may be unprepared to raise a child. In this circumstance, a young woman may seek to terminate her pregnancy. In most Sub-

Saharan African countries, abortion is largely illegal. Nevertheless, it is common: An estimated 4.2 million abortions occur annually in Africa, more than a quarter of them among 15–19-year-olds. While some of these young women may be able to locate a trained provider and afford a safe procedure, the vast majority undergo clandestine procedures performed under crude conditions, endangering their health and often their lives. Adolescents frequently make up a large proportion of patients who are hospitalized for complications from such procedures. In Malawi, Uganda and Zambia, hospital-based studies show that adolescent women represent one-fourth to one-third of patients suffering from complications, and in Kenya and Nigeria, more than half of women with the most severe abortion complications are adolescents. Each year, an estimated 12% of maternal deaths in Africa are attributable to unsafe abortion.

Most adolescents are aware that sexual activity puts them at risk of getting pregnant or contracting HIV. Their knowledge is not detailed, however, and myths are common. For example, many adolescents think that a young woman cannot get pregnant the first time she has sexual intercourse or if she has sex standing up. Some adolescents believe they can identify someone living with HIV by their outward physical appearance; others report that HIV can be transmitted through a mosquito bite or that a man who is HIV-positive can be cured by having sex with a virgin (Guttmacher Institute, 2007).

While women in Sub-Saharan Africa are now less likely to be married in their teenage years than they were in the past, a substantial proportion of women still marry at a young age. Although rates vary considerably from country to country, roughly four in 10 women in Sub-Saharan Africa marry before turning 18 and six in 10 women do so by age 20. In contrast, slightly more than one in 10 men in Sub-Saharan Africa marry before turning 20.

A Sub-Saharan African woman who marries at a young age is likely to marry a man who is older than she is. She will often have her first child within a few years of getting married, in part because childbearing may be one way a young woman seeks to ensure the stability of her marriage and acquire status in her community. With motherhood the primary focus of her life, she may leave school and may have limited control over her daily activities. Moreover, she may be highly vulnerable to coercion and sexual violence and to contracting HIV or other STIs because she lacks individual autonomy and power, as well as information, education and access to services.

Women who marry in their early teenage years are at an even greater disadvantage, lacking the experience, skills and sense of self that even a slightly older woman may be able to bring to her marriage and family. Moreover, pregnancy and childbearing at a young age when a woman is still developing physically pose serious health risks for a young woman and for her infant, contributing to high levels of maternal and infant deaths and complications.

However, if a woman delays her marriage, even for a few years she may be able to pursue her education further and obtain skills that increase her access to employment, health care and other resources. Experts agree that formal education for adolescent women is key to delaying marriage and to addressing the poverty, low status and social norms that drive the marriage timing decision. For those young women who are already married, it is important to recognize that contrary to what some may think, marriage does not protect women from HIV or unplanned pregnancy. To plan the number of children they want to have and to safeguard their health, married adolescents must have access to comprehensive reproductive health services that take into account their age and the age of their spouse, power differentials, social networks, negotiation skills and social norms around childbearing (Guttmacher Institute, 2007).

Researchers postulate that gender-based violence and gender inequality are important determinants that place women at greater risk of contracting the HIV/AIDS virus (UNAIDS, 2005; Garcia-Moreno & Watts, 2000). Gender-based violence refers to a range of harmful custom behaviours against girls and women, including intimate partner violence, domestic violence and assaults, child sexual abuse and rape. Forced sex is not the only cause of HIV infection; in addition, the attitudes and mindset that underlie the act of forced sex, the disrespect for the rights of others, including the failure to disclose one's HIV status, all contribute to spreading the HIV virus. According to Chinkdanda (as cited in Van den Berg & Van Rooyen, 2007), women become victims to men's abusive behaviour and sexual violence because of women's perceived traditional role in society as 'the weaker sex' and in some cases women are even 'relegated to the same status as children'. Prevalence estimates for gender-based violence vary widely as a result of differing definitions of violence, but current estimates indicate that between 8% and 70% of women worldwide have been physically or sexually assaulted by a male partner at least once in their lives (Auerbach, Byram & Kandathil, 2005). Moreover, it is reported that one of the driving forces behind the HIV/AIDS epidemic in South Africa, is rape. By estimate there are more than one and a half million rapes in this country each year (Meel, 2005). Many times this can be ascribed to stereotypical male behaviour, which associates

masculinity with having easy access to women and in an attempt to emphasize male control women are being forced to have sexual intercourse.

Evidence also exists that gangs regard girls in their area as their 'property' with a view that they 'must be available for sexual intercourse' - thus increasing the risk for gang rapes and HIV infection. Moreover, results from other South African studies inter alia demonstrated that 25% of sexually active females admitted that they had been forced to have sexual intercourse; that child sexual assault, forced first intercourse and adult sexual assault by non-partners were significantly correlated with increased sexually risky behavior. Although those suffering from forced sexual intercourse believe that there is a good possibility that they are HIV positive, they are less willing to go for testing. Despite the fact that there is a visible association between the increase in sexual violence against women and the increased incidence of HIV infection in South Africa, HIV infection as a result of sexual assault has merited much less attention in this country (Meel, 2005). Focusing on the development and implementation of future HIV/AIDS prevention programs, the government and NGOs have to take cognizance of how sexual abuse affects the way 'survivors' interpret HIV risk awareness initiatives, understanding both their impact on individual risk reduction and how a history of abuse might further affect the spreading of HIV/AIDS (Anderson, et al., 2004).

Gender stereotypes, combined with age differences between partners in a sexual relationship, may constitute a risk factor for women (UNAIDS, 2005). Many women, especially younger females, cannot refuse unwanted sex or negotiate protection from pregnancy and STIs, including HIV, because they fear retaliation, resulting in multiple adverse physical, social and emotional outcomes (Dunkle, et al., 2004).

Age influences the vulnerability of female students in two ways. Firstly, female students notwithstanding their cultural background often prefer to have sexual relationships with older men. These men, in view of their sexual behaviour (the possibility of having had multiple sexual partners), carry a higher risk of infecting their current female partner(s) with HIV. Secondly, younger female students' risk of HIV infection is further increased due to their inexperience in negotiating for safer sex. Furthermore, in situations of forced sex or coercion, whether by strangers, acquaintances, family members, boyfriends or 'sugar daddies', negotiating condom use is virtually impossible (Marcus, 2002).

Contributing to the escalation of this risk factor is the unique South African phenomenon that female submissiveness, barricaded beliefs regarding male dominance, high levels of sexual crime and the fear of HIV infection propel men towards seeking increasingly younger groups of females for sexual relationships (Le Clerc- Madlala, 2002). This has direct implications for younger females because of their biological, immunological and/or hierological susceptibility, which changes in age, making them more vulnerable to infections in their teens and early twenties.

Younger females' reproductive tract is not fully developed and the skin is more likely to rip or tear during sexual intercourse, which increases the risk of HIV infection. In addition, research findings have demonstrated that women who began their sexual activity before the age of 17 are more prone to herpes simplex infections, which cause cellular changes and may result in cervical cancer. Moreover, research findings by the Kaiser Family Foundation (2001) have demonstrated that 33% of girls between the ages of 12 and 17 years have already had sexual intercourse; that girls even as young as 8 years are sexually active; and that 4% of girls between the ages of 12 and 17 years have already been pregnant (Henry Kaiser Family Foundation, 2001).

The literature also points to the fact that young women are even becoming greedier in their financial expectations when bargaining for sexual favors (Le Clerc-Madlala, 2002). Female students might also see sex with older men as a means to increase their social status. The financial position gained by these practices compensates for their lack of social and sexual power.

Levine and Ross (2010) warn that females' submissiveness and sexual liaisons should not only be linked to students from an African cultural background, but are applicable to Western gender roles as well. Male students' financial status becomes a risk factor when they do not have the financial resources to buy expensive accessories. South Africa's high unemployment rate may be seen as a contributing factor in pressurizing male students to prove their masculinity in other ways than their financial means (Barnes, 2011).

Study findings by Mudzusi and Asgedom indicate that male college students have more sexual partners than female students. The high number of sexual partners among males than females may be related to cultural practices in most areas in Africa where the aspect of polygamy is not shunned upon. It is also related with gender issues where males have the freedom to propose sexual relationships compared to females. The fact that men/students who have more sexual

partners are valued high may also be a contributory factor for males to have several sexual partners.

Misconceptions about HIV/AIDS amongst South Africans are often linked to cultural beliefs and convictions, such as “individuals that have been bewitched because ancestral spirits have been disobeyed and aggravated; ancestral spirits purportedly punishing individuals to fall ill; that diseases that were initiated by ancestors is seldom fatal and can be over- come by offering sacrifices to restore the positive relationship between the individual and the ancestor” (Van den Berg & Van Rooyen, 2007). Culture and gender may be linked to myths surrounding HIV that make women more vulnerable to HIV/AIDS infection. These factors are entwined with one another, and must be viewed as universal to females, with individual effects and influences on their behavior and how members of the opposite sex and the community see them. Research suggests that widely believed myths still exist amongst many cultures, thus reinforcing negative attitudes about safer sex, one of the most prominent of these myths being the virgin-cleansing myth, i.e. the belief that sex with a virgin will cure HIV infection and AIDS (Levine & Ross, 2002). If these myths are believed in specific cultural groups, there is a possibility that many female students, in view of their gender, are the ‘victims’ of gender-based sexual violence and rape by HIV-positive men in their communities believing them to be virgins. In contrast, female students may take part in these ‘sugar daddy’ practices and prostitution, not only because of the possible enhancement of financial and social status, but due to the myth that HIV is only found among young people, and that unprotected sex with older men is therefore seen as ‘safe’ (Levine & Ross, 2002). The myth that HIV does not cause AIDS, and that it is only a method used by Western cultural groups to restrict their population growth, might lead to students (both male and female) from African cultural backgrounds not considering the risk of HIV infection being a reality (Le Clerc-Madlala, 2002). Myths that condoms have microscopic holes in them, which can let the HIV virus through, might improve the chances of male students not using condoms (which are already viewed in a negative light).

The ever-increasing statistical records of HIV/AIDS prevalence, especially in South Africa and other sub-Saharan countries, further bear testimony of the fact that current HIV/AIDS intervention programs have failed to address the underlying concepts of masculinity and high-risk violent practices of sexuality. What is warranted is a new and inclusive understanding of the HIV/AIDS crisis, recognizing that it not just a health issue, but also a developmental, gender, social and economic issue that should be regarded inclusively. Moreover, in a country such as

South Africa, deeply rooted AIDS-related stigmas and fear of abandonment (especially women), create a barrier to HIV testing and have negative consequences for AIDS prevention and treatment (Meiberg, Bos, Onya, & Schaalma, 2008). Thus it is imperative that future HIV/AIDS educational programs, both at school and tertiary educational levels, should also address issues such as poverty reduction, gender inequality, stigmatization and discrimination, which place people at greater risk for HIV, STIs and unwanted pregnancy. In practice, this implies the coordination of HIV prevention activities with strategies that address the poor economic conditions and unequal gender norms that encourage young people, including students, to engage in risky sexual relationships (Gordon, 2008). Any national policy should be inclusive, involving all stakeholders in the process, including students.

2.6 Conclusion

Young people across the world are highly informed about sexual matters and the consequences of specific and particular sexual behaviours. Above all, young people know very well that abstinence, being faithful to one sexual partner and the use of condoms protects them from all sexually implicated consequences. It has been noted in this section that male and female young people experience the HIV and AIDS differently, as their positions and conditions are not the same in their societies. It is important to consider issues like individuals' socio-economic status, social class, ethnicity, race, cultural values and personal behaviour when attempting to understand the prevalence of HIV and the effects of AIDS in Africa, South Africa.

Chapter 3: Research Methodology

3.1 Introduction

A research process is strongly influenced by what is known as the methodology of a research, which defines the method of carrying out the research and presenting the methods for data collection and measurement, as well as the techniques used for data analysis (LoBiond & Haber, 2011). This chapter seeks to outline the methodology to be employed for the study. It presents the research design, population, sample and sampling techniques, ethical considerations, data collection instrument and methods to be used in data gathering, as well as data analysis.

3.2 Study approach

This study is descriptive in nature. The focus of a descriptive study is on the situation as it is, that is, conditions that exist, practices that prevail, beliefs, attitudes and ongoing processes (Babbie, 2001). The researcher aimed at analyzing the attitudes and perceptions of male and female students towards abstinence, being faithful to one sexual partner, and condom use, in order to gain insight into the reasons for the increasing prevalence of HIV/AIDS among young people in South Africa in spite of the high levels of knowledge regarding the epidemic.

3.3 Study design

Polit and Hungler (2010) define the research design as an overall plan for obtaining answers to questions being studied and handling difficulties encountered during the research. The research design used for this study will be a mixed methods approach, specifically the one known as the convergent parallel mixed methods. This is a form of mixed methods design in which the researcher merges quantitative and qualitative data in order to provide a comprehensive analysis of the research problem.

In mixed methods, the researcher collects both forms of data at roughly the same time and then integrates the information in the interpretation of the overall results (Tashakkori & Teddle, 2010). This design or method has been chosen for this particular study in an attempt to take advantage of the strengths of both quantitative and qualitative approaches, so as to achieve the best understanding of the study problem. It has also been carefully chosen as data collected was of

both quantitative and qualitative nature, which also imposed a need for the researcher to employ both statistical and text analysis of the data.

3.4 Research setting

Burns and Grove (2007) state that the research setting is the environment in which the research study takes place and can be a natural or controlled environment. Natural settings are real-life study environments without any changes made for the purpose of the study.

The study was conducted in the University of Venda. It is situated in Thohoyandou under Thulamela Municipality, in the scenic Vhembe District of the Limpopo Province of South Africa. The University enrolls an average of 11 000 full-time contact students per year. The university has different nationalities which include native South Africans (Pedis, Xhosas, vhaVenda, xaTsonga, Swatis and Zulus), Zimbabweans, Nigerians, Ghanaians and Congolese.

3.5 Study population

According to Silva & Menezes (2009), population is the total number of individuals who have the same characteristics defined for a specific study. The study population will comprise of male and female young people in the University of Venda. This population was chosen mainly for its availability and easier accessibility, which means the study would be less time and financially costly.

3.6 Research methods

Research methods include the steps, procedures and strategies for gathering and analyzing the data in a research investigation (Polit & Hungler, 2010).

3.6.1 Sample and sampling techniques

A sample is a set of elements taken from a larger population according to certain rules (Johnson & Christensen, 2009). Creswell, (2006) defines a sample as a subgroup of the target population that the researcher plans to study for the purpose of making generalizations about the population; it forms a manageable subset of a population.

A sampling method is a strategy used to obtain a sample. The method can either be probability or non-probability sampling (Burns & Grove, 2007). Probability sampling is a sampling

technique wherein the samples are gathered in a process that gives all the individuals in the population equal chances of being selected (Burns & Grove, 2007). Non-probability sampling on the other hand is a sampling technique where the samples are gathered in a process that does not give all the individuals in the population equal chances of being selected. A non-probability sampling approach was used for this study. In a non-probability sampling approach, each unit in the population has no equal chance of being selected and the sample can be said to be representative of the population from which it has been selected and as such generalizations of finding can be made to the population (Burns & Grove, 2007). Convenience sampling method was particularly used for this study. This sampling method, also known as haphazard sampling, involves selecting haphazardly those cases that are easiest to obtain for a sample and the same process is continued until the required sample size is reached (Welman, 2005). The sample in this study comprised of thirty-two (32) students, male and female in the University of Venda. Considering that most of the data to be collected would be qualitative in nature, the researcher chose a smaller sample to avoid overwhelming amounts of data that would be difficult to present and analyze.

Inclusion criteria are the characteristics that the respondents must have in order to be included in the study (Burns & Grove, 2007). The respondents for this study had to meet the following criteria: male and female students enrolled at the University of Venda for the academic year 2016; availability as resident students of the University of Venda campus; willingness to voluntarily participate in the study.

3.6.2 Data collection instrument

Burns and Grove (2007), define data collection as the precise systematic gathering of information relevant to specific research objectives or questions. Data can be collected in several ways depending on the study and can include a variety of methods. However, the research's objective must be accomplished with the instrument used. Literature on research indicates that descriptive research data can be collected through the use of interviews and questionnaires (LoBiond & Haber, 2011). The data for this study were gathered with the use of a semi-structured questionnaire that was developed to achieve the research aim and objectives.

Burns and Grove (2007) state that a questionnaire is a printed self-report form designed to elicit information and is developed with specific items to assist with the data collection. It is used to gather information from a large number of participants that can be easily quantified and analyzed. A semi-structured questionnaire was developed to elicit responses relevant to

achieve the aim of the study. The aim of the questionnaire was to obtain information regarding the knowledge of young people about the “ABC” strategy in the prevention of HIV/AIDS, as well as their feelings, attitudes and perceptions towards it. The advantages of using a questionnaire to collect data in this study are that it requires less time and energy to administer and that it is less costly (LoBiondo & Haber, 2011). The other advantage stated by Polit, et al., (1999) is that the absence of an interviewer ensures that there is no bias in the responses that reflect the participant’s reaction to the interviewer rather than to the questions. Furthermore, there is greater assurance of anonymity and no interviewer bias.

In order to collect the needed data or information for this study, as a researcher, I developed a measuring instrument to be given to all the participants, to ensure uniformity and consistency. The questions formulated were guided by the objectives of the study and the research questions.

The literature relevant to the study, as well as other questionnaires used in similar studies were consulted to provide valuable insight. As supported by Taylor, Peplau & Sears (2010) the following criteria for the development of a questionnaire was followed for this study: the concept was to be relevant to the study question; concepts were translated into items; there was one question per item; items were worded clearly; the most important items were placed at the beginning of the questionnaire.

Accordingly, the researcher developed a questionnaire in order to obtain the relevant information needed for this study. The instrument addressed issues concerning the knowledge of young people about the “ABC” strategy of HIV prevention, their feelings, perceptions, and attitudes towards it, the perceived susceptibility and severity to HIV/AIDS, factors that would affect the adoption of “ABC” strategy as well as its benefits. When designing the questionnaire, the aspects quoted by Taylor, et al., (2010) above were considered as well as the following: avoidance of wording bias; clarity of the questions; ability of the respondent to give accurate information; length of the questionnaire; amount of time it would take respondents to complete the questionnaire; concepts under the conceptual framework.

The design of the questionnaire took time and effort, and was drafted a number of times in consultation with the supervisor of the study at the University of Venda (UNIVEN) who would

critically review and verify the interpretations of the questions in the questionnaire before being finalized and approved.

3.6.2.1 Pilot study/ Pre-testing of the instrument

Polit & Hungler (2010), state that a pre-test is done with individuals who have similar characteristics to those who will be used in the study. A pre-test of an instrument is a trial run for detecting inadequacies and unforeseen problems before going to the expense of a full-scale study. It is done to determine the clarity of questions, effectiveness of instructions, completeness of the response set and the time required to complete the questionnaire (Burns & Grove, 2007).

Polit, et al., (2008), state that a pre-test aims to verify the level of inclusivity and acceptability of the questionnaire and improving the instrument if necessary and also testing the feasibility of the study.

With the approval of the supervisor, this questionnaire will be administered to two (2) individual students. These 2 who are to participate in the pre-test will be excluded from the actual study. Once the pre-test produces positive results and comments, then the actual study will presume.

3.6.2.2 Measures to ensure validity

Validity is defined as a measure of truth or falsity of the data obtained through using the research instrument (Burns & Grove, 2007). Babbie (2001) defines validity as the degree to which an instrument measures what it is supposed to be measuring.

3.6.2.2.1 Content Validity

Polit, et al., (2008) state that content validity is concerned with the adequacy of coverage of the content area being measured. Babbie (2001) indicates that content validity refers to how much a measure covers the range of meaning included within a concept. Due attention was paid by the researcher in the development of the questionnaire to ensure that the items included really were representative of what needed to be elicited in accordance with the study objectives and major question. The procedure to establish content related validity as suggested by Burns & Grove (2007) was followed and it included literature review, the involvement of content experts (supervisor) and representatives of the relevant population.

The questionnaire was developed following extensive literature review, which assisted the researcher to determine the boundaries of the study. The draft questionnaire was submitted to the supervisors of the study at UNIVEN. The questionnaire was only administered after a pre-test was done.

3.6.2.2 Face Validity

Face validity according to Polit, et al., (2008) refers to whether the instrument looks as though it is measuring the appropriate construct. Polit, et al., (2008), state that it is the extent to which a measuring instrument looks as though it is measuring what it purports to measure. The questionnaire was constructed so that it could measure the attributes to be studied which were the knowledge, attitudes, and perceptions of male and female students towards the “ABC” strategy for HIV/AIDS prevention. In ensuring face validity, the questionnaire was subjectively assessed for presentation and the relevance of the questions. The questionnaire was evaluated by the supervisor before approval.

3.6.2.3 Reliability of the instrument

Creswell (2002) indicates that reliability means that individual scores from an instrument should be nearly the same or stable on repeated administrations of the instruments. Test-retest method of reliability was conducted.

3.6.2.3.1 Test-Retest Reliability

Trochim (2006) explains that the test-retest reliability is used to assess the consistency of a measure from one time to another. This approach assumes that there is no substantial change in the construct being measured between the two occasions. Five students were chosen to fill the questionnaire once it has been pre-tested and approved by the supervisor. All the 5 students would fill in the questionnaires twice at an average of two weeks. The correlation was calculated in order to estimate how consistently the students responded to the same questions within the two weeks interval.

3.7 Data analysis

Data analysis is a systematic organization and synthesis of research data, a testing of the research hypothesis using the data (Polit & Hungler, 2010). Data collected for this study were cleaned, coded and analyzed with the assistance of a statistical consultant. Descriptive and inferential statistics were used. Tables and figures were done on the computer using the Microsoft

Excel, which formed the quantitative context of this study's data analysis. As for the qualitative data analysis, thematic coding was employed.

3.8 Ethical considerations

According to Polit & Hungler (2010), the protection of the rights of human subjects has become high priority among members of scientific and health care communities. After acquiring an ethical clearance to carry out the study from the University Ethics Committee, the following ethical issues will be taken into consideration:

3.8.1 Informed consent

The purpose of the study was explained to the students in the covering letter that accompanies the questionnaire. The respondents were informed in writing that participation is voluntary and the purpose of the study and participation needed from the respondents were also explained (Babbie, 2001). A consent form was attached to the questionnaire for the respondents to sign.

3.8.2 Anonymity

Anonymity was assured to ensure that the identity of the students who participated in the study was not to be linked with their individual responses. The respondents were not expected to write their real names on the questionnaires, rather pseudonyms were used in this case, so that their names would not be linked to any particular completed questionnaire (Babbie, 2001). The respondents were assured that the information would be used for the purposes of the research and the results of the research will be made available to them if they requested it.

3.8.3 Confidentiality

For confidentiality's sake, all questionnaires were distributed in non-transparent envelopes and participants were instructed to seal in their responses before handing them back. These completed questionnaires were kept safely under lock and information in soft copy was kept in the researcher's laptop and an external hard disk only, both secured with a password only known to the researcher.

3.8.4 Benefit

The respondents were informed that they would not receive any remuneration for participating in the study. They were however, in clear language, informed that their participation in the study would be greatly appreciated as the information gathered would assist in planning future health education for young people.

3.8.5 Right to withdraw from the study

The respondents were informed that they had the right to decide voluntarily whether to participate in the study without the risk of incurring any penalty and that they had the right to ask questions, to refuse to give information or to terminate their participation meaning that they could withdraw from the study.

3.9 Conclusion

The chapter outlined the proposed research methodology to be used for the study, addressing the population, research setting, data collection instrument, recruitment of study participants, data collection, data analysis, ethical issues that are to be carried out in the study. In the next chapter, the data collected will be presented, analysed and discussed.

Chapter 4: Data Analysis

4.1 Introduction

This chapter presents and discusses the findings of data collected from the participants. This data were collected to address a set of objectives and research questions derived from the main aim, which is that of investigating Univen students' knowledge, attitudes and perceptions towards the "ABC" strategy for HIV prevention, and how these consequently affect their sexual behaviour, whilst also taking a close look at the gender relations among these students.

Data were collected through the use of a questionnaire wherein some respondents were helped to understand questions that seemed to be complicated to them. Data collected were qualitative and quantitative in nature. The sample was comprised of both male and female Univen students living on campus who range from 2nd year to postgraduate levels and who are aged between 20 and 34 years of age. First-year students were left out as they may not yet possess attitudes and perceptions that reflect the true essence of University life.

The findings of the study are presented in themes, graphs and charts. The data are categorized under overarching themes and presented in sections. The first section comprises of biographical information of respondents; the second section is organized under the following themes: knowledge on HIV/AIDS, attitudes and perceptions on the 'ABC'-strategy for prevention, and the availability, accessibility and impact of information about HIV to University of Venda students.

4.2 Biographical data

This section discusses the biographical information of participants which is presented according to age range, sex, level of study, sexuality, and marital status.

The table below presents the gender of the participants.

Table 1: Sex

Sex	No.	%
Males	16	50%
Females	16	50%
Totals	32	100%

The selection of participants in this study was gender balanced; this enabled the study to get equal representation of both genders in responses and ensured that the study results are not gender biased. This kind of balance was particularly important for this study as one of its main objectives is to understand the power relations that exist across genders within sexual relationships, thereby making it gender sensitive.

The table below summarizes the age range of the participants that were involved in the study.

Table 2: Age range

Age range	Males		Females		Total No.	Total %
	No.	%	No.	%		
20-22	2	12,5%	1	6,25%	3	9,4%
23-28	10	62,5%	11	68,75%	21	65,6%
29-34	4	25%	4	25%	8	25%
Totals	16	50%	16	50%	32	100%

As can be seen in the table above, the majority of participants (65,6%) were aged between 23 and 28 years, followed by 29 - 34 years (25%), then 20-22 years (9,4%). No participants aged between 35 and 40, and 40+ were available. This may be because people in this age group are difficult to find and approach in campus; most of them stay off campus and are not comfortable discussing their sex habits.

Table 3: Marital status

Marital status	Males		Females		Total No.	Total %
	No.	%	No.	%		
Single	15	93,75%	15	93,75%	30	93,8%
Engaged	1	6,25%	0	0%	1	3,1%
Married	0	0%	1	6,25%	1	3,1%
Divorced	0	0%	0	0%	0	0%
Totals	16	50%	16	50%	32	100%

The above table illuminates that the majority of undergraduate students at the University of Venda are unmarried and still depend on their parents and bursaries financially. Married (3.1%) and engaged (3.1%) students are way fewer than those who are single (93.8%). Divorced students were never found to participate in this study (0%).

The table below demonstrates that the majority of participants (93.8%) were heterosexually oriented. Only a few (3.1%) were bisexual and (3.1%) homosexual. This may mean that the majority of students in the University of Venda are heterosexual. It may also mean that homosexuals are still hidden in the university, considering that the university is in the rural of Limpopo Province with people mostly whose culture still do not accept or tolerate homosexuality.

Table 4: Sexuality

Sexuality	Males		Females		Total No.	Total %
	No.	%	No.	%		
Heterosexual	16	100%	14	87,5%	30	93,8%
Bisexual	0	0%	1	6,25%	1	3,1%
Homosexual	0	0%	1	6,25%	1	3,1%
Totals	16	100%	16	100%	32	100%

Table 5 below presents the level of education of participants involved.

Table 5: Level of study

Level of study	Male		Female		Total No.	Total %
	No.	%	No.	%		
2 nd year	5	31,25%	4	25%	9	28,1%
3 rd year	5	31,25%	3	18,75%	8	25%
4 th year	3	18,75%	6	37,5%	9	28,1%
Post-grad	3	18,75%	3	18,75%	6	18,8%

Totals	16	100%	16	100%	32	100%
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The above table shows that the majority of participants (81.25%) were undergraduate students, only a few (18.75%) were post-graduate. The results of this study are therefore more representative of undergraduate students, who are the majority. Most post-graduate students fall under that 29-40-year age group which is difficult to approach and discuss sexual matters with on campus. It is by chance that the majority of participants for this study were 3rd year students since the sample was selected haphazardly.

4.3 Knowledge about HIV, abstinence, being faithful to one sexual partner, and condom use

This section sought to assess the students' knowledge on HIV/AIDS and the 'ABC' (abstinence, being faithful and condomise) strategy that exists at UNIVEN. The data demonstrates high levels of knowledge about HIV/AIDS as well as the 'ABC' strategy among Univen students.

To assess their knowledge about HIV/AIDS and the ABC strategy for HIV prevention, general statements in the form of a table were posed where participants were asked to indicate, by a show of a mark (tick or cross), if these statements were true or false. The majority of participants (93.8%) got all these correctly, with only a few (6.2%) who got one or two wrong.

Statements about HIV and the ABC prevention method	True	False
1. HIV/AIDS stands for Human Immune Deficiency Syndrome/Acquired Immune Deficiency Syndrome.		
2. South Africa has the highest number of people living with HIV/AIDS in the world.		
3. Sexual contact is the leading route for HIV transmission in South Africa.		
4. Forcing students to take a HIV test is against the law.		
5. Univen has an HIV/AIDS policy.		
6. Univen's HIV/AIDS policy is freely accessible to students and staff.		
7. I can get free HIV testing at Univen.		
8. Condom distribution is one of Univen's HIV prevention strategies.		
9. ABC stands for; Abstain, Be faithful, and Condom use.		
10. Abstaining reduces one's chances of contracting HIV.		

11. Being faithful to one sexual partner means one is totally safe from contracting HIV.		
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The majority of participants (93.8%) got all these correctly, with only a few (6.2%) who got one or two wrong, displaying high levels of knowledge in students about HIV/AIDS and its prevention as found by Jabuli (2013), whose study findings revealed that the levels of knowledge in young people about HIV and sexual matters were very high. It also revealed that young people know about condom use as a means of prevention against unwanted pregnancies and HIV as well as other STIs. This suggested that young South Africans at HEIs are well informed about sexual matters and the ways of preventing pregnancy and STIs.

In addition to these, participants were asked what they understood by the term sexual abstinence. The majority of participants (96.8%) were able to define abstinence correctly and accurately. Most of them defined sexual abstinence as:

Not engaging in sexual intercourse at all (X, 23-28, male, 3rd year).

Or

Not having sex (Special, 23-28, female, postgraduate)

Only one participant (3.2%) got the definition of sexual abstinence not as accurate as others did as he defined it as:

It is preventing addiction or behaviour (Susan Mabite, 23-28, female, 3rd year).

Data also showed that University students are knowledgeable about ways in which HIV can be transmitted. For instance, when asked to list ways in which HIV can be transmitted, all participants correctly listed these as follows:

“Sex, needles, and blood transfusion” (Mujuru, female, 29-34, postgraduate).

“Sexual contact and through sharp objects” (Mugabe, male, 23-28, 3rd year).

“Unprotected sex, sharing sharp objects with positive individuals, mother to child transmission, blood transfusion” (X, male, 23-28, 3rd year).

“Sex, sharing sharp objects with someone who is infected, and through wounds” (Scuby, female, 23-28, postgraduate).

“Unprotected sexual intercourse and sharing sharp metal objects” (Zenzo, female, 23-28, 2nd year).

Although not all of them listed them all, participants were able to list unprotected sex, sharing of sharp objects or needles, blood transfusion, mother-to-child transmission, and contact of body fluids as the major avenues for HIV transmission, as can be seen in the observations above.

4.4 Attitudes regarding HIV prevention strategies (sexual abstinence, being faithful to one sexual partner, and condom use)

This section sought to determine attitudes of UNIVEN students on the ‘ABC’ prevention strategy. To this effect students demonstrated positive attitudes towards the HIV prevention strategy (abstaining from sex, being faithful to one sexual partner and condom use).

To determine attitudes towards the ‘ABC’ strategy, a tool was developed, which contained nine statements about HIV/AIDS. This was presented to participants in a table, as follows:

	1	2	3	4	5
1. A person must be concerned about their HIV status only if they feel sick.					
2. You can tell if a person has HIV by looking at their appearance.					
3. If I demand condom use during sex my partner will leave me.					
4. I can get HIV if I work close to a person with HIV.					
5. Having HIV or AIDS means that a person is dying soon.					
6. If I abstain from sex I won't have many friends.					
7. Having multiple sexual partners makes me man/woman enough.					
8. Demanding condom use during sex means that I do not trust my partner.					

9. If I participate in the University's HIV/AIDS matters my peers will think I have HIV.					
10. Virgins should not bother testing for HIV.					

The results on the above table are discussed in the sub-headings that follow.

(i) *A person must be concerned about their HIV status only if they feel sick.*

The majority of participants (93.8%) either disagreed or strongly disagreed with this statement. This reveals that Univen students are concerned with their HIV status and they do not wait until they feel sick to go and get tested, this may be attributed to their awareness that there is free and visible HIV counseling and testing within the campus.

A smaller percentage of participants (3.1%) were neutral with regard to this statement while another (3.1%) strongly agreed with it.

(ii) *You can tell if a person has HIV by looking at their appearance.*

The majority of participants (90.625%) strongly disagreed with the above statement while 6, 25% of participants simply disagreed and 3,125% of them remained neutral.

(iii) *If I abstain from sex I will not have many friends.*

Most of the participants (87.5%) either disagreed or strongly disagreed with the above statement while only a few (6.25%) agreed with it and another (6.25%) were neutral. This demonstrates that although the majority of University students are sexually active, most of them are not driven by peer pressure to indulge in sex, contrary to what was found by Sabone et al., (2007) in their study that peer pressure made it difficult for students to abstain from sex until marriage.

(iv) *Having multiple sexual partners makes me man/woman enough.*

The majority of participants (96.9%) disagreed with this statement, illustrating that although we live in a society wherein according to Mah & Halperin (2008), male virility is often measured by how many sexual partners one has at any given time; Univen students, particularly male ones, don't think having multiple sexual partners makes them any better than they are, not necessarily meaning they are all faithful in their relationships though.

However, a few (3.1%) strongly agreed with the statement, thus displaying the existence of some elements of students whose culture, backgrounds, and individual personalities that may have negative effects in their sexual behaviour.

(v) *If I demand condom use during sex my partner will leave me.*

The majority of students (75% males & 81.25% females) disagreed and strongly disagreed with the above mentioned statement, showing that Univen students do not compromise their health over securing romantic relationships as indicated by Rosenthal, et al., (1998), in whose study men admitted to using the promise of romance to gain their sexual desires and disclosed a reluctance to use condoms, with some admitting that they refused condom use altogether, leaving women with the choice of foregoing safer sex or jeopardizing a potentially satisfying romantic relationship. 12.5% males and 0% females agreed with the statement, illustrating some male reluctance to use condoms. Another 12.5% males and 18.75% females were neutral with the statement, demonstrating that some students are undecided on their stance on condom use in their relationships.

(vi) *Virgins should not bother testing for HIV.*

The majority of students (96%) strongly disagreed with this statement, thereby displaying positive attitudes among Univen students pertaining HIV prevention. This further proves that Univen students are aware of the fact that they are not completely immune and safe from contacting HIV by other means besides sexual intercourse.

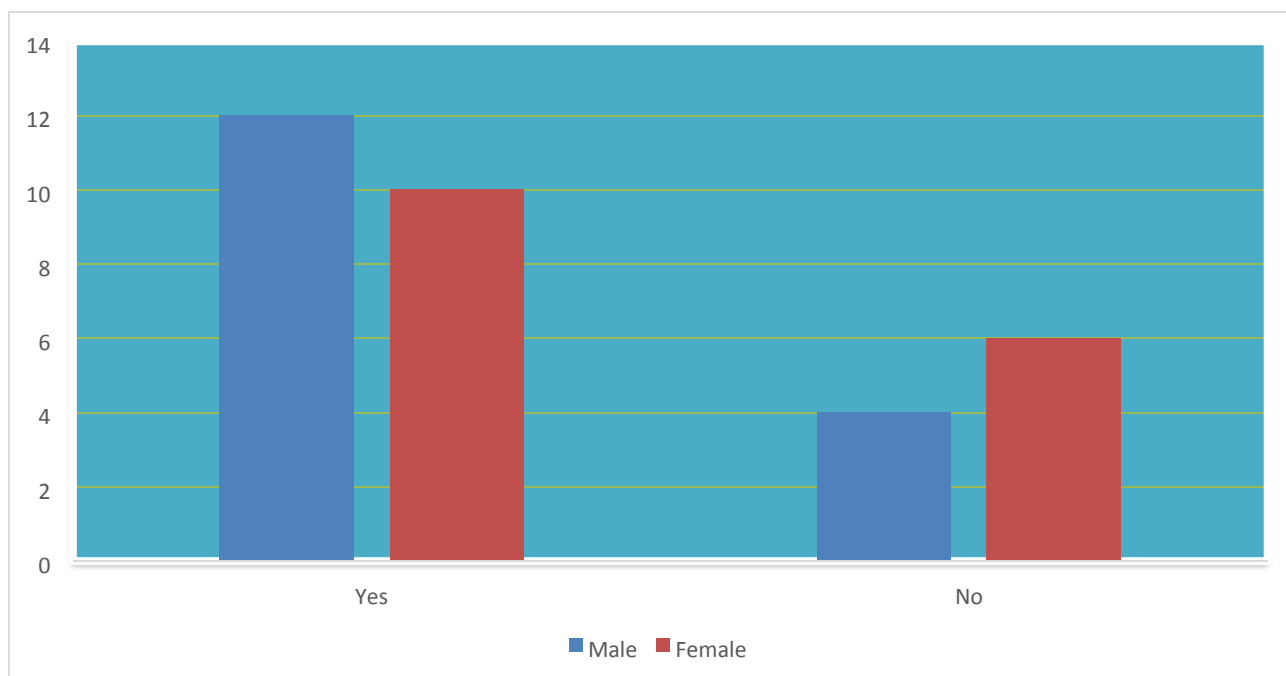


Figure 1: Do you as a University student think abstaining from sex until marriage is possible?

As suggested by figure 1 above, when asked whether as University students, they thought abstinence from sex until marriage was possible or not, the majority of participants (68.75%) reported it as possible (75% males and 62,5% females), whilst a very significant (31.25%) denied it as a possibility (25% males and 37.5% females). This indicates that female students, more than their male counterparts believe that abstaining from sex while at University is impossible. This may be because females usually date older guys who dominate the decision-making related to sex, as pointed out by Harrison, Xaba & Kunene, (2001), that owing to the power inequality in sexual relationships, women remain ill-equipped to advocate their own sexual health.

For those participants who thought abstaining from sex until marriage is possible, most of them cited having to hold on to one's personal beliefs to make abstinence a possibility. For example:

It is very possible, it's a matter of holding on to what you believe in and have patience until the day of marriage comes (Mujuru, 29-34, female, postgraduate).

It is all about individual choices not necessarily being a University student (X, 23-28, male, 3rd year).

If you go to church and pray it's possible (Thabo, 20-22, male, 2nd year).

The above responses reveal that University students' personal and religious beliefs play a role in determining how they think about sexual matters. Of the 68.75% participants who pointed out the possibility of abstinence, the majority of them are sexually active, as also revealed in a study on the perceptions of undergraduate male and female students not participating in HIV/AIDS prevention activities in Botswana by Sabone et al., (2007), whose findings have shown that students felt that abstinence could be a good way of preventing the spread of HIV/AIDS but they believed that it was not practical for them.

Some of the participants who deemed abstinence as impossible expressed their arguments as follows, with one pointing to peer pressure as the greatest obstacle to this kind of behaviour:

With this much pressure we put on each other in classes, rooms and even gatherings it is just impossible not to fall in. Abstaining from sex would mean abstaining from peers (Mcubed BW, 20-22, male, 2nd year).

Another participant mentioned that sexual intercourse is too pleasurable to resist:

It's not possible because sex is a basic need and it's so pleasurable that we cannot resist it until marriage (Michael, 23-28, male, postgraduate).

4.5 Perceptions regarding HIV prevention (sexual abstinence, being faithful to one sexual partner, and condom use)

This section sought to assess students' perceptions regarding the ABC-strategy for HIV/AIDS prevention. To this effect both open- and closed-ended questions were asked as will be seen in what follows.

Firstly, a table of 6 statements about these mentioned matters was developed for participants to indicate how they agreed or disagreed with as follows; (1) is for Strongly Agree, (2) is for Agree, (3) is for Neutral, (4) is for Disagree and (5) is for Strongly Disagree

	1	2	3	4	5
1. Any person has the potential of getting HIV.					
2. Correct use of condoms protects people from contracting HIV.					
3. The only way to know my HIV status is through an HIV test.					
4. HIV awareness helps people protect themselves from HIV infection.					
5. Circumcised men should not bother using condoms.					
6. If I am faithful to one sexual partner I should not be concerned about HIV as I am safe.					

University students have positive perceptions when it comes to HIV and how it is transmitted, this is revealed by their responses to the following 3 statements represented in the below graphs which were part of the above 6 from the questionnaire:

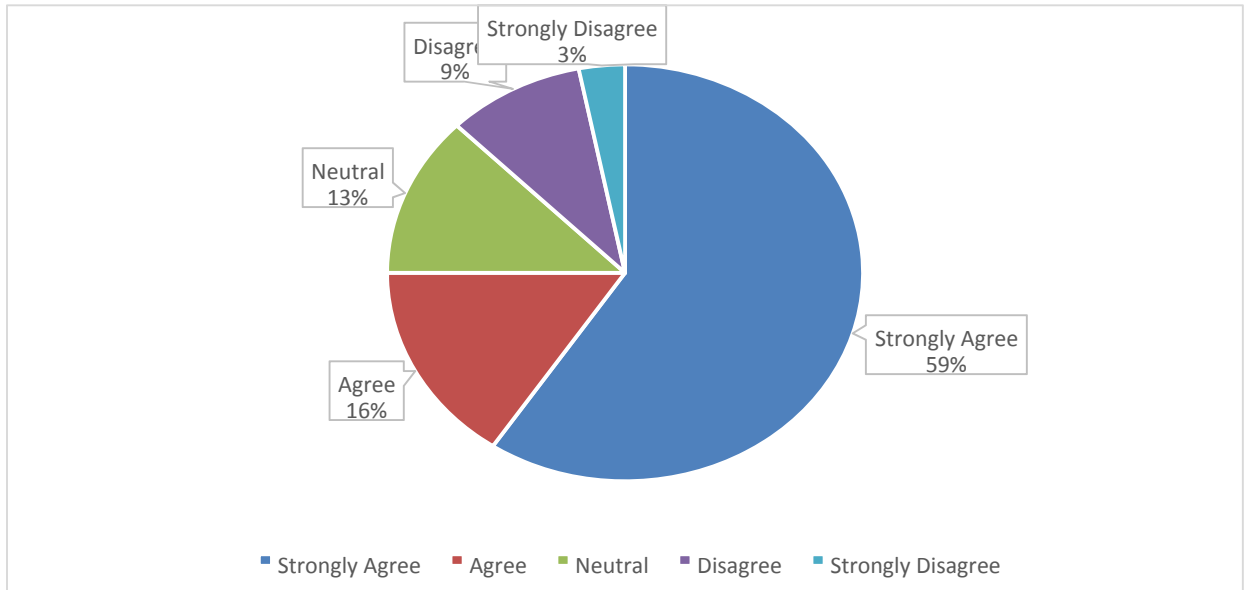


Figure 2: Any person has the potential of getting HIV.

The responses displayed on figure 2 above tell a story that the majority of University students (59%) strongly agreed and (16%) agreed with the opinion that anyone may be infected with HIV at any time during the course life. This is what is referred to as the perceived susceptibility to a disease in the Health Belief Model (Ott et al., 2002) that was used in this study to explain human health behaviour. This is a good sign, assuming that once they know they are susceptible to HIV, students may then decide to stay healthy by protecting themselves (abstaining, practicing fidelity and using condoms), as articulated by the Health belief Model. It is however, not much of a good sign as some participants (9%) disagreed with the statement that anyone is prone to HIV infection and a fewer (3%) actually strongly disagreed with the statements, displaying negative perceptions and low levels of knowledge for some students. Another part of the participants (13%) decided to neither agree nor disagree with the statement.

To further assess their knowledge, attitudes, and perception regarding HIV, its infection, and prevention, the statement below was presented to participants and they were asked to indicate how they either agree or disagree with. Their responses are as presented in the graph below:

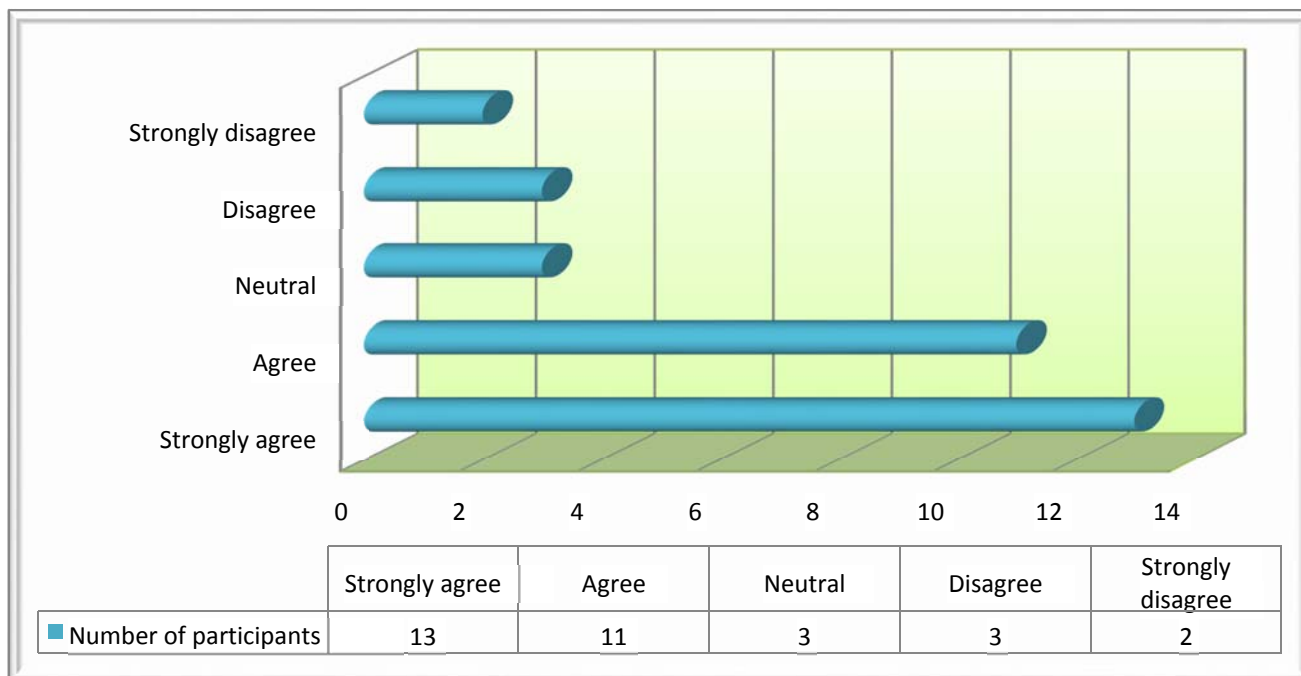


Figure 3: The correct use of condoms protects people from contracting HIV.

As displayed in figure 3 above, when asked to indicate if they agree/disagree with the opinion that correct condom use protects individuals from HIV infection, the majority of participants (40,6%) strongly agreed and another (34,4%) agreed. This shows that students are aware of the usefulness of condom use in preventing HIV infection, as suggested by Jabuli (2013) whose study findings revealed that young people knew about condom use as prevention against unwanted pregnancies and HIV as well as other STIs.

As explained in the theoretical framework of this study, once students realize that they may be predisposed to HIV infection, they may choose to take action when indulging in sex and use condoms to prevent infection. However, a significant 9, 4% disagreed with the opinion and a 6, 2% actually disagreed strongly. Another significant 9, 4% chose to remain neutral. The number of participants who disagreed/strongly disagreed with the opinion that condom use protects from HIV prevention may reflect ignorance from a few students or simply a negative insight with regard to condom use.

In yet another attempt to assess students' knowledge, attitudes, and perceptions regarding HIV, its infection, and prevention, the statement below was presented to them and were asked to indicate how they either agree or disagree with. Their responses are as presented in figure 4 below:

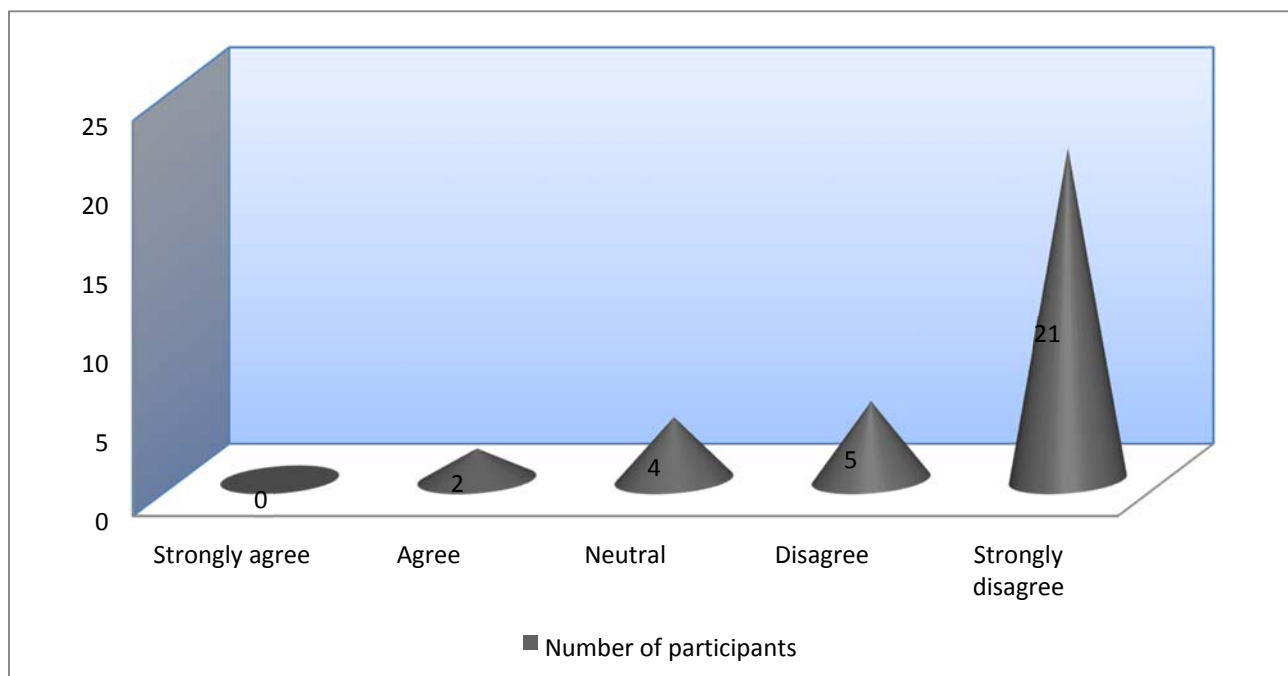


Figure 4: If I am faithful to one sexual partner I should not be concerned about HIV infection as I am safe.

The majority of Univen students do not think that being faithful to one sexual partner makes one immune to HIV infection, but only reduces chances of one being infected. This is displayed in figure 4 above, according to which the majority of participants (65, 6%) strongly disagreed with the opinion that if one is faithful to his/sexual partner then they are safe from HIV infection and should not be concerned of it, followed by a 15,6% who simply disagreed. While the majority of participants disagreed with this opinion, a few (6, 3%) agreed with it and another (12, 5%) neither agree with nor disagreed with. Although most Univen students know that fidelity does not totally protect them from HIV infection, there is still a need for those who perceive this as total safety to be further educated.

4.6 Gender relations and sexual behaviour

This section sought to compare male and female students' sexual behaviours, as these could possibly be affected by the power relations that exist between the two genders. Numerous researchers have found that there are differences in sexual conduct and perceptions of male and female individuals, owing to the power relations that have already been mentioned in the previous sentence. For example, according to de Bro, Campbell & Peplau, 1994, young women

feel more positive towards condoms and are more committed to their use than men. However, condom use is influenced by egalitarian partnerships with women's use of condoms being hindered by repressive relationship dynamics and gender attitudes. That is, in relationships in which women are typically viewed as subordinate to the male, women lack the power to assert condom use. Furthermore, successfully negotiating condom use can be hindered by women perceiving a negative reaction from partners, including fear of emotional or physical abuse (de Bro et al., 1994).

The table below (Figure 5) illustrates that from the 32 participants involved in the study, 28 participants (87,5%) reported being sexually active. Only 4 female participants (12,5%) reported not having had their sexual debut yet. In other words, 100% of male participants for this study were sexually active, whilst 75% of their female counterparts were. The graph below displays the ages of sexual debut for those sexually active participants.

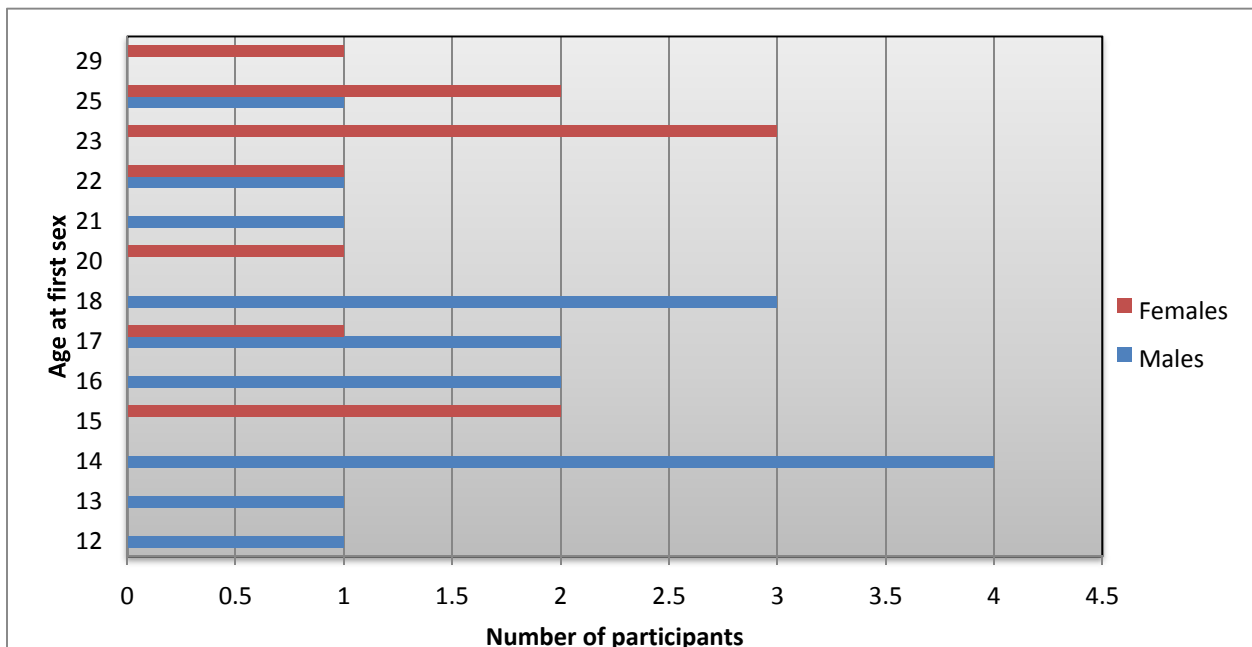


Figure 5: How old were you when you first had sex?

Male individuals have their sexual debut earlier than their female counterparts. This is supported by Family Health International, 2002, according to whom, surveys show that, on average, slightly more than 40% of women in Sub-Saharan Africa have had pre-marital sex before age 20; among young men, sex before marriage is even more common. As displayed in the graph above, the youngest age at first sex (12) was reported by a male participant whilst the oldest

(29) was reported by a female participant. The youngest age at first sex for females is 15, reported by two participants. In addition, what emerges from the graph is that ages 12 to 14 at first sex are only occupied by males, with older ages 23 to 29 mainly dominated by female participants.

To further compare both genders' sexual behaviours, participants were asked the number of sexual partners they had had in the last two months. Responses as presented in Figure 6 below reveal that male Univen students had had more sexual partners compared to female students.

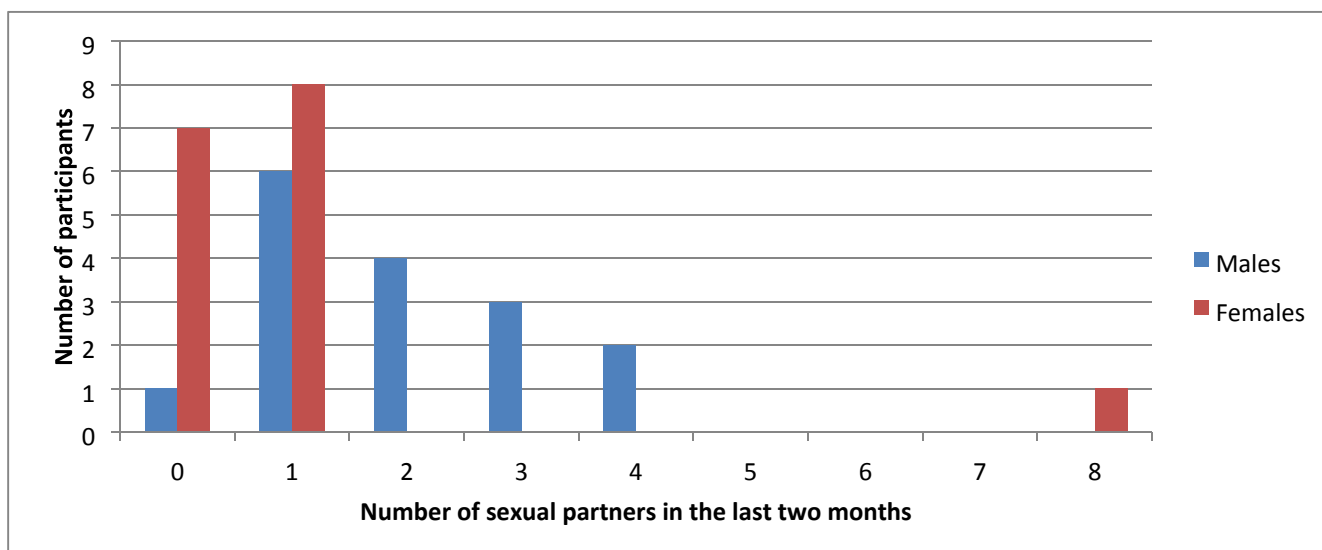


Figure 6: How many sexual partners have you had in the last two months?

As displayed on figure 6 above, when asked the number of sexual partners they had had in the last two months, the majority (50%) of female students reported having had only one sexual partner compared to (37.5%) males, whilst 43.8% of them reported not having had any sexual partner(s) at all and only one (6.2%) reported having had 8 sexual partners. When it came to their male counterparts, the majority (37.5%) reported having had only one sexual partner in the last two months, whilst only one reported not having had any sexual partner at all and a significant (25%), (18.75%), and (12.5%) reported having had 4, 3, and 2 sexual partners, respectively. From the above displayed data, it is clear that male students have more sexual partners compared to their female counterparts. It is, however, comforting to learn that the majority of Univen students, both male and female, had had only one sexual partner in the last two months, at least by the time data were collected for this study.

In another attempt to investigate how gender relations affect students' sexual behaviours, mainly condom use, participants were asked how many times they had had unprotected sex in the last two months. Again, as articulated by de Bro et al., 1994, that young women feel more positive towards condoms and are more committed to their use than men, this study found that female students used condoms more than male students. This is displayed in Figure 7 below:

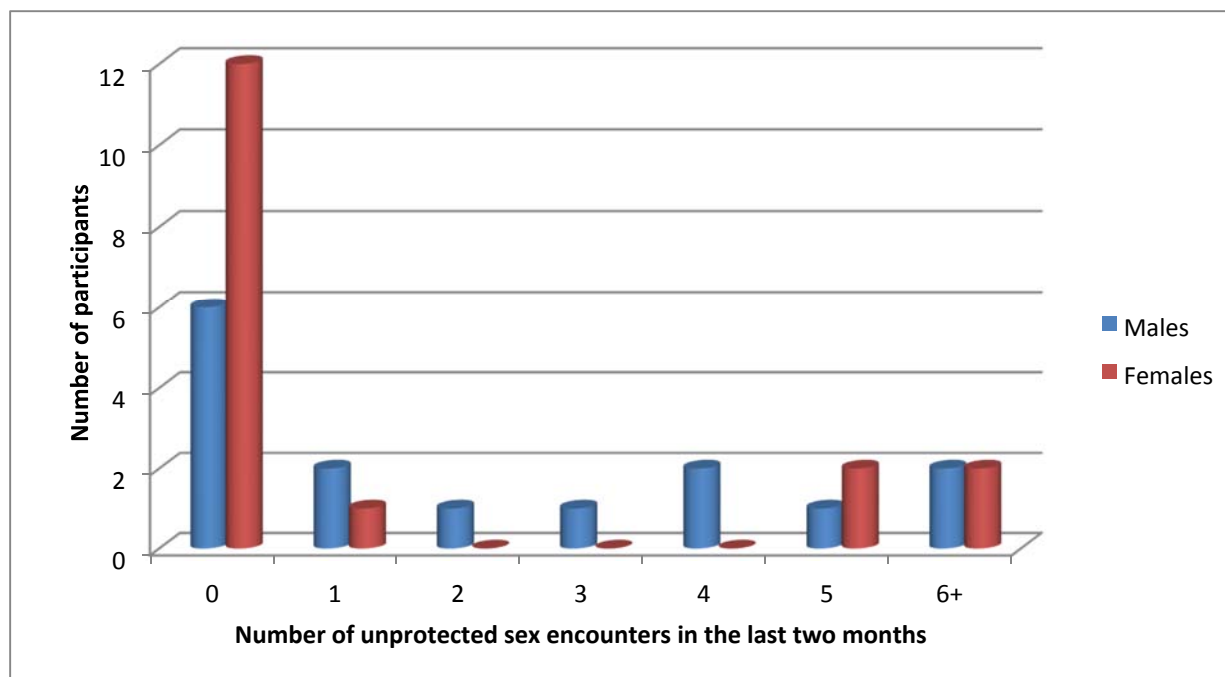


Figure 7: How many times have you had unprotected sex in the last two months?

The above graph (*Figure. 7*) displays information on the number of times the participants had unprotected sexual encounters in the last two months. The majority of female students (75%) reported not having had any unprotected sex at all, compared to 37,5% males, 6.25% reported having had only one unprotected sexual encounter compared to 12.5% males, while 12,5% females had 5 encounters and another 12.5% females had 6 and above encounters. Furthermore, one male participant 6.25% had unprotected sex two times while another 1 male participant 6.25% had unprotected sex three times. Other two male participants 12.5% reported having had 4 encounters of unprotected sex and another 6.25% had 5 unprotected sex encounters. Disturbingly, 2 male participants (12.5%) reported having had more than 6 unprotected sex encounters.

To further investigate the power relations that exist between female and male students in their sexual relationships, the researcher had the following question asked in the questionnaire: “*Who initiates sex between you and your partner/s?*” *Explain your response*

The data demonstrates that Univen students almost equally initiate sexual intercourse with their partners.

When asked the above question, half (50%) of male participants responded that they together with their partners equally initiate sex. Their responses were as follows:

Both of us, we discuss our feelings before having sex (Mugabe, 23-28, male, postgraduate).

We both do, depends on both our moods (X, 23-28, male, 3rd year).

Both because humans have sexual urge which may to both partners taking turns to initiate such (Coque, 23-28, male, 3rd year).

Us, I have several sexual partners and whenever I have sex with them we all initiate (Bomber, 29-34, male, 4th year).

Both of us in the sense that usually the partner who wants to engage in sex is the first one to initiate (Skhokho, 23-28, male, 2nd year).

From the above-mentioned responses, one can quickly conclude that University male and female students equally initiate sex in their sexual relationships as these male students reported that is the case. However, the other half of male students who were presented with this question responded in a manner that rather shows male dominance in intimate relationships with their female counterparts, with some displaying a belief that as men they are responsible for that in a relationship. Fifty percent of male participants reported that they themselves initiate sex in their sexual relationships as exemplified below:

I do. Whenever my partner(s) are around my mood turns from romantic to erotic, therefore I believe I am the one (MncubedBW, 20-22, male, 2nd year).

Me. Because I am a guy it is my duty to always initiate (Thabo, 20-22, male, 2nd year).

I initiate because I tell my partner I want intercourse (Muroja, 29-34, male, 3rd year).

Myself, I tell her we should have sex then she comes to my room and I don't waste time (John Zwane, 23-28, male, 3rd year).

Female participants on the other hand responded to the question as follows:

I do when I feel like it, I believe in gender equality. If he also feels like it he can initiate too (Supa, 23-28, female, 4th year).

Both of us. Because sex is between two people we should both initiate (Scuby, 23-28, female, postgraduate).

I initiate mostly but sometime he does, it depends on either of us how we feel at that particular time (Bongani, 29-34, female, 4th year).

Both of us, feelings just arise and everything just flows (Spector Harvey, 23-28, female, 4th year).

The above-mentioned responses are of the majority (56.25%) of female participants who commonly reported that they equally initiate sex with their partners, pointing out that it actually just depends on how either partners or one partner feels at a given point in time. However, some of the female participants pointed that it is their male partners who initiate sex, with some indicating that they believe and feel that it is the male partner's duty to do so. The responses below are those of female participants who reported that their partners are the ones who initiate sex in their intimate sexual relationships:

A few (18.75%) female Univen students however feel as if they do not do much as far as initiating sex in their relationships is concerned.

My partner. He calls me to his residence and starts flirting (Susan Mabite, 23-28, female, 3rd year).

My partner usually initiates I rarely initiate because I am naturally shy (Candy, 23-28, female, postgraduate).

Furthermore, a fewer (6.25%) female Univen students actually feel it is their male partners' duty to initiate sex in their intimate relationships.

It's usually my partner, he is the man in the relationship (Babes, 20-22, female, 2nd year).

Male Univen students (50%) initiate sex alone in their sexual relationships compared to 6.25% females who reported they do, displaying male dominance in sexual intercourse amongst students in their relationships.

Another question asked to determine gender relations was: “*Who initiates condom use between you and your partner/s during sex? Explain your response*”.

The majority of male participants (43.75%) felt they themselves alone initiate condom use, as can be seen in the responses below:

Me. My partner seems not to have a problem with either way, condom or no condom at all works for her (Thabo, 20-22, male, 2nd year).

I am the only one who initiates condom use with all my sexual partners (Bomber, 29-34, male, 4th year).

I am the one responsible for initiating condom use since I am not sure of my partner’s sexual history in order to protect myself from HIV and STDs (Skhokho, 23-28, male, 2nd year).

Me. My partners rarely do (Skhokho2, 23-28, male, 4th year).

Myself because I don’t engage in unprotected sex (Zakes Khumalo, 29-34, male, 4th year).

A significant 31.25% of male participants, however, felt they equally initiate condom use with their partners in their intimate relationships.

Below are responses from male students who feel they equally initiate condom use with their partners:

Both of us (Mugabe, 23-28, male, 3rd year).

We both do, depending on what we agree on at the moment (X, 23-28, male, 3rd year).

Both because our health matters (Coque, 23-28, male, 3rd year).

Both of us, we are not ready to have kids (Tsotsi, 23-28, male, postgraduate).

Furthermore, fewer male participants (18.75%) felt like it is their partners who initiate condom use in their relationships:

My partner. Sometimes when we start engaging I just want to go ahead without a condom and then my partner will remind me (Michael, 23-28, male, postgraduate).

My partner. She always plays it safe when it comes to unwanted pregnancy (McubedBW, 20-22, male, 2nd year).

My partner (John Jende, 23-28, male, postgraduate).

Only one male participant (6.25%) reported him and his partner do not use condoms at all.

We don't use those (Zama, 23-28, male, 2nd year).

The majority of female participants (37.5%) reported that they equally initiated condom use with their sexual partners:

Both of us because we are both not yet ready to have kids (Scuby, 23-28, female, postgraduate).

We discuss it before having sex (Zenzo, 23-28, female, 2nd year).

Both parties, sex is done unplanned and we would be protecting ourselves from unwanted children (Spector Harvey, 23-28, female, 4th year).

However, some female participants (31.25%) expressed it was their responsibility to initiate condom use in their sexual escapades:

I do. I don't trust men (Supa, 23-28, female, 4th year).

I do. To avoid pregnancy (Susan Mabite, 23-28, female, 3rd year).

I initiate and actually they are always present and ready for use (Bongani, 29-34, female, 4th year).

I initiate condom use, I always check that because I do not want to contract HIV/AIDS and I do not want to get pregnant (Candy, 23-28, female, postgraduate).

I usually do, my partner doesn't seem to really care (FirstLady, 29-34, female, postgraduate).

Only one female participant reported it is her partner who initiates condom use and another one reported she and her partner do not use condoms:

My partner, he is not ready to be a father (Babes, 20-22, female, 2nd year).

We don't use those (Sasha, 29-34, female, postgraduate).

The above data postulate that the majority of male students (43.75%) are the ones who initiate condom use in their relationships, compared to 31.25% female students who shared the same responsibility. The majority of female students (37.5%) reported that they equally initiate condom use with their partners, compared to a 31.25% male students. Furthermore, 18.75% male students and 6.25% females reported that their partners are the ones who initiate condom use.

Fewer students, 6.25% and 6.25% females reported they do not use condoms at all, and another 18.75% female students reported they were sexually inactive.

To further probe the role of gender relations in sexual behaviour, this question was asked; *“Would you or have you ever had sex for monetary or other material benefits? Explain your response”*

All (100%) male participants reported that they have never had sex for any monetary or material benefits.

No. Have never really been presented with the opportunity (X, 23-28, male, 3rd year).

No. Sex to me is led by attraction and feelings, I don't do it for money (McubedBW, 20-22, male, 2nd year).

No. I respect myself more than material things (Thabo, 20-22, male, 2nd year).

No, I have not, it's always for fun and enjoying sex, not for money (Muroja, 29-34, male, 3rd year).

Not at all. In situations like this the person paying might demand unprotected sex, which is risky (Tsotsi, 23-28, male, postgraduate).

No. Because many of those people who are selling or buying sex have a high risk of contracting HIV (Zakes Khumalo, 29-34, male, 4th year).

Although all male participants reported not having ever benefited financially or otherwise from sex, some 12.5% admitted they have bought sex in exchange for money.

No. I have never got the opportunity for benefit. But I have bought sex in exchange for monetary value (Michael, 23-28, male, postgraduate).

No but I once paid a hooker to quench my sexual desire (Coque, 23-28, male, 3rd year).

Furthermore, all female participants (100%) also reported that they have never had sex for financial benefits, with most declaring that they would never in their lives exchange sex for money.

No and I would never do that, I value myself too much for that, I would rather stay with no money or material things (Mujuru, 29-34, female, postgraduate).

No. I only have sex for pleasure (Susan Mabite, 23-28, female, 3rd year).

No, because it has negative consequences. You may end up being infected with HIV/AIDS or STDs (Scuby, 23-28, female, postgraduate).

No. I have only had sex grounded on the physical attraction I felt for my partner then (Zenzo, 23-28, female, 2nd year).

No. When I indulge in sex it will be for love (Xi, 23-28, female, 4th year).

No, sex is not all about money (Sama, 29-34, female, postgraduate).

No, I can't have sex for monetary benefits, my health is much important than material things (Chelsey, 23-28, female, postgraduate).

Never and don't think I would ever (First Lady, 29-34, female, postgraduate).

No it's against my principles (Babes, 20-22, female, 2nd year).

Never, it's never been my style (Sasha, 29-34, female, postgraduate).

Unlike it was found by Mudzusi & Asgedom in their study on the prevalence of risky sexual behaviours amongst undergraduate students in Jijjiga University in Ethiopia, that a considerable number of respondents engaged in sex with older partners particularly for material

and financial benefits, Univen students rather displayed a dislike for such behaviour, as manifested by their responses above. Most of their reasons in not indulging in sex for monetary and material benefits were based on their personal beliefs and principles that are against such practices.

One female participant, however, admitted that if opportunity presents itself, she may try having sex for monetary benefits.

Not really, but I once got money as a bonus. It wasn't intentionally done but however, if the money is good I would honestly try (Supa, 23-28, female, 4th year).

The majority of Univen students have never had sex in exchange for money and other material things, however, some male students have bought sex with money and a fewer female students would take money for sex if they are presented with the opportunity.

The following section sought to assess students' responsiveness to HIV awareness activities rendered by campus health promoters in the university campus. Students' responses will help campus health structures evaluate the effectiveness of their activities and make decisions on either improving or maintaining them.

4.7 Students' responsiveness to awareness campaigns and health services by campus health promoters

Figure 8 below presents information on the number of times students have attended HIV awareness campaigns held in Univen campus.

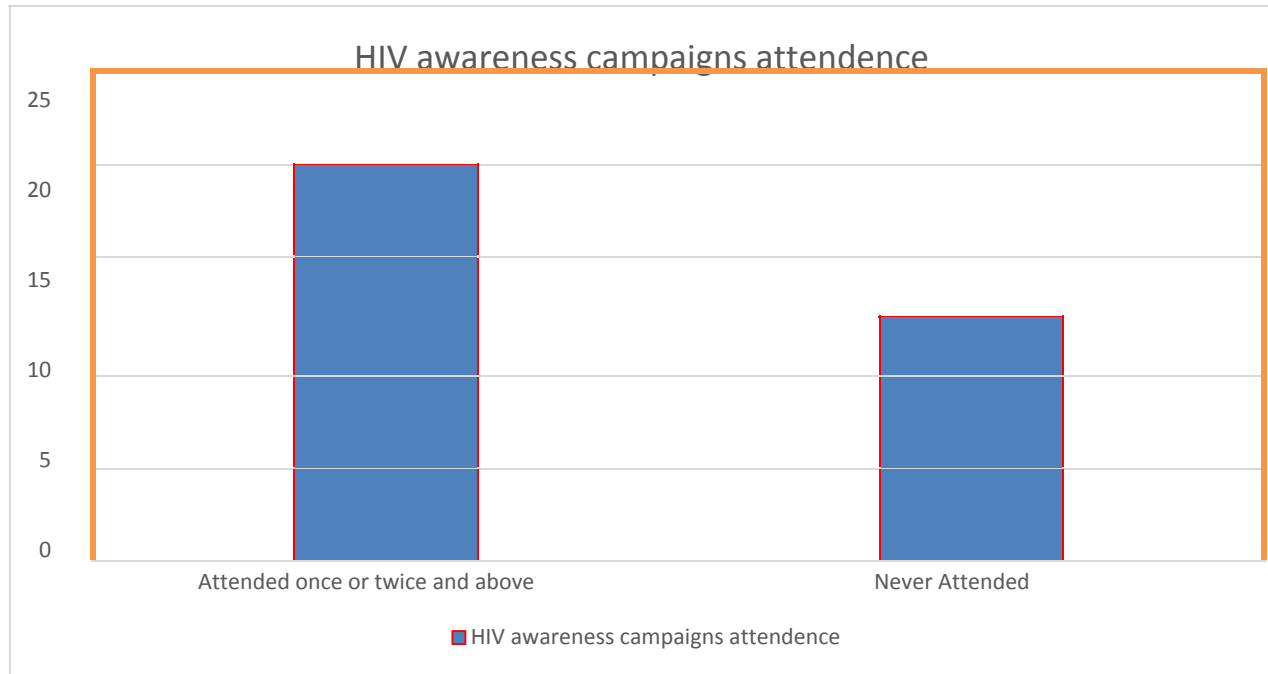


Figure 8: How many times have you as a student ever attended any workshop or health awareness campaign conducted by the University wherein you received information about condom use?

According to the bar graph above, of the 32 participants who were asked if they had ever attended any HIV health awareness campaign conducted in University campus, 20 (62,5%) of them reported having attended at least once or twice and above, whilst 12 (37,5%) reported having never attended these. From the above data, it can be concluded that the majority of Univen students have for once or more attended HIV awareness campaigns in the campus.

A considerable percentage (37,5%) of students who reported having never attended any of these events doubtlessly have different reasons for it. Some authors have put the blame on individual perceptions created by societal expectations of how male and female students should handle sexual health matters, as suggested by Rao Gupta (2000) that; Social norms about female sexuality make it very difficult for women and girls around the world to protect themselves from HIV infection. Women and girls are often encouraged to remain uninformed about sexual matters and/or remain sexually passive. Traditional norms of virginity for unmarried girls impede young women's freedom to seek important sexual health information, including knowledge about HIV risk. Women often have limited access to sexual health information and services because of a misguided fear that it will encourage sexual activity (Rao Gupta, 2000).

Societal expectations of men and boys also have an impact on male vulnerability to HIV/AIDS. Social norms about masculinity often assume that men are knowledgeable and experienced when it comes to sexual issues. This can have the negative effect of preventing men from seeking sexual health information or admitting their lack of knowledge about HIV risk reduction (Rao Gupta, 2000).

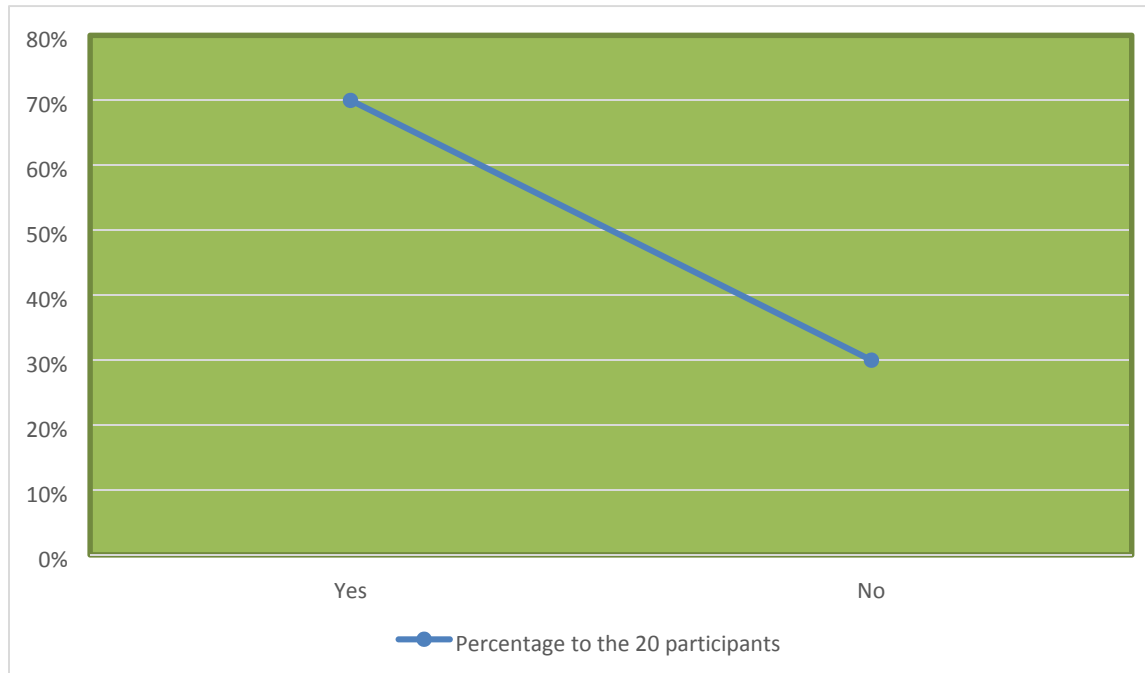


Figure 9: Have any of these campaigns positively impacted you to change your sexual behaviour? Yes/No.

Of the 20 students who reported having attended awareness campaigns at least once or twice, 70% reported having been positively impacted by these campaigns as far as sexual attitudes and behaviour are concerned, with 30% reporting these did not impact them in anyway.

The majority of students (70%) who reported having attended awareness campaigns in campus attested that these campaigns have helped them turn around their sexual behaviours positively. For example, one participant pointed out that:

I am now aware of the risks of sex; therefore, I am practicing safe methods which I learned via these campaigns (Mcubed, 20-22, Male, 2nd year).

These awareness campaigns on campus have really helped me keep on abstaining (Special, 23-28, Female, Postgraduate).

Some participants pointed out that the information from these events is important and helpful, although they as students at times fail to practice what they are taught.

Since I attended these I've learnt the importance of condom use, although at times my partner and I fail using them (Babes, 20-22, female, 2nd year).

However, a significant 30% of students who have attended awareness campaigns on campus have not been impacted by these as far as positive sexual behaviour is concerned, which is a cause for concern. Participants had different explanations to this, one responded explained as follows:

The people who are supposed to teach us are unkind and they mock people, they are just unfriendly so at the end you lose interest in the messages that they will be putting across (Scuby, 23-28, female, postgraduate).

The above response demonstrates that there are impediments in that students are discouraged by the attitude of health personnel when going for consultation in the health centre.

Two other participants pointed out that these campaigns do not affect them since whatever is taught there are things that they already know about, they responded:

It was information I already had, just the basics so it did not explain or teach much. It was more or less just a venue to distribute condoms and encourage students to continue using them (Candy, 23-28, female, postgraduate).

There is nothing new that they were teaching that I didn't know (Tsotsi, 23-28, male, postgraduate).

Univen HIV awareness campaigns affect students' sexual behaviours differently, some students take whatever information from these events and use it to turn around their sexual behaviour for the better, some feel the information is good but they themselves cannot practice whatever it is that they would have learnt due to different factors, whilst some feel these do not impact them in anyway as the information rendered is what they already know as University students.

To assess the effectiveness of Univen HIV awareness campaigns on students' sexual behaviours, this question was asked; *"Do you think that the manner in which students are given information about matters concerning HIV/AIDS, pregnancy, and sexual behaviour is effective enough to really promote positive attitudes and behaviour?"*

The majority of participants (75%) agreed that the information concerning HIV/AIDS, pregnancy, and sexual behaviour, and the manner it is given are effective enough to promote positive attitudes and behaviour.

Yes, it is enough, but the ball remains in the court of the students themselves whether they are taking the matters seriously or not giving attention to the warnings at all (Mujuru, 29-34, female, postgraduate).

Yes. The information is well broadcast and it is understandable (Mcubed BW, 20-22, male, 2nd year).

To some extent it does. However, I believe by the time most people get to University they are already well informed about these things (Supa, 23-28, female, 4th year).

Yes. Discussing leads to understanding from different views and these meetings just give it all (Susan Mabite, 23-28, female, 3rd year).

I think it promotes both positive and negative attitudes and behaviours. Sometimes acquiring knowledge triggers them to want to experiment even more (Zenzo, 23-28, female, 2nd year).

Yes, because a number of students are now aware and responding positively (Muroja, 29-34, male, 3rd year).

It is effective but more still needs to be done in the campaign to control AIDS through active participation of all students (Coque, 23-28, male, 3rd year).

The information is enough but people tend to do what they want (John Jende, 23-28, male, postgraduate).

Yes, it is enough, all that is left is for students to make the right choices (Bongani, 29-34, female, 4th year).

The information or campaigns do not convince students enough to abstain or use condoms (Zuma, 23-28, female, postgraduate).

Yes, but these campaigns are not well marketed so most of the students do not know about these campaigns (Bomber, 29-34, male, 4th year).

Yes, it is enough, it is just up to students to decide if they want to live an HIV free life (Zama, 23-28, male, 2nd year).

Yes. It is really effective in promoting positive attitudes since vast amounts of information is available concerning HIV/AIDS and pregnancy (Skhokho, 23-28, male, 2nd year).

Yes, but students choose not to (Skhokho2, 23-28, male, 2nd year).

Yes, it is effective but after all it's up to an individual to use the information or not (John Zwane, 23-28, male, 3rd year).

It is effective, it's just that people don't utilize the information being given by the health promoters (Zakes Khumalo, 29-34, male, 4th year).

Yes (Spector Harvey, 23-28, female, 4th year).

Yes, it is enough, but students continue doing whatever they want, I don't think knowledge really has much to influence actual behaviour (FirstLady, 29-34, female, postgraduate).

The information given is enough but it does not necessarily change all students' behaviours since as people we have different personalities and situations that shape our behaviour at the end of the day (Babes, 20-22, female, 2nd year).

Yes, it's only that students will go on and engage in risky behaviours regardless of the information they would have received (Sasha, 29-34, female, postgraduate).

Fewer participants (25%), however, felt the information is not effective enough.

It's not effective, there is need to explore new strategies rather than giving people flyers that they can just throw away without reading (Tsotsi, 23-28, male, postgraduate).

No it is not effective enough. There are very few campus health programs such as workshops. To get information, one has to approach the clinic, but not all students have the courage to ask face-to-face. They should create an online health teaching app (Candy, 23-28, female, postgraduate).

No it's not. They are mainly being taught about condom use rather than abstaining (Chelsey, 23-28, female, postgraduate).

It's not enough, I suggest that every month there should be campaigns (Sama, 29-34, female, postgraduate).

No. firstly, the people who are giving information should be trained to try and change perceptions of students about them then information distribution should come after (Michael, 23-28, male, postgraduate).

No, there is need for effective communication strategies and to have people with relevant qualifications to design strategies for effective communication (Scuby, 23-28, female, postgraduate).

It is not enough, awareness campaigns and interventions should touch every aspect of young people's lives, variables like social class, gender, race, and geographical location should all be taken into consideration and addressed accordingly (X, 23-28, male, 3rd year).

Chapter 5: Discussion of study findings and recommendations

5.1 Introduction

This chapter presents the discussion of the study findings and recommendations. Contained in the chapter is the overview of the findings, discussion of the findings, recommendations, implication of the study and conclusion.

5.2 Overview of the findings

This study was about the knowledge, attitudes, and perceptions of University students regarding the ABC strategy for HIV prevention and how these consequently affected their sexual behaviour, whilst also taking a close look at the manner in which the gender relations that may exist across the two genders of students affected their way of thinking and behaving.

On the knowledge of University students regarding the HIV infection, prevention and management, participants were found to be well informed. However, the study has shown that Univen students display inconsistent attitudes towards the ABC method for HIV prevention. First participants displayed positive perceptions through their responses to the given questions. Students displayed that they are aware that anyone is prone to HIV infection; that the correct and consistent use of condoms protects from infection; and that marital fidelity does not mean one is totally safe from being infected.

The study had added a portion on gender power relations to determine the dynamics around sexual behaviour. To this effect the study demonstrates skewed power relations between male and female students in the sense that male students were more dominant, as a way of showing their masculinity, in sexual relationships. Furthermore, male participants were more sexually active as compared to their female counterparts. For instance, as the findings show all male participants reported they were sexually active compared to three quarters of female participants. This is in line with the regional literature which has shown that male individuals have their sexual debut earlier than their female counterparts; (Family Health International, 2002). Furthermore, it was revealed that male students have more sexual partners as compared to their female counterparts (Family Health International, 2002).

On condom use, the study also demonstrates that, unlike in the past, in this university, women are in a position to negotiate condom usage in their sexual relations. This, as the findings show,

is inconsistent with male responses, where the majority claim to be decision makers with regards to the sexual activity. The study shows that the three quarters of female students do not engage in a sexual intercourse without protection. On the other hand, the majority of male students reported not to have had protected sex in the last two months and only 37.5% of male students reported not having had any unprotected sex. On students' responsiveness to awareness campaigns and health services by campus health promoters, the majority of participants reported having had attended HIV awareness campaigns, and the majority reported having been positively impacted by their presence in these events.

5.4 How the findings answered the research objectives

In this section the focus is on the discussion on how the findings have answered the research questions. These are discussed under six headings:

5.4.1 Knowledge about HIV, abstinence, being faithful to one sexual partner, and condom use.

This sub-section sought to assess the students' knowledge on HIV/AIDS and the abstinence, being faithful 'ABC' strategy that exists at UNIVEN. First and foremost, the data have demonstrated high levels of knowledge about HIV/AIDS as well as the 'ABC' strategy among Univen students.

The findings have shown that the majority of participants clearly understood this strategy in the sense that they provided meanings of the letters A, B, and C correct and accurate. Findings have also shown that Univen students are knowledgeable about ways in which HIV can be transmitted. This affirms Jabuli (2013), who revealed that the levels of knowledge in young people about HIV and sexual matters were very high. It also revealed that young people know about condom use as prevention against unwanted pregnancies and HIV as well as other STIs. This suggested that young South Africans at HEIs are well informed about sexual matters and the ways of preventing pregnancy and STIs.

5.4.2 Attitudes regarding HIV prevention strategies (sexual abstinence, being faithful to one sexual partner, and condom use)

The above objective sought to determine attitudes of UNIVEN students on the 'ABC' prevention strategy. The study has demonstrated mixed attitudes towards HIV prevention strategy (abstaining from sex, being faithful to one sexual partner and condom use). The study, in this regard, further reveals that Univen students are vigilant when it comes their HIV status, in the sense that they do not wait until they feel sick to go and get tested, this may be attributed to accessibility of free HIV counselling and testing facilities within campus. Although the majority of Univen students are sexually active, most of them are not influenced by peer pressure or conformity to indulge in sex as the majority strongly disagreed with the notion that if they abstained from sex they would have fewer friends.

The study has also shown no gender difference with regard to the attitudes towards multi-sexual partners. Univen students do not think having multiple sexual partners makes them any better than they are, not necessarily meaning they are all faithful in their relationships though. This is because most participants responded that they do not think having multiple sexual partners makes them men, women enough.

The findings also show that Univen students believe abstaining from sex until marriage is possible. However, a significant number of Univen students reported sexual abstinence until marriage as impossible and the majority of these were female. This demonstrates that female students, more than their male counterparts believed that abstaining from sex while in University is impossible.

5.4.3 Perceptions regarding HIV prevention (sexual abstinence, being faithful to one sexual partner, and condom use)

The findings demonstrate that Univen students are perceptive when it comes to HIV and how it is transmitted. The majority of these students agreed with the fact that anyone may be infected with HIV at any time during the course life. This is what is referred to as the perceived susceptibility to a disease in the Health Belief Model that was used in this study to explain human health behaviour. This is a good sign, assuming that once they know they are susceptible to HIV, students may then decide to stay healthy by protecting themselves (abstaining, practicing fidelity and using condoms), as articulated by the Health belief Model.

Most students agreed with the fact that correct and consistent use of condoms protects one from HIV infection. The majority also agreed that being faithful to one sexual partner means one is totally safe from HIV infection. This demonstrates adequate knowledge and positive perception in students.

5.4.4 Gender relations and sexual behaviour.

The study also sought to determine gender relations with regards to sexual behaviour. To this effect the findings reveal that, in line with the literature, male individuals start having their sexual debut earlier than their female counterparts. Furthermore, male engage in multiple relations than female students, this is supported by study findings by Mudzusi & Asgedom (2013), which indicated that male college students had more sexual partners than female students. The high number of sexual partners among males than females may be related to cultural practices in most areas in Africa where the aspect of polygamy is acceptable. It is also related with gender issues where males have the freedom to propose sexual relationships as compared to females. The fact that men/students who have more sexual partners are valued high may also be a contributory factor for males to have several sexual partners (Mudzusi & Asgedom, 2013).

The study has also revealed that male have had more unprotected sex compared to female participants, in the last two month. This implies that male participants are more sexually active and at a higher frequency than girls. The study has also shown more progressive views with regard to initiation of sex in intimate relationships. The majority of both male and female students reported they equally initiate on sex in their intimate relationships. However, it is also noteworthy to indicate that a significant number of male students who felt like it was their duty initiate and some female ones who reckoned on that. Furthermore, most male students reported they felt like it is entirely their duty to initiate on condom use in their relationships with female students.

All male students reported they have never and would never have sex for monetary or material benefit. They pointed out they only have sex for pleasure. Some, however, reported they have used money to buy sex from sex workers. The majority of participants on the other hand also reported that they have and would never have sex for monetary reasons. However, one female participant admitted she has never done so because she had never been presented with such an opportunity, she went on to point out that if such an opportunity ever presented itself she may accept it.

5.4.5 Students' responsiveness to awareness campaigns and health services by campus health promoters

When asked if they have ever attended any HIV awareness campaign conducted on campus, most students reported they had for once or more attended HIV awareness campaigns in the campus. This is good; however, the percentage of those students who had never attended these campaigns was still significantly large, hence a lot still needed to be done to encourage more students to participate.

Furthermore, in the majority who reported having attended these campaigns once or above, the majority reported these campaigns have positively impacted their sexual behaviour. Other participants who have attended these campaigns, however, reported they did not benefit much as far as their sexual behaviour was concerned, mainly because they claim they only received information they already knew.

As found by Maviza (2013) in their study on the effects of HIV/AIDS awareness campaigns on University of Venda students' sexual behaviour, perceptions of students on the effectiveness of HIV/AIDS awareness campaigns at Univen varied according to individuals. The majority perceived the campaigns as being effective since they provided services to students like condom distribution and HIV testing. Data showed that, students viewed the awareness campaigns to be effective since there were many students who were now testing via the VCT campaigns (Maviza, 2013).

5.5 Study Limitations

The researcher experienced some challenges during the research period. The main challenge was keeping to agreed times because the respondents did not stick to the agreed times for returning completed questionnaires. The researcher also faced problems in meeting deadlines for the proposed timeframes as it proved difficult to get signatures from authorities at times.

5.6 Conclusion

This study was about the knowledge, attitudes, and perceptions of university students regarding HIV/AIDS and sexual abstinence, being faithful to one sexual partner, and condom use as prevention strategies. The study was conducted in the University of Venda, located in the Vhembe District of Limpopo Province in South Africa. A sample of University of Venda students

were asked to participate in the study as respondents. The study was gender balanced and the majority of participants were found to be heterosexually oriented. In their responses, Univen students proved to be well informed about matters of HIV infection and prevention as they defined major terms correctly and were able to give correct answers to questions designed to probe their level of knowledge. Through their responses, the students also proved to have mixed attitudes towards HIV and its prevention, for example they expressed that they think sexual abstinence and condom use are effective ways of prevention yet the majority of them pointed out that they cannot abstain, with a fewer pointing out that they do not use condoms at all. Furthermore, Univen students proved to be perceptive of HIV and its prevention as they agreed that anyone is prone to HIV infection; that the correct and consistent use of condoms protects from HIV infection; and that being faithful to one sexual partner means one is totally safe from infection. Last but not least, students' responses have shown that they are receptive to campus health HIV awareness activities as their majority reported having attended the events once or twice. The majority of Univen students revealed that the information given through these events is effective and adequate enough to foster more positive and healthy sexual behaviours in students. A fewer students however expressed that these do not help in as far as fostering positive change is concerned. The following recommendations were made from this conclusion.

5.7 Recommendations

This section encompasses researcher's recommendations based on the study conclusions. The recommendations are directed to various stakeholders including policy makers and Universities, particularly Univen (all relevant entities such as campus health promoters). The recommendations are as follows:

5.7.1 Recommendations for policy makers

Policy makers should always strive to promote the health and well-being of the Higher Education Community at individual, group and institutional levels through strengthening existing capacity, systems and structures responding to the pandemic. Policies should be designed towards the sensitization of HEIs' top management on the potential impact of HIV/AIDS on the institutions. These policies should favor HIV prevention, address treatment, care and support and impact mitigation in accordance with the sector policy and guidelines developed by the Department of Education.

5.7.2 Recommendations for the Institution

Curricular

HIV/AIDS and life skills education should be integrated into the curricula at all levels and must be made compulsory, almost similarly as one participant suggested:

There should be quarterly campaigns wherein classes are suspended and students urged to attend these campaigns and when returning to classes they are asked about what they learnt from the campaigns and make presentations in class for marks about what they learnt there (Bomber, 29-34, male, 4th year).

Campus Health/Clinic

Programmatic interventions promoting safe sexual practices should be strengthened, including making condoms easily accessible to both students and staff within the University campus and other places of residence. Existing HIV prevention programmes and services should pay particular attention to the protection of female students, gay students, and supporting staff, since these have been identified as the most vulnerable socio-sexual categories to HIV infection.

Students could also be recruited from their most comfortable areas like residences and they could be incorporated into planning of these events and activities in order to suit their timeframes to encourage mass participation, as suggested by HEAIDS (2010) in their guidelines for higher education institutions to promote an institutional response to HIV/AIDS, that HIV/AIDS provides another opportunity for universities to engage with their students in a productive manner, and universities should fulfill this potential by administering peer education and student volunteer programs. Giving out free gifts as incentives during these campaigns could also help encourage more students to attend.

5.7.3 Recommendations for the community

The University has a duty to team up with the local and regional communities in tackling all social pathologies, including HIV/AIDS, through community outreach programmes. As an academic institution, the University should keep in contact with the communities as far as information dissemination and research are concerned, and likewise, community members should be encouraged to help University researchers with information that they may need when conducting studies on this pandemic. Health promoters from outside campus setups could also

make the culture of discussing sex and sexuality between parents/guardians and children more flexible and acceptable. Additionally,

5.7.4 Recommendations for future studies

Future researchers should focus on the factors that hinder condom use amongst students, in a bid to create safer environments for them. More research should be conducted to address the socio-economic, religious, cultural and traditional values and political factors that may influence students' sexual behaviour directly in.

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ANNEXURE C: Questionnaire

I, Jabuli Mkhambisi, a student in the School of Human and Social Sciences, Department of Gender and Youth Studies at the University of Venda, am hereby conducting a research on the knowledge, attitudes and perceptions of University male and female students towards the 'ABC' strategy for HIV prevention: A case study of a selected university in the Limpopo province of South Africa.

This questionnaire will probably take you 10-15 minutes to complete. The best response is the one that you think is the most appropriate to your circumstance. Try to complete at a time when you are least likely to be distracted and not to spend much time on any one question, as your first thoughts are usually the best.

There are no financial or non-financial personal benefits to be given for participating in this research but however, the study results from this research will be used for academic assessment at the above mentioned university hence can also be used as a platform for conducting relevant studies in this area for the improvement of HIV awareness and prevention campaigns in the nation, especially as far as abstinence, faithfulness, and condom use are concerned. The information you give will be used for the purposes of this study only and will be kept safe for confidentiality reasons. Also for sake of clarity, the participation in this research is voluntary, as you have the right to withdraw from participation if ever you feel so.

Your participation in this study will be greatly appreciated, please do not hesitate to contact me if you have any questions pertaining this study.

Cell: 0719102451

Email: jmkhabisi@gmail.com

Name (please note: do not provide real name(s)).....

Signature.....

Date.....

Section A: Biographical data

(Please tick where appropriate)

7. Gender

Male	<input type="checkbox"/>
Female	<input type="checkbox"/>

8. Age range

20-22	<input type="checkbox"/>
23-28	<input type="checkbox"/>
29-34	<input type="checkbox"/>
35-40	<input type="checkbox"/>
40+	<input type="checkbox"/>

9. Marital status

Single	<input type="checkbox"/>
Engaged	<input type="checkbox"/>
Married	<input type="checkbox"/>
Divorced	<input type="checkbox"/>

10. Sexual orientation

Heterosexual	<input type="checkbox"/>
Homosexual	<input type="checkbox"/>
Bi-sexual	<input type="checkbox"/>

11. Level of study

2 nd year	<input type="checkbox"/>
3 rd year	<input type="checkbox"/>
4 th year	<input type="checkbox"/>
Postgraduate	<input type="checkbox"/>

12. School

School of Agriculture	<input type="checkbox"/>
School of Education	<input type="checkbox"/>
School of Environmental Sciences	<input type="checkbox"/>
School of Health Sciences	<input type="checkbox"/>
School of Human and Social Sciences	<input type="checkbox"/>
School of Law	<input type="checkbox"/>
School of Management Sciences	<input type="checkbox"/>
School of Mathematical and Natural Sciences	<input type="checkbox"/>

Section B:

(i) Knowledge based questions

(Please indicate if the following statements are true or false by ticking where applicable).

Statements about HIV and the ABC prevention method	True	False
13. HIV/AIDS stands for Human Immune Deficiency Syndrome/Acquired Immune Deficiency Syndrome		
14. South Africa has the highest number of people living with HIV/AIDS in the world		
15. Sexual contact is the leading route for HIV transmission in South Africa		
16. Forcing students to take a HIV test is against the law		
17. Univen has a HIV/AIDS policy		
18. Univen's HIV/AIDS policy is freely accessible to students and staff		
19. I can get free HIV testing at Univen		
20. Condom distribution is one of Univen's HIV prevention strategies		
21. ABC stands for; Abstain, Be faithful, and Condom use		
22. Abstaining reduces one's chances of contracting HIV		
23. Being faithful to one sexual partner means one is totally safe from contracting HIV		

(Please fill in the provided spaces below the questions)

24. What do you understand by abstinence?

.....

.....

25. Please list ways in which HIV can be transmitted

.....

.....

(ii) Attitude based questions

(Please indicate how you agree or disagree with the following statements by ticking where applicable; (1) is for Strongly Agree, (2) is for Agree, (3) is for Neutral, (4) is for Disagree and (5) is for Strongly Disagree)

	1	2	3	4	5
26. A person must be concerned about their HIV status only if they feel sick					
27. You can tell if a person has HIV by looking at their appearance					
28. If I demand condom use during sex my partner will leave me					
29. I can get HIV if I work close to a person with HIV					
30. Having HIV or AIDS means that a person is dying soon					
31. If I abstain from sex I won't have many friends					
32. Having multiple sexual partners makes me man/woman enough					
33. Demanding condom use during sex means that I don't trust my partner					
34. If I participate in the University's HIV/AIDS matters my peers will think I have HIV					

(Please fill in the provided spaces below the questions)

35. Do you as a University student think abstaining from sex until marriage is possible?
(answer yes or no and explain your answer below)

Yes	
No	

.....

.....

.....

(iii) Perception based questions

(Please indicate how you agree or disagree with the following statements by ticking where applicable; (1) is for Strongly Agree, (2) is for Agree, (3) is for Neutral, (4) is for Disagree and (5) is for Strongly Disagree)

	1	2	3	4	5
36. Virgins should not bother testing for HIV					
37. Why bother about HIV prevention, everyone is bound to die at some point anyway					
38. Any person has the potential of getting HIV					
39. Correct use of condoms protects people from contracting HIV					
40. The only way to know my HIV status is through an HIV test					
41. HIV awareness helps people protect themselves from HIV infection					
42. Circumcised men should not bother using condoms					
43. If I am faithful to one sexual partner I should not be concerned about HIV as I am safe					

Section C: The role of gender/power relations in sexual behavior *(Please*

fill in your responses in the provided spaces below the questions)

44. How old were you when you first had sex?

.....

45. How many sexual partners have you had in the last two months?

.....

46. How many times have you had unprotected sex in the last two months?

.....

47. Who initiates sex between you and your partner/s? Explain your response

.....

.....

.....

48. Who initiates condom use between you and your partner/s during sex? Explain your response

.....
.....

.....
.....

49. Would you or have you ever had sex for monetary or other material benefits? Explain your response

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

Section D: Students' responsiveness to awareness campaigns and health services by campus health promoters

(Please tick where applicable and fill in the blank spaces provided)

50. How many times have you as a student ever attended any workshop or health awareness campaign conducted by the University wherein you received information about condom use?

Once	
Twice and above	
Never	

If once or twice and above, have any of these campaigns positively changed your behavior or attitude as far as abstinence, being faithful, and condom use are concerned?

YES	
NO	

Explain your answer:

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

51. Do you think that the manner in which students are given information about matters concerning HIV/AIDS, pregnancy, and sexual behavior is effective enough to really promote positive attitudes and behavior?

.....

.....

.....

.....

52. What do you think could be done to encourage students to participate more in HIV awareness activities?

.....

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.....

.....