



**Health and Wellness Sciences Faculty
Department of Nursing Sciences**

**Potential health risk factors amongst students at a
Higher Education Institution in the Western Cape with
regard to sexuality and HIV/AIDS**

By

Nomzamo Peggy Tabata

Student Number: 193056739

Thesis submitted in fulfilment of the requirements for the degree

**Master of Technology: Nursing
Faculty of Health and Wellness Science**

CAPE PENINSULA UNIVERSITY OF TECHNOLOGY

Supervisor: Dr H. Vember

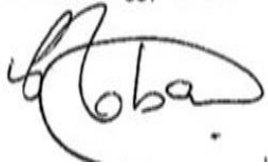
Co- Supervisor: Prof T. Matsha-Erasmus

Bellville

DECLARATION

I, Nomzamo Peggy Tabata, hereby declare that the contents of this dissertation represent my own unaided work and that the dissertation has not previously been submitted for academic examination towards any qualification. It represents my own opinion and not necessarily those of the Cape Peninsula University of Technology.

Nomzamo Peggy Tabata

A handwritten signature in black ink, appearing to read 'Nomzamo', with a large, sweeping flourish that loops back under the name.

Sign

Date: 03/12/2018

ABSTRACT

Health risks are continuing to be a challenge worldwide. Globally, young people aged 15-24 are amongst the most vulnerable groups. It was revealed that between 2007 and 2010, the rate of HIV infection increased in this age group. In sub-Saharan Africa, three out of four new HIV infections are amongst girls aged 15 to 19 years of age. Young women aged 15 to 24 are twice more likely to live with HIV than men in 2019. South Africa is the country with the largest human immunodeficiency virus (HIV) infected population in the world, with an estimated 7 million people living with HIV and 380 000 new HIV infections in 2015. University students are a very important group of young people because they are being prepared for the world of work and to assume leadership roles. However, they are the group most exposed to a range of health risks, particularly regarding sexuality and HIV/AIDS. The aim of this study was to explore potential health risk factors amongst students at a Higher Education Institution (HEI) in the Western Cape with regard to sexuality and HIV/AIDS. The objectives of the study were to explore the factors that may increase health risk behaviours amongst students at an HEI and to discover and describe the knowledge university students have regarding potential health risks related to sexuality and HIV/AIDS. A qualitative research design was employed. Focus group interviews were done to collect data and a thematic content analysis was employed to analyse the data. Results revealed that the university students engaged in high-risk sexual behaviours, such as transactional sex, casual sex, multiple partner sexual relationships and unprotected sex. Such behaviours lead to a high-risk of contracting STIs and HIV/AIDS. Among the factors that were found to be contributing to these risky behaviours, was the new-found freedom of being away from the supervision of parents. Peer pressure at HEIs, as well as abuse of alcohol and drugs, also contribute to risky behaviours. Recommendations were that there should be organised and measured approaches to expose both lecturers and the students to HIV/AIDS education through an integrated curriculum design. There should be teamwork amongst lecturers, support staff and students to create powerful discussions and an exchange of ideas to clarify issues regarding HIV/AIDS, sexuality and other related topics to reduce high-risk behaviours and promote solid constructive attitudes amongst the university community.

KEYWORDS: Students, Higher Education Institutions, High-risk behaviour, HIV/AIDS, Knowledge, Attitude.

ACKNOWLEDGEMENTS

I am forever grateful to my Lord Jesus Christ, for his unfailing love, his faithfulness and for providing me with strength, protection, provision of wisdom, knowledge and understanding throughout this study and in my personal life.

I also wish to thank:

- My supervisor Dr Hilda Vember, for her professional guidance, encouragement, continuous support, significant corrections and assistance throughout my studies and in my personal life.
- Professor Thandi Matsha-Erasmus, for her financial assistance.
- My family especially my daughters Phindile Loyiso Tabata and Yondela Phumzile Tabata for the support, love and understanding.
- CPUT HIV Unit Director and staff, as well as the CPUT peer educators.
- CPUT Counselling Department.
- CPUT Nursing Department.
- All my friends, especially Lungisile Tshitshi and Ntombomzi Mcanjana for their support and assistance.
- All the participants who sacrificed their time to take part in this study.

TABLE OF CONTENTS

DECLARATION	i
ACKNOWLEDGEMENTS	iii
TABLE OF CONTENTS	iv
LIST OF FIGURES	xi
LIST OF TABLES	xii
LIST OF APPENDICES	xiii
LIST OF ABBREVIATIONS	xiv
DEFINITION OF CONCEPTS	xv
Chapter 1	1
The Orientation of the study	1
1.1 Introduction	1
1.2 Background	2
1.3 Problem Statement	2
1.4 Justification of the study	3
1.5 Aim	3
1.6 Objectives	3
1.7 Research Question	4
1.8 Theoretical framework	4
1.9 Literature review	5
1.9.1 Global impact	5
1.9.2 National impact	6
1.9.3 Provincial impact (Western Cape)	7
1. 10 Research Design and Methodology	7
1.10.1 Design	7
1.10.2 Method of data collection	8
1.10.3 Advantages of focus group discussion	8
1.10.4 Disadvantages of focus group discussion	8

1.11 Research setting.....	8
1.12 Population.....	8
1.13 Sampling.....	9
1.13.1 Inclusion criteria	9
1.13.2 Exclusion criteria	9
1.14 Recruitment of research participants.....	9
1.15 Data Analysis	10
1.15.1 Data presentation.....	10
1.16 Rigour.....	10
1.17 Trustworthiness	10
1.17.1 Credibility	10
1.17.2 Transferability.....	11
1.17.3 Dependability	11
1.17.4 Confirmability.....	11
1.18 Ethical consideration	11
1.18.1 Declaration of Helsinki	12
1.18.2 Autonomy	12
1.18.3 Beneficence	12
1.18.4. Justice	12
1.18.5 Confidentiality	12
1.18.6 Non-maleficence	12
1.19 Chapter division	12
1.20 Summary	13
Chapter 2.....	14
Literature Review.....	14
2.1 Introduction	14
2.2 Theoretical framework	14

2.2.1 Individual perception	15
2.2.2 Modifying factors.....	16
2.2.3 Benefits of preventative measures	16
2.3 Student life	16
2.4 Higher Education Institution (HEI).....	17
2.5 High-risk behaviours	18
2.6 Students and HIV/AIDS.....	21
2.7 Tertiary students' knowledge about potential health risks.....	22
2.8 Attitudes of tertiary students towards potential health risks	23
2.9 Knowledge and attitudes towards condom use	25
2.10 Summary	25
Chapter 3.....	26
Research Design and Methodology	26
3.1 Introduction	26
3.2 Qualitative research.....	26
3.2.1 Constructivism.....	26
3.2.2 Bracketing.....	27
3.3 Research design.....	27
3.3.1 Descriptive design.....	28
3.3.2 Exploratory design	28
3.3.3 Contextual design.....	29
3.4 Research setting.....	29
3.4.1 Cape Technikon	29
3.4.2 Peninsula Technikon	29
3.5 Population.....	30
3.6 Sampling.....	30
3.6.1 Convenience sampling.....	31

3.6.2 Recruitment	31
3.6.3 Inclusion and exclusion criteria.....	32
3.7 Method of data collection.....	32
3.7.1 Focus group discussions (FGDs).....	32
3.7.2 Advantages of FGDs	33
3.7.3 Disadvantages of FGDs	33
3.7.4 Interview schedule and probing questions	33
3.8 Process of data collection.....	34
3.8.1 Recording of FGDs	34
3.8.2 Data saturation.....	35
3.8.3 Moderator’s role	35
3.9 Data protection and management.....	35
3.10 Data analysis	36
3.10.1 Transcribing data.....	37
3.10.2 Ordering and organising data.....	37
3.10.3 Coding	37
3.10.4 Reflexivity.....	38
3.11 Rigour in qualitative research	38
3.11.1 Credibility	39
3.11.2 Transferability.....	39
3.11.3 Dependability	40
3.11.4 Confirmability.....	40
3.12 Ethical Considerations.....	40
3.12.1 Autonomy	40
3.12.2 Beneficence	41
3.12.3 Justice.....	41
3.12.4 Non-maleficence	41

3.12.5 Right to privacy and confidentiality	42
3.12.6 Informed consent.....	42
3.13 Summary	43
Chapter 4.....	44
Results.....	44
4.1 Introduction	44
4.2 Biographical Data.....	44
4.3 Themes	44
4.4 Theme 1: Contributing factors to risky behaviour	45
4.4.1 New-found freedom	46
4.4.2 Reckless behaviour.....	46
4.4.3 Alcohol and drugs	46
4.4.4 Pressure from peers and influence	47
4.4.5 Multiple partners	47
4.4.6 One-night stands of sexual contact	48
4.4.7 Early-stage sexual engagement	48
4.4.8 Transactional sex	49
4.4.9 Unprotected sex	49
4.4.10 Lack of communication with parents	50
4.4.11 Knowing the status of a sexual partner.....	50
4.4.12 Socio-economic background.....	51
4.5 Theme: 2 Knowledge	52
4.5.1 Ignorance	52
4.5.2 Misconception	52
4.5.3 Information needed	53
4.5.4 Education needed	54
4.5.5 Uninformed decisions.....	54

4.5.6 Partner testing.....	55
4.5.7 Teen pregnancy.....	56
4.5.8 Condoms.....	56
4.5.9 Abstinence	57
4.6 Theme 3: Attitude.....	57
4.6.1 Towards HIV/AIDS awareness campaigns on campus	57
4.6.2 Poor service delivery at on-site student health services	58
4.6.3 Health risks	58
4.6.4 Health services referrals	59
4.6.5 Stigma and judgement	59
4.7 Summary	60
Chapter 5.....	61
Discussion of Results.....	61
5.1 Introduction	61
5.2 Themes	61
5.2.1 Theme: 1 Contributing factors to risky behaviour	61
5.2.2 Theme: 2 Knowledge.....	68
5.2.3 Theme 3: Attitudes	74
5.3 Summary	77
Chapter 6.....	78
Conclusions, Limitations and Recommendations.....	78
6.1 Introduction	78
6.2 Conclusions	78
6.2.1 Objective One.....	78
6.2.2 Objective Two	79
6.2.3 Objective Three	80
6.3 Limitations.....	81

6.4 Benefits of the findings to the HEI and to students.....	81
6.4.1 Higher Education Institutions	81
6.4.2 Students	81
6.5 Recommendations of the study	82
6.6 Areas for further research.....	82
6.7 Conclusions	82
References.....	84

LIST OF FIGURES

Figure 1: The number of people living with HIV on antiretroviral therapy globally, 2010–2015.....	6
Figure 2 Conceptual Model of HBM	15
Figure 3: Ecological model to enable and shape the environment of adolescence sexual and reproductive health.....	24

LIST OF TABLES

Table 1: Flow diagram illustrating students who were conveniently sampled for the study31
Table 2: Themes and subthemes45

LIST OF APPENDICES

APPENDIX A : Research Information sheet and Informed consent.....	93
APPENDIX B : Permission approval letter.....	96
APPENDIX C : Request letter to conduct study.....	97
APPENDIX D : Briefing sheet for interview and consent to audio record.....	98
APPENDIX E : Letter from student counselling.....	99
APPENDIX F : Interview Guide: Focus Group Discussion (FGD).....	100
APPENDIX G 1: Example of one transcript group.....	102
APPENDIX G 2: Coding Thematic Analysis.....	114
APPENDIX H : Ethics Approval.....	132

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CDC	Centre for Disease Control
DoE	Department of Education
FGDs	Focus group discussions
HBM	Health Belief Model
SCT	Social Cognitive Theory
HEAIDS	Higher Education HIV/AIDS Programme
HEI	Higher Education Institution
HIV	Human Immunodeficiency Virus
KZN	KwaZulu Natal
LO	Life Orientation
NSP	National Strategic Plan
SA	South Africa
STI	Sexually Transmitted Infection
SPSS	Statistical Package for the Social Sciences
UNAIDS	United Nations Programme on AIDS
WC	Western Cape
SADEC	Southern African Development Countries

DEFINITION OF CONCEPTS

Student

“A person who is studying at a tertiary institution” (South African Concise Oxford Dictionary, 2002:1165).

Human Immunodeficiency Virus (HIV)

According to Mostafa (2015:43) HIV is defined as “Human Immunodeficiency Virus”. It is an extremely movable virus due to its fast-changing nature. This has caused different strains of HIV, namely HIV-1 and HIV-2. Both types can cause AIDS. They can be transmitted through sexual contact, body fluids and mother-to-child.

Acquired Immunodeficiency Syndrome (AIDS)

According to Kortenaar *et al.* (2009:115), “AIDS is a syndrome of opportunistic diseases or infections that is caused by HIV”. It occurs in patients who have been infected by HIV and their immune system is deficient. It can lead to death if there is no intervention, such as antiretroviral therapy.

Sexually Transmitted Infections (STIs)

According to Espejo (2011:95) “STIs are infections acquired by sexual activities, this may include mutual masturbation, kissing, vaginal, oral and anal intercourse”. The organism that causes STI may pass from person to person through bodily fluids, semen and blood.

Sexuality

According to Cieslik and Simpson (2013:96), sexuality is defined as “the way that people intimately relate emotionally and physically to one another in everyday practices”. It is further explained that almost everyone is unconvinced about open discussions regarding sexuality, whereas it helps to be open about it when one wants to explore one’s desires as they go through puberty and identity.

Attitudes

According to Kambole (2007:4) “An attitude can be defined as a positive or negative evaluation often based from one’s motion and beliefs of people, objects, events, activities and ideas or just about anything in your environment that can create an inclination for action”.

Knowledge

According to Kaplan (1964) as cited by Burns and Grove (2007:13), knowledge is essential information acquired in a variety of ways, expected to be an accurate reflection of reality and incorporated and used to direct a person’s actions. Knowledge can be acquired through traditions, authority, borrowing, trial and error, personal experience, role modelling, intuition and reasoning. Burns and Grove (2007:13), further explain that “You need to question the quality and credibility of new information that you hear or read”.

Behaviour

Refers to the manner in which one acts or conducts her or himself towards others. It can be a bad or a good behaviour. This definition applies to animals as well (Salati, 2004:8).

Health Risk

“It is a harm that is caused by some specific danger or threat. These factors exist before a problem arises or continue over time. A community or the general environment can contribute towards the problem” (Kambole, 2007:5).

CHAPTER 1

THE ORIENTATION OF THE STUDY

1.1 INTRODUCTION

Health risks are continuing to be a challenge worldwide. This is confirmed by the UNAIDS (2012:29) which indicated that young people aged 15 to 24 are amongst the most vulnerable groups globally. The Centre for Disease Control and Prevention (CDC, 2012a) revealed that between 2007 and 2010, the rate of HIV infection increased in this age group. According to Global HIV & AIDS Statistics (2017) in sub-Saharan Africa, three out of four new HIV infections are amongst girls aged 15 to 19 and young women aged 15 to 24 are twice as likely to live with HIV as men in 2019. South Africa (SA) is the country with the largest human immunodeficiency virus (HIV) infected population in the world, with an estimated 7 million people living with HIV and 380 000 new HIV infections occurring in 2015 (Jette, 2017:273-274). Jette (2017) continues to reveal that South Africa is carrying 17% of global HIV-related problems. Swaziland Central Statistical Office and Macro International Inc. (2008:222) revealed that in Swaziland, HIV prevalence amongst young people of 15 to 24 years is at 31%. A survey that was conducted in 2012 states that in South Africa, the rate of new HIV infections had reached 25% of the population. This population is women aged 15 to 24 years and this rate is four times greater than that of men in the same age group. This age group accounts for nearly 27% of all new HIV infections globally (UNAIDS,2012:29). These young people are learners, students, employed and unemployed young people.

University students are a very important group of young people because they are being prepared for the world of work and to assume leadership roles. According to Vember (2013:62-63), students at university are preparing for life in the future. However, they are most exposed to a range of health risks, particularly regarding sexuality issues. They are also the group who could turn the tide regarding HIV/AIDS. The question is *what can be done to get these university students to apply what they have been taught in their homes, churches, communities and high schools regarding sex and HIV/AIDS?* Can Higher Education Institutions (HEIs) help them to become more knowledgeable and to change their attitude and behaviour in a way that may safeguard them from potential health risks? Also, despite having this knowledge, *why do so many young people still contract HIV/AIDS?* These are some of the challenges that prompted the researcher to engage in this study. The HIV/AIDS epidemic over the past years has and still affects many families and communities. It was revealed that in, Mngungundlovu, KwaZulu Natal (KZN) neighbourhood have reported alcohol abuse and early sexual engagement as barriers to schooling and these could have negative effects such as rape for the health status of learners. This was revealed when exploring socio-ecological level for prevention of sexual risk behaviours of the youth (Khuzwayo & Taylor, 2018).

1.2 BACKGROUND

Every year, this HEI enrolls approximately thirty-four thousand students from different socio-economic backgrounds (CPUT Annual Report, 2016:12). They are coming from different high schools nationally and internationally. Several of them also come from rural areas outside of the Western Cape (WC). A survey conducted by Snider (September 8th US News and World Report, 2014) indicated that 23 % of these HEI students are also full-time employees and attend classes on a part-time basis. Some of these different groups are enrolling for the first time at a university. For some of them, it is also their first time away from home and in another province. This new-found freedom could pose problems for them (Vember, 2013). Hence, they are faced with various challenges, including those of sexuality and HIV/AIDS. However, they all have the same goal of completing their chosen qualification. Therefore, the researcher finds it vitally important that HEIs should come up with comprehensive strategies and interventions to assist these young people to cope with these challenges. The integration of HIV/AIDS education into all curricula is currently high on the agenda at HEIs in South Africa and it is on-going (HEAIDS, 2010:6). According to Van Deventer (2009), cited in Hill, Draper, De Villiers, Fourie, Mohamed, Parker, and Steyn (2015:3), Life Orientation (LO) is “life-in-society”, which helps learners to produce their desired living, learning and overall well-being. Centre for Sexualities, AIDS and Gender (2016:14), stated that the children and adults can benefit from the qualities of integrated curricula, because it can provide different ways of learning and encourage their involvement in promoting good attitudes and behaviours towards sexuality and prevent the spread of HIV/AIDS. Furthermore, it will enable students to build meaning, gain insights, use fresh knowledge and improve their thinking skills in real world. Potential health risks are dominating in the HEIs, whether they are sexual or non-sexual. It is important that these issues be dealt with for this group to understand the implications and consequences thereof. According to Kelly (2001:1-4), “there is enough evidence to suggest that students at HEIs in Africa are at risk of contracting HIV/AIDS. They experiment with sexual activities”. Prostitution is also rife at HEI campuses (Vember, 2013:61). Engaging in unprotected sex with multiple partners remains a concern at these HEIs (Vember, 2013:61). This all contributes to risky behaviours. A study done by Kabiru, Beguy, Undie, Msiyaphaza Zulu, and Ezeh (2010) and Moloney, Hunt, Joe-Laidler and MacKenzie (2011), cited by Cieslik and Simpson (2013:100), stated the effect of poverty as a leading contributory factor to risky behaviours, such as unsafe or early sex. In these instances, some students make wrong choices, because they need the money, and this leads to risky behaviours. They seemingly also lack knowledge about HIV/AIDS (Cieslik & Simpson, 2013:100).

1.3 PROBLEM STATEMENT

In several countries, there is a significant decline in new HIV infections. However, there are still signs of increased risk in the sexual behaviour of young people (UNAIDS, 2013:2). It was revealed that in sub-Saharan Africa, HIV is widespread amongst young people between the ages of 15 to 24. However, there was a decline of 42% between 2001 and 2012. According to the UNAIDS Global Report (2013:17), the HIV/AIDS infection rate amongst young women in Sub-Saharan Africa is still twice as high as that of young men. Burke (2010), cited by Goosen (2013:10) revealed that another high-risk behaviour is that of alcohol use. High alcohol use, especially amongst students, can affect their decisions negatively and this can lead to life-threatening circumstances. Many researchers have concluded that alcohol, poverty and drugs lead to unsafe casual sex, which could result in HIV and STI transmission (Mbatha & Ally, 2013:2-4). According to Ng’ang’a, Ochanda,

Imbuga, Lang'at-Thoruwa', Ngumi, Monda, Mwangi, and Xi (2015:2), universities have not been spared from the HIV scourge. It is further explained that it is estimated that the real impact of the scourge will not be felt until 2050. It is known that universities have a key responsibility for developing human resources and providing society with leadership direction. In this case, universities should be involved in addressing the HIV/AIDS issues at a personal and at a professional level in their efforts to combat this epidemic, as students can be exposed to potential health risk factors in the environment within HEIs.

1.4 JUSTIFICATION OF THE STUDY

Students in HEIs are held in high regard by their different communities, as they are recognised as privileged and as the more knowledgeable members of their society (De Bois & Stauber, 2003, cited by Cieslik & Simpson, 2013:134). The purpose and justification of this study is to empower them with knowledge regarding HIV/AIDS and sexuality. It is also to educate them about their attitudes and behaviours that may place their health at risk. According to Vember (2010:9), "HIV/AIDS and sexuality have become the greatest threat to the continent's development and many affected countries are losing valuable community members". Students in HEIs are regarded as role models in their respective communities. Yet, new infections are still observed amongst these young people. The higher education sector has been criticised for its inability to produce skilled human resources that South Africa (SA) requires. It has been clouded by dropouts, financial constraints and some students are struggling to complete their studies within a limited timeframe. This has caused HEIs to pay less attention to their secondary problems of HIV/AIDS (HEAIDS, 2010:7).

According to UNAIDS (2012:15), behaviour change is complex. For this group to change their behaviours and attitudes, they must be informed regarding the risk factors which might lead them to being infected with STIs or the HIV. Young people need to be motivated to take care of their sexuality and to make informed choices. These choices are based on socio-cultural norms as well. The youth should be empowered sexually by opening platforms for reflection and they should be helped to clearly express their thoughts and feelings about sex and sexuality (Shefer, Kruger, Macleod, Baxen and Vincent, 2015:83). This shows that the "scare tactics" that are used are not effective and sustainable anymore. Therefore, HEIs should rather aim at developing students and academics to be able to manage and speak openly about sexuality issues in the lecture halls (Turnbull, van Schaik, and Wersch, 2016:9).

1.5 AIM

The aim of this study was to investigate potential health risk factors amongst students at an Higher Education Institution (HEI) in the Western Cape with regard to sexuality and HIV/AIDS.

1.6 OBJECTIVES

The objectives of the study were to:

- Explore the factors that may increase health risk behaviours amongst students at an HEI.

- Explore and describe knowledge of university students regarding potential health risks related to sexuality and HIV/AIDS.
- Explore the attitudes students have towards health risk behaviours, regarding HIV/AIDS and other sexuality-related behaviours.

1.7 RESEARCH QUESTION

What are the factors that may contribute to the increase of health risks amongst students at HEIs?

1.8 THEORETICAL FRAMEWORK

The theory that will be applied in this research, is the Theory of the Health Belief Model (HBM). According to Skinner, Tiro, and Champion (2015:75), the HBM has been one of the most widely used conceptual frameworks in health behaviour research to explain the change of health-related behaviour and as a guiding framework for intervention. This is done by focusing on the attitudes, knowledge and beliefs of individuals. However, Coulson, Goldstein, and Ntuli (1998:64) argued that even the health promoters sometimes get confused by the behaviour of people when they are not realistic about their own risks in many circumstances. This theory examines the point of view of an individual and how they would view the risk and effect (susceptibility and severity) based on their background, for example, geographical location, age, race and sex. It also involves a clue to action that can activate the behaviour change. In this case, the participant is able to watch certain programmes on television (TV) about health promotion, or have a conversation with peers, family or even academics. This could lead to perceived benefits; meaning if an individual believes that condom use will help to prevent HIV or taking a test will assist with early diagnosis, he/or she would benefit (Tarkang & Zotor, 2015). Hence, the HBM will assist to understand the participant's perceptions, their beliefs, behaviour, knowledge and attitudes towards HIV/AIDS and related sexuality issues. This might help in personal responsibility and choices that the participants make to prevent themselves from contracting the HIV and STI's (Skinner et al., 2015:75).

However, health still needs a collective action so that people can change their behaviour and try to overcome their social barriers (Robbins, Lauver, Le, Davis, Langley and Carlstrom, 2004:267) as cited by (Bowman & Denson, 2014:125). Skinner et al. (2015:75), have also confirmed that HBM has been used to foresee preventative health behaviours and it has worked for sexual behaviours respectively. It is important for HEIs to understand that students do have a social life. When health behaviour is addressed, students need support and encouragement without judgement. The HBM is relevant for this research because it deals with individual behavioural change.

The HBM is supported by Social Cognitive Theory (SCT) (Tarkang & Zotor, 2015). The SCT has three divided, shared natures that have a causal effect relationship, influencing the procedures that are entailed by this theory; namely the person, the environment and the behaviour (Zimmerman, 1989). Slavin (2012) states that this theory focuses on the significance of observational and self-regulated learning of behaviour with the emphasis of stages that inform behaviour modelling. Bandura (1989) states that people learn through direct experiences. Furthermore, Bandura reveals that people observe and imitate the behaviours of others. Both HBM and SCT are relevant for this research.

1.9 LITERATURE REVIEW

An extensive literature review of books, journals and articles was done on health risk behaviours, related to sexuality and HIV/AIDS. The spread of HIV/AIDS amongst university students is a problem and a concern. Students need to be informed about sexual behaviour, STIs and HIV/AIDS. It has been researched and stated by many researchers that if you improve knowledge about HIV/AIDS, it can improve attitudes and behaviour towards people living with HIV (PLHIV) and of HIV itself (Platten, Pham, and Nguyen, 2014). Refer to Chapter Two for in-depth discussion of the literature review.

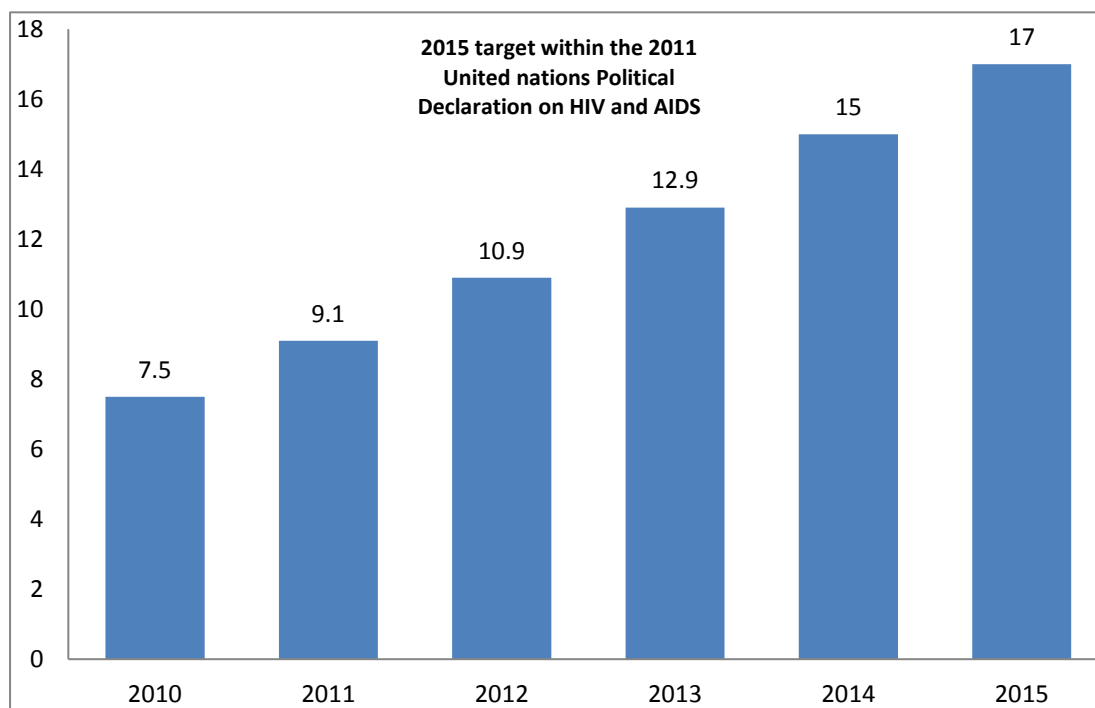
1.9.1 Global impact

HIV's impact has affected many countries of the world. In Asia, Taiwan has been at nearly a 15% HIV infection rate per year since 1997. This rate was the fastest in Asia and caused by lack of knowledge and negative attitudes towards the disease (Tung, Ding, and Farmer, 2008:1). Global HIV and AIDS statistics 2018 facts sheet has revealed that globally, an estimated 36.9 million people were living with HIV in 2017. However, many countries have made great strides in education regarding the prevention of HIV transmission and behavioural interventions to reduce risky behaviours, especially amongst young people age 15 to 24 (UNAIDS Global Report, 2013:14).

In some countries, there is evidence that there is still an increase in the number of sexual partners that young people engage with. These countries include Burkina Faso, Congo, Cote d'Ivoire, Ethiopia, Gabon, Guyana, Rwanda, South Africa, Uganda, United Republic of Tanzania and Zimbabwe (UNAIDS Global Report, 2013:14). A study that was conducted in two private universities in Ghana in 2014 revealed that 71.8% of the participants did not regard themselves as 'at risk' of HIV infection, although 52% of them admitted that they had sexual intercourse, including unprotected sexual intercourse, prior to this research (Asante, Bofo, and Nyamekye, 2014:15). In a study conducted in Canada, many researchers revealed that sexual health knowledge amongst all university students is minimal. It was further reported that the results of different researchers indicated that, although students are familiar with the names of many STIs, they do not know how they are transmitted, the symptoms and how to be diagnosed (Cassidy, Curran, Steenbeek, and Langille, 2015:20).

According to the Swaziland Central Statistical Office and Macro International Inc. (2008:222), young people between the ages of 15 to 25 are the most susceptible group in Swaziland to get infected with HIV. UNAIDS Global report (2016:7), reveals that the HIV prevalence in many countries is higher in cities, and this is where these HEIs are situated. Furthermore, this is where these young people encounter great opportunities, vibrancy and anonymity of urban life at the same time. However, these opportunities are capable of increasing risky behaviours that may lead to increase the risk of getting HIV infections, as these students interact for more prospects. This creates more challenges in HEIs in most of the countries. Since HEIs are a microcosm of communities in which these students are found.

Figure 1: The number of people living with HIV on antiretroviral therapy globally, 2010–2015



Sources: Global Aids Response Progress Reporting (GARPR) 2016; UNADS 2016 estimates

1.9.2 National impact

It was estimated that there are 7,1 million people live with HIV in South Africa (SA) (National Strategic Plan (NSP), 2017-2022:6). Amongst these people, HIV prevalence for 15 to 49 years of age was estimated at 19,1% and the overall population prevalence was at 12,8%. However, the plan is to eradicate the HIV infections by reaching all key and vulnerable population with customised and targeted intervention (National Strategic Plan, 2017-2022:6-9). As it was mentioned that the new HIV infections have increase target to reduce the HIV infections, especially for the young people aged 15 to 24 in South Africa (National Strategic Plan (NSP), 2012-2016:11).

The Higher Education HIV and AIDS programme (HEAIDS) is an intervention of the national Department of Education (DoE). It was restructured in 2009 to assist HEIs and the Department of Basic Education to combat HIV threats. HEAIDS reacted to the assumption that students and staff members in the HEIs are living with HIV or AIDS. Some students are facing a high-risk of HIV infections (HEAIDS, 2010:1). The NSP (2012-2016:22), reveals that the results of a household survey that was done in 2008 in South Africa, showed that there was 11% of HIV positive people that are injecting drugs recreationally. These people are likely 10,000 to 50,000 in South Africa.

Health care systems in South Africa are carrying a huge burden because of sexually transmitted infections (STIs) and HIV/AIDS. The burden can deplete resources from education if not addressed urgently. This can lead to an increase in absenteeism and in

dropouts. There is a great need to expand HIV/AIDS training in schools, as 26% of infections are in the age 15 to 19 brackets (Vember, 2010:37).

1.9.3 Provincial impact (Western Cape)

South Africa is one of the countries with the largest number of HIV infections (UNAIDS Gap Report, 2014). Although many countries, including South Africa, have made great strides in HIV prevention education, young people age 15 to 24 have not really changed the behaviour regarding multiple partners. This could put them at risk for contracting HIV (UNAIDS Global report, 2013:14). A study that was done in one of the universities in the Western Cape (WC) to understand trends in HIV risk behaviour of incoming first-year students over a six-year period (2007- 2012), disclosed that these students are already sexually active, by the time they enter universities. They also do not use condoms and they are engaging in alcohol and drug use that could negatively influence their power of making decisions. They are having multiple partners and have not been tested for HIV. The study continues to show that the percentage of students reporting having had vaginal sex increased from 44% in 2007 to 51% in 2012 and the condom-use percentage decreased from 60% in 2007 to 51% in 2012. These students were tired of being told about HIV prevention. Despite these results, it further revealed that 45% of these students are not yet sexually active (Blignaut, Jacobs, and Verganani, 2015:15). Another study that was done in nine schools between the Eastern Cape (EC) and the Western Cape (WC) revealed that powerful discussions in classes of Life Orientation (LO) regarding gender and sexuality, revealed that, for example, women must take responsibility for sexual practices at a young age. It further made known that schools in general still believe that scaring students will direct them away from sex and those scare tactics would make learners control their sexual activities more (Shefer *et al.*, 2015:82).

In a study conducted amongst schools in the Western Cape, Hill *et al.* (2015:2) suggested that promoting healthy lifestyle behaviour is the responsibility of the schools because children spend many hours at school. If learners are engaged in projects promoting a healthy lifestyle at school level already, they would be equipped with more knowledge on sexuality and HIV/AIDS issues when they enter universities. A study that was done in one of the HEIs in the Western Cape showed that the influence of an HIV/AIDS peer education programme was welcomed by staff, peer educators and other students. It further revealed that students felt empowered and they were so sure that they could deal better with people who are affected and infected by HIV/AIDS. They wanted these programmes to be frequent on their campuses. Others also felt that there was an increase in people who are going for testing and they were confident enough to make informed decisions about their social life (Vember, 2013:169-170).

1. 10 RESEARCH DESIGN AND METHODOLOGY

1.10.1 Design

A descriptive, explorative, contextual qualitative design was used. The focus of a descriptive design is to discover what is happening in a circumstance or situation. It also focuses on the fact that the data can be confirmed if necessary, with the individuals involved (Denzin & Lincoln, 2018:810-811). Refer to Chapter Three for an in-depth discussion.

1.10.2 Methods of Data Collection

Focus group interviews were conducted to collect data. Focus group interviews have been described as a method of collecting research data in qualitative research. It is a group discussion where a group of six to eight participants who are sharing a certain characteristic will be discussing a specific topic (Silverman, 2014:206). Focus groups were divided into groups of five to ten. Focus group discussion (FGD) duration time was 60 to 90 minutes and was clearly explained to the participants. It was revealed that focus groups that are less than 60 minutes are not likely to be effective, because the subject was not discussed in-depth, as required. The FGD's focus on various views and the researcher could gather enough data in an hour's time (Patton, 2015:477). The researcher recorded the dialogues with a digital hand recorder. The researcher explained the nature and purpose of the research to all the participants. All participants signed a written consent form, prior to the focus group interviews (refer Appendix A for an information sheet and consent form). The researcher asked questions from the interview guide (refer Appendix F). There were no emotional discomforts to any of the research participants during the research. If any discomfort would occur, the researcher would refer them to the Student Counselling Department for counselling (refer Appendix E).

1.10.3 Advantages of focus group discussion

According to Rule and John (2011:66) focus groups, storytelling and interviews are a few of the many ways that data can be collected in a research project. Focus group interviews can be used as a method on its own to collect data and it can be used with other methods in research (Schwandt, 2015:122). According to Patton (2015:478), the advantages of focus groups are that participants can easily share and argue about ideas and in the process, they gain insight into the pressing matter at hand and quality data is generated and improved in the process.

1.10.4 Disadvantages of focus group discussion

The major disadvantage of focus group interviews is when there are dominant members of a group who want to influence the quiet members in the discussion. This means that the participants might influence each other, as there is no single response (Polit & Beck, 2017:511).

1.11 RESEARCH SETTING

The setting was an HEI in the Western Cape. The selected institution has two main campuses where the research took place. The researcher booked a venue on the two respective campuses to do the focus group interviews, to secure confidentiality and privacy.

1.12 POPULATION

Polit and Beck (2012:273) describe population as the whole collection of a targeted group of individuals or objects that have some common characteristics in which the researcher is interested in. The population for this research was female and male students at the university in the Western Cape. This selected university is widely diverse, therefore all the different cultures, races, religions and genders were included in this research. These

targeted individuals were also needed to meet the research inclusion criteria (refer to Inclusion and Exclusion Criteria, Sections 1.13.1 and 1.13.2).

1.13 SAMPLING

This selected HEI has six faculties and it is broadly diverse. Sampling is the method of choosing individuals who are representative of the population being studied (Grove, Burns, Gray and 2013:708). They continue to describe sample as a subset of the population that is chosen for a certain research. There are two types of sampling techniques, namely probability and non-probability sampling (Schwandt, 2015:277). From these two types, non-probability sampling was selected for this research. Convenience sampling, also called “accidental sampling”, was then employed. Convenience sampling is a type of sampling that is used to gather information from participants who are readily available. The researcher constantly went to the two main campuses of this selected HEI and visited each faculty in an attempt to recruit five to seven students for discussion. These individuals were recruited until a minimum number was reached, regardless of their diversity (Maree, 2016:197-198). Examples of convenience sampling could be a classroom of students or subjects who attend a support group (Burns & Grove, 2011:305). Students who were available and willing signed a consent form and participated in the research.

1.13.1 Inclusion criteria

- Students that were currently registered with the HEI.
- Students had to be 18 years or older.
- Males and females were included.
- Part-time and full-time students were selected for inclusion.
- Students staying inside or outside of these two campuses.

1.13.2 Exclusion criteria

- Both male and female students that were not registered with this HEI.
- Both male and female students that was younger than 18 years old.

1.14 RECRUITMENT OF RESEARCH PARTICIPANTS

Participants were selected from the two main campuses of the HEI. Students could belong to any faculty or department at this selected HEI. All students who availed themselves voluntarily and who were willing to sign a consent form, were able to participate in this study.

The researcher contacted the HOD’s of the various departments to inform them regarding the research. Once ethical approval was obtained from the Health and Wellness Sciences Faculty Research Committee, the researcher contacted the lecturers across faculties to get appointments to address the students on both campuses to inform them regarding this research project. The researcher asked for voluntary participation, as the contact details of both the researcher and the supervisor were left on the information sheet with the students. All focus groups were conducted at convenient times for the students, so that it did not impact on their class times.

1.15 DATA ANALYSIS

Responses from all these focus group interviews were audio recorded. The researcher listened to the responses and transcribed them into a Microsoft Word document. It was recommended to immediately listen to recordings after an interview, as data analysis can be done at the same time with data collection (Jooste, 2018:346). This assisted the researcher to be able to listen to the audio responses and compare the typed document. The transcribed data was also given back to respondents to verify if that is the information they gave. This is called ‘member checking’ and was to ensure the trustworthiness of the research data (Streubert & Carpenter, 2011:67). Coding was done on all the transcriptions and a thematic content analysis was applied.

1.15.1 Data presentation

Data was presented in various themes and subthemes and was discussed and referred to by means of the transcriptions.

1.16 RIGOUR

In qualitative and in quantitative research, the researchers have a responsibility of providing the proof of their data. This means they need to show how valid, reliable or trustworthy the information is. Therefore, in qualitative research, the researcher is directed by trustworthiness with its methods, whereas in quantitative, the researcher is directed by validity and reliability to prove how valid the data that is generated is. Hence, there is rigour; it incorporates trustworthiness, validity and reliability. Trustworthiness involves the methods of credibility, transferability, dependability and confirmability (Jooste, 2018:350-351).

1.17 TRUSTWORTHINESS

According to Lincoln and Guba (1985), as cited by Schwandt (2015:308-309), trustworthiness is the quality that makes the study remarkable to the readers; they also discussed standards that can prove trustworthiness. These standards included credibility, transferability, dependability and confirmability. It is important for a researcher to be trustworthy and flexible because they have a responsibility of telling the truth about the research so that participants can trust and respect the researcher (Jooste, 2018:313).

1.17.1 Credibility

According to Lincoln and Guba (1985), as cited by Schwandt (2015:308-309), credibility focuses on how the researcher had portrayed the experiences of the participants. To develop credibility of the study, the researcher spent hours in the HEI engaging with students. Sometimes, the researcher was invited by the students to come and listen to their health education talks that they facilitated in their hostels or in their classes, as part of their project presentations related to HIV/AIDS. The researcher participated in many workshops with the HIV/AIDS Unit in this HEI, as Polit and Hungler (1997:305); Botes (2003:180); Brink *et al.* (2012:172) as cited by Jooste (2018:351), suggest that trust and relationships are built through spending more time and engaging with the participants.

1.17.2 Transferability

According to Botes (2003:181); Burn *et al.* (2013:202) as cited by Jooste (2018:353), transferability is mentioned when the participants are applying the findings from this research to other experiences or incidents of the same problem. This means that this research would be able to help the HEI students to make an informed decision and educate their peers as well. Peer educators of this HEI would be able to share or transfer the knowledge.

1.17.3 Dependability

According to Lincoln and Guba (1985), as cited by Schwandt (2015:308-309), dependability focuses on the methods to confirm that these procedures were consistent, traceable and documented. The researcher provided all the various research steps and justification of the processes that took place when the data was collected and analysed to ensure dependability and trustworthiness of the study. According to Polit and Hungler (1997:306), as cited by Jooste (2018:354), dependability states the stability of the findings over time and conditions. This emphasised the fact that if the same research could be repeated, the same findings would be reached.

1.17.4 Confirmability

According to Lincoln and Guba (1985), as cited by Schwandt (2015:300-309), confirmability focuses on the fact that the findings of the research can be confirmed. In this research, the findings could be confirmed by audio recording, transcripts and the independent coder. All the data of this research was kept at the Nursing Department in a locked cupboard for audit purposes. Only the researcher with the permission of the supervisor and the supervisor who could access the research with a key.

1.18 ETHICAL CONSIDERATION

Every researcher must be aware of ethical issues when planning to conduct research. It was vitally important that the researcher gain permission to do research. For this study, ethical clearance was obtained from CPUT and the Faculty of Health and Wellness Sciences Research and Ethics Committees (refer to Appendix H). Support letters (refer to Appendix E) were obtained from the Student Health Centre and Student Counselling Services. This was pre-causative, in case a student might have become sensitive and reacted to some of the questions that were asked during the focus group interviews. The student could then be referred to Student Counselling for attention. A permission letter (refer to Appendix B) was also obtained from the Director of the HIV/AIDS Unit, in support of this study. Each participant signed a written consent, prior to participating in this study both the participation in the focus groups and for permission to be recorded. An information sheet regarding the study was attached to this consent form (refer Appendix A).

1.18.1 Declaration of Helsinki

Developed by the World Medical Association in 1964, the Declaration of Helsinki was the first significant effort of the medical community to regulate itself. It is legally binding. It consists of 35 ethical principles and includes:

- voluntary consent, risk or benefit ratio and the right to withdraw from the study;
- additional principles for medical research combined with medical care; and
- access of participants to the best-proven methods identified by the study. (www.crede.co.za).

The researcher will also adhere to the following ethical principles discussed below.

1.18.2 Autonomy

Every individual has the right to make decisions for him or herself. It is a guiding principle and it is binding for health professionals and they should adhere to it unless it is outweighed by another principle (Pera & van Tonder, 2011: 72).

1.18.3 Beneficence

Beneficence relates to the researcher's duty to do no harm to all participants. Some philosophers divide the principle of beneficence into one that ought not to harm, but prevent or remove harm, as well as do or promote wellness (Pera & van Tonder, 2011:55).

1.18.4. Justice

The principle of justice is the obligation to be fair to all. All participants were treated equally and with respect (Mulaudzi, Mokoena, and Troskie, 2010:204).

1.18.5 Confidentiality

Emphasises the importance of protecting and safeguarding every individual's privacy because everybody has a right to confidentiality (Pera & van Tonder 2011:150).

1.18.6 Non-maleficence

Non-maleficence provides a concrete guidance of how to prevent harm in the care of a participant (Pera & van Tonder, 2011:55). The research participants, their organisations and communities must not be harmed at any stage of the research (Rule & John 2011:112).

1.19 CHAPTER DIVISION

Chapter One: The orientation of the study

The orientation of the study. This includes the research problem and the background of the research, the aim and objectives of the study, the significance of the study, definition of terms, the research design, methodology and analysis.

Chapter Two: Literature review

An extensive literature review of books, journals and articles, done to determine how health risk behaviours affect students globally, nationally and provincially in HEIs.

Chapter Three: Research design and Methodology

The research design and methodology are discussed in detail in this chapter. The rigour and trustworthiness are also discussed.

Chapter Four: Results

The research results and the implantation of the data are presented in this chapter. The themes and subthemes that emerged are also presented.

Chapter Five: Discussion of results

In this chapter, the results of the study are discussed into detail.

Chapter Six: Conclusions, Limitation and Recommendations

This chapter will conclude the study by highlighting the conclusions, limitations and the recommendations made on the basis of its findings.

1.20 SUMMARY

Chapter One described the orientation and background of the study. It also highlighted the methodology, design and analysis that were applied to this study. The ethical principles applied in this project were well defined in this chapter. Chapter Two will follow, discussing the literature review that was done.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

A literature review is a systematic way of demonstrating the amount and level of information that exists in study (Holloway & Galvin, 2017: 36-42; Mohan, 2013:135). This amount of work is produced by researchers who established the original work on the topic. There are reports, summaries or references that are originating from another person other than the researcher. These are secondary sources (Holloway & Galvin, 2017: 36-42; Mohan, 2013:135). Researchers review the literature to discover what is already well-known about the topic and recognise those who have done all the work. Other reasons are to recognise the gaps in knowledge and provide the opportunities for researchers to build on each other's work. It also clarifies the predicted issues that are related to the research question(s) (Holloway & Galvin, 2017: 36-42; Mohan, 2013:135).

The review of literature in this chapter places emphasis on publications, articles, books and internet sources that deal with findings on university students and potential health risk factors regarding sexuality and HIV/AIDS. The literature has been reviewed under the following major headings: students' life, Higher Education Institutions (HEIs), high-risk behaviour, students and HIV/AIDS, knowledge and attitude. Programmes that have been recommended for intervention will be considered.

2.2 THEORETICAL FRAMEWORK

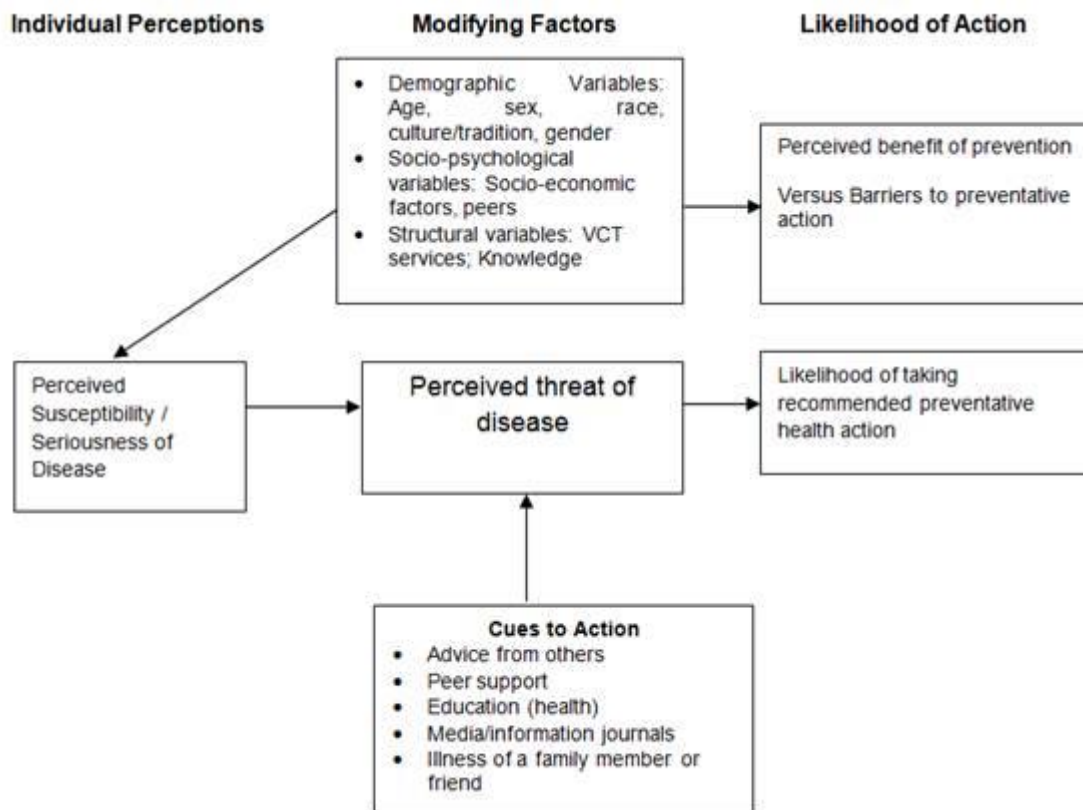
According to Majelantle, Keetile, Bainame, and Nkawana (2014:2), many theories have been established and used to try and comprehend health behaviours and their outcomes. They added that out of these theories, such as the theory of reasoned action, planned behaviours and the risk reduction model (and others), have been used to analyse health behaviours. No single theory can be singled out to discuss health behaviours, hence one or more cognitive theories may be combined (Michielsen, Chersich, Temmerman, Doms and Van Rossem, 2012:18, as cited by Wirtz, Kamba, Jumbe, Trapence, Gubin, Umar, Stromdahl, Beyrer, and Baral, 2014).

The most common theory that is tailored to all is the Health Belief Model (HBM) and it is the most generally used theory. Skinner et al. (2015:75) have confirmed that the HBM has been used to foresee preventative health behaviours and it has worked for sexual behaviours respectively. However, these theories were unable to interpret the communities' thinking about the spread of HIV amongst young people. Therefore, Social Cognitive Theory (SCT) goes into detail on the relationship between the individuals, their behaviours and their environment in which they find themselves in. It has been relevant and used to direct studies that are related to HIV/AIDS knowledge, attitudes and beliefs of young people. This theory was able to develop the prevention approaches that are intended for youth. In this research, the theory refers to university students and the HEIs as the environment (Bandura, 1986; Bandura, 1988:5). The premise of these theories is that actions are based on a person's intentions and behaviours. These theories of group behaviour can be used to study individuals as a group. The HBM, as well as SCT, were used in the study to investigate the factors associated with potential health risk behaviours amongst university students (Michielsen et al., 2012:18, as cited by Wirtz *et al.*, 2014).

According to Dennill, King, Lock and Swanepoel (1999) and Polit and Beck (2004) as cited by Tarkang and Zotor (2015), HBM was among the first theories that were established to describe the process of change in relation to health behaviour. It was revealed that HBM was one of the first models of health-promoting behaviours. It is still the greatest, widely acknowledged conceptual framework for health behaviours. The theory clarifies the behaviours of health from a social psychology viewpoint. This is accomplished by using theories of value-expectancy and the making of choices (Kronenfield & Glik, 1991; Mikhail, 2001:159-165). Onega and Lancaster (2000:265-283) as cited by Tarkang and Zotor (2015) reveals that the HBM is divided into three key components as illustrated in Figure 2.

Figure 2 Conceptual Model of HBM

(Onega & Lancaster, 2000:265-283 cited by Tarkang & Zotor, 2015)



2.2.1 Individual perception

Perceived risk and effect are individual's views or beliefs regarding the risk of developing a health problem and the potential negligence and consequences of the health problem based on their background; for example, age, sex and geographical location (Janz & Becker, 1984;11:1-47), as cited by (Wirtz et al., 2014). This research focused on potential

health risk factors amongst university students regarding their sexuality and HIV/AIDS. In this study, individual perceptions concerning the student's belief about their vulnerability to HIV/AIDS and their perceived harshness of HIV/AIDS will be explored and described.

2.2.2 Modifying factors

According to McCormack (1999) and Onega (2000) as cited by Tarkang and Zotor (2015), modifying factors involve demographic, socio-psychological and structural factors. Furthermore, they mentioned that these variables can influence the individual's perception which leads to one's health-related behaviour.

The socio-demographic factors, for example, would influence the student's perception of vulnerability to HIV and the seriousness of contracting HIV. The students could also be influenced by socio-economic and structural factors to make certain decisions regarding perceived benefits or barriers. These students are coming from different provinces with different backgrounds, therefore, some of these young peoples' socio-economic factors may influence their decisions toward risky behaviours (Tarkang & Zotor, 2015).

2.2.3 Benefits of preventative measures

In this research, the benefits of preventative measures would be the fact that the students would use safety measures (using condoms) or abstinence to prevent HIV infections or seek help by accessing information. Therefore, the benefits of preventative measures would depend on their perception of weighing benefits against barriers. One needs to believe that by taking a certain action would assist in preventing a certain danger from occurring (Janz & Becker, 1984; 11:1-47), as cited by (Wirtz et al., 2014). HBM cues to action require motivation from the individual to conform to the prescribed remedy, be it to be involved in health education activities or peer support groups etc. (Polit & Hungler, 1999).

2.3 STUDENT LIFE

According to Mbatha and Ally (2013:1) students are part of an educational community. Student life refers to the period of a student leaving the parents behind for the first time and heading to a HEI. This phase can also be referred to a Grade 12 high school learner who's going to be starting a new journey at an HEI (HEAIDS, 2017:4). This is a crucial stage for most of the students and families as HEIs offer a transitional phase of being a young adult. In this phase, even the students do not regard themselves as children anymore, although they are not completely adults (Myers, Kelly, and Motuba, 2012:9).

Being young and being a student leaving home for HEIs means taking responsibility for your own actions and setting goals for yourself to achieve your qualification (HEAIDS, 2017:4). Students also enter this stage of their lives, where, as students, they do not have any major obligations, except for concentrating on their studies. During this phase of their lives, they are exposed to a life that is full of fun, joy, freedom and risks. It can also be lonely at times (HEAIDS, 2017:4).

According to Freitas (2017:294-314), colleges do not only provide students with academic processes but also with accommodation in its residences. Some of the

residences are in public spaces, while others are private. The students are staying on their own and some are sharing with other students. New friendships are formed in these residences. Allison and Risman (2014:103) reveal that students tend to lose focus when they are at HEIs. Instead of creating the norm of committing to their main purpose of being at HEIs, they have a habit of “hooking-up” with friends with no intention of studying. Allison and Risman (2014:103) define “hooking-up” as a casual sexual behaviour that involves kissing and other behaviours that could lead to oral or penetrative sex and other risk behaviours. The students tend to do this as groups, which is where the influence of peers takes place. According to Bogle (2008); Freitas (2008); Kimmel (2008); Wade and Heldman (2012) as cited by Allison and Risman (2014:103), ‘hooking-up’ has taken over on many college campuses. It has created sexual grounds in residences situated on HEIs campuses and even in private residences.

Student life relates to freedom, sexual experiments, inconsistent condom use, alcohol and drug abuse, having sex with multiple partners and dating older people (blessers). All of these features expose young people to a high-risk of contracting sexually transmitted infections (STIs) including HIV and other health risks (Abels & Blignaut 2011; Mutinda, Govender, Gow & George, 2013, as cited by (Ngidi, Moyo, Zulu, Adam, and Naidu Krishna, 2016). White (2015:268) added by saying that American colleges and universities are also facing these same health risks, including sexual assault. However, White (2015:269-270) reveals that despite all these challenges, students are supported with counselling, mentoring, coaching and academia. All these support systems are to assist students to make informed decisions about their future.

2.4 HIGHER EDUCATION INSTITUTION (HEI)

According to Brook, Fergie, Maeorg and Michell (2014:3), HEIs are viewed as a place of multiple, complex and diverse social relations, identities, communities, knowledge and practices. They further say that people (students) would enter these broad varieties of social relations by enrolling at the HEIs for the first time. They enrol with the expectation of furthering their studies and acquiring skills and knowledge through universities.

White (2015:267) suggests that as soon as these students are admitted, HEIs need to attend to the challenges immediately so that they will be able to ensure that more students will graduate. Much of the research has suggested that multiple interventions that have been employed to assist students to complete their studies successfully, have proved to be futile (White, 2015:267). According to HEAIDS (2017:4-5), HEIs welcome all students from all walks of life, providing support academically and mentally. There is additional support to all those who are not coping well in the initial stages of entering HEIs. The HEIs have provided different departments to support these students even outside of their academic life. These departments consist of Student Affairs, Student Counselling, Student Health Clinic, Health and Wellness clusters and more. These departments are designed to assist students academically, physically, socially, emotionally and spiritually. Each year, students are orientated to all these departments (HEAIDS, 2017:4-5; Status Update, 2018:2-3).

Additionally, the minister of Higher Education and Training, Doctor (Dr) Blade Nzimande, revealed in his 2014 speech that poverty and financial suffering of the HE students, were among the priorities of government. The minister called upon different stakeholders, including the National Student Financial Aid Scheme (NSFAS), to assist

students in their education and in improving their lives financially. The minister also encouraged the partnership between employers in industries and institutions, as this will assist in the required experience needed for employment in the future (Nzimande, 2014). Despite all the aforementioned support, students are still exposed to high-risk health factors.

According to HEAIDS (2010) as cited by Ngidi et al. (2016), South African universities are continuing to have great concerns with the high incidents of health risk factors about HIV/AIDS and other social health-related risks. Furthermore, these institutions also introduced peer educators to assist and influence student's behaviour changes and communication. Peer educators are young people (students) who advise and develop other students, since they are also students, but they are trained to be able to do all these activities (HEAIDS, 2015:17). In addition, there were suggestions that with regards to student's background and cultural belief systems, educators should be empowered and be updated so that they can understand the student's behaviour and their transition pathway better (Brook, Fergie, Maeorg and Michell, 2014:8) and (Vember, 2013:38).

Braxton (2000), as cited by Johnson, Wasserman, Yildirim and Yonai (2014:76) agree by saying that now is the time for educators to look at different models that can assist to recognise the factors that contribute to student's stubborn and uninformed decision-making. This will improve the challenges around communication academically and socially. Aud, hussar, Johnson, Kena, Roth and manning *et al.* (2012) as cited by Johnson et al. (2014:76) reveal that focussing on one model limits the educators in terms of understanding the students' paradigm. They further say that a single paradigm affects the improvement of graduation rates and the period that students take to complete their qualification. Some of the students complete a four-year course in six years, which has serious ramifications for HEIs (Aud *et al.*, 2012, as cited by Johnson *et al.*, 2014:76). Many types of research have surveyed the connection between social, academic integration and student's determination. Robbins, Lauver, Le, Davis, Langley and Carlstrom (2004:267) as cited by Bowman and Denson (2014:125), have identified the indicators of collective involvement that are critical and identical with social integration. These include the level in which students feel associated to the HEIs environment, the quality of student's relationships with peers, faculty and others in HEIs and the involvement of students in campus accomplishments.

2.5 HIGH-RISK BEHAVIOURS

Health risks are continuing to be a burden amongst young people across the world. All over the globe, the sexual health of young adults has been a concern and is identified as a serious matter by leading health organisations (Kwete *et al.*, 2016). Sub-Saharan Africa has been challenging numerous global health and growth issues, as it is the fastest-growing region in the world (Vember, 2013:33). Many researchers have done a lot of work researching factors that may increase health risk behaviours amongst young people. According to Burke (2010:26), as cited by Mbatha and Ally (2013:2), South Africa has been mentioned as one of the countries with the highest alcohol consumption and drug use in the world. These can lead to high-risk behaviours. These can be unprotected sex, unwanted or unplanned pregnancies, contracting STI's and HIV. Burke (2010) further mentions that consequences of alcohol to students who abuse it, lead to academic failures and absenteeism. Alcohol and drugs are problematic, especially if they are taken regularly and are depended upon. This dependency can lead to psychological, physical or financial

problems and it becomes impossible to stay away (HEAIDS, 2017:50). According to the South African Department of Social Development as cited by HEAIDS (2017:50), people who use substances are suffering from serious health and socio-economic difficulties. They added that in South Africa, young people aged 15 and older consumed more alcohol than any other African countries. This leaves the students in vulnerable spaces. Furthermore, experimentation, boredom, peer pressure, lack of recreational facilities and poverty are mentioned as contributing factors. Spending time with people who are substance abusers can lead students to the same behaviours. Whitehill, Rivara, Moreno (2014) add by citing marijuana and cannabis as having more negative influences on underage college students. They further stated that these substances are common, and they can lead to fatal accidents amongst these young people.

UNAIDS Global Report (2012:29) revealed that new STI's and HIV infections are occurring in young people and they account for nearly 27%. Mengistie, Wolie, Abawa, Ebre, Aderan (2015) disclose that unprotected sex is a threat to the health and existence of millions of youths. They further elaborate that every day, over 700 young people aged 10 to 24 are infected by HIV/AIDS. Vember (2013:115) added by stating the contributing influences that lead to risks of getting HIV/AIDS and STIs include violence-related behaviours, alcohol and substance abuse, suicides attempt, bullying, sexual activities, multiple sexual companions and unplanned pregnancies.

In a study that was done between 2013 and 2014 regarding sexual knowledge, contraception and accessing contraceptive methods amongst university students, it was revealed that the rate of unintended pregnancies and STIs has gone up. It was a great concern to the health department (Turnbull et al., 2016:9). The study also revealed that there was an assumption that sex and relationship education that was provided in schools was sufficient. These outcomes clearly exposed that the HEIs need to address these issues adequately. It also exposed that although the universities provide this information, they need to identify that even adult students do not have enough knowledge on these matters (Turnbull *et al.*, 2016:9).

The CDC in Taiwan (CDC Taiwan, 2013) has revealed that 40% of the HIV-infected population in Taiwan are young individuals between 20 and 29 years. According to Hedayati-Moghaddam, Eftekhazadeh-Mashhadi, Fathimoghdam and Pourafzali (2015), STIs and HIV/AIDS occurrences are more advanced in youth, globally. They further revealed that in Iran, an incidence of unprotected sexual contact amongst university students has not been researched frequently.

In a study that was done in Spain about the sexual behaviour and risk of STIs in young female healthcare students, it was discovered that one in every three women was at risk of contracting STIs by not practising safe sex or using male or female condoms in their casual vaginal sexual relationship with men. This study also exposed that the reason for unprotected sex was found to be that these women want to reach an orgasm and feel the pleasure of interaction with their sexual partners in a more natural way. These behaviours expose them to a high-risk of contracting STIs (Navarro-Cremades, Palazón-Bru, Marhuenda-Amorós, Tomás-Rodríguez, Antón-Ruiz, Belda-Ibañez, Montejo and Gil-Guillén, 2016:8).

The changes in society have brought new obstacles such as communication patterns for youth throughout the world. Parents are still finding it difficult to talk about sex to their children and vice versa. Even partners that are in sexually active relationships find it

difficult to talk about intimacy and sexual issues; they rather bypass it (Seloilwe, 2015; Viljoen, Thorne, Thomas, Bond and Hoddinott, 2016). It was revealed by learners that even in their Life Orientation classes, the teachers themselves make them feel uncomfortable with their comments (Bawa, 2018:6). One learner quoted a teacher saying that “why would he buy the cow when he’s getting the milk free of charge”. These are the values of Life Orientation that most young people encounter in South Africa. The harmful sexual education in our schools and in HEIs that is promoted by so-called role models, leads to confusion amongst youth. It encourages the control of men over women, referred to as “toxic masculinity” (Bawa, 2018:6).

Although there are some communication barriers amongst parents and their children, there are parents who initiate sexual talks. Most of the time, these parents are trying to open a platform for communication with young people. Usually, these are parents who are educated. However, there are also those traditional parents who are still finding it difficult to discuss sexual matters, or educating their children about these issues (Kim, 2007; 2009, as cited by Seloilwe, 2015).

According to UNICEF (2011) as cited by Denno, Hoopes, and Chandra-Mouli, (2014), 1 300 000 and 800 000 young girls and boys respectively, were still living with HIV worldwide. In 2012, The Ministry of the People revealed that China’s CDC showed an increase of new HIV infections from 0.96% to 1.73% between 2006 and 2011 amongst young students (Min-Chen, Liao, Liu, Fang, Hong, Ye, Li, Tang, Pan, W. and Liao, 2016:2). Even today, people worldwide still recognise HIV/AIDS as a bigger health problem. The awareness of health care providers needs to be evaluated regularly to improve lives and combat new infections (Kuate, Huang, Rashid, Ma, Yuan, Escalera Antezana, and Zhang, 2016).

A study that was conducted between 2013 and 2014 in Britain about sexual knowledge, contraception and accessing contraceptive methods among university students, highlighted that the greatest number of students found that the sex education they had received, was poor. They also said that they needed more information about sex and sexual health. It was also recognised that sex and relationship education (SRE) was not enough and therefore HEIs need to include sexual health and HIV into their curricula (Turnbull *et al.*, 2016:13-19).

Another study about knowledge, attitudes and practices towards premarital sex and HIV/AIDS amongst Mizan-Tepi university students in South West Ethiopia, declared that the students had a good knowledge and attitude about premarital sex and HIV/AIDS, the causes and the way it is transmitted, however they were not applying and putting this knowledge into practice (Mengistie *et al.*, 2015). Regardless of the great strides in fighting the HIV epidemic over the decade, it is still a root cause of illnesses; the number of people living with HIV and the amount of deaths from HIV/AIDS continues to grow globally (Mengistie *et al.*, 2015).

A study that was done by the Human Sciences Research Council (HSRC) at technical vocational education and training (TVET) colleges in South Africa about HIV knowledge, attitudes and behaviours, revealed that 59.5% of students and 57.5% of staff confirmed that they consumed alcohol. Furthermore, it was revealed that other substances are used. Eleven per cent of these students were using marijuana, whilst 5% of the staff also confirmed the use of it. Crack cocaine was used by 2% of students and 1% of staff.

Mandrax, tik, nyaope and wunga were also used by students and staff members, 1% and 0.6% respectively (Setswe, Mbelle, Mthembu, Mabaso, Sifunda, and Maduna, 2017).

The above results linked with another study that was done in South Africa that was evaluating the influence of an HIV/AIDS peer education programme at the HEI in the Western Cape. One of the findings was that the assumption of peer education is that students are more receptive to the influence of their peers. Though peer educators were trained and equipped, they themselves had experienced drug use, multiple partners and other violent behaviours. They were struggling to apply the knowledge they had learnt or ought to have learnt, in their normal circumstances. Peer educators are students themselves, therefore they share related values and benefits with their fellow students (Vember, 2013:157-158).

According to Tildesley, Hops, Andrews (1993:28(9):853-80) as cited by Abbasi-Ghahramanloo, Fotouhi, Zeraati, and Rahim-Movaghar (2015:5), youth are easily influenced by their peers. People that are involved in certain behaviours, are more likely to be attracted to others involved in that same behaviour. The behaviours could take on any form relating to substance use or abuse. They concluded by saying that the effect that peers and friends have on each other, constitutes some of the most important factors that can spread the impact of high-risk behaviours amongst young people (Tildesley *et al.*, 1993:28[9]:853-80, as cited by Abbasi-Ghahramanloo *et al.*, 2015:5).

2.6 STUDENTS AND HIV/AIDS

According to UNAIDS (2013b), incidents of HIV/AIDS have been a big challenge all over the world. These patterns vary between countries and regions. The focus of this study is on potential health risks amongst students at HEIs about HIV/AIDS and sexuality. Therefore, the focus would be on students, HIV/AIDS infections and their sexuality. Globally, young people are faced with greater numbers of STIs and HIV/AIDS. Small countries, like Iran, are more challenged because their total population consists of 35% young people aged between 10 and 24 years old (Statistical Centre of Iran, 2012, as cited by Hedayati-Moghaddam *et al.*, 2015). A study that was done to evaluate the prevalence of sexual and reproductive behaviours amongst undergraduate university students in Mashhad, a city in Northeast of Iran, revealed a 15% prevalence of premarital sex during student life. The numbers of males indulging in premarital sex while at HEIs, were higher than in females. Male students experience sexual relationships four times more than female students (Hedayati-Moghaddam *et al.*, 2015).

In Spain, a study conducted by Navarro-Cremades *et al.* (2016:8) on sexual behaviour and the risk of STIs in young female healthcare students, revealed that one in every three women was at risk of contracting an STI by not using condoms in their casual vaginal sexual relations with men (Navarro- Cremades *et al.*, 2016:8). A study that was done in China regarding a hidden challenge for HIV/AIDS control on a comparison of sexual knowledge, attitude and behaviour between female Chinese college students from urban areas and rural areas, suggested that the students from rural areas engaged in the same level of sexual activity, as those from urban areas. These results correlated with the recent study that was done in South Africa (Min Chen *et al.*, 2016). Furthermore, Vember (2013:34) reveals that the youth all over the world share many similarities, therefore the

experiences of being a young person are as diverse as the cultures, depending on the area the person is coming from.

As HEAIDS serves an overwhelmingly young population, they have noted that young people, especially in their late teens to early 20s, are challenged by HIV. HEAIDS is striving to steer these students safely through programmes that are focussing on HIV prevention (HEAIDS, 2015:9). UNAIDS Global Update (2016:8) has revealed that in 2015, young girls and women aged 15-24 years were accounting for 20% of new HIV infections. This is an alarming situation as these young people are vulnerable. However, by 2030, the United Nations commits on ending the HIV/AIDS pandemic (UNAIDS Global Update, 2016:8).

2.7 TERTIARY STUDENTS' KNOWLEDGE ABOUT POTENTIAL HEALTH RISKS

According to Grove *et al.* (2013:8-9), knowledge is vital information that is learned through traditions, authority, borrowing, trials and errors, personal experiences, role modelling and mentorship, intuition, reasoning and research. According to Steinberg (2008:5) the youth are shown to be more risk-seeking than children. This is because of neurocognitive changes around the puberty stage of their lives. Steinberg (2008) continues to reveal that there are parts of the brain that release a chemical called dopamine. This chemical develops at this age and helps people to see rewards and take action towards them. For example, when students are attending HEIs bashes, there are many rewards to bargain for like alcohol, drugs and sex. All these rewards entice that part of the brain and the struggle of self-control, becomes more challenging because that specific part of the brain, is not fully developed at this stage. Young people generally enjoy a good life, more than any other age groups. They are not thinking about potential health risks. These behaviours can affect not only their academic future but the rest of their lives negatively (Chandra-Mouli, 2015; Steinberg, 2008:5).

Bawa (2018:6) revealed that most of the youth in South Africa do not understand how their bodies work. This is the result of conservative sex education that is linked to religion. Bawa (2018:7) continues to reveal that even teachers avoid the issues that are related to body changes. This leaves the scholars uninformed. They cannot differentiate when the bodily changes happen and whether it is a healthy or a harmful reaction (Bawa, 2018:6).

Health Minister Dr Motsoaledi reacted to the statistics that were revealed by researchers in 2017, that new HIV infections have increased amongst youth aged 15 to 24. This was the study that was done by HSRC of the 5th HIV Prevalence, Incidence, Behaviour and Communication for 2017. Dr.Motsoaledi made a request to mothers, fathers and guardians to allow the Health Department to come to schools to promote attentiveness about HIV/AIDS and probe the issues of multiple partners and blessers. The minister revealed that parents were against his request. Their reason was that they do not want the department to complicate the lives of their children and to encourage sex (Motsoaledi, 2018:4). Although the parents were refusing the minister's request, a study was done between parents and youth communication patterns on HIV/AIDS, STIs and sexual matters. It was found that parents are still uncomfortable talking about these issues with their children. Instead, they threaten them with contracting STIs or falling pregnant if they are involved in sex. This study also revealed that another reason could be that parents

might be lacking information (Seloilwe, Magow, Dithole, and Lawrence, 2015). According to Svanemyr *et al.* (2015:S8), students can be involved in high-risk situations and they do have the ability to control the high-risk behaviours when they are equipped with necessary resources, skills and knowledge. They further state that when students recognise resources and opportunities, their behaviour will be redirected to opportunities, instead of risky behaviours.

2.8 ATTITUDES OF TERTIARY STUDENTS TOWARDS POTENTIAL HEALTH RISKS

According to Kambole (2007:4), an attitude can be defined as a learned tendency to evaluate things in a certain way. This tendency can be positive or negative, depending on one's motion and beliefs of people, objects, events, activities and ideas or just about anything in your environment that can create an inclination for action. A study that was done in Botswana about knowledge, opinions and attitudes towards HIV/AIDS amongst youth, revealed that there are still misconceptions about HIV transmission amongst learners. These misconceptions differ depending on which age the learner started to be sexually active and their level of education (Mejalantle *et al.*, 2014).

Another study that was done in South Africa about predicting primary and secondary abstinence amongst adolescent boys and girls in the Western Cape, revealed that the attitude or perceived negative consequences of abstinence and social norms were reasonably and consistently linked with intentions to abstain from sex but not with the sexual activity itself. Additionally, this showed that if social norms, attitudes and risk perceptions are addressed before sexual debut, they can promote sexual abstinence amongst youth (Eggers, Mathews, Aaro, McClinton-Appolis, Bos and de Vries, 2016:1425).

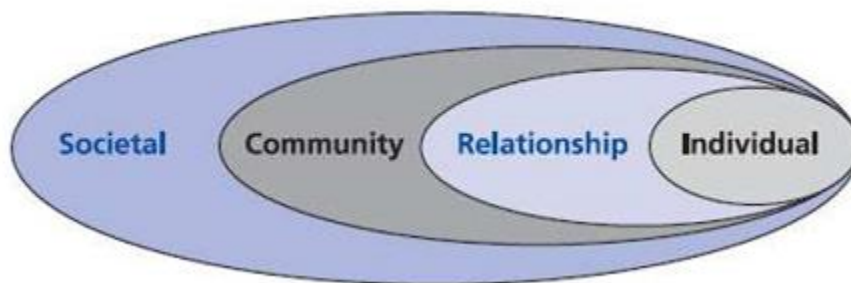
According to Ukhtomsky's (1966) and Uznadze (1961) as cited by Tretyakova, Fedorov, Dorozhkin, Komarova, and Sukhanova, (2016:8287-8288), studies "on a dominant" and theories of attitudes, revealed that the foundation of personal health is probably done by health saving attitudes. They further say that this attitude is possible by introducing certain activities. In the case of students, their attitude towards health whether passive, active and creative attitudes, can assist to preserve and promote health. These attitudes are possible by implementing high responsibilities about health education, development, promotion, motivations and behavioural change in faculties. These attitudes should be addressed not only with students but with everyone that is involved.

Ham, Hariiri, Kamb, Mark, Ilunga, Forhan, Likibi and Lewis (2015:27) discovered that in healthcare centres, the healthcare providers show negative attitudes towards young men who complain about STIs. They prefer to listen to what these patients are reporting, rather than examining them. They added by stating that if these attitudes are not addressed, they can delay the partner treatment process or HIV prevention can be missed. Hence Dinkins (2011:2) as cited by Selenga and Jooste (2015:9), encourages health care workers to have empathy towards human beings, especially to patients as they are guided by ethics. Additionally, empathy eliminates challenges and it promotes effective cooperation on everyday communication. Navarro-Cremades *et al.* (2016:9) agree by saying that even the university curriculum should not solely rely on education for the sexual behaviour and risk of STIs in students. They should include precise programmes about preventative techniques. This was revealed after there was an assessment of sexual risk behaviours

amongst female healthcare students from Spain. This could assist these students to be able to promote more initiatives, positive attitudes and public awareness campaigns in their communities and when they are qualified, this can continue to the workplace (Navarro-Cremades *et al.*, 2016:9).

There is so much evidence that norms and attitudes towards gender and sexuality are formed during childhood and at teenage years. These are the drivers of sexual behaviours amongst youth (Svanemyr, Amin, Robles, and Greene, 2015: S13). However, Svanemyr *et al.* (2015) discuss and outline an ecological model and promising approaches that could create an enabling environment for adolescent sexual and reproductive health. They revealed that these approaches need group interaction because the factors that are affecting young people are interlinked. The figure below outlines the framework and the application collectively.

Figure 3: Ecological model to enable and shape the environment of adolescence sexual and reproductive health



(Adopted from Krug *et al.* (2000) as cited by Svanemyr *et al.* (2015:S8).

Svanemyr *et al.*, (2015:S8) revealed that the approach should start at the individual level, where the focus would be empowering the youth, both socially and economically. This could be done by helping them create efforts that enable them to access resources that are needed. At the relationship level, a focus would be to build healthy relationships by supporting and strengthening a positive attitude in their relationships, instead of judging them. This could include partners, parents, peers and other sexual partners because these are the people that influence their sexual experiences. The community would assist to create positive social norms and promote safe sexual behaviours. Access to sexual reproductive health education, involving institutions, schools, neighbourhood and workplaces, are of utmost importance. The societal level would support them by promoting the laws and policies. Educating youth about their rights, would assist them to be able to negotiate in their sexual relationships, understanding their economic, social, health and education positions around society (Svanemyr *et al.*, 2015:S8).

According to Bawa (2018:6), young people can only be knowledgeable through inclusive sex education. This will assist them in informed decision-making. They will be skilled in knowing whether their human rights are violated or not. Additionally, Bawa (2018), revealed that empowering classrooms with issues that are related to sex education, makes the teaching space relevant. It also becomes appropriate to change the public's attitude. Additionally, one of the stakeholders in Dr Motsoaledi's report revealed that out of nine provinces in South Africa, five provinces showed low consistent condom usage. These were sexually active children under the age of fifteen (15) years, especially boys. These

provinces were Western Cape, Eastern Cape, Mpumalanga, Free State and KZN (Motsoaledi, 2018:4).

2.9 KNOWLEDGE AND ATTITUDES TOWARDS CONDOM USE

According to Hojat, Shapurian, Nayerahmadi, Farzaneh, Foroughi, Parsi, and Azizi (1999) as cited by Hedayati-Moghaddam *et al.* (2015), youth are using condoms in their sexual experimentation. Hedayati-Moghaddam *et al.* (2015) continue to state that many researchers have revealed that in different countries, the occurrence of unprotected sex is high amongst university students. They added by stating that condoms are used as the best vital contraceptive technique these days. People are aware that condoms are efficient and can prevent STIs, unintended pregnancies and HIV. Their quality was tested for strength, leakage, lubrication and proper packaging (Brown, DUBY, Bekker, 2012:48 &98) and (Holmes, Levine & Weaver, 2004, as cited by Navarro-Cremades *et al.*, 2016:1).

According to Granich, Gilks, Dye, DeCock, and Willians (2009) cited by Myers *et al.* (2012:10), although there is enough knowledge about condoms in HEIs, negative attitudes are still observed. Furthermore, they reported that the condom knowledge is not applied by students. A study done in Spain on female students by Navarro-Cremades *et al.* (2016:8), revealed that women want to reach an orgasm, thus are not using the condoms as they want to experience sexual intercourse naturally. They claim that condoms prevent orgasms from happening spontaneously. However, these behaviours make them vulnerable to STIs.

HEAIDS has introduced pre-exposure prophylaxis (PREP) at universities. This is a treatment that can be taken by people who are at a high-risk of contracting HIV. It is known as “Truvada” and is an anti-retroviral medicine that can be taken daily. HEAIDS has presented PREP to Nelson Mandela University, University of Venda, Rhodes University, University of Limpopo, University of Free State, Vaal University of Technology and the University of Zululand. It was revealed that the PREP was previously introduced to sex workers and to men having sex with men by the Department of Health, as this population was pronounced as a high-risk (Status Update, 2018:15).

2.10 SUMMARY

In this chapter, the literature was reviewed according to the objectives of the study. This chapter explored the major topics about the student’s life, Higher Education Institution (HEI), high-risk behaviours, Student and HIV/AIDS, knowledge and attitude. In the following chapter, the research design and methodology will be discussed.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

Methodology serves as a guide. This is the process where researchers collect the data, to analyse, describe and to explain the phenomena (Maree, 2016). Sandelowski (2000) stated that in methodology, there has to be some knowledge of the world, which includes theory, method or paradigm. It is the design and methodology that will explain how the researcher is going to gather the data, analyse and describe the results. Methodologies analyse and develop the kinds of problems that are worth being researched (Schwandt, 2015:201). According to Bazeley (2013:8), methodology is an idea of how the investigation should proceed.

In this case, the complete research strategy will be revealed by the choice of the method the study has employed. The method that the researcher chooses is going to add to the generation and development of knowledge. However, the method and the tool has to be clear and well-defined. This will help to understand the issue that has been investigated (Silverman, 2013:122-123). Methods are specific research techniques that are used by a researcher to design a particular research and to assemble and examine data.

The aim of the research and the nature of the data that is going to be collected, needs to be considered when these methods are employed (Schwandt, 2015:199; Denzin & Lincoln, 2018:809). The methodology employed in this research is discussed below under the following headings: qualitative research, research design, population and sampling, method of data collection, rigour and trustworthiness.

3.2 QUALITATIVE RESEARCH

Qualitative and quantitative are both adjectives that describe the type of research that is employed in a study. Qualitative research describes data in the form of words (non-numeric) and quantitative research defines it as numeric (quantifying) respectively (Schwandt, 2015:256-260). According to Clow and James (2014:39), quantitative research is organised data and can be analysed through statistical techniques. Quantitative research makes use of reasonable judgement. A researcher is able to start with a hypothesis and then perform data collection to confirm the hypothesis. By doing this, it makes the quantitative analysis quick, inexpensive and easy to execute (Mohan, 2013:139).

According to Holloway and Galvin (2017:12-13), qualitative research focuses on peoples' reality within their social and cultural context. This approach helps the researcher to understand the participant's experiences, thoughts and ideas. According to Clow and James (2014: 39), qualitative research is unstructured, and it can give findings that are subjectively interpreted. Mohan (2013:139) explains that it is expensive and requires labour. The research paradigm that was utilised in this study is constructivism.

3.2.1 Constructivism

According to Schwandt (2015: 35-37), constructivism is a vague term with different meanings, depending on the context in which it is used. It can be used for experimental

purposes, but it is mostly used in the Social Sciences. According to Denzin and Lincoln (2018:19-20 and 98), constructivism is one of the five paradigm models which connects many realities. It also allows for an understanding between the researcher and the participants in the natural world, through a set of methodological procedures. Transactional information is valued by constructivists because it is built on anti-foundational dialogues. According to Schwandt (2007), as cited by Bazeley (2013:23), constructivists maintain that knowledge is not discovered but constructed and produced through experiences, interactions, practices and opinions by human beings. In this research, constructivism was relevant, because students, as individuals, acquire risky behaviours through their own experiences in their natural settings. The students were able to share, construct and contribute their experiences amongst themselves in their own world. In this case, the environment was the two main campuses. The researcher was able to focus on gathering knowledge and gain insight and understanding of the students' way of life in their own setting.

The researcher, as a professional interacting with youth at her workplace, has always enjoyed listening to the stories of her clients and enjoyed analysing these stories. Hence, she embarked on a qualitative study. Qualitative research empowers researchers socially. It gives one the opportunity to associate with the diverse group of people (Silverman, 2013:120-122). There are many techniques in qualitative research that could be used to extract data from participants. Hence, qualitative methodologies are what attracted the researcher to engage with this method (Silverman, 2013:120-122). However, Mohan (2013:139), revealed that a qualitative approach relies on a researcher's ability to be able to remain neutral whilst interacting with participants. This is referred to as bracketing. The researcher endeavoured to bracket herself outside of her subjects at all times, throughout the research process and the duration of this study (Schutz, 1899-1956, as cited by Schwandt, 2015:22).

3.2.2 Bracketing

According to Jooste (2018:346), bracketing was established so that the researcher would control her or his bias. This would assist the researcher to set aside her thoughts and rather focus on what was perceived about the phenomenon. In this research, the focus group discussions (FGDs) were used and the researcher was able to suspend all her thoughts by being neutral during the entire process of data collection. This helped the researcher to realise the real experiences of the participants in their own world. Participants were able to talk freely and expressed their thoughts without being judged and without the researcher's personal views. The researcher became more interested in the study phenomenon after working with youth during Clinical Trials. The researcher remained objective through-out the data collection process.

3.3 RESEARCH DESIGN

A descriptive, exploratory and contextual qualitative design was applied to this study to collect data. This design is mostly used to direct the growth of future research and to understand the circumstances better. In this research, the researcher was using focus groups. The researcher was exploring the thoughts and ideas of the participants in detail, as this method suited the situation (Clow & James, 2014:4-5). The researcher used this design to find out what the participants know about the phenomenon and their perceptions. This design assisted the researcher to get rich and detailed information from the

participants. This would enlighten the researcher and other participants about the current situation. It is essential that the research design must fit in with the selected topic and research questions. Descriptive research was used to explore fresh parts of this research and define circumstances as they existed (even globally), as discovered during the literature review. In this particular research, it was used to explore the potential health risk factors amongst students at a higher education institution (HEI) in the Western Cape with regard to sexuality and HIV/AIDS. The researcher interacted with both genders and tried to probe as much as she could (Grove *et al.*, 2013:20). However, Holloway and Galvin (2017:12) emphasise the fact that researchers need to handle the research participants with care and sensitivity, as their behaviour is the result of their lifestyle. The researcher was conscious of this throughout the research process.

3.3.1 Descriptive design

According to Clow and James (2014:6), a descriptive design describes the characteristics of a participant or other phenomenon in answering the questions of how what, who, when and where. They continue to explain that with descriptive research, researchers do have an understanding of the topic, but the researchers want more information in order to conclude on the knowledge. Furthermore, Mohan (2013:136) reveals that descriptive research is intended to respond to questions that are interrogative. This will assist the researcher to be able to thoroughly discover opinions, attitudes and situations about the participants. This research was intended to assist the participants to make more informed decisions in their personal experiences. The participants would be able to equip their peers and communities with ample information. The students would be more equipped to discuss freely the potential health risks and the risk factors that could negatively impact their future.

3.3.2 Exploratory design

According to Clow and James (2014:4-5), an exploratory design starts by outlining the problem itself or it will involve an initial inspection of the situation or the issue so that it can recognise the limitations that need further investigation. When little is known about the phenomenon in a big community, the first thing that the researcher thinks about, is how to explore and discover more about certain phenomena. This is typical of qualitative research. This will assist the researcher to prepare or to find out more about the phenomenon. Qualitative research is aimed at exploring what is not known (Green & Thorogood, 2018:18). In this research, the researcher used exploratory research to try and find out the participant's own understanding of their perception of factors that may increase health risk behaviours. The researcher was also exploring their knowledge and attitudes towards potential health risks, with regard to their sexuality and HIV/AIDS. According to Grove *et al.* (2013: 370), exploratory research is intended to bring more understanding situations or issues. In this research, the researcher intended to empower the participants, should they be faced with similar situations in their communities. The students would be able to discover and understand the reasons of their risky behaviours. Once these reasons are discovered, then it would be easy to implement innovative methods. Educating youth and communities about their rights, would assist them to be able to negotiate in their sexual relationships, understanding their economic, social, health and education positions around society (Svanemyr *et al.*, 2015:S8).

3.3.3 Contextual design

According to Schwandt (2015:41), contextualism is an opinion that focuses on specific events within some background of beliefs and practices. According to Silverman (2014:345-347), qualitative social research regards the issue of context as a very crucial matter. He further emphasises that researchers must try to be observant on how participants create some context for their actions and not make assumptions. A contextual design was used because the researcher wanted to understand and describe the real experiences of the participants in the context of their natural environment. The FGDs of this research were conducted in the natural setting at both of these campuses. The researcher spent more time on these campuses to interact with the participants in their social activities and in their own environment.

3.4 RESEARCH SETTING

The institution of higher education under study was formally recognised on the 1 January 2005. This merger was the culmination of the Cape Technikon and Peninsula Technikon that became one institution. This unification was part of the national transformation process that transformed the higher education landscape in South Africa (CPUT website, 2015). It enrolls approximately 30, 000 students per year and has six faculties. It has six campuses and four service points. It offers a range of undergraduate and postgraduate programmes from different faculties. The university offers qualifications ranging from a National Diploma, Bachelors, Masters and Doctoral degrees in Technology. The university is broadly diverse, comprising Blacks, Coloureds, Indians, Whites and students from abroad. Some students stay onsite in campus residences while others live outside the campuses, in rented residences. Some students are still staying at home with their families (CPUT website, 2015).

3.4.1 Cape Technikon

In 1920, it was a Cape Technical College. Later, in 1960, it became a college for Advanced Technical Education. The College was forced to serve a certain race during the apartheid era, therefore it was for white students only. In 1990, it became a Cape Technikon in the new era, where it now is open to all races (CPUT website, 2015).

3.4.2 Peninsula Technikon

It was a Peninsula Technical College in 1962. It was formed to accommodate a certain number of coloured apprentices in different trades and was situated in Cape Town until its relocation to Bellville in 1967. In 1970, it became a College of Advanced Technical Education. It was renamed Peninsula College of Advanced Technical Education and it was designed for coloured people only. In 1987, it became the Peninsula Technikon, which then served all races. Only two campuses within the university were selected (conveniently) because of financial and practical constraints. The participation in the research was voluntary.

3.5 POPULATION

According to Brink (2006:123), as cited by Jooste (2018:334), population is defined as a group of individuals whom the researcher wants to research. Additionally, the research is unable to reach the entire population. The researcher focused on a certain group of individuals that made up the population. It was obligatory that the researcher outlined the target population, bearing in mind the sampling criteria (see 3.6.3) (Grove *et al.*, 2013:351; Mohan, 2013:190). In this research, the population was university students on the two main campuses of a university in the Western Cape. The target populations were females and males from a HEI in the Western Cape. This selected university is broadly diverse, therefore all the different cultural, racial, religious affiliations and genders were included in this research.

3.6 SAMPLING

Sampling is the process of collecting a fixed group of individuals from the whole population. A sample represents the group of people that are selected for the study from this entire population (Grove *et al.*, 2013:351). There are two types of sampling techniques, namely probability and non-probability sampling. This research has used non-probability purposive sampling because participants were chosen due to their relevance to the research question and to the problem that needed to be addressed (Schwandt, 2015:277). According to Polit and Beck (2017:254 and 736), non-probability is when participants are selected from the population by means of non-random technique. They continue to mention that non-probability sampling would remain predominant because of its practicality. According to Sidani (2015:130-131), non-random sampling techniques are mostly used in health intervention evaluation research because they are reasonable and stress-free. Sidani (2015:130-131) further explains that no matter what method is used to recruit, ethics procedures must always prevail. The researcher has used non-probability purposive, convenience sampling from the two techniques, as it is usually employed in qualitative research. Convenience sampling, also called 'accidental sampling', was selected (Grove *et al.*, 2013:364). An example of convenience sampling could be a classroom of students or a group of people that are attending a clinic. Convenience sampling is self-explanatory. This means that the researcher gathered information from the participants that were freely available. They met the inclusion criteria and they were willing to read the information letter and sign the consent form (refer Appendix A). This particular research was using students from the two main campuses at an HEI that were readily available (Holloway & Galvin, 2017:147).

The researcher selected the participants for the research from the population successfully and the individuals that were selected formed the sample population. The research participants were students who were staying inside and outside of the selected campuses. Their ages varied between 18 and 26 years. These students also came from different provinces. They were also all studying towards different qualifications across the six different faculties. The year level of studies also varied (Grove *et al.*, 2013:351-354; Holloway & Galvin 2017:143).

3.6.1 Convenience sampling

Table 1: illustrating students who were conveniently sampled for the study

Participants	Campus A	Campus B
Males	9	4
Females	12	6
Age	19 – 26	18 – 26
Year of study	7 second years 13 third years 1 fourth year	5 first years 2 fourth years 3 third years
Home town	2 WC 13 EC 4 KZN 2 Gauteng	1 WC 7 EC 1 KZN 1 NW

WC - Western Cape
 EC - Eastern Cape
 KZN - Kwa-Zulu Natal
 NW - North West

3.6.2 Recruitment

According to Butterfield *et al.* (2003) cited by Sidani (2015:124-125), recruitment is a method of discovering and enlightening potentially eligible people to be included in a specific research study, to meet the aim and objectives of the study. After ethical approval was obtained from the Research and Ethics Committees from the Health and Wellness faculty at CPUT (refer to Appendix H), the researcher embarked on the recruitment process. Support letters were also obtained from Student Health and Counselling Services from CPUT (refer to Appendix E). This was a pre-causative action taken, should any participant react sensitively to any of the interview questions, they could be referred for counselling assistance. The researcher started to connect with all the Head of Departments (HODs) on both these main campuses to ask permission to address students about this research. This was a process that was time-consuming, but rewarding, as all the HODs in the various faculties that were approached, were supportive and cooperative. Hence, the recruitment process was successful. Students were recruited from the two main campuses and they could belong to any faculty.

Prior to the commencement of the research, while waiting for ethical clearance, the researcher got involved with several workshops held on these two campuses. These workshops were facilitated by the staff of the HIV Unit of the HEI. This gave the researcher exposure to observe the students and, later, to interact with them. This was important in order to establish relationships with students and discuss the importance of taking part in this research study (Sidani, 2015:125). The current director of the HIV/AIDS unit, as well as the peer educators, was very helpful in also recruiting students to participate in the research. The peer educators invited the researcher to their group discussions at the

residences where she could also interact with all students. The researcher also visited the selected university during times when students were mulling about in the student centre or visiting the library, in order not to disrupt their study programmes too much. All students that were available to participate voluntarily and were willing to read the information letter and sign the consent form, participated (refer to Appendix A). The FGDs took place by arrangement with all students at a time and place that suited them. The researcher and students would meet at an arranged convenient time and venue inside the selected campuses for the FGDs. The FGDs took approximately 70 minutes. Patton (2015:477) revealed that FGDs focused on various views and in an hour's time, the researcher could collect enough information.

3.6.3 Inclusion and exclusion criteria

This research had sampling criteria which had involved both inclusion and exclusion criteria. Sampling criteria also called eligibility criteria, involve essential characteristics that are going to determine the target population. The sample was chosen from the target population. Criteria are very important as they are going to assist in guiding essential features (Grove *et al.*, 2013:352-353; Schwandt, 2015:46-47). The criteria were as follows:

3.6.3.1 Inclusion criteria

The researcher selected university students that were currently registered with this selected HEI. The university is greatly diverse, therefore all genders were included. Students could stay inside or outside the campus. These students could be at any level of education and 18 years and older, in order for them to sign consent to participate in the study.

3.6.3.2 Exclusion criteria

The researcher took note of exclusion criteria as well. This criterion stipulated features that the target population does not have (Polit & Beck, 2017: 728). Students below 18 years of age, were not considered to participate in this research. Students who were not registered with the selected university in 2017, were excluded.

3.7 METHOD OF DATA COLLECTION

3.7.1 Focus group discussions (FGDs)

Focus group discussions are a method of collecting qualitative data from participants. Recruited focus groups usually consist of five to ten people. It is a specific style of group interview where a researcher or facilitator would ask the specific questions to produce different views about a particular matter. In focus group interviews, participants communicated amongst themselves and to the interviewer about the particular issue. The conversations became more free-flowing because they were expressing their experiences and their feelings (Silverman, 2014: 206-207).

In commercial market research, focus groups are also used as a major tool. All standard ethical procedures were adhered to and maintained throughout the research process (Silverman, 2014:206-207). In this specific research, the researcher conducted five FGDs in English. The number of the research participants in each FGD was between five and eight. The focus group discussions and recordings lasted for approximately 70 minutes each. A digital recorder was utilised to do the recordings. All interviews were transcribed

afterwards. The interaction was well managed between the researcher and the participants. There was no remuneration offered. This was clearly stated in the consent form and explained to the participants.

3.7.2 Advantages of FGDs

FGDs can be used even if the researcher has minimum resources. One of the advantages of focus groups is that they are well-organised (Polit & Beck, 2017:511).

FGDs are gatherings where people are sharing their experiences, beliefs and cultural values. In this research, the researcher was able to build an understanding which made the participants comfortable to tell their stories. The questions and answers were established through verbal interaction. FGDs do not depend on the thoughts of the researcher, or of the individual. Everyone is entitled to his or her opinion (Holloway & Galvin, 2017:125-127). Many authors have confirmed that focus groups are popular data collection methods in social, health and assessment research. Furthermore, Schwandt (2015:122) and Stewart and Shamdasani (2015:3-6) state that focus groups have been used for almost 100 years for influential communication studies. In many behavioural science disciplines, the researchers depended on focus groups for the collection of key data. They can be used as a method on its own to collect data and they can be mixed with other methods as well (Schwandt, 2015:122; Stewart & Shamdasani, 2015:3-6). In this research, the researcher had used the focus group as a primary data collection method.

3.7.3 Disadvantages of FGDs

A disadvantage of focus groups is that some participants become quiet and uncomfortable to express their opinions in front of others (Polit & Beck, 2017:511). The other disadvantage of focus groups is that the researcher might be biased and ask leading questions (Jooste, 2018:344).

3.7.4 Interview schedule and probing questions

The interview schedule was used to collect data for this study (Refer to Appendix F). The following questions were included in this schedule:

- What is your perception of youth sexual health?
- What are some of the risky sexual behaviours young people engage in?
- What in your opinion are Sexually Transmitted Infections (STIs) and Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome (HIV/AIDS)?
- Who do you think is at risk of contracting HIV and why? (Probing).
- What does the community think of people living with HIV/AIDS?
- Why? (Probing)
- What is your role in the community with regards to HIV/AIDS?
- What do you think are the factors that may contribute to the increase of health risks to students at Higher Education Institutions (HEIs)?
- Do you think students have enough knowledge regarding potential health risks relating to sexuality?
- Why? (Probing)
- What are the attitudes that students at HEI's have towards health risks regarding HIV/AIDS and sexuality?

- What factors would influence young people to make informed decisions with regards to sexuality and HIV/AIDS?
- Where can you go if you have STIs when you are around the campus?
- What do you think of the staff and facilities?

Do you have any suggestions how the staff and facilities can improve to minimise health risks?

3.7.4.1 Probing

In order to extract rich data, probing questions were also included and used when required, for example, “why are you saying ‘Yes?’”. In questions such as “Do you think students have enough knowledge regarding potential health risks relating to sexuality?”, the participants would describe the knowledge they have and their experiences.

3.8 PROCESS OF DATA COLLECTION

Data were collected from March to June 2017, during different weeks, because the researcher did not want to interfere with the student’s examination timetable. FGDs lasted approximately 70 minutes. These FGDs were conducted with those students that agreed to meet with the researcher. These students were willing to participate voluntarily after they had read and signed the consent form. The aim and the purpose of the research were explained in advance to the participants (refer to Appendix A). The researcher obtained written permission to record all interviews. This recording was emphasised and highlighted in the information letter and consent form as well. The venues and times for these FGDs were organised by the researcher. The venues that were used to do the FGDs, were normally utilised for audiometry purposes, hence it was not so visible and privately situated. This assisted the researcher to prevent threatening environments.

Five FGDs were conducted in English. During these FGDs, only the researcher, participants and the moderator were in the room so that the participants could participate voluntarily and freely. The researcher reminded the participants that they could withdraw at any stage during the interview process, if they felt uncomfortable. The researcher reassured them that their responses would be confidential. They did not have to mention their names. The researcher addressed them as P1, P2 etc. After each FGD, the researcher summarised and thanked the participants for participating in the research.

Schwandt (2015:66) emphasises the importance of gathering data correctly. Data collection needs proper planning by evaluating your purpose and what needs to be answered. This study used one of the approved methods to collect data in qualitative research focus groups. It was an appropriate tool to use as it helped the researcher answer the research question and it was relevant for the purpose of the research.

3.8.1 Recording of FGDs

According to Silverman (2014:43-45 and 330-331), audio recordings and other graphic images have gradually become a significant part of qualitative research. Additionally, they give the researcher the actual details of the conversation about their social life. The researcher has the responsibility of asking permission to record the discussions from the

participants. In this research, the researcher had a separate permission consent page (refer to Appendix D) that explained the purpose of the project. The researcher clarified to the research participants the reason for the recorder as it would be impossible to remember everything or to note overlaps. It was also explained to the participants that if they were uncomfortable with the recording, the researcher would respect that decision. The participants read and signed the consent for the audio recording separately. The researcher used the Olympus Digital Voice Recorder to record the FGDs. The recordings assisted in the transcription of the data as they could be replayed and improved the quality of the typed transcripts (Silverman, 2014:330). The data that was collected, was transcribed by a professional transcriber. The researcher and the supervisor listened to the recordings, comparing them to the transcripts. This was done to check for any discrepancies and to perform the necessary corrections.

3.8.2 Data saturation

Interviews were conducted until the same information appeared several times and there was no more new information coming forth from the participants. This meant that data saturation had taken place (Jooste, 2018:353; Silverman, 2014:124). According to Denzin and Lincoln (2018:812), saturation is not about looking for repetition only, it can put together the same thoughts and developments in different experiences, events, context and instances.

3.8.3 Moderator's role

During data collection, the moderator was present to assist by observing and listening to the process. The moderator also ensured that the research participants were given respect and treated fairly. The researcher introduced the moderator to the participants prior to the commencement of the FGDs. It was important for the researcher to create this mutual relationship. The researchers and research assistants are expected to treat the research participants with respect and fairness (Holloway & Galvin, 2017:98). In this study, the moderator was an experienced journalist, who was used to doing interviews. She was calm, and the participants were participating freely.

3.9 DATA PROTECTION AND MANAGEMENT

Papanikitas (2013:18-19) reveals that confidentiality is used to protect the data collected. This data might be medical records or other personal information. Papanikitas further explains that this data could be in hard copies or it could be computer records. Furthermore, Jooste (2018:310) states that there must be no trace of the identity of the participant or health care institution. In this research, the data was transcribed, organised, developed into categories and coded by the researcher, with the help of the supervisor. The researcher and the supervisor listened to the recordings and compared the recordings to what was transcribed, to ensure trustworthiness. All the recordings and transcribed data that were collected, are kept in a locked safe in the Nursing Department of the selected HEI where the researcher was a registered student for the duration of her studies. The supervisor is the only person who has access to the key for the safe. The supervisor would give the researcher access to the data on request, particularly during the publication of these results, in an article format. This data included all the recordings of the FGDs, the transcribed documents and the consent forms that were signed by the research participants. The data will be stored for five years. The researcher informed the research participants about the storage of the

data, as Papanikitas (2013:19) stated that the participants have the right to be told about how the data would be stored and the reasons for storing the data.

3.10 DATA ANALYSIS

Data analysis involves the process of questioning the data collected whilst reducing the bulk of information collected by organising it and providing meaning to the data. This included the researcher doing member checking to verify the information. During data analysis, it was important that the researcher took the purpose of the research into consideration, so that the research did not lose its focus (Grove *et al.*, 2013:46; Holloway & Galvin, 2017:287). Member checking is when the researcher goes back to the participants to confirm or verify the information. This is very important for qualitative research because it relates to credibility (Jooste, 2018:351-352). Denzin and Lincoln (2018:811-812) describe member checking as a verification method rather than a validation method. They continued to say it was for confirming the trustworthiness of the data and the analysis.

In qualitative research, the details of information are gathered through focus groups and individual interviews, as well as observations. This information can be collected and analysed at the same time. The data analysis process goes through different stages (Holloway & Galvin, 2017:288). In this particular research, the researcher collected the data using FDGs as a tool. Thematic content analysis was employed to analyse the data that was collected. According to Gibson and Brown (2009:138), as cited by Bazeley (2013:190-191), thematised analysis comprises working out the connections amongst code categories and the significance of such connections. These connections assisted the researcher to understand the thinking and statements of the research participants. All the FDGs were audio-taped. The researcher listened and re-listened to the voice recordings. The researcher familiarised herself with the recordings as the professional interviewer was going to transcribe them. This process was an initial stage of the data analysis and ensured accuracy. The data was transcribed by a professional transcriber. The transcribed documents were thoroughly checked by the supervisor and the researcher against the recordings, to ensure the accuracy of the information. Jooste (2018:346) states that it is important to do data collection and data analysis simultaneously, as this enables the researcher to concentrate and shape the study as it progresses.

The researcher organised and categorised the data with the help of the supervisor. Themes were generated through data collected from the participants' responses in the FDGs. The coding process involved identifying data as belonging to a theme and beliefs. From the coding process, the researcher wanted to get the ideas, perceptions and the tones of the participants. Descriptive keywords were grouped together, reorganised and linked in order to combine meaning (Grbich, 2013, as cited by Saldana, 2016:9). The categories were further broken down into themes. Themes are the results of the coding, categorisation and critical reflection (Saldana, 2009:13, as cited by Bazeley, 2013:190). The themes were considered as part of the findings and the results will be discussed in Chapter Four.

3.10.1 Transcribing data

According to Schwandt (2015:306), transcription is a process of transcribing what was said by the research participants. Schwandt (2015:306) further explains that the participants were responding to what was asked by the researcher or to each other. In this research, the data was transcribed by a professional transcriber. The data was transcribed according to what was said by the research participants through the recordings in the FGDs (refer to Appendix G1). The recordings of the FGDs were transcribed at the end of each FGD. The data were transcribed verbatim into Microsoft Word documents. After each and every transcription, the researcher would print the transcripts and listen to them, comparing them to the recording. In this way, the researcher was able to listen to the FGDs transcripts and make any corrections if necessary. In one of the FGDs, there was a participant who spoke isiXhosa because he was more comfortable in his mother tongue and he was eager to participate in the research. Both the moderator and the researcher are IsiXhosa speaking, hence the researcher allowed the participant to participate in isiXhosa, as the university is diverse and all the students fortunately in that group, understood IsiXHOSA. The researcher was applying the ethical issue of justice, as stated by Papanikitas, (2013:7) (see Justice, Section 3.12.3). That part of the interview was translated into English by the interviewer as the interviewer is fluent in isiXhosa and English. The researcher checked the accuracy of the translation, as the researcher was a Xhosa speaking person and she was fluent in English. This assisted the researcher to engage more with the recorded data and was able to listen, read and make corrections when it was necessary.

3.10.2 Ordering and organising data

In this research, the researcher put together the information from the FGDs and the information from the moderator's observations. All this data was collected, transcribed and coded. The researcher put the data in an orderly manner so that it could make sense and it could be dealt with in manageable steps (Papanikitas, 2013:159-160).

3.10.3 Coding

According to Jooste (2018:344), coding is an easy type of bookkeeping duty where the data that was collected, are documented as numbers on a well-controlled record sheet. Similarly, Denzin and Lincoln (2018:424) agree by saying that coding marks sections of data with terms to conclude, classify and account for these segments. Bazeley (2013:125) reveals that in qualitative analysis, coding is an essential skill, as it is used as an instrument to investigate data, for trying statements and making conclusions. In this research, coding would assist the researcher to determine whether the topic was familiar to the research participants. The researcher created a table so that the responses of the participants could be spread into themes, categories and sub-categories for analysis. This simplified the process for the researcher to sort and assess the responses of the participants. Denzin and Lincoln (2018:424-425) state that at the beginning of coding, the researcher must focus on the data and be able to explore what the data means. They continued to elaborate that the researcher must be able to read and analyse the data by wording, paragraphs and incidents. The researcher was assisted by the supervisor to read and analyse the data in this research and to do the coding. During coding, the researcher and the supervisor highlighted those

statements that had important comments and similar descriptions in the transcripts with different colours (refer to Appendix G2). These comments and descriptions were the reflections of what was said by the participants. The highlighted statements were formulated by the researcher to make sense. The researcher formulated these meanings into clusters of themes. Thematic content analysis was applied with colour coding to interpret the data. According to Saldana (2016:4), the coding process can range in size from a single to a full paragraph or an entire page of text. The researcher used Word and typed the data on the left two-thirds of the page and the right margin was used to write codes. This assisted the researcher to organise and cluster the comparable coded data into categories. The themes were compiled into a final list of all the FGDs. Coding is a “critical link”, it links the data collected and the interpretation of meaning (Charmaz, 2001, as cited by Saldana, 2016:4). All the relevant extracts from each transcript, were placed under the appropriate heading on the final list of themes. This final list formed the basis of the results in Chapter Four.

3.10.4 Reflexivity

According to Diaz (2002), cited by Denzin and Lincoln (2018:160), reflexivity is a way of acknowledging what has been done by the participants and the researcher in a study. Diaz (2002) in Denzin and Lincoln (2018) continued to elaborate by saying that reflexivity replicates how the research was directed. In this research, it reflected the involvement of the researcher amongst the participants. The researcher participated in many workshops with the HIV/AIDS Unit in this selected HEI. This gave the researcher enough time to familiarise herself with participants. The researcher was visiting the HEI during weekends to observe the lifestyle of students. Some students would invite the researcher to their health education discussions. This made the researcher work closely with participants. However, reflexivity stresses the self-reflection on one’s biases in the investigation (Schwandt, 2015:268). The researcher professionally worked on Clinical Trials and she was aware of the ethical issues and biases that might occur. This assisted the researcher to be able to bracket herself outside of the research during data collection (refer to Section 3.2.2).

3.11 RIGOUR IN QUALITATIVE RESEARCH

According to Jooste (2018:350), rigour incorporates all strategies, namely trustworthiness, validity and reliability. According to Denzin and Lincoln (2018:797-809), rigour in qualitative and in quantitative research had been a long debate between researchers. However, the debate was settled by Guba (1981) and Guba and Lincoln (1985) by presenting the term trustworthiness. Guba and Lincoln (1985:328) as cited by Denzin and Lincoln (2018:801), revealed that trustworthiness entails credibility, transferability, dependability and confirmability. They further explained that with these four criteria, trustworthiness can be established in qualitative research. Guba and Lincoln (1985) cited by Schwandt (2015:308-309) emphasised methods that could be used to establish these criteria. They mentioned member checking and peer debriefing would be suitable for credibility and auditing would be useful for dependability and confirmability. Trustworthiness is very important in qualitative research, as it is significant to prove the quality of the research and its findings (Schwandt, 2015:308-309). In this research, trustworthiness assisted the researcher to be more consistent when the data was collected and analysed. The researcher had to ensure that there are no threats that can affect the findings of the research. The researcher needed to know that qualitative research is directed

by trustworthiness and its precise methods. Trustworthiness replaced validity and reliability, which are used in quantitative research. This helped the researcher to understand that rigour could be recognised differently in qualitative and in quantitative studies. During the research, the measures that were taken to ensure rigour are seen as valid scientific knowledge (Jooste, 2018:350-357). The data that was collected by the researcher for this study is kept in the Nursing Department. All the data is in a locked safe and only the supervisor and the researcher, with permission of the supervisor, will have access to the key, should she require some of her data for publication purposes. In this way, the researcher maintained trustworthiness throughout the study. The researcher will now elaborate further on strategies of trustworthiness below.

3.11.1 Credibility

According to Polit and Hungler (1997:304-305) cited by Jooste (2018:351), the credibility of a study includes the performance of examining in such a way that the acceptability of the results is improved, and credibility is demonstrated. Jooste (2018:35) further explains that the credibility can be shown by lengthy meetings and determined observations. The researcher spent numerous hours at the selected university to engage with students. Prolonged engagement made it uncomplicated and easier for the researcher to collect the data and to do member checking, as she was already a familiar face on these two campuses, having interacted with students at various levels before. The researcher ensured that the participants' views were accurate as portrayed by them. The credibility of the study was ensured through the findings that were traceable backwards from the data collection to show accuracy. Schwandt (2015:309) states that credibility focuses on how the researcher has portrayed the experiences of the participants. Schwandt (2015) continued to say that credibility focuses on the confidence in the true reflection of what really happened. In this study, the researcher maintained credibility by using the member checking technique.

3.11.1.1 Member checking

Member checking has been described by many researchers as a way of confirming the truth. This is done by going back to the research participants to critically discuss and confirm what they have said and comparing it to the researcher's findings (Polit & Hungler, 1997:306; Botes, 2003:181; Brink *et al.*, 2012:172, as cited by Jooste, 2018:351-352). According to Guba and Lincoln (1985) cited by Schwandt (2015:309), member checking is one of the most appropriate techniques to establish credibility in the research. The researcher maintained member checking by going back to the participants to interact with them, whilst confirming what they had said during the FGDs.

3.11.2 Transferability

According to Lincoln and Guba (1985) cited by Bazeley (2013:410), transferability is the substituting of generalisation. They directed this term precisely to be able to transfer knowledge from incident to incident. The researcher's responsibility was to offer the participants enough knowledge about the topic so that they could be able to apply the information in their own experiences in real life (Schwandt, 2015:309). The quality of the results of this research would be able to help HEI students to make informed decisions about their social and sexual life in their experiences (Jooste, 2018:353). In this research, the peer educators of the selected HEI were part of the FGDs. This meant that knowledge

would be transferred in all directions on campus, to all faculties and departments and later to their communities where they live and come from.

3.11.3 Dependability

According to Polit and Hungler (1997:306) as cited by Jooste (2018:354), dependability refers to how constant the findings obtained are, should the same research be repeated. Guba and Lincoln (1985) as cited by Schwandt (2015:309), agree by stating that dependability focuses on the methods to confirm that these procedures were consistent, traceable and documented. Dependability in this study was achieved by including appropriate research questions, aims and a research design. Guba and Lincoln (1985) as cited by Schwandt (2015:309) further confirms that auditing procedures could establish dependability in this research. The researcher maintained dependability in this research by being consistent when the data was collected. The same questions and probing were done with all the FGDs. The researcher provided all the techniques used to collect and analyse the data. As stated, the data will be kept at the Nursing Department in a locked safe for audit purposes for five years with only the supervisor who has access to the key.

3.11.4 Confirmability

According to Guba and Lincoln (1985), as cited by Schwandt (2015:309), confirmability focuses on establishing the fact that the data and interpretation of an investigation could be confirmed. They explain the methods that could be used to do the confirmation. They mention auditing and triangulation as suitable methods for confirmability (Schwandt, 2015:309; Polit & Hungler 1997:307, as cited by Jooste, 2018:355). For this research, the researcher obtained confirmability by aligning the objectives and the FGDs questions. Lincoln and Guba (1985) further concur that confirmability was similar to objectivity. The findings of this research could be confirmed by the audio recordings, transcripts and by the participants through member checking. The researcher, with the permission of the supervisor, would be the only people who can access this data.

3.12 ETHICAL CONSIDERATIONS

Every researcher has to be aware of ethical issues when planning to conduct a study. A research proposal should be submitted and approved by the relevant authorities. This approval is the allowance for the researcher to be able to conduct the research (Jooste, 2018:309). This research proposal was approved by the Cape Peninsula University of Technology's (CPUT) Health and Wellness Sciences Faculty Ethics Research Committee (refer to Appendix H). Support and permission letters were obtained from the Student Counselling and at the HIV Unit, respectively (refer to Appendix E; Appendix B). After ethical approval was obtained, the researcher commenced with the data collection. Ethical principles were adhered to according to the Declaration of Helsinki, as discussed in Section 1.18.1. and upheld throughout this study.

3.12.1 Autonomy

Autonomy is the principle of respect. It is a self-rule, meaning that the participant must be able to make a free and informed decision to participate in the research (Papanikitas,

2013:6). Jooste (2018:311) agrees by saying that nobody should pressurise the research participants in their decisions. All the participants in this research gave their consent of their own volition. Each participant signed the consent form before the commencement of the FGDs. It was the researcher's obligation to maintain respect throughout the research. They signed a separate consent for recording of the FGDs (refer to Appendix D). Anonymity and confidentiality were maintained throughout the research process, by not using their names during the focus group discussions. Each FGD was numbered as FGD1, 2 etc.

3.12.2 Beneficence

According to Papanikitas (2013:6), beneficence is the principle of a good deed. Beneficence means that there are no harmful physical or psychological experiences for the research participants. It was the researcher's obligation to execute the research in such a way that the research was more beneficial to participants than the research itself (Jooste, 2018:311). In this research, the researcher obtained a letter from the student counselling department (refer to Appendix E). This was to ensure that if there are any discomforts, the participants would be referred for counselling. The participants were informed that anonymity and confidentiality would be respected at all times. They were informed that the results of the research would be presented to them, should the faculties require this from the researcher. Individual groups of students were also encouraged to contact the researcher, should they wish to read more of the results and the outcomes. The researcher informed them that the data collected would be kept in a locked up safe in the Nursing Department. Nobody would have access to the data except the supervisor and the researcher with the permission of the supervisor. In this research, no participant was harmed or reacted negatively during the focus group interviews and discussions, therefore no referrals for counselling were necessary.

3.12.3 Justice

The principle of justice includes participants' right to fair treatment and privacy (Papanikitas, 2013:7). The researcher should ensure that participants are treated fairly and the right to justice should prevail. In this research, all the participants were treated equally and with respect. In this study, the researcher explained to the participants that there would be no reimbursement for participating. The researcher and the participants had a mutual agreement about their participation in the study, which was totally voluntary. The researcher provided participants with her contact details, as well as that of the supervisor, should they need to discuss any concerns about the study (Jooste, 2018:311). All the data that would be collected, would be made available if they needed it. All of this information was clearly explained in the informed consent form (refer to Appendix A).

3.12.4 Non-maleficence

According to Papanikitas (2013:6), non-maleficence is a principle of not doing any harm if it can be avoided. This was confirmed by Jooste (2018:311) stating that non-maleficence is essential. This means avoiding or minimising unnecessary harm or risk, directed to research participants. In this research, the researcher obtained a letter from the Student Counselling Department (refer to Appendix E). This was to prevent any kind of harm directed toward research participants that could avail itself during data collection. Participants in this research were not exposed to any harm or risk throughout the study.

None of the participants reacted sensitively or in a negative way to any of the interview questions.

3.12.5 Right to privacy and confidentiality

According to Papanikitas (2013:17-18), confidentiality is a cornerstone of the calming connection between a doctor and the patient. He continues to state that the right to confidentiality originates from the right to autonomy. Participants were assured about the privacy by the researcher. Confidentiality was kept and respected throughout the research. A private, quiet room was utilised for the FGDs. Jooste (2018:310) mentions that besides the researcher and the supervisor, no additional people should have access to the information or identities of the participants. Jooste (2018:310) continues to emphasise that the participants should be aware of any information that was gathered during the research process. The researcher asked for separate permission from the participants to record the discussions (refer to Appendix D). No names were mentioned during FGDs and there were no names documented anywhere. The participants were informed that there would be no link between them and the recordings. The researcher protected the privacy of the participants by making sure that no information was shared to any third party. Confidentiality was maintained throughout the research process.

3.12.6 Informed consent

According to Jooste (2018:312), informed consent is a communication of acceptance in the need for truthful and respectful give-and-take between the researcher and the people whom they study. According to Sidani (2015:131), the consent process is divided into three steps. The major purpose of informed consent is to notify the person about the aim or the intention of the research. Sidani (2015:131) continues to explain the three steps by saying that, firstly, the researcher needs to inform the potential participants about the purpose, the risks and the benefits of the research. The second step is to ensure that the participants understood all the processes and concerns and that they were clarified. The third step is to ask the participant to sign the consent form, to show that all the information has been given and clarified. If the participant agreed voluntarily, then the participant could sign. Neethling (2001) as cited by Jooste (2018:83-84) supports Sidani by saying that by signing off the consent form, the participant is consenting to injury and risk of injury. However, it must not be intentional. It was further explained that the consent form must be free, voluntary and have full knowledge of the level of the potential pre-judgment. In this research, the researcher obtained written consent from all the students that participated. They were informed that their participation was voluntary, and they could withdraw at any time if they were not comfortable. Participants were above 18 years of age, therefore eligible to sign their own consent form. Confidentiality was emphasised by the researcher. Students agreed to sign the consent form (refer to Appendix A).

During the FGDs, the permission was requested from students to do audio recording. The purpose of the audio recording was to assist to capture all the details of the FGDs for data analysis later. This was explained in detail to all the students. The researcher informed the students about the formal ethical permission from the university (refer to Appendix H). The consent form was critical because research participants have the right to know that they are being researched and what they are being researched on (Schwandt, 2015:156-157).

3.13 SUMMARY

This chapter has concentrated on the research methodology and design used in the research. The research setting, and sampling technique were described. The method of data collection and the method employed to analyse data, were discussed as well as the ethical considerations applicable to the study. Trustworthiness, reflexivity, rigour, credibility, transferability, dependability and confirmability, which are all important aspects in qualitative research, were also considered. The next chapter will discuss the findings of the interviews.

CHAPTER 4

RESULTS

4.1 INTRODUCTION

This chapter presents the findings from the focus group discussions (FGDs) conducted in this study. This section demonstrates the experiences and thoughts of the participants based on the research questions that were answered. It will be presented in different themes. This research was conducted on two campuses of the selected Higher Education Institution (HEI) in the Western Cape (refer to Chapter Three). Five FGDs were conducted. A summary is provided at the end of the chapter.

The aim of this research was to investigate potential health risk factors amongst students at an HEI in the Western Cape regarding sexuality and HIV/AIDS. The objectives of the research were to:

- Explore the factors that may increase health risk behaviours amongst students at an HEI.
- Explore and describe knowledge of university students regarding potential health risks related to sexuality and HIV/AIDS.
- Explore attitudes students have towards health risk behaviours, regarding HIV/AIDS and other sexuality- related behaviours.

4.2 BIOGRAPHICAL DATA

The biographical background that was revealed during the FGDs in this project consisted of the participant's gender, age, year of study. It was also explored whether students were living inside the campus residence or in off campus accommodation, privately or with their families. Students were also asked about their hometowns. The total number of research participants was 31 students from both campuses. There were 18 females and 13 males. The participants were at different levels of their undergraduate education. The study included seven (7) second years from campus A, and one (1) fourth (4) year from campus A, and thirteen (13) third years from campus A. There were five first years in campus B. There were two fourth (4) years from campus B, three (3) third years from campus B. The age of these students varied between 18 and 26. They were from different provinces across South Africa. There were three from the Western Cape, twenty from the Eastern Cape, five from KwaZulu Natal, two from Gauteng and one from the North West Province. There were fifteen students that were staying inside the campus residence and the others were staying in rented communal flats whilst some were living with families and relatives.

4.3 THEMES

The five FGDs were conducted and recorded. The data that were collected were transcribed by a professional transcriber. Thematic content analysis was employed to analyse the data. Coding was done by the researcher with the help of the supervisor and data were categorised and arranged into themes and subthemes. This was achieved when the researcher was revisiting, re-reading and re-analysing the transcripts. The following themes and subthemes emerged from the data analysis according to the objectives and research question that were set out to be achieved in this study.

Table 2: Themes and subthemes

Themes	Subthemes
1. Contributing factors to risky behaviour	<ul style="list-style-type: none"> • New-found freedom • Reckless behaviour • Alcohol and drugs • Peer pressure • Multiple partners • One-night stands of sexual contact • Early-stage sexual engagement • Transactional sex • Unprotected sex • Lack of communication with parents • Knowing the status of a sexual partner • Socio-economic background
2. Knowledge	<ul style="list-style-type: none"> • Ignorance • Misconceptions • Information needed • Education needed • Uninformed decision • Partner testing • Teen pregnancies • Condoms • Abstinence
3. Attitude	<ul style="list-style-type: none"> • Towards HIV/AIDS awareness campaigns on campus • Poor service delivery at on-site student health services • Health risks • Health services Referrals • Stigma and judgmental

4.4 THEME 1: CONTRIBUTING FACTORS TO RISKY BEHAVIOUR

The HEIs are challenged by the risky behaviour of the students and are striving to do all to support them. Doctor (Dr) Blade Nzimande, revealed in his 2014 speech that poverty and financial suffering of the HE students were amongst the priorities of government, as these are some of the most important factors that are contributing to the high risk behaviour of the students (Nzimande, 2014).

4.4.1 New-found freedom

All the participants who attended FGDs agreed that being away from home gave them a sense of freedom at HEIs:

I think another thing that plays a role is that like the whole transitioning because when you are at home, there's like all these your parents and your family that's like guiding you and when you come to university especially if it's like away from all of that and then there's none of that, protection and then that's like only thing you prefer. (FGD1)

Other participants agreed with what was said about new-found freedom and being away from home:

And also it's a freedom you know when you were in high school you were under the protection of your parents. They would guide you and they were watching you and you did not have freedom but when you come to university you get freedom you are free you get to do things that you were unable to do then back at home you just irrationally we do not think before we do things we tend to forget things that our parents taught back and we just ignorant as she said. (FGD3)

When you actually get to varsity you are more advanced in terms of now I am open I am not home I do not have to be sneaking out of the window all of those things here I have my own place to stay no one will tell me what time to come in what time to do this and that. (FGD4)

4.4.2 Reckless behaviour

Some participants described the reckless behaviour of students as follows:

I think in these days we as youth we are careless when it comes to sexual health and those kind of stuff and the thing is we like I do not know how to put this but some people they say we like to be wild we like to do things without even thinking which is sometimes a risk. (FGD3)

We act so recklessly we do not think before we do that is how I see it. (FGD5)

I think university is actually a platform for sexual intercourse. (FGD4)

4.4.3 Alcohol and drugs

Participants revealed that there are many consequences related to alcohol and drug abuse at HEIs:

In nowadays they get involved in group sex by actually think it's cool they get drunk in a group and do group sex and I do not think condoms, and everything is involved in that...(FGD2)

For instance now there's clubs, there's bashes there is a lot of stuff that youth attend to those social events, the thing is when we attend those events we sometimes especially if there is alcohol, when we attend those things we tend to be drinking too much and we end up doing things that we did not want to do like, for instance, end up doing unprotected sexual intercourse or something or engaged in taking drugs like those kind of things...(FGD3)

It is very bad in res, people sleep around a lot and those Friday's nights where people go out and drink when they come back with those Ubers they find themselves sleeping in some other people's rooms nobody thought of a condom it's very bad in res. (FGD5)

4.4.4 Pressure from peers and influence

All the participants have mentioned pressures and influences from peers as one of the most significant factors that affect their behaviour:

If you are not involve in a sexual activity then that means (wena meaning you) are living in the old days, you don't fit in in this generation that we are living in now so it it's also comes to a matter of whether you want to fit in that certain group so it comes to that that pressure. (FGD1)

If you do not have a girlfriend or you do not have sex you are seen as someone who is not in the right trend so all societies we are now living has improved that it is cool for you that you can have sex. (FGD2)

And also peer- pressure, following friends doing wrong things so you do things without thinking for yourself. (FGD3)

..know that back then it was the thing to do and if you were not doing it then you are not part of the crew, you not cool. (FGD4)

It goes with the influence friend's influence, friends influence when you have a broke boyfriend you do not need a boyfriend most of them they will go to the blessers. (FGD5)

4.4.5 Multiple partners

Participants articulated multiple partner relationships as a fashion (statement). They revealed that it is not a certain gender that is doing it, but rather 'everyone':

...I was chatting to my cousin the other time she had three sim cards I was asking what are you doing with these sim cards and then she was like noo.... I have three partners and each one of them has her own sim card. (FGD1)

*I think 2017 there is this new trend that is going around which is "**pause life**" so I think that is the major problem because first of all we as youth are not protecting ourselves enough with one partner so there is "pause life" which is multiple partners it's okay to jump to the next person it's a norm now the thing with this you are not protecting yourself*

with this one and the next one and the next one. You trust all these people, but you do not necessarily know these people. (FGD3)

Some participants also added to this by saying that there is nothing wrong with having more than one partner:

I think, it's just cool having more than one boyfriend or having more than one girlfriend. (FGD4)

4.4.6 One-night stands of sexual contact

Participants revealed that when they attend parties on campus or visiting nightclubs, they end up with a casual sexual partner for the night:

And at times we people have one night stands and it has become a trend not really it should not be motivated but somehow it is done and the next thing you said I do not know what I was doing and we forget about it and you never really think about the cause or the fall of it or whatever comes out of it. (FGD4)

People tend to just sleep with people they like casual I do not know what they call they call the one-night stands or the cookies at the bash you see all those things. (FGD2)

...the thing is when we attend those events we sometimes especially if there is alcohol, when we attend those things we tend to be drinking too much and we end up doing things that we did not want to do like, for instance, end up doing unprotected sexual intercourse or something or engaged in taking drugs like those kind of things. (FGD3)

4.4.7 Early-stage sexual engagement

The participants revealed that sexual engagement at a young age is trending, starting in high school. Some further highlighted this by stating that it started even before they enter HEIs:

...with my experience I know losing my virginity at young age. For me I know that back then it was the thing to do and if you were not doing it then you are not part of the crew, you not cool. (FGD4)

... for me like what I have noticed about today's youth is that sexual interactions are happening like quite at early stage than before. You'd find out that children aged thirteen to fourteen are engaging in sex. (FGD1)

I would like to also add on that I feel like we brag about being sexual active I feel like it's a competition. (FGD2)

...when it comes to youth of today's generation, compare to that generation, I think they are reaching their puberty in early stage, I am not sure what is their reasons behind it though, because if its food do the changing in dieting by this I clear remember when in primary of that time when you remember I don't even know..so, what a girl is, or to get a kiss from a girl is something else or a big hug or something else you go jump and celebrate

but nowadays hey when I look at them, the ones that I remember now kiss for them is just like it's nothing... (FGD1)

...when you were youth from 13-15 years old upwards to 21-22 you were very sexual active...(FGD5)

4.4.8 Transactional sex

Participants revealed the fashion of transactional sex at our HEIs and the reasons and circumstances why they indulge in transactional sex:

When you actually get to varsity you are more advanced in terms of now I am open I am not home I do not have to be sneaking out of the window all of those things hear I have my own place to stay no one will tell me what time to come in what time to do this and that I can actually date someone older no one will care...(FGD4)

You want to have lace weave but you won't afford a lace wave, so the better way for you is to go and have someone to be your blesser and that ...because most of the time, these people that you are dating as a blesser people, that's not dating it's an exchange, so they give us money and we sleep with them, so if someone is going to buy me an iPhone 6 for R14 000, of course he can tell me to sleep without a condom and actually I won't feel guilty. (FGD1)

Some participants were against transactional sex, viewing it as prostitution, whilst others were saying that circumstances force them to involve themselves in transactional sex. This is how they described it:

And also doing like having sex for money it's not good it is part of prostitution as well. (FGD3)

the trend of sugar mamas and sugar daddies who exploit students by promising them lavish life you see the best cars being parked at res. (FGD5)

Sometimes students know but there are social factors like poverty you know somebody would like in residence hungry and this guy would just come and you know I can buy you airtime here is 200 and you know you have been eating nothing you will just go buy yourself food so it will end up being like that because you want money for food and you know that HIV is there and all that but because of the situation. (FGD2)

4.4.9 Unprotected sex

Participants acknowledged that their sexual activities are not protected. This is how they explained their thoughts:

My view is that the youth of today is not really safe. They do not take care of themselves in terms of sexual relationships or in any sexual activity that they participate in. (FGD3)

We are irresponsible, the youth of today refuse I do not know whether they refuse or they do not want to use protection. There is this thing of have you seen anyone eating sweets in

a wrapped paper or whatsoever and it has become the new trend where people do not want to use condom. (FGD4)

Some students mentioned that sex with protection, is an obstacle:

Another thing is that safe sex and unprotected sex is not the same, laughing, if you are doing sex without a condom you are enjoying. That it's a fact we cannot run away from it you enjoy it and when you are doing it with a condom eish...there is that thing there is a difference...tasteless. (FGD5)

4.4.10 Lack of communication with parents

Participants said that their parents and even the teachers at school, are still avoiding communication regarding issues related to sexuality and sex:

I think it all start at home because I think in a black society like lately parents if if if like most of the time ok, most of the time in my high school some of the girls when you reach like let's say twelve or thirteen, your parents they take you to clinic for contraceptive, so it came to my mind that ok, our parents, they are scared of us getting pregnant, they are not scared of us getting HIV. (FGD1)

you know even the teacher we try and rush- rush just to get away from it anything that have to be explained will rush it not like really be like you know what you need to know this because in future you will need this so I think it starts from the top-down or as the bottom up that is where we lacking everywhere. (FGD4)

Other participants revealed that religion and culture inhibit sexual talks and education between youth and parents:

Also religion and culture play a part on that (sexuality). Just to emphasize I was watching this video in Zimbabwe in rural areas and I forgot what the name of it and there was this kid and I forgot what the name of the kid in the video. (FGD2)

And also some if they do have access to them because there is stigma so if there are condoms here the brother or the sister will be curious to know why condoms so you end up hiding things or you do not speak freely about sexuality based on (ukoyika) being scared. (FGD2)

Some students also reveal that because their parents are very strict with them, they tend to pretend as if they do not know anything:

We still want to be angels to our parents even though we are doing our things aside but we want to be seen as innocent face whenever my mom sees me does not know I am the devil inside. (FGD4)

4.4.11 Knowing the status of a sexual partner

Most FGDs members divulged that students sleep around without even finding out the status of their partners. They also mentioned that some partners do indeed go and test, however they do not wait for the window period, instead they trust their partners:

I think people should respect the word “trust” it’s a big word, you don’t give it to anyone, even if you go and test every month every time, I don’t know what you are doing and this thing called window period because most of the people if we can go and test now and then we negative okay fine we can do it, what about the window period, people don’t wait for that they just take the first results and then they are happy with that I think trust should be respected, it’s not a word to give it to anyone...(FGD1)

.....You know there is this thing that you have to go and test after 3 months so they have this question that "what if have what if I go back and have so they do not want to know if they have or not. (FGD3)

I would also like to agree with you in terms of ignorance when it comes to sexual behaviours ignoring that we might actually run the risk of contracting HIV/AIDS and the system we talked about that if my girlfriend is negative I am also negative of which is incorrect you cannot test by somebody else you have to go by yourself and find out that you are really negative so in that sense I would say that you really negative. (FGD2)

4.4.12 Socio-economic background

Participants pointed out that family background contributes to uninformed decisions, as some of the students are coming from poor backgrounds and others are coming from rich or middle-class backgrounds:

Poverty is key, its number one factor that actually drives everything, if you know where you come from, its different when you coming from better family. The family is poor and so forth and so forth, now you come from a community where you know for sure there is nothing there it’s not a matter of saying that I’m poor, yes you are poor but at the same time you are also poor in the sense that you are not equipped with enough information. (FGD1)

Sometimes students know but there are social factors like poverty you know somebody would like in residence hungry and this guy would just come, and you know I can buy you airtime. Here is R200 and you know you have been eating nothing you will just go buy yourself food so it will end up being like that because you want money for food and you know that HIV is there and all that but because of the situation. (FGD2)

...you do not know what that person has been through you do not know if that person has HIV/AIDS you tell yourself that I am there just to chow his or her money you do not know whether you are going to chow that money in hospital or something...(FGD3)

...so whatever community you are from people expect you to dress well as the university student to behave the same do not know the financial conditions are not the same and those are the biggest and peer pressure and the fact that we are not from the same homes maybe my parents will be able to buy me this and your parents will be able to buy you that and you also you want to be in the same level so you make sure that you have a blesser. (FGD5)

4.5 THEME: 2 KNOWLEDGE

The knowledge has been described as vital information that is learned. It can be learnt by different ways that include personal experiences and role modelling. Hence, the HEIs provide not only academic knowledge, but programmes that are supporting students in all areas of their lives (Grove et al., 2013:8-9).

4.5.1 Ignorance

Some participants confirmed that they do not take time to find out what is happening around the campus. Others prefer to ignore activities that are happening around them:

You know what there are lots of things that we don't know, because the minute we see T-shirts and tents, we know that they are testing and you don't want to know because the testing is done publicly, and you are scared of your reaction. I wish they can be strategic, no testing rather encourage us to go to the clinic for testing. (FGD1)

I think my perception of today's youth or youth's sexual health is that we know the things that we supposed to do but then sometimes we I cannot say we choose not to do them but it does not happen we ...like in terms of care what I mean by that things like protected sex, abstinence, contraception we know all those things it's not like we do not know but we get statistics that the youth is continuously getting infected but there is so much information there is so much you can do to protect yourself....(FGD3)

Some participants confirmed that to engage in sexual activity is a priority and it is more important than having a disease. They would rather risk their lives, than not have sex:

I am trying to say is that people do not see having a disease as something that is wrong because everyone seems to have disease it does not matter what type of disease so the issue of HIV is mostly in something that we like which is sexuality. So people are saying it is better to have HIV than not to have sex. (FGD2)

I would say a lot of us don't want to unlearn and learn, that's the major problem, especially amongst us as youth, that's why we are dying of HIV/AIDS, people don't want to learn, people will only learn once they are in the dead end. Something has to happen in order for them to learn, that is the problem ignorance kills. (FGD1)

4.5.2 Misconception

Participants shared stories about misconceptions amongst students. These are some of their stories:

I heard something somewhere that it takes men 8 times to have sex with infected woman to be infected with HIV I do not know if that is true or not. (FGD4)

I am sure that out of 10 people there is one person who has heard that you can sleep with someone who is HIV positive and don't get it and you will be like let me try this because of the spur of the moment and then consequently you will get the virus thinking that you would not get it so it's the ignorance and also that ego that I do not know where it's coming from. (FGD5)

...I think another one that we not taking into consideration is the one of heee... I don't know if but it's more particurlaly on men it's called that if you are circumcised, that cultural thing yes it goes to that point that of if you are circumcised then you have got a low risk of infecting HIV, so as well it's part of those hee.... risk factors, it's not maybe I am not sure if I could bring this to this platform for men not go through circumcison, jaa, jaa.... (FGD1)

4.5.3 Information needed

Some participants were voicing out that more information at a departmental level would help to empower students and to avoid or minimise risks:

I also think that if we would have proper channels to follow we would make informed decisions like apparently, I also myself do not know like if you one of those people who struggles financially as in like anything whatever there are places to go to make a provision for

...Youth is not well informed in regard to health and when it comes to sex because what we do we just do for the fun of it not the consequences that might happen after. (FGD4)

Some participants were still blaming their families and their high schools, claiming that the information was inadequate for them:

...if there was someone to say that if you engage yourself in unprotected sex you going to have such and such not just pregnant, people know the common ones even sometimes when you are labelled to be the outcast, you know when you are not sexually active yourself, you will be labelled as outcast. (FGD1)

..if I particularly back then seriously well informed maybe my decision in life would have been different towards the decision that I have already taken regarding the subject at hand. If the teacher was teaching me at the time with more forceful in terms of you need to know this and you know...even if we were writing exams because I do not remember us writing like this being included or something serious other than that...(FGD4)

Another participant, who was a peer educator, revealed that there is still more work that needs to be done around our HEIs:

Yes I feel as maybe as peer educators we do our best but not as peer educators only but the whole campus we are doing our best there is internet, these key people of high intelligence they know how to use computers they know that even on TV I think there is enough knowledge but the problem is the practise I think that is where the problem is so we feel that there is enough information even though the practise is not taking place that is the biggest issue here especially for me as a peer educator. (FGD5)

4.5.4 Education needed

Participants were open about the fact that they want fun, educational activities and flexible approaches to sexuality. Some participants suggested the introduction of health and sexual education in departments to avoid boredom. This would assist them to make better choices in life:

...I think when you open a dialogue to talk about issues and then you realise no man I was actually I had fear of nothing and you do not know you are scared of something that you do not know so if you don't know anything about something then you will be scared of because you don't know, but now if there's dialogue, no man you can't. (FGD1)

I think we should make it more fun like we have activities and educational ones not too formal or serious also people if you approach them too seriously you already turning them off. (FGD2)

...I think more awareness is needed and also awareness that are not too serious because people get bored with these serious kinds of awareness, come with the awareness that will make them interested and squeeze in this one because it is a reality that we can never run away from. (FGD5)

It was better if we had a corner in the commerce building about raising HIV awareness I think people would take more interest when we notice that something like that is going on. (FGD4)

... it's like maybe introduce more activities to the youth....and maybe try to engage with them and maybe keeping our youth busy... (FGD1)

Some participants acknowledged the role of social media in assisting with education and communication. This is how they elaborated on this issue:

I also think the media played a big role in terms of like combating the stigma because they've realise that many black households we don't speak about such stuff so they bring those into our homes through watching the soapies and scenarios so that we can talk about HIV/AIDS and whole lots of telly topics that gets the conversation going one way or the other. (FGD1)

There were some participants who were still confused about sexually transmitted infections:

And you cannot get like STI through sexual intercourse only some of them you can get them through like the toilet something like that. (FGD1)

Okay HIV is in the immune system and infections are not in the immune system. (FGD2)

4.5.5 Uninformed decisions

There were many reasons that were raised by participants that contributed to their uninformed decision-making:

Definitely alcohol abuse, drug abuse, the numerous events that take place the social events I guess also being free the concept of being free no parents no one is telling you what to do at certain time you do anything anytime you want no one is guarding you I think those are the contributors. This not caring about one's health and trying to be cool about the next person or people I think these are contributors...(FGD3)

Also the university students especially those who stays at res we know what happens there we know how exposed we are and today's youth want to experiment and experience everything so it goes back to the three some and what-what. (FGD2)

..if you know that you don't have a iPhone or you don't have that thing let alone the material things, they must leave you.....if you are here, don't accept any favour because of sexual favour...or you must go through a sexual process and then those people must abuse you, no man, so if you are accepting your situation and you know that you are poor and you are working towards having your own things.....then go through that process...just accept your situation, let the material benefits go. (FGD1)

4.5.6 Partner testing

The participants themselves confirmed that talking about testing with your partner, is a delicate issue:

And also like it's not easy you cannot just say to someone lets go test some people are very sensitive on such issues so it's easy for them to feel that you disrespect them you do not trust them and trust is another thing in a relationship...(FGD5)

...I hear a lot of people saying whenever they ask their partners to go and test with them they like is there anything like if I were to ask my boyfriend if I had a boyfriend lets us go and test together he will ask why do you want to be tested are you not sleeping with me alone or is there anything you hide and it is not because you do not trust yourself but it is you guys be both on the better position of knowing each other's status. (FGD3)

The participants confirmed that partners do not want to test but rather, they rely on their partner's status to determine theirs:

I would also like to agree with you in terms of ignorance when it comes to sexual behaviours ignoring that we might actually run the risk of contracting HIV/AIDS and the system we talked about that if my girlfriend is negative I am also negative of which is incorrect you cannot test by somebody else you have to go by yourself and find out that you are really negative so in that sense I would say that you really negative. (FGD2)

Some participants revealed that the students do go and test but only if there is an incentive. This is how they discussed the issue:

At the beginning of the year there is usually at the student centre I do not know if it's there now I usually hear at the beginning of the year, there are people who test HIV and this year they were giving away R50 voucher so people went to test because they were receiving something in return not to test to see if they have HIV or not but because of something they are getting. (FGD3)

Some went to test to get a USB. (FGD3)

4.5.7 Teen pregnancy

Participants revealed that being sexually active started at lower grades and have advanced to HEIs, hence the increase in the teen pregnancy rates:

...the core of everything starts to primary in high school I get to see this guy everyday I'm dating someone who is in class or it's more ja...(FGD4)

In my first year here my friend was already pregnant in March first year at university but everywhere you go there are condoms it is really have to do with ignorance. (FGD3)

these past days I saw an article of a Ten- year- old girl with a child, she is having a child and I was wondering a Ten-year-old-child with a child that means that the youth today is more reckless they just want to explore these things. (FGD2)

4.5.8 Condoms

Some participants voiced that some young people do not want to take ownership of using condoms:

What I am saying is that we know there is female condom there is a male condom if a lady feel like want to practise safe sex and they want to be healthy its either you carry a male condom and you encourage your partner to use a condom or you use your female condom I am sure you have been taught on how to use that and I am not talking to you ladies I am not specifically talking to ladies in general but they just do not use them. (FGD3)

Some participants pointed out that they do not trust condoms:

In my opinion I think that everyone who is sexually active is at risk that is how I see not necessarily say it is like this I see it as everyone who is sexually active being at risk of getting HIV because we can never be too sure about anything even the use of condoms can never be sure because anything can happen so everyone is at risk. (FGD2)

I mean we are all not safe and we cannot trust condoms they are not 100% either so ja. (FGD4)

There were some participants who still have confidence in condom use:

I think there is a change with these flavoured condoms because most of the students are using them and if you can get in the unit there is a box there on weekends that box is empty, so they are using them now but when there was no flavoured condoms that box was always full, but I think there is a change now. (FGD5)

Some participants pointed out that condoms bring about trust issues in the relationship:

..if you propose a condom to a guy he will think you do not trust him.(FGD5)

4.5.9 Abstinence

The participants have revealed that they knew about the A, B, C Education, A (Abstinence), B (Be faithful) and C (Condomised); although they are still not practising it. This is how they remembered abstinence education:

I'm thinking about another thing now, when we were growing up, when we first heard about these things of HIV/AIDS, they used to say there was something called "A, B and C", therefore I think it was that "B" that spoiled everything, because they would teach you whilst you are still young to be faithful. (FGD1)

I abstain only when I feel like I am ready then I will go on contraception. (FGD3)

...if ABC were introduced Abstain, Be faithful and Condomise, this did not work people are not faithful you try by all means but they are not but you know that condom is always a choice...(FGD5)

4.6 THEME 3: ATTITUDE

There is so much evidence that norms and attitudes towards gender and sexuality are shaped during childhood and during teenage years. Hence, an attitude has been described as a learned tendency to assess effects in a certain way. These norms and attitudes are the drivers of sexual behaviours amongst youth (Kambole, 2007:4; Svanemyr *et al.*, 2015:13).

4.6.1 Towards HIV/AIDS awareness campaigns on campus

The participants acknowledged that there are campaigns around the campus, but they choose not to attend them. Students think that they will be forced to test to find out their HIV status. One of them stated that:

...every time there are awareness's we always ignore them because of testing, here at varsity, they have been talking about testing, but we do not care. (FGD1)

Some participants were saying that awareness campaigns are not well marketed. Sometimes they hear about them but they still miss out because they did not know about them in advance:

"No, we are not informed but I went to the other one at res it was about HIV". (FGD4)

Some of the peer educators, who were part of these FGDs, stated that when they try to speak to some students about health issues around the campuses, there is always an assumption that they are HIV positive. This is how the peer educator explains it:

Pregnancy, HIV, STI those are...I think maybe if I am speaking to them they see a peer educator they think I am speaking about HIV whereas you could have flu and need to go to the clinic but because she is talking about this so obvious people will think that I have HIV. (FGD3)

4.6.2 Poor service delivery at on-site student health services

Participants have raised concerns of not being accommodated at campus clinics in terms of their health issues and their time tables. Doctors come on certain days and they must wait to be referred:

I never tried to find the reason for this because the doctor that is there only comes for certain hours and she leaves so I think they must try and get a permanent person there for that post because I think that is the problem. (FGD2)

There is a suggestion box and I also feel that when you write something there and see you dropping it immediately they open it and see it it's a student she said this and that so it is not confidential or anonymous so they should put it outside not inside so that when you outside you should write something and drops it there. (FGD1)

Some participants were concerned about the older health care givers, as they felt that they cannot relate to them. Older doctors or nurses are chastising them. In men's clinics, male students prefer male doctors or male nurses:

...also you find that the doctor is very old (age) we would like to be seen by younger people because the older ones in any clinic they always shout at you but if it's a young person at least you will also relate and down and sometimes end up talking about something else whereas an older person will just shout at you so I think if they can bring younger staff that will be great. (FGD5)

Some participants tend to differ with other participants in terms of the service delivery at the clinic and the respect they receive. This is how they elaborated:

I would go to the campus clinic if you suspect you have an STI you would go to the campus clinic and if you have an STI they will give you treatment and at some point they would or might refer you to student counselling then you can be able to make informed decision or they might refer you to peer educator if you are uncomfortable to speak with the counsellor you are referred to Peers then you can choose who are you comfortable with...(FGD3)

The confidentiality is good because they assure you that even if you are here whatever you are here for it won't...nobody will know about it they even restrict friends coming together the way they are confidential. (FGD4).

4.6.3 Health risks

Some group members were of the opinion that because they are newcomers, they do not know what is happening around the campus:

I would not know because we still fresh and do not know other students but ourselves ja I do not know. (FGD4)

.... the youth of today is not really safe they do not take care of themselves in terms of sexual relationships or in any sexual activity that they participate in, they always trying to be liberal everyone is trying to be liberal in nowadays...(FGD3)

Other students acknowledged that young people are more vulnerable to risks, than any other people:

I think even the reason that there were units like HIV/AIDS, student counselling was because the statistics have shown that at university at primary or high school they noticed that is where the rate is higher at young people and there is a certain age of young people...(FGD5)

... I think today's youth has been more reckless in terms of their conduct with respect to sex and whatever. (FGD2)

4.6.4 Health services referrals

Students showed a negative attitude towards the referral system and appointment system of the campus clinic. Students do not understand that the referral system can only be done by a doctor. Emergencies at the clinic depend on the severity of the problems:

Like if you go there like in the morning let's say at half past eight in the morning and you have a class they will book you for your free time let's say you are free at 11:30 they will book you that time rather than seating there for the whole day at the end of the day you are not getting what you wanted to get. (FGD3)

Sometimes you find that you have classes and you say what if I book at two, then they said that no you can't book at two.....it can't be like.....you show them your timetable and I'm very busy I won't have time to come here, can I make bookings for tomorrow, they say no you can't book for tomorrow you supposed to book for today I don't understand why can't you book for tomorrow the students are busy just like everybody else you can't exactly eemmm.....predict when are you going to get sick, the first thing that they are going to ask you is that do you have an appointment? You don't have an appointment come back at seven o' clock, that's a problem for me. (FGD1)

In terms of I think if the university can make more resources available to our clinic and not have only a certain doctor who will tell you that I am not specialising in this area you can go to another clinic at least it can have different doctors and have own x-rays in the campus because now if we are sick we go for an x-ray in Groote Schuur and you take the whole day there and sometimes they will tell you to come back or they will admit you of which if they have those equipment's here in school they can check you and only refer you for traditional hospitals but already identified what is the problem, so I think in terms of resources more staff and make the venue bigger than it is now I think that will kind of assist. (FGD5)

4.6.5 Stigma and judgement

Students are still afraid of being seen entering the campus health clinic:

My thing is within that building there is student development, student affairs, counselling, financial aid, so why the clinic have to stand out what if you are going to counselling or financial aid, so when you hear such talk clearly there is something deeper than what she

is saying maybe they say I saw so and so going to the clinic for ABCD that is why we draw the conclusion that if I go to the clinic they will think I go for HIV or I am pregnant it is really weird that it stick out on its own while there are other offices in the building. (FGD3)

I also think the media played a big role in terms of like combating the stigma because they've realise that many black households we don't speak about such staff so they bring those into our homes through watching the soapies and scenarios so that we can talk about HIV/AIDS. (FGD1)

Some students revealed that, although communities have been taught, there is still more education needed around stigma, when people hear about HIV/AIDS:

I would like to say people act for me honestly because people in the communities they pretend that they understand and in the public they understand but you cannot confirm that sometimes people act like they understand it but they not for instance if my child would have HIV and now I tell the school for safety other parents would have an issue with it and they would not say direct to me or teacher they will probably take it to the SGB to say we do not want the child here and they will make up and they will not say directly that the child is going to infect other kids and they try to make means so I feel for me that communities in my personal opinion for now they are acting they know it is there but they are acting. (FGD5)

4.7 SUMMARY

This chapter presented the results that were obtained from the data collected in the FGDs. The biographical data of the participants was summarised. The themes and subthemes which emerged from the transcribed data were presented. The following chapter will discuss and report on the results from the study and it will be relating the findings of this study to the literature review and the theoretical framework.

CHAPTER 5

DISCUSSION OF RESULTS

5.1 INTRODUCTION

This chapter will be discussing the results of the focus group discussions' (FGDs) responses of this study. The aim of this study was to explore potential health risk factors amongst students at an Higher Education Institution (HEI) in the Western Cape with regard to sexuality and HIV/AIDS.

5.2 THEMES

The five FGD's were conducted and recorded in English. The numbers of the research participants in each FGD were between five and eight. The following themes emerged from the data analysis according to the objectives and research question that were set out to be achieved in this study.

5.2.1 Theme: 1 Contributing factors to risky behaviour

The risky behaviours of the students in the HEIs are greatly influenced by many social factors. Among their responsibilities and priorities as students, they are faced by interpersonal processes like succumbing to peer norms, socio-economic background, social status and other factors.

5.2.1.1 *New-found freedom*

The students, who were the participants, revealed that being away from home gave them a sense of freedom at HEIs. Other students indicated that they could not wait to be away from their parents so that they could be on their own. They also wanted to be autonomous and free in order to make their own decisions. This relates to the individual student perceptions relating to the HBM, as the model states that behavioural changes take place by shifting potential risk producing situations, risk perceptions, beliefs and outcome expectations (King, 1999, as cited by Tarkang & Zotor, 2015).

According to Myer *et al.* (2012:9), universities have the tendency to give this freedom and autonomy to students during this transitional stage. Parents are not there to guide and reprimand them. When these students arrived at these HEIs, they feel that sense of adulthood, although they are not adults yet. Status Update (2018:2-3) reveals that these students are supported as they begin their vision and journey into HEIs, regarding academia, socialising and making new friends and acquaintances and adjusting culturally and mentally. Hence, orientation programmes at HEIs play a major role in assisting these students to adapt to their new surroundings and new-found freedom (Status Update, 2018). However, it also reminds them about this freedom without experience and how it can impact their future at university. Additionally, it reminds them that this new-found freedom comes with responsibilities as a young adult (HEAIDS, 2017:4-5; Status Update, 2018:2-3).

Dube, Hallett, Gregson and Garnett (2005) as cited by Myers, Kelly, and Motuba (2012:9), agree by stating that this new-found freedom is full of prospects. Nevertheless, these opportunities can include sexual activities, alcohol and drugs, which could impact their future negatively, if they are not mature enough to handle the pressures from fellow students. Brook, Fergie, Maeorg and Michell (2014:3), state that universities are seen as places of multiple, complex and diverse social relations, identities and communities. As a student, you have all these freedom and choices in front of you, followed by consequences.

5.2.1.2 Reckless behaviour

Students admitted in the FGDs that they do act recklessly and engage in activities that put them at risk of contracting HIV/AIDS and other STIs. According to HEAIDS (2017:4), life in the HEIs comes with the logic of being carefree. As a student, the only responsibility is to concentrate on your academic studies and learn to be professional whilst your future is crafted. Furthermore, they do not have to think before they do things, as one participant expressed himself. Students in one group believed that HEIs are the right platform for sexual activities. This is confirmed by LatifnejadRoudsari, Javadnoori, Hasanpour, Hazavehei and Taghipour (2013) as cited by Hedayati-Moghaddam, Eftekharzadeh-Mashhadi, Fathimoghadam, and Pourafzali (2015), people at age 15-24 (mostly secondary and university students), involve themselves in high-danger activities, particularly high-risk sexual activities, without considering consequences. LatifnejaRoudsari *et al.* (2013) added by saying that if these behaviours are not contained, they can contribute to the STI and HIV/AIDS epidemics in HEIs.

This is in line with the HBM, as these behaviours are promoted by modifying factors like demographics and socio-economic factors. These students are coming from different provinces, which in turn can also be divided in rural and urban communities. For some of the first years, entering HEIs means their first time of being in a city or urban town. This is all too overwhelming, hence they have individual uncertainties of how they would be treated by their fellow students, if they do not conform to what everyone is doing at HEIs (Wirtz, Kamba, Jumbe, Trapence, Gubin, Umar, Stromdahl, Beyrer, and Baral, 2014). The likelihood of perceived benefits in taking preventative action, instead of succumbing to peer pressure, is perceived as a barrier. HBM's perceived risk and effect are individual's views or beliefs with regard to the risk of developing a health problem and the potential negligence and consequences of the health problem based on their background, for example age, sex and geographical location (Janz & Becker, 1984;11:1-47, as cited by Wirtz *et al.*, 2014). In some of these students, these are new behaviours as they are away from home and they have peers to please. SCT regards learned behaviours through witnessing, as some of these students are imitating their friends (Bandura, 1986). Bandura thus concurs with the modifying factors of the HBM, that advice from peers in similar situations and information from media, adds to the psycho-social variables that make students indulge in high-risk behaviours (Tarkang & Zotor, 2015).

5.2.1.3 Alcohol and drugs

According to Burke (2010:26) as cited by Mbatha and Ally (2013:2), when alcohol is abused, it may have many consequences such as crime, accidents, unprotected sex, unplanned or unwanted pregnancies, contracting STIs and HIV. High-risk behaviours because of alcohol and drug abuse in HEIs, were cited many times by students. Some

students acknowledged that when there is alcohol, they have a habit of drinking too much. This causes them to end up doing things that they did not want to do. These included unprotected sex, group sex and drug use. These risky behaviours were unplanned, but because they were intoxicated with drugs or alcohol, they lose all inhibitions and do not realise the seriousness of the implications of these high-risk behaviours, which are perceived threats of STIs and HIV and AIDS (Skinner, Tiro, and Champion, 2015:75). This leads to uninformed decisions because the judgement is diminished by alcohol and drugs and constitutes major barriers to preventative action or measures.

The HBM cues to actions requiring motivation from the individual to conform with the prescribed remedy, be it to be involved in health education activities or peer support groups (Tarkang & Zotor, 2015). Bandura (1986) talks about perceived self-efficacy, referring to people's judgement of their ability to arrange and perform specific behaviours that are required to deal with different forthcoming situations. This "self-belief" about the student's capacity, influences how they behave and how much effort will be spent in changing their behaviour (Bandura, 1977, as cited by Tarkang & Zotor, 2015).

Burke (2010:26) as cited by Mbatha and Ally (2013:2), further revealed that absenteeism is rife amongst students and the failure rate at HEIs is high. This further leads to high drop-out rates of students at HEIs. This contributes to the psycho-social factors of poverty and depression, as these drop-outs becomes a burden to their already impoverished families, as well as the tax payer. According to McCormarck (1999) and Onega (2000) as cited by Tarkang and Zotor (2015), HBM's modifying factors involve socio-psychological factors like peers and socio-economy. Furthermore, they mentioned that these variables can influence the individual's perception which leads to one's health-related behaviour. The socio-psychological factors, for example, would influence the student's perception of vulnerability to HIV and the seriousness of getting HIV due to alcohol's influence. These students then develop no sense of agency and credibility, as they have a low self-esteem (SCT-Bandura, 1989). Alcohol and drugs are a serious public problem, when someone is addicted to them. The person might need professional help, because the problems can be clinical, psychological and physical. Amongst young people, it is associated with negativity and it is commonly followed by high-risk behaviours (Abbasi-Ghahramanloo, Fotouhi, Zeraati, and Rahim-Movaghar, 2015:5) and (HEAIDS, 2017:50).

5.2.1.4 Peer pressure

The students quoted the impact of peer pressure and influences when arriving at HEIs. Students mentioned that having a sexual partner or an older sexual partner (blesser), is the requirement to 'belong'. They also stated that if you do not adhere to these requirements, you are regarded as someone who is living in the 'olden days'. The HEIs' environment has made the students rely on their peers for advice. That advice would be such as "it is cool to have multiple partners or group sex". Tildesley *et al.* (1993:28(9):853-80) as cited by Abbasi-Ghahramanloo *et al.* (2015:5) revealed that pressure from peers and friends to conform, are the most common factors that can influence high-risk behaviours amongst young people. Tildesley *et al.* (1993:28(9):853-80) describe youth as people who can be influenced by their peers easily. This is a result of wanting to be part of the group. They often advise each other inadequate information and make uninformed decisions based on the information from a friend. Most of the time, these decisions lead to high-risk behaviours.

Vember (2013:115) concurs with Tidesley *et al.* (1993:28(9):853-80) that young people get 70% of their sexual information from their peers, whether correct or uninformed. It was evident that through this advice, the students were witnessing other behaviours (right or wrong) and imitating their friends. This is in line with one of the concepts of SCT, namely role modelling. Participants cited transactional sex as a common practice amongst the students. Some of them confirmed that they could not resist it because everyone was doing it and there were expensive gifts attached to it.

5.2.1.5 Multiple partners

All the students who participated in the FGD's, expressed that having multiple sexual partners was a fashion in HEIs. They also mentioned that it was not just a certain gender that is doing it, but everybody. Some students added by saying that there is nothing wrong with having multiple sexual partners. There was even a term that students were using to refer to multiple partners "Pause life". According to Caetano, Linhares, Pinotti, Maggio da Fonseca, Wojitani and Giraldo (2010:43-46) as cited by Min-Chen, Liao, Liu, Fang, Hong, Ye, Li, Tang, Pan. and Liao (2016:6-8), having multiple sex partners is one of the greatest significant causes in acquiring HIV infections and STIs. A survey that was done in 2000 by the Ethiopian Demographic Health amongst unmarried individuals showed that multiple sexual contact amongst single people is very common, particularly amongst young people aged 20 and above (Mengistie, Wolie, Abawa, Ebre, Aderan, 2015:597). Vember (2013:117-118) revealed that the HEIs peer educators are trained and are well equipped with information and knowledge that is related to multiple sexual partners. Yet, in a study done by her in 2012, 14% of these trained peer educators at HEIs still engaged in multi-partner sexual activities. HEIs offer different workshops where students participate in numerous awareness programmes across all campuses. However, they do not practice safe sex and still have multiple sexual partners.

Vember (2013) and Mengistie *et al.* (2015) research relates to the modifying factors in the HBM of knowledge and support. Even though knowledge is being imparted through various peer education training programmes, VCT and other HIV/AIDS related campaigns, students still put themselves at risk by indulging in these high-risk behaviours. Students still fail to see the perceived benefits of preventive action, versus the high-risks that they take all the time (Tarkang & Zotor, 2015). The students revealed that when they attend parties at HEIs, or visiting nightclubs, they end up in a one-night stand with a casual sexual partner. They have also mentioned that when they attend these places, they do not plan to get casual partners or one-night stands of sexual contact, it just happens. According to Myer *et al.* (2012:10), A HEAIDS' study discovered that sexual contact and especially casual sex partners are triggered by alcohol and drugs. Once again, students tend to ignore the cues to action in taking preventative measures but put themselves at risk of contracting STIs and HIV/AIDS (Wirtz *et al.*, 2014).

According to the South African Department of Social Development as cited by HEAIDS (2017:50) people who are using substances are suffering from serious health and socio-economic difficulties. They added that in South Africa, young people aged 15 and older consumed more alcohol than any other African countries. This leaves the students in vulnerable spaces, where unplanned casual sex happens, as stated by participants during this research. Furthermore, experimentation, boredom, peer pressure, lack of recreational facilities and poverty, were mentioned as contributing factors in most of the focus group discussions. Spending time with people who are substance abusers can lead students to the same behaviour, as young students easily succumb to peer pressure (HEAIDS, 2017:50).

SCT alludes to credibility (Bandura, 1988) and young students seek this from their friends, as was clearly revealed in this study. So, in order to be regarded as credible, one needs to be 'in with the crowd', hence participating in high-risk behaviours, sometimes knowingly and other times, unknowingly, as some of the participants shared in the group discussions.

5.2.1.6 Early-stage sexual engagement

Another group of students revealed that sexual engagement happens very early in their lives and that it all started even before they entered the HEI. Some students agreed by saying that it was like a competition to be sexually active at 13- and 14-years-old. Mengistie *et al.* (2015) is in agreement by saying that sex experimentation starts with teenagers. This stage is characterised by reckless, risk-seeking behaviours. Denno, Hoopes and Chandra-Moulie (2014) state that compared to the past years, boys and girls reach puberty prematurely, hence these young people start experimenting at an early stage with sexual activity and put themselves at risk of contracting HIV and other sexually related infections. Their bodies developed much faster and physically they feel more mature, hence they think they are ready for sexual activity. Additionally, they mentioned that risky sexual behaviours and reproductive health problems amongst teenagers can have serious permanent consequences in their adulthood. They further added by saying that those problems could even affect their generations negatively (Denno *et al.*, 2014:2; Seloilwe *et al.*, 2015).

The ecological model states clearly that the relationships should be improved amongst individuals, families and sexual partners, to assist these students to make informed decisions regarding their sexuality (Svanemyr *et al.*, 2015:S8). It reveals that to improve and build strong healthy relationships, a focus should be on supporting these students psychologically and creating enabling environments for them to establish their own identities and to develop into responsible young adults, who will take responsibility for their own sexuality. This could be done by giving realistic advice either in support or disapproval of their relationships.

Participants mentioned in the FGDs that parents and guardians tend to chastise them, when they disapprove of friendships, instead of having an open conversation with them. Furthermore, creating comfortable and relevant conversations around sexuality, would promote positive attitudes, create positive social norms and safe sexual behaviours. This could include partners, parents, peers, HEIs and other sexual partners because these are the people that influence their sexual experiences (Krug *et al.*, 2000, as cited by Svanemyr *et al.*, 2015:S8).

5.2.1.7 Transactional sex

Transactional sex was cited by most students during the interviews as a common practice in HEIs. Some students said that circumstances around them force them to do it. Poverty and hunger in HEIs residences, were mentioned as a reason. Some students indicated that transactional sex is not only about monetary value that is exchanged. It also involves the buying of food, gifts, lace weaves and expensive cell phones. Myer *et al.* (2012:11) agree that the incidences of multiple and simultaneous partnerships are influenced by poverty. This concurs with the modifying factors of the HBM (Tarkang & Zotor, 2015), as it cites poverty as one of the major factors as to why young people find it difficult to take

preventative measures in contracting diseases like HIV/AIDS and STIs and put themselves at risk to health factors.

Students also do not perceive the seriousness of these diseases, as they are so focussed to get out of the poverty trap and to be in line with their peers (Tarkang & Zotor, 2015). In these occurrences, older sexual partners (blessers, ‘sugar daddies’ or ‘mamas’) take advantage as they are aware that some of these students are beautiful and needy. They entice them with expensive gifts in exchange for sex. According to McCoy, Watts and Padian (2010:1281-1282); Yan, Chen and Wu *et al.* (2009) and Yan, Li, Bi, Xu, Li and Maddock (2010:767-782) as cited by Min-Chen *et al.* (2016:8), even recently, there is a surprising number of female students from Chinese high schools and in universities that are involved in transactional sex with older men during their spare time. Minister Motsoaledi, the Minister of Health refers to these men as “evil men”, as they entice students with a luxury lifestyle (Motsoaledi, 2018:4). However, there were some students who were against transactional sex during the interview session. They stated it as prostitution. According to the Minister of Higher Education and Training, Dr Blade Nzimande (2014), a lack of skills, training and financial distress of HEI students, were some of the priorities for the government. The minister was pledging, with all the stakeholders including National Student Financial Aid Scheme (NSFAS), to assist in improving the life of the students, financially (Nzimande, 2014).

5.2.1.8 Unprotected sex

The students acknowledged that their sexual life is endangered, and they are not taking responsibility for their own lives. This is in line with the unlikelihood of taking recommended preventative health action, despite having the knowledge and support systems on HEIs. The HBM cues to action require motivation from the individual to conform with the prescribed remedy, be it to be involved in health education activities or peer support groups (Tarkang & Zotor, 2015).

Other students uttered that safe sex is uninteresting. They described it as “tasteless”. Some described protected sex as “someone who is eating a sweet with a wrapped paper”. According to Navarro-Cremades *et al.* (2016:8), female students prefer not to practice safe sex because they want to reach an orgasm in a natural way. Furthermore, they revealed that these women want the sensation of better contact during sexual interaction. However, the unsafe sex leads to the risk of STIs and HIV.

According to Kelly (2001:1-4), students in African universities are not practising safe sex. Kelly further mentioned that high-risk activities are rife in HEIs. Hedayati-Moghaddam *et al.* (2015) concur with Kelly (2001) by revealing that there is a high rate of unprotected sex in different countries amongst university students. The students are experimenting with casual sex and multiple partners without condoms. The participants in the FGDs also mentioned that the students discuss the misconceptions amongst themselves and they tend to go and practice these misconceptions to prove them. In this process of proving them, the delusions of the unprotected sex are practised. The students also mentioned that sex with condoms, was boring and the condoms are not 100% safe. On the contrary, Brown *et al.* (2012:48 & 98), has clearly explained that condoms are effective in preventing STIs and unplanned pregnancies and their quality is tested for the strength, leakage and lubrication. This clearly shows that there is a crucial need of continuous sexual education amongst these students, to remove the misconceptions and to support the growing education about the use of condoms.

5.2.1.9 Lack of communication with parents

According to the students who participated in the FGDs, parents and teachers are sceptical to talk about sex, sexual health and reproductive issues with their children and learners/students. According to Vember (2013:115), it was discovered that 70% of the students received most of the information about sexuality from their friends. There were nearly 50% of students that reported that they do receive information from home (parents/guardians). Only two per cent of these young people reported their lectures as a source of information. Vember (2013) added by stating the alarming concern about the truth of the information from the friends. Furthermore, the lack of these communications could impact negatively on the integration of sexuality and HIV/AIDS into mainstream curricula in HEIs. The students highlighted that even at their high schools, teachers would always try to avoid these issues. Some students also mentioned religion and culture as a blockade, when it comes to sexual talks. Culture, tradition and gender issues are also stated by the HBM as a barrier for important role players, like parents and teachers, to communicate to children on these important issues of sexuality and HIV/AIDS. Tung *et al.* (2015:879) reported that in Taiwan, family members and health professionals talk about sexual issues with their youth the least because of their culture. However, teachers are regarded as reliable sources of information because they are respected as part of Taiwanese traditional ethics. This is in line with SCT when it refers to role models. These students saw their teachers as role models.

However, at HEIs, peers look at each other as role models. According to Seloilwe *et al.* (2015), parents are supposed to be the first line of communication with their children with regard to sexuality. This communication would assist in avoiding unwanted pregnancies, contracting STIs and other early sexual activities. According to Kim (2007), and Kim (2009) as cited by Seloilwe *et al.* (2015:5), there are some parents who initiate these sexual talks with their children. Most of the time, it is those families who are knowledgeable and well-educated. One of the barriers of sexuality talks between young people and their parents, is the lack of information. With regards to school teachers, there are beliefs and opinions that if you are teaching sex issues, you are encouraging sex (Bastien *et al.*, 2011:8:25, as cited by Svanemyr *et al.*, 2014:S9).

Students in these FGDs also referred to their lecturers (academics) who were not comfortable talking about sexuality and HIV/AIDS in the classroom. Orientation programmes during these students' first year at HEIs, should include all topics related to sexuality and HIV/AIDS. Within the HEI, where this study took place, an extensive compulsory "first-things-first" programme is conducted throughout the first term for all first-year students. The programme aims at ensuring that taking care of one's health, is the first priority of every South African. It encourages health seeking behaviours and enhancement of quality of life of young people through regular testing and screening of HIV, STIs, TB, cancer and cardio vascular risks (HEAIDS, 2018:1). This programme also includes extensive walkabouts and discussions with other support services on HEIs like Campus Health Services, Counselling and other support services. However, this study revealed that many students were unaware of such services on their respective campuses.

5.2.1.10 Knowing the status of sexual partner

Most of the participants indicated that students were sleeping around with their partners without knowing or finding out their status of HIV. Some students alluded that some partners would go and do testing. However, they would not go back after three months for a re-test. It was pointed out by the students that they trust their sexual partners. There were assumptions that if your sexual partner was HIV negative, it means that the other partner was HIV negative. Once again, it was clear that these students subjected themselves to high-risk behaviours. Greene and Gary (2011), as cited by Svanemyr *et al.* (2015:S12), revealed that there are gender norms and attitudes that are related to masculinity that are disadvantaging girls and young women when it comes to discussing safe sex issues with their partners. This finding concurs with the gender and culture issues discussed in the HBM (Minugh & Rice, 1998:485). In this case, boys and men force these girls and women to indulge in sex, without knowing their HIV status. Myer *et al.* (2012:) adds by stating that increased HIV vulnerability, is as a result of intimate partner violence, rape and other forms of gender-based violence.

5.2.1.11 Socio-economic background

According to the Minister of Higher Education and Training, Dr Blade Nzimande (2014), the lack of skills and training and economic suffering of HEI students were of great concern. The government pledged to improve the life of students financially (Nzimande, 2014). The effects of socio-economic background were cited many times by students. The students revealed that coming from a poor background and for example, being expected to dress a certain way, has made them vulnerable. The participants revealed that the students were making uninformed decisions based on material things in exchange for sex. The blessers (older sexual partners) were cited as a source of financial refuge and material supplies. The blessers could be older men or older women. The students also reported that students were not concerned about the HIV status of these blessers. All they wanted was financial stability in order to live comfortably and above the bread line. Sallar (2009:3) revealed that in regions where there is financial steadiness and all-inclusive implementation of sex education policies, students tend to tolerate each other. In addition, the ecological model, Svanemyr *et al.* (2015:S8-S9) ascertain the role of the communities among these students. The community could assist to create positive social norms and promote safe sexual behaviours. Access to sexual reproductive health education, involving institutions, schools, neighbourhoods and work places, are of the utmost importance. Furthermore, several interventions that focus on economic empowerment and reduction of poverty, could assist in reducing vulnerability of these young people, whilst improving their financial status and negotiation skills (Svanemyr *et al.*, 2015:S8-S9).

5.2.2 Theme: 2 Knowledge

The HEIs are not only providing academic curricula, in order for students to achieve a diploma or a degree but they also provide awareness programmes regarding HIV and sexuality. This is one way to empower students with knowledge and life-skills to take care of their lives socially. However, the students do not show interest to participate in these awareness programmes, although they do not have insight or enough knowledge about their social and sexual issues (Turnbull *et al.*, 2016:9).

5.2.2.1 Ignorant

The participants in the FGDs acknowledged that they did not show interest in any activities that are happening around the campus. Some students revealed that they are aware of some activities, however they choose to ignore them. Both males and females reported that students desire sex so much that they do not care about having infections. Young people generally enjoy a good life more than any other age groups. Hence, they ignore all these educational and awareness activities around the HEIs. They are not thinking about the potential health risks or the threat of diseases. Although they are equipped with knowledge, the HBM cues to action require motivation from the individual to conform with the prescribed remedy, be it to be involved in health education activities or peer support groups (Tarkang & Zotor, 2015).

The students do not realise that these behaviours can affect not only their academic future, but the rest of their lives negatively (Chandra-Mouli, 2015; Steinberg, 2008:5). Amongst these students there were peer educators who were emphasising that students do not want to learn, although there is so much that they are doing as peer educators.

According to Vember (2013:157-158), peer educators are trained and are well equipped to impart valuable knowledge to their fellow students/peers. Peer educators engage in various discussions on topics such as sexuality, HIV/AIDS and life skills on the residences, where they attract a large number of students (Vember, 2013). Vember (2013) also revealed that students enjoyed these discussions with their peers and requested that it should happen more frequently. This concurs well with SCT.

Bandura (1986) talks about people learning from their own different understandings and practices. The theory also reveals that people can learn from witnessing other people's behaviours around them. This puts young people in a perilous position regarding equipping themselves with the relevant knowledge, as the theory foresees that with enough knowledge of sexuality, young people are able to defend themselves from risky situations (Bandura, 1986). However, despite intensive orientation and awareness programmes regarding sexuality and HIV/AIDS, students still engage in risky behaviours, as was evident in this study. According to Svanmeyr *et al.* (2015:S8), students can be involved in high-risk situations but they do have the ability to control the high-risk behaviours, when they are equipped with necessary resources, skills and knowledge.

5.2.2.2 Misconceptions

The students also reported misconceptions that are held around the campus. Some students indicated that they have heard that for men to get HIV, they must indulge in unprotected sex with someone who is HIV positive at least eight times. Other students added by saying that they have heard that you could have unsafe sex with an HIV positive person, however you could still not be infected. They revealed that if you are circumcised, you have a low risk of infecting others with HIV. According to Majelantle *et al.* (2014:6), misconceptions about the spread of HIV amongst learners exist and they vary according to their gender and the level of education. They further added that more education is needed amongst these students. Tung *et al.* (2015:878-879) was in agreement with the misconceptions and added that students still believe that mosquitoes are a mode of transmitting HIV. The students acknowledged that out of these misconceptions, students still do go and experiment as illustrated in the following quote:

I am sure that out of 10 people there is one person who has heard that you can sleep with someone who is HIV positive and don't get it and you will be like let me try this because of the spare of the moment and then consequently you will get the virus thinking that you would not get it so it's the ignorance and also that ego that I do not know where it's coming from. (FGD5).

This response could mean that students are still not fully equipped and have inadequate knowledge regarding sexuality and HIV/AIDS issues. These misconceptions are therefore still not dispelled amongst students. These confusions may result in unprotected sex, leaving them vulnerable. This is in line with HBM's individual perceptions. An individual's perception that a health problem is personally relevant, will contribute to taking vital action to prevent the health difficulty. The student's motivation to take action against a health-risk related issue, would be to understand the health risk. This would assist them to make a health-related goal decision (Tarkang & Zotor, 2015). The modifying factors also influence the student's decision-making as some students do not know where to find the correct information to clarify the misconception at hand. Sometimes the students would walk around with a health problem, not wanting to disclose it, as they are afraid of stigma. Janz and Becker (1984) as cited by Wirtz *et al.* (2014) has stated that HBM suggests that the possibility of adopting the preventative action, is influenced by the individual's perception, modifying factors, cues to action and self-efficacy. Accessing information and educational health activities as students suggested, would promote healthy behaviours.

5.2.2.3 Information needed

Nearly all students that participated in the FGDs, shared that they do not know where to go on their campuses, when they needed advice. This included financial, health and social advice. Some students were still blaming the inadequate information regarding health and sexuality they have received from their families and from their school teachers for their current ignorance. Amongst the participants, we had peer educators who were reporting that as much as they themselves are working hard to assist all over the campuses, there is still some more that is needed to be done, regarding awareness and orientation to assist students on campuses. Some students admitted that they were not aware of student health and counselling services on their campuses. They also revealed that the lack of information is leading students to risky behaviours, such as transactional sex, multiple sexual partners, unprotected sex, etc. According to Vember (2013:44), student life in the HEIs usually creates social circumstances where the students find themselves in high-risk situations or environments. In addition, Svanemyr *et al.* (2015:S7), describe the sexuality of young people as strongly influenced by many factors. Factors such as social, cultural, political, inequalities and economical, play a major role in affecting the lives of students at HEIs. These contribute majorly to the students' weaknesses.

The ecological model regards building an enabling environment for the youth, involving different stakeholders, such as families, community members, leaders, as well as policy-makers. This is crucial towards the empowerment of young people in order for them to understand their human rights. This will assist them to be able to negotiate their sexuality and make informed decisions (Krug *et al.*, 2000; Turmen, 2000; Gupta *et al.*, 2008; Brofenbrenner, 1979; Garbarino, 1985, as cited by Svanemyr *et al.*, 2015: S7-S8). Seloilwe *et al.* (2015) agree that parents are supposed to be the first line of communication with their children with regards to sexuality. Although the universities provide this information, they

need to identify that even adult students do not have enough knowledge on these issues (Turnbull *et al.*, 2016:9).

5.2.2.4 Education needed

Students requested fun educational activities to relieve their boredom and to occupy some of their new-found freedom. Students requested that more innovative approaches should be embarked upon to educate them on sexuality on their campuses. They are ignoring the usual awareness programmes and do not visit the mobile clinic as they find it boring and rhetoric. The students revealed that some sexual issues are still difficult to talk about. However, if there are dialogues and focus group discussions, where students can participate in discussing the real issues around high-risk behaviours and sexuality, then it will be more fruitful and worthwhile attending. Some students reported that they wish they can have these discussions in their faculties. These educational activities would assist to eliminate the boredom and promote informed decision-making. Tung *et al.* (2015:878-879) approves the educational programmes, declaring that they would assist in decreasing stigma, whilst promoting safe sexual decisions amongst these students. According to Rehle *et al.* (2010) as cited by Myer *et al.* (2012:14), health communication programmes should be trustworthy. They further added that these programmes should be relevant and be able to create interchanges amongst the HEI students. In this way, students will easily engage with their peers effectively, even in their lectures. Gacoin (2014) and James *et al.* (2004) as cited by Ngidi *et al.* (2016:102), add that there is a need for the circulation of updated, accurate education around sexuality and HIV/AIDS issues to empower the students and their communities. The community mobilisation can nurture intergenerational statements in support of young people. This can be done by involving communities in public education efforts, inviting church leaders, traditional leaders, neighbourhood watches and other different stakeholders. Engaging all these leaders in sexuality issues, will assist in promoting positive attitudes, positive social norms and it can generate community support (Kesterton & Cabral de Mello, 2010:7; Denno *et al.*, 2015:56:S22-41, as cited by Svanemyr, 2015:S12). SCT discusses experiences of people that are taught from their own life lessons, as well as from others. The theory also reveals that people can learn from witnessing other people's behaviours around them, therefore young people can also learn from older students' experiences. According to SCT (Bandura, 1986), young people need to have enough knowledge and experience in order to safeguard themselves against peer pressures and risky situations (Bandura, 1986).

5.2.2.5 Uninformed decisions

All the participants reported many reasons that led them to make uninformed decisions. Alcohol and drug abuse were cited many times by the students. The freedom of being away from home and being allocated your own room, gave them a sense of being independent and feeling like a real adult. This allows them to make their own decisions, without any parents advising or reprimanding them. The peer pressures were also mentioned as they were desperate to belong and to be wanted. Students want to be trusted by their peers. This was leading the students to behave in certain ways, like dating an older man for material gifts and transactional sex.

As HEAIDS (2017:50) stated, alcohol and drug abuse lead to serious health and socio-economic complications. These problems lead these students to make uninformed

decisions, because they are not sober-minded. The students are away from the supervision of parents. They are exposed to other female students who are surviving by transactional and unprotected sex for financial security. They were likely to join in as most of their friends were doing it. The casual sex was happening unexpectedly, as a result of alcohol and drugs and these one-night stands with casual partners, were unprotected sex as, they were not planned.

Amongst some students, it was evident that although the parents were not there, their parenting style had a substantial influence in the way the students were behaving and carrying themselves at the HEI and amongst other students. Some of them said that they were quite happy to be spectators. According to Bandura (1989), SCT speaks about learnt behaviours through observations. The participants expressed that during weekends at their campus residences, they would watch the beautiful cars that were visiting students. They uttered that these cars belong to the blessers (older, rich sexual partners) and the students would come back with expensive gifts. The participants revealed that it was difficult to resist the temptation, as some would have expensive cell phones and weaves, hence, 'everyone' started to have a blesser.

Bandura (1986) adds that role modelling plays a vital part in the empowering of the individual in new situations where one needs to make a decision. During the FGDs, the students voiced that amongst themselves, it was easy to notice those that were raised well and those who had role models. They were not easily influenced by peer pressure or the circumstances at the HEI. As Tildesley *et al.* (1993:28(9):853-80) cited by Abbasi-Ghahramanloo *et al.* (2015:5), stated peers and friends affect one another and contribute to the most important factors regarding indulging in high-risk behaviours amongst young people.

5.2.2.6 Partner testing

The students acknowledged that it was difficult to discuss the HIV testing with their sexual partners. Some participants disclosed that it was a sensitive issue as the partner would bring up issues of 'trust' and 'disrespect'. Other participants revealed that some partners do not test but rather rely on the other partner's results. There is an assumption that if my partner is HIV negative, then I am also HIV negative; forgetting the sleeping around without using condoms. The students also revealed that they are scared to talk about testing, as they might lose their sexual partners and the benefits attached. According to Montaner (2011), as cited by Myer *et al.* (2012:13), most people do not want to go and do HIV testing, especially men and those who are aware that they might be infected with HIV. This is a serious risk behaviour, as it put students in vulnerable situations as some of these students depend on certain individuals financially. Some students revealed that they are scared of knowing their HIV status, that is why they rather ignore the campus awareness programmes, as stated in the quote below:

You know what there are lots of things that we don't know, because the minute we see T-shirts and tents, we know that they are testing, and you don't want to know because the testing is done publicly, and you are scared of your reaction. I wish they can be strategic, no testing rather encourage us to go to the clinic for testing. (FGD1).

It was evident in the response that these students are misunderstanding the facts. They do want the information, but they want it in strategic ways. Hence, they were suggesting

dialogues, focus group discussions and fun educational activities. The lack of information is placing these students' health in a compromised position.

5.2.2.7 Teen pregnancies

The students said that the prevalence of teen pregnancies is the result of early sexual interactions amongst the youth. They have confirmed that their sexual interactions were not a sudden development at HEIs. It all started at the lower grades, prior to entering the university. Participants shared that there are young people from primary schools who gave birth already. Although condoms are free and are everywhere, they are not used. They have confidently recognised that the youth is irresponsible. This is confirmed by Mengistie *et al.* (2015), who said that youthful age is the stage where young people experiment with sex. Whilst they are experimenting, they are confronted with many high-risk situations, such as contracting HIV, STIs, unplanned pregnancies and illegal abortions. Patton *et al.* (2012:379:1665-75) as cited by Chandra-Mouli *et al.* (2015:S2), reported that most of the adolescent births happen in developing countries. They added by saying that Latin America is faced with 18% of these births, while sub-Saharan Africa is dealing with 50% annually.

According to Turnbull *et al.* (2016:13-19), the students have been given sexual knowledge and contraception through education and orientation. However, these young people were complaining that the information that they were given, was insufficient. Additionally, Turnbull *et al.* (2016:9) also stated that in this century, the rate of unplanned pregnancies and STIs, have increased drastically. Therefore, sex and relationship education provided at schools, is not enough. This means if this knowledge can be integrated into curricula by allowing students to participate in group discussions, projects and assignments, students would learn and benefit more. In this way, credibility would be demonstrated through determination, reflection and observations. The students want these discussions in their faculties. This education would assist them to make informed sexual decisions, together with their families and their communities. Some students shared in the groups that there are no such information sessions happening in the rural areas where they are coming from. They suggested that this kind of information would be easily transferred amongst the peers and in work places as some of them are full-time employees (Polit & Hungler, 1997:304-305, as cited by Jooste, 2018:351).

5.2.2.8 Condoms

It was pointed out that young people do not want to practise safe sex. The participants testified that the students do not want to use condoms as students stated that condoms are unreliable. They cannot be trusted 100%. Although some students still believed in the use of condoms, they were saying that it brings trust issues in their sexual relationships. Other students revealed that they have noticed an increase in the use of condoms and that the students use flavoured condoms. Even in the bathrooms, the boxes of condoms do not last for a long time, meaning that if an individual believes that condom use will help to prevent HIV or taking a test will assist in early diagnosis, he/or she would benefit (Tarkang & Zotor, 2015).

HBM relates to individual perceptions about health. It will assist to understand what influences the participant's perceptions, their beliefs, behaviour, knowledge and attitudes towards HIV/AIDS and related sexuality issues. The significant psycho-social factors about condom use, are the student's willingness to use a condom and the support from

parents about condom use. This might help in personal responsibility and choices that the participants make to prevent themselves from contracting HIV and STIs or putting themselves at risk to acquire these infections. This would be a benefit to students and to families as it will be a preventative measure (Tarkang & Zotor, 2015). Skinner et al. (2015:75), have confirmed that the HBM has been used to foresee preventative health behaviours and it has worked for sexual behaviours, respectively. It is important for HEIs to understand that students do have a social life. When health behaviour is addressed, students need support and encouragement without judgement. The HBM is relevant for this research because it deals with individual behavioural changes.

5.2.2.9 Abstinence

The students remembered that when they were still young, they were taught about the abstinence (A), be faithful (B) and condomise (C) premise, although they were saying that they did not understand it because they were too young at the time. Some students reported that they do have choices if they do not want to abstain. They said that they can just use contraception. Abstinence was perceived as prevention from unwanted pregnancies. There was still confusion between abstinence and contraception amongst the students. The students stated that there are messages about abstinence, but they ignore them. Ngidi *et al.* (2016:102) articulated that the students are confronted by these sexual abstinence messages.

However, peer pressure and the new-found freedom, have played a role in their sexuality. Students need safe sexual education and support, instead of addressing them with abstinence. Bawa (2018:16), agrees by stating that an inclusive sex education will play a great role amongst these young people. It will influence them in making informed decisions. Eggers *et al.* (2016:1426) queried what abstinence meant for the youth that were already sexually active. Abstinence would mean less sex, if they have the skill to negotiate. Therefore, assertiveness training and communication skills would assist in their behaviours. In line with Bandura, Grove *et al.* (2013:8-9) (refer to Chapter Two) states that knowledge is vital information that is learned through personal experiences, role modelling, trials and errors and perceptions. Sexual knowledge, including abstinence, is essential for university students, as it will assist them to negotiate sex and make informed decisions.

5.2.3 Theme 3: Attitudes

The foundation of maintaining personal health, is based on a person's attitudes. On HEIs positive attitudes are encouraged by exposing students to various sexuality and HIV awareness programmes. These awareness programmes should be directed not only to students but to everyone Ukhtomsky's (1966) and Uznadze (1961) as cited by (Tretyakova *et al.*, 2016:8287-8288).

5.2.3.1 Towards HIV/AIDS awareness campaigns on campus

Different attitudes towards awareness campaigns on campus were cited by students. It was highlighted that the campaigns were there to promote healthy lifestyles and help create informed decision-making. Few participants stated that they do acknowledge the awareness

campaigns around the university, but they choose to overlook them. The students displayed negative attitudes towards the activities that are happening around the campus and the foundation of these attitudes was a lack of knowledge that led them to ignorance. Navarro-Cremades *et al.* (2016:9) state that even the universities should not solely depend on education for sexual issues amongst the students. There was also an assumption that if there are awareness tents, students think that they are forced to test for HIV. The peer educators, who were part of the FGDs, reported that if they are raising health issues amongst their peers, there was an HIV stigma attached to it.

According to Tung *et al.* (2015:878-879) the college students do not have enough knowledge about HIV/AIDS. They further mentioned that students with moderate knowledge may influence each other to have a moderate attitude towards the issues of HIV and promote unsafe sexual practices. The Minister of Health made a plea about raising HIV awareness in schools. However, the parents were against it, saying that it would promote sex. Many researchers have revealed shocking statistics about HIV amongst the youth (Motsoaledi, 2018:4). Svanemyr *et al.* (2015:S8) discovered that students have the ability to control high-risk behaviours when they are equipped with necessary resources, skills and knowledge. The participants were lacking knowledge, as they were not always aware about the educational campaigns that were happening around the campus.

5.2.3.2 Poor service delivery at on-site student health services

Dinkins (2011:2) as cited by Selenga & Jooste (2015:9) describes empathy as one of the essential foundations of ethical behaviour to other human beings. Furthermore, it can be challenging to understand one's need or to co-operate effectively without empathy, especially if you are dealing with the community. Hence the students were raising their concerns about the way the campus clinic is operating. They have reported that they are not accommodated in terms of discussing their health issues. Sometimes they would go to the clinic and do not report what they wanted to report because of the limited time they are given. They have also mentioned that they have put some suggestions in the suggestion box.

However, they feel that there is no anonymity as sometimes the suggestions are taken out and read whilst they are still there or in front of them. Some students reported that they do not feel comfortable discussing their health issues with older health care givers, as they get shouted at. Ham *et al.* (2015:27) revealed that health service centres are not addressing the STI issues enough, especially from the male perspective. Ham *et al.* (2015) added that they avoid examining them, although these students are unable to describe their symptoms correctly. Although students were unhappy, there were some students that reported positive experiences in respect of the treatment by the healthcare practitioners. They mentioned that when they visited the campus clinic, they have experienced respect, confidentiality and were given the information about health issues that they were seeking.

5.2.3.3 Health risks

The risky behaviours of students were quoted many times by all groups. Amongst these groups, there were some that were saying that they are new students at HEI, therefore they are not aware of what is fashionable around the campus. Some students acknowledged these reckless behaviours of the young people, hence they volunteer to assist as peer educators in this HEI. They continue to emphasise that the information is accessible, the

problem is still the application. UNAIDS Global update (2016:8) revealed that harmful gender norms and inequality, poverty, violence and food insecurity, are some of the root problems of sexual risks amongst young women and adolescent girls. According to the South African Department of Social Development as cited by HEAIDS (2017:50) people who use substances are suffering from serious health and socio-economic difficulties. They added saying that in South Africa, young people aged 15 and older, consumed more alcohol than in any other African countries. This leaves the students in vulnerable spaces. Furthermore, experimentation, boredom, peer pressure, lack of recreational facilities and poverty were repeatedly mentioned as contributing factors. Spending time with people who are substance abusers, can lead students to the same behaviour. Whitehill *et al.* (2014), add that the use of marijuana and cannabis also influenced underage college students negatively. They further stated that these substances are common, and they can lead to fatal accidents amongst these young people.

5.2.3.4 Health service referrals

Health service referrals, bookings and emergencies were reported as problems by students who participated in FGDs. The groups did not seem to understand how these three processes are taking place. Students did not understand that the referral system can only be done by a doctor. Emergencies at the clinic depend on the severity of the problem. These students also revealed that they prefer younger healthcare workers, as it was easier to talk with them and to relate to them. They continued to mention that older healthcare practitioners shout at them and this does not make it easier to speak out or to seek help. Some participants described their experiences as painful as the booking and the referral systems are a serious concern to them and could be harmful to their academic life. According to Pich, Hazelton, Sundin and Kable (2010:270) as cited by Selenga and Jooste (2015:10), the long wait in the clinics make the patients very frustrated as they do not understand the reasons. However, Selenga and Jooste (2015) recommend a patient-centred communication between the nurses and the patients, as this will produce a confident outcome for both parties. The SCT discusses the relationship between people, their behaviour and the environment, as some of people normalise their behaviour through aggressiveness and strength in order to achieve certain behaviours (Bandura, 1989). This study focused on exploring the enthusiasm and interaction between the students and risky behaviours they acquire through observing others when they are in their environment.

5.2.3.5 Stigma and judgement

Stigma was reported by students as a stumbling block towards many health activities at the HEI. Brown *et al.* (2012:28) describe stigma as the very significant negative feelings that are linked to someone or a group of people. Some participants informed the researcher that if you are attending the campus health service, there will be suspicious remarks or comments made that will follow you and harm your reputation. Ham *et al.* (2015:27) state that the healthcare providers show negative attitudes towards young men who complain about STIs. These kinds of behaviour are encouraging stigma and uncertainties amongst the students and it is the reason why they stay away from campus activities. Robbins, Lauver, Le, Davis, Langley and Carlstrom (2004:267) as cited by Bowman and Denson (2014:125) state that health still needs a collective action so that people can change their behaviour and try to overcome the obstacles. The students also revealed that although so much has been done to educate communities, there are still a lot more strategies that need

to be implemented to fight stigma against health issues. Setswe *et al.* (2017) discovered that there are large numbers of students and staff members from TVET colleges in South Africa who have positive attitudes towards people living with HIV.

However, there are some students and some staff members in these colleges who are still refusing to be connected with PLHIV. These groups do not want to share anything with people that are infected with HIV. They are complaining about the fact that HIV positive people are immoral. Furthermore, it was revealed that they do not want to share accommodation and socialise with them. In contrast, the ecological model (Svanemyr *et al.*, 2015:S8) speaks about approaches that can enable the environment in our communities. These approaches include the building of healthy relationships by supporting and strengthening a positive attitude in the relationships instead of judging others. Furthermore, communities could assist to create positive social norms (Svanemyr *et al.*, 2015:S8). The HBM modifying factors in the course of seeking health behaviour involves social stigmas and limited resources. These factors could influence the perceptions of social barriers, bringing uncertainties of not knowing how one would be treated (Wirtz *et al.*, 2014). However, Sallar (2009:3) said that in regions where there is financial steadiness and all-inclusive implementation of sex education policies, students tend to tolerate each other.

5.3 SUMMARY

This chapter discussed the findings of the study. The findings were compared with the literature which was reviewed, as well as the theoretical framework, according to the objectives of the study. The following chapter (6), will discuss conclusions, limitations, recommendations, as well as future research and benefits.

CHAPTER 6

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

The aim of this study was to investigate potential health risk factors amongst students at an Higher Education Institution (HEI) in the Western Cape with regard to sexuality and HIV/AIDS.

The objectives of the research were to:

- Explore the factors that may increase health risk behaviours amongst students at an HEI.
- Explore and describe knowledge of university students regarding potential health risks related to sexuality and HIV/AIDS.
- Explore attitudes students have towards health risk behaviours, regarding HIV/AIDS and other sexuality- related behaviours.

Chapter one gave an overview of the research study. A comprehensive literature review relevant to the study was discussed in Chapter Two. Chapter Three discussed the research design and methodology. Results were presented in Chapter Four. In Chapter Five, the results were discussed. In this final chapter, conclusions, limitations and recommendations will be discussed.

6.2 CONCLUSIONS

6.2.1 Objective One

The first objective was “To explore the factors that may increase health risk behaviours amongst students at an HEI”. From the findings of the research, the following factors challenged the students who were participants:

- The participants found the new-found freedom of being away from home. This new freedom offers great prospects experimenting in high-risk behaviours without restrictions.
- The transitional phase of the participants at HEI displayed reckless behaviours. The students are exploring sex, alcohol and drugs.
- Alcohol and drugs are on the rise amongst university students. They consumed more than the limits and it has led them to serious social harms, including impeding their future plans.
- Peer pressure contributed to the vulnerability of the participants, as they succumbed to risky behaviours with their peers.
- Multiple sexual partners were another factor that was contributing to the vulnerability to STIs, because of the coinciding relationships of the participants.
- The participants were exposed to one-night sexual rendezvous unexpectedly, due to boredom, alcohol and drugs.
- When they arrived at the HEI, some of them were sexually active already.

- Transactional sex was another factor that exposes participants to health risk behaviours. It is encouraged by poverty and longing for social status.
- The students did not see anything wrong with unprotected sex. They were saying that protected sex was boring and was out-of-date.
- The participants were blaming the lack of communication with their parents.
- Knowing the status of a sexual partner was not a concern to the participants.
- The socio-economic backgrounds were other factors that led the participants to transactional sex.

The Health Belief Model (HBM) and the Social Cognitive Theory (SCT) were used to demonstrate health promoting behaviours, as well as the significance of observational and self-regulated learning behaviours of the students. Both these theories focus on health seeking behaviours and health outcomes. In this study, the HBM as well as SCT, were applied in this study to investigate the factors associated with potential health risk behaviours amongst university students. The HBM has been used to foresee preventative health behaviours and it has worked for sexual behaviours, respectively. In this research, the students showed so many factors that led them to high-risk behaviours. The HBM examines if the students would take the related action, if they feel that a negative action can be avoided. However, it is necessary to help these students to realise that they have the potential to avoid these high-risk behaviours. This can only happen when the students have a true knowledge of these factors that led them to such behaviours. Then only will they be able to take preventative action (Tarkang & Zotor, 2015).

Social Cognitive Theory (SCT) goes into detail on the relationship between the students, their behaviours and their environment, in this instance, the HEI which they find themselves in. Knowledge, attitudes and the beliefs of the students were explored in this study. The students need to realise and be sensitised to these factors, in order for them to apply the preventative approaches and actions (Bandura, 1986;1989:5).

6.2.2 Objective Two

The second objective was “To explore and describe knowledge of university students regarding potential health risks related to sexuality and HIV/AIDS”. From the findings:

- The participants were ignorant with regard to potential health risks and they showed no interest in campus activities.
- The participants still believed in misconceptions and they would go and practice these misconceptions after sharing them with their peers.
- The participants acknowledged that they needed more information with regards to sexuality and HIV/AIDS.
- Sexual education was needed in faculties according to the students, they suggested FGDs, dialogues, fun educational activities and flexible approaches.
- The participants acknowledged that uninformed decisions were influenced by peer pressure, alcohol and drugs. The participant’s decisions were based on wanting recognition from fellow students.
- Although HIV/AIDS information was available at this HEI, partner testing was not discussed in the sexual relationships. Students declared that it remained a sensitive issue.
- The students recognised that teen pregnancy rates were still high at HEIs as a result of unprotected sex.

- The students had a number of justifications not to use the condoms, namely inconvenience, negative impressions on their sexual relationships and that it was boring.

The foundation of the HBM and the SCT theories are that actions are based on a student's intentions and behaviours. According to the results, the students had the knowledge with regard to potential health risks. However, the knowledge was not accurate, as it was coming from peers and was related to misconceptions. The students were ignorant because of the lack of correct knowledge. Svanemyr et al. (2015:88) claim that students who are involved in high-risk situations should have the ability to control the high-risk behaviours if they are equipped with necessary resources, skills and knowledge. They further state that when students recognise resources and opportunities, their behaviour will be redirected towards opportunities, instead of risky behaviours. The HBM cues to action require motivation from the students to conform to the prescribed remedy, be it to be involved in health education activities or peer support (Tarkang & Zotor, 2015). These students have suggested strategic approaches in order to equip them to deal with high-risk behaviours. This is an indication that they are determined to change their behaviour, if resources and support were made available to them.

6.2.3 Objective Three

The third objective was "To explore attitudes students have towards health risk behaviours, regarding HIV/AIDS and other sexuality-related behaviours". With regards to attitudes, these are the findings:

- The students did not show an interest in activities that are happening around the campus; not because they did not want to, but they did not understand the purpose of the HIV/AIDS awareness campaigns on campus.
- The students did not understand the standard operating procedures of the campus clinic. Hence, they were complaining about the poor service delivery at the on-site student health services.
- The students still think that they are not high-risk because they are new comers and they do not know what is happening around the university. Some students were aware that young people are more vulnerable, than any other people. However, there were students in the groups that were more involved in activities that were happening on the two campuses.
- The students did not understand that the referral system can only be done by a doctor. Emergencies at the clinic depend on the severity of the problems.

Some participants were guilty of stigmatisation and were judgemental towards their fellow colleagues, when they attend the campus clinic. The students who were peer educators, were also labelled when they were doing the educational talks. According to Skinner *et al.* (2015:75), the HBM has been one of the most widely used conceptual frameworks in health behaviour research to explain changes of health-related behaviour and as a guiding framework for intervention. This is done by focusing on the attitude, knowledge and beliefs of individuals. The students displayed negative attitudes towards the activities that were happening around the campus. The foundation of these attitudes was the lack of knowledge that led them to ignorance. When health behaviour is addressed, students need support and encouragement without judgement. Ham *et al.* (2015:27) state that healthcare providers show negative attitudes towards these young students who complain about STIs and who visit the campus clinics. This behaviour is

encouraging stigma and uncertainties amongst the students. This is the reason they stay away from campus activities. Robbins, Lauver, Le, Davis, Langley and Carlstrom (2004:267) as cited by Bowman & Denson (2014:125) state that the health of students still needs a collective action, so that they can change their behaviour and try to overcome the obstacles. Anecdotal evidence by a peer educator during a discussion group, revealed that after having undergone all the training as a peer educator on the campus, he stopped “beating the hell out of his partner” when she refused to give him sex (Vember, 2013). Navarro-Cremades *et al.* (2016:9), agree by stating that even the universities should not solely depend on education for the sexual issues amongst the students, but that more collective efforts by all stakeholders on HEIs should take responsibility to engage with students around all these issues related to sexuality and HIV/AIDS and other high-risk behaviours. This will also combat the stigma that is still rife on these two campuses.

6.3 LIMITATIONS

The results of this study were limited to the experiences of the students who attended the FGDs from the two main campuses only, while the university has six campuses. The nature of the study was sensitive, as the researcher needed students that were willing to talk in group sessions about their risky sexual behaviours. This was a limitation, as some students who could contribute more, were not willing to engage openly. It was also challenging to find a common space and time, where students were free to meet for the discussion groups, so as not to disrupt their classes too much.

6.4 BENEFITS OF THE FINDINGS TO THE HEI AND TO STUDENTS

6.4.1 Higher Education Institutions

The results of this study will assist the management of the HEIs to implement interventions that are necessary and relevant to support the students and the staff regarding sexuality issues. For example, more support staff and services need to be made available for students. The results could assist in integrating HIV/AIDS into the curricula across all the faculties.

6.4.2 Students

The students would not benefit themselves only, but their fellow students, work colleagues, families and their communities at large, would also benefit, as they would be able to impart their informed knowledge gained. The students would be able to initiate more recreational activities. Older females could mentor younger females and the same with males. Buddy systems could be formed in order for the younger students to have a role-model that she/he could look up to for correct advice and leadership. The students would be able to come up with ground-breaking ideas to overcome poverty and empower each other with social and life skills.

6.5 RECOMMENDATIONS OF THE STUDY

The students who participated in this research, perceived themselves as a high-risk population because of their reckless behaviour regarding their sexuality, therefore it was recommended that:

- There should be organised, measured approaches to expose both lecturers and the students in HIV/AIDS education through integrated curriculum design.
- The students should be exposed to formal life skills and assignments on the basics of HIV, health issues and behaviours, involving topics like alcohol abuse, sexuality and sexual relationships across all faculties.
- There should be teamwork between lecturers, support staff and students to create powerful discussions and exchange of ideas to clarify HIV/AIDS, sexuality issues and other related topics to reduce high-risk behaviours and promote the sustainability of educational and awareness programmes amongst the university community.
- Suggestions from students for recreational time and types of activities, especially for afternoons and weekends, when the students are not in classes, should be taken up by the various university structures.
- Financial aid should be provided and supervised in order for student structures to apply it meaningfully.
- Introduce programmes on self-esteem that will boost the student's confidence; being in charge of their sexual life when they decide to be sexually active.
- Strengthen the existing structures of peer educators and strategic messaging, awareness campaigns and continuous orientation of support departments via mass SMS's or students' email addresses.

It is recommended that the universities address the hurtful gender norms and violence against women. This could be done by involving and mobilising all male students, male lecturers and community leaders to participate actively in mass media campaigns. By involving males, it will promote mutual respect in their sexual relationships, in families and in communities.

6.6 AREAS FOR FURTHER RESEARCH

Further research needs to be done to understand the degree to which peer pressure influences the sexual risk-taking behaviour amongst the students in HEIs. Furthermore, programmes that aim to prevent high sexual risk at HEIs should be structured in various cultural and socio-economic contexts.

6.7 CONCLUSION

The purpose of the research was to explore potential health risk factors amongst students at HEIs with regard to HIV/AIDS and sexuality. The aim and the objectives of the study have been met. Many students are sexually active at an early age and mature faster. The

lifetime and current prevalence of sexual contact amongst them, need a diplomatic strategy to change high-risk behaviours into more functional and improved behaviours in order to prevent STIs and HIV/AIDS amongst these students. There is a necessity for continual discussions and empowerment on sexual matters at HEIs, so that the misconceptions, lack of knowledge and attitudes are dealt with. As Navarro-Cremades *et al.* (2016:9) suggested, the university curriculum should include specific programmes about sexuality and issues around it, so that the students get appropriate and relevant information. The hope is for these students to be able to apply and transfer the information to families, communities and at their work.

REFERENCES

- Abbasi-Ghahramanloo, A., Fotouhi, A., Zeraati, H. and Rahim-Movaghar, A., 2015. Prescription drugs, alcohol and illicit substance use and their correlations among Medical Sciences Students in Iran. *International Journal of High Risk Behaviors and Addiction*, 4(1):e21945. DOI:10.5812/ijhrba.21945.
- Allison, R. and Risman, B. J., 2014. "It Goes Hand in Hand with the Parties": Race, Class and Residence in College Student Negotiation of Hooking Up. *Social Perspectives*, 57(1), pp.102-123. <http://www.jstor.org/stable/44289988>. (Access on 30 Jun18).
- Asante, K. O., Boafo, I. M., and Nyamekye, M., 2014. Identifying gender differences in Ghanaian university students' sexual practices, attitudes and knowledge regarding HIV. *Journal of Psychology*, 5(1), pp.: 9-18 (2014). (Accessed 19 July 2016).
- Bandura, A., 1986. *Social Foundations of Thought and Action: A cognitive Theory*. Englewood Cliffs: Prentice Hall.
- Bandura, A., 1988. Organisational application of social cognitive theory. *Australian Journal of Management*, 13(2): 275-305.
- Bandura, A., 1989. Social cognitive theory. In: Vasta, R. ed. *Annals of Child Development*. 6: 1-60. Pennsylvania:Jessica Kingsley Publishers.
- Bawa, K., 2018. Lack of honesty a let-down: Shifting views on sex in schools crucial. *Cape Times*: 18 Apr. 18. (No indication of author. The article appeared on page 6 of the Cape Times, 18 Apr issue).
- Bazeley, P., 2013. *Qualitative Data Analysis, Practical Strategies*, London: Sage.
- Blignaut, R. J., Jacobs, J. and Verganani, T., 2015. Trends in HIV risk behaviour of incoming first year students at a South African university: 2007-2012. *Journal of Social Aspects of HIV/AIDS*, 12(1), pp.39-50. (Accessed 19 July 2016).
- Bowman, N. A. and Denson, N., 2014. A Missing Piece of the Departure Puzzle: Student-Institution Fit and Intent to Persist. *Research in Higher Education*, 55 (2), AIR Forum Issue (March 2014), pp.123-142. (<http://www.jstor.org/stable/24571782>). (Accessed 30Jun18).
- Brook, Heather, *et al.* (Ed) 2014. "Introduction." *Universities in Transition: Foregrounding Social Contexts of Knowledge in the First Year Experience*, University of Adelaide Press, South Australia, 2014, pp. 1–10. *JSTOR*, www.jstor.org/stable/10.20851/j.ctt1t304xh.4.
- Brown, B., Duby, Z. and Bekker, L.G., 2012. People who inject drugs & other people who use drugs. *An Introductory Manual for Health Care Workers in South Africa*.
- Burns, N. and Grove, S. K., 2007. *Understanding Nursing Research*. 4th Ed. St. Louis, Missouri: Elsevier Saunders.

Burns, N. and Grove, S. K., 2011. Understanding Nursing Research. 5th Ed. Maryland Heights: *Elsevier Saunders*.

Cape Peninsula University of Technology website, 2015 www.cput.ac.za (accessed October 2016).

Cape Peninsula University of Technology website, 2016. www.cput.ac.za (accessed October 2016).

Cassidy, C., Curran, J., Steenbeek, A. and Langille, D., 2015. University Students' Sexual Health Knowledge: A scoping Literature Review. *Canadian Journal of Nursing Research*, 47(3), pp.18-38. (Accessed on 19 July 2016).

Center for Disease Control, Department of Health, Executive Yuan of Taiwan (CDC Taiwan). 2013. Statistics of HIV/AIDS: Monthly report. Retrieved from <http://www.cdc.gov.tw/info.aspx?treeid=1f07e8862ba550cf&nowtreeid=6c5ea6d932836f&tid=58114AFB86117F53>.

Centres for Disease Control 2007-2010., 2012. Estimated HIV incidence in the United States. *HIV Surveillance Supplemental Report*, 17(4). <http://go.usa.gov/p8P4>. (Accessed Nov 2015).

Centre for Sexualities, AIDS and Gender., 2016. Integrating HIV and AIDS into the curriculum at the University of Pretoria: Time for transformation?. *Pretoria: Centre for Sexualities, AIDS and Gender*, University of Pretoria.

Chandra-Mouli, V., Svanemyr, J., Amin, A., Fogstad, H., Say, L, Girard, F. and Temmerman, M., 2015. Twenty Years After International Conference on Population and Development: Where Are We With Adolescent Sexual and Reproductive Health and Rights. *Journal of Adolescent Health*, 56(2015) S1-S6.

Cieslik, M. and Simpson, D., 2013. Key Concepts in Youth Studies. London: *Sage Publication*.

Clinical Research Education and Development (CREDE). <http://phrp-nihtraining.com/users/login.php> NIH-Protection of Human research Participants. (Accessed May 2016).

Clow, E. and James, K.E. 2014. The Marketing Research Process. In: *Essentials of Marketing Research: Putting Research into Practice*. Thousand Oaks: Sage Publication.

Coulson, N., Goldstein, S. and Ntuli, A., 1998. Promoting Health in South Africa: An Action Manual. Sandton: Heinemann Higher and Further Education (Pty) Ltd.

Denno, D.M., Hoopes, A. J. and Chandra-Mouli, V., 2014. Effective Strategies to Provide Adolescent Sexual and Reproductive Health Services and to Increase Demand and Community Support. *Journal of Adolescent Health*. <http://www.jahonline.org>.

Denzin, N. K. and Lincoln, Y. S., 2018. The SAGE Handbook of Qualitative Research, 5th Edition, Thousand Oaks: Sage.

Eggers, S.M., Mathews, C., Aarø, L.E.,McClinton-Appolis, T., Bos, Arjan E. R, de Vries, H., 2016. Predicting Primary and Secondary Abstinence Among Adolescent Boys and Girls in the Western Cape, South Africa (<https://doi.org/10.1007/s10461-016-1438-2>).

Espejo, R., 2011. *Opposing Viewpoint Series: Sexually Transmitted Diseases*. Farmington Hills: Greenhaven Press.

Freitas, A., 2017. Beyond acceptance serving the needs of transgender students at Women's Colleges. *Humboldt Journal of Social Relations*, 39, pp. 294-314. (<http://www.jstor.org/stable/90007886>) (Accessed 18Jun 18).

Global AIDS Update., 2016.

http://www.unaids.org/sites/default/files/media_asset/global-AIDS-update-2016_en.pdf.

Global HIV &AIDS Statistics. 2017. Fact Sheet-World AIDS DAY 2018. (aidsinfo.unaids.org) (Accessed May 2019).

Goosen, G., 2013. Resources, needs and alcohol use among white female students at a South African University. *Histories of the Present Pres* . Some communities imagined (pp 1-18). Pretoria.

Green, J. and Thorogood, N., 2018, *Qualitative Methods for Health Research*, 4th Edition, London: Sage.

Grove, S. K., Burns, N. and Gray, J. R., 2013, *The practice of nursing research, appraisal, synthesis and generation of evidence*, *Elsiever Saunders*: St. Louis Missouri.

Ham, DC., Hariri, S., Kamb, M., Mark, J., Ilunga, R., Forhan, S., Likibi, M. and Lewis, DA., 2015. Quality of Sexually Transmitted Infection Case Management Services in Gauteng Province, South Africa: An evaluation of health providers' knowledge, attitudes and practices.

HEAIDS., 2010. *Communication strategy for the Higher Education HIV and AIDS Programme 2009 and beyond*. Pretoria: Higher Education South Africa.

HEAIDS, 2015. *Baseline/situational study: Towards understanding HIV and AIDS teaching and learning at TVET colleges*. Pretoria: Universities South Africa.

HEAIDS., 2017. *Student Guide: Road to your social, Mental and Physical wellbeing*. Bellville: CPUT.

HEAIDS., 2018. *First Thing First (HIV/STI/TB) CAMPAIGN*. Pretoria: South Africa.

Hedayati-Moghaddam, M. R., Eftekhazadeh-Mashhadi, I., Fathimoghadam, F. and Pourafzali, S. J., 2015. Sexual and reproductive behaviours among undergraduate university students in Mashhad, a City in Northeast of Iran. *Journal of Reproduction and Infertility*, 16(1), 43-8.

Hill, J., Draper, C. E., De Villiers, A., Fourie, J.M., Mohamed, S., Parker, W.A. and Steyn, N., 2015. Promoting healthy lifestyle behaviour through the life-orientation curriculum: Teachers' perception of the health kick intervention. *South African Journal of Education*, 35(1),1-09. (Accessed on the 11 May 2016).

Holloway, I and Galvin, K., 2017. *Qualitative Research in Nursing and Healthcare*, Fourth Edition, Wiley Blackwell: Chichester, West Sussex, UK.

Jette, A. M. 2017. Physical Therapy and the Global HIV/AIDS Pandemic, *Physical Therapy*, 97 (3), 273–274, (<https://doi.org/10.1093/ptj/pzx003>).

Johnson, Leigh, *et al.* 2014. "THEMBISA version 1.0: A model for evaluating the impact of HIV/AIDS in South Africa." *Cape Town: Centre for Infectious Disease Epidemiology and Research working paper, University of Cape Town (2014).Emerging Johannesburg (2014): 185.*

Johnson, D.R Timothy H. Wasserman, Nilay Yildirim and Barbara A. Yonai
Source: *Research in Higher Education*, Vol. 55, No. 1 (FEBRUARY 2014), pp. 75-100.
Published by: Springer (Stable URL: <http://www.jstor.org/stable/24571753>)

Jooste, K. 2018, *The principle and practice of nursing and health care, Ethos and professional practice, management, staff development and research*, 2nd edition, Pretoria: Van Schaik publishers.

Kambole. M. M. 2007. *The attitudes of Physiotherapist in Gaborone and Ramotwa towards treating people living with HIV/AIDS.*

Kelly, M. J. 2001. *Challenging the challenger. Understanding and Expanding the Response of Universities in Africa to HIV/AIDS.* Washington, DC: The World Bank for the ADEA Working Group on Higher Education.

Khuzwayo, Nelisiwe, & Taylor, Myra. (2018). Exploring the socio-ecological levels for prevention of sexual risk behaviours of the youth in uMgungundlovu District Municipality, KwaZulu-Natal. *African Journal of Primary Health Care & Family Medicine* , 10(1), 1-8. <https://dx.doi.org/10.4102/phcfm.v10i1.1590>.

Kortenbout, W.; Mtshali, N.; van Dyk, A. C.; Van Wyk, N. C.; Basson, P. M.; Leech, R.; and Mchunu, G. 2009. *Communicable Diseases in Southern Africa.* Pinelands: Pearson Education.

Kronefield, J. J. and Glik, D. C. 1991. Perceptions of risk: Its applicability in medical sociological research, *Research in the Sociology of Health Care*, 9, 307-334.

Kuete, M., Huang, Q., Rashid, A., Ma, X. L., Yuan, H., Escalera Antezana, J. P. Zhang, H. 2016. Differences in Knowledge, Attitude, and Behavior towards HIV/AIDS and Sexually Transmitted Infections between Sexually Active Foreign and Chinese Medical Students. *BioMed research international*, 2016, 4524862. doi:10.1155/2016/4524862.

Majelantle RG, Keetile M, Bainame K, Nkawana P. 2014. Knowledge, Opinions and attitudes towards HIV and AIDS among Youth in Botswana. *J Glob Econ* 2: 108. doi:10.4172/economics.1000108.

- Maree, K. (Ed) 2016. First Steps in Research. 2nd Ed. Pretoria: Van Schaik Publishers.
- Mbatha, M. and Ally, Y. (Ed) 2013. Some communities imagined. Pretoria: Eduard Fourie & Martin TerreBlanche.
- Mengistie, Z.; Wolie, E.; Abawa, E.; Ebre, E.; Adera, A. 2015. Knowledge Attitude and Practice Towards Premarital Sex and HIV/AIDS among Mizan-Tepi University Students, South West Ethiopia. *Science Journal of Public Health*, 3 (4), 592-599. doi:10.11648/j.sjph.20150304.30.
- Mikhail, B. I. 2001. Transcultural adaptation, Health Belief Model Scales, *Journal of Nursing Scholarship*, 33(2), 159-165.
- Min-Chen, M.; Liao, Y.; Liu, J.; Fang, N.; Hong, N.; Ye, X.; Li, J.; Tang, Q.; Pan, W. and Liao, W. 2016. Comparison of Sexual Knowledge, attitude and Behavior between Female Chinese College Students from Urban Areas and Rural Areas: A Hidden Challenge for HIV/AIDS control in China. (<http://dx.doi.org/10.1155/2016/8175921>).
- Minugh, P.A.; Rice, C. and Young, L. 1998. Gender, Health Beliefs, Health Behaviors and Alcohol Consumption, *The American Journal of Drug and Alcohol Abuse*, 24:3, 483-497, DOI:10.3109/00952999809016911.
- Mohan, V. 2013, *Understanding Nursing Research*, Random Publications: New Delhi (India).
- Mostafa, R. 2015. HIV/AIDS, Translation Researches, Ed, New York: Hayle Medical publishers.
- Motsoaledi, A. 2018. *Infections in youth soar: Plea to raise HIV awareness in schools*. Cape Times: 18, Jul. 18. (Author indicated.).
- Mulaudzi, F. M.; Mokoena, J. D.; Troskie, R. 2010. *Basic Nursing Ethics in Practice*. Sandton: Heinemann Publishers.
- Myers, L.; Kelly, K. and Motuba, T. 2012. An 'appreciative inquiry' into the DramaAidE Health Promoters project. Cape Town: Candre.
- National Strategic Plan for HIV and AIDS, STI's and TB, 2012-2016. Draft zero for consultation. August, 2011. <http://www.ecdoh.gov.za/uploads/files/170307131246.pdf>.
- National Strategic Plan for HIV and AIDS, TB and STI's. 2017 -2022. Let Our Actions Count. (<http://sanac.org.za/download-the-full-version-of-the-national-strategic-plan-for-hiv-tb-stis-2017-2022-2/>).
- Navarro-Cremades F, Palazón-Bru A, Marhuenda-Amorós D, Tomás-Rodríguez MI, Antón-Ruiz F, Belda-Ibañez J, Montejo ÁL, Gil-Guillén VF. 2016. Sexual behaviour and risk of sexually transmitted infections in young female healthcare students in Spain. *PeerJ* 4:e1699 <https://doi.org/10.7717/peerj.1699>.

Ng'ang'a, Z. W., Ochanda, A., Imbuga, M., Lang'at-Thoruwa', C., Ngumi, V., Monda, E., Mwangi, M. and Xia, X., 2015. Biological sciences and HIV and AIDS Integration Module (Kenya). (Accessed 15 May 2016).

Ngidi, N. D.; Moyo, S.; Zulu, T.; Adam, J. K. and Naidu Krishna, S.B. 2016. Qualitative evaluation of selected social factors that impact sexual risk-taking behaviour among African students in Kwazulu-Natal, South Africa, SAHARA-J: *Journal of Social Aspects of HIV/AIDS*, 13 (1), 96-105. DOI:10.1080/17290376.2016.1218792. (<http://dx.doi.org/10.1080/17290376.2016.1218792>).

Nzimande, B.E. 2014. Minister of Higher Education and Training. State of the Nation Address Debate. (Online). 18 Feb. Parliament, Cape Town. <https://www.gov.za/speech-delivered-minister-higher-education-and-training-dr-be-nzimande-mp-debate-state-nation>. (Access on 18 Aug 18).

Papanikitas, A. 2013. Medical Ethics and Sociology. (2nd Ed) London: Mosby Elsevier.

Patton, M. Q. 2015, Qualitative Research & Evaluation Methods, Fourth Edition, Sage Publications: Thousand Oaks.

Pera, S. and van Tonder, S. 2011. Ethics in Healthcare. Lansdowne: Juta and Company Ltd.

Platten, M., Pham, H. N. and Nguyen, H. V. 2014. Knowledge of HIV and factors associated with attitudes towards HIV among final-year medical students at Hanoi medical university in Vietnam. BMC public health, 14(1), p.1. (Accessed on 10 Feb 2016).

Polit, D. F. and Hungler, B. P. 1999. Nursing research: Principles and Methods, 6th Ed, Philadelphia: Lippincott.

Polit, D.F. and Beck, C.T. 2012, Nursing Research, Generating and Assessing Evidence for Nursing Practice (9th Ed). Wolter Kluwer/ Lippincott Williams & Wilkins.

Polit, D.F. and Beck, C. T. 2017, Nursing Research, Generating and Assessing Evidence for Nursing Practice (10th Ed). China: Wolters Kluwer.

Remenyi, D. 2013. Field Methods for Academic Research- Interviews, Focus Group and Questionnaires in Business and Management Studies. United Kingdom: Academic Conferences and Publishing International.

Reynolds Z, Gottert A, Luben E, Mamba B, Shabangu P, Dlamini N, et al. (2018) Who are the male partners of adolescent girls and young women in Swaziland? Analysis of survey data from community venues across 19 DREAMS districts. PLoS ONE 13(9): e0203208. <https://doi.org/10.1371/journal.pone.0203208>.

Rule, P. and John, V. 2011. Your guide to Case Study Research. Pretoria: Van Schaik Publishers.

Sandelowski, M. 2000. Focus on Research Methods. Whatever Happened to Qualitative Description? *Research in Nursing & Health*, 2000, 23, 334-340. ([https://doi.org/10.1002/1098-240x\(200008\)23:334::AID-NUR9>3.0.CO;2-G](https://doi.org/10.1002/1098-240x(200008)23:334::AID-NUR9>3.0.CO;2-G).)

Sallar, A. M. 2009. Correlates misconceptions in HIV knowledge and attitude towards people living with HIV/AIDS among in-school and out-school adolescents in Ghana. *African Health Sciences*. Volume 9, Issues 2: 82-91.

Salati. 2004. The knowledge and attitudes of Physiotherapists towards patients with HIV/AIDS in the Lusaka Province, Zambia.

Saldana, J. 2016, *The Coding Manual for Qualitative Researchers*, London: Sage.

Schwandt, A. T. 2015. *Dictionary of Qualitative Inquiry*. 4th ed. Thousand Oaks: Sage Publication.

Selenga, M. and Jooste, K., 2015. The experience of youth victims of physical violence attending a community health centre: a phenomenological study. *Africa Journal of Nursing and Midwifery*. Volume 17, Issues 1: 29-42. <http://hdl.handle.net/10520/EIC186372>.

Seloilwe, E. S.; Magow, M. M.; Dithole, K. L. and Lawrence, J. S., 2015. Parent and youth communication patterns on HIV and AIDS, STIs and sexual matters: Opportunities and challenges. *Journal of Child and Adolescent Behaviour*. 3 (3), 203. doi:10, 4172/2375-4494.1000203.

Setswe, G.; Mbelle, N.; Mthembu, J.; Mabaso, M.; Sifunda, S. and Maduna, V. 2017. HIV Knowledge, attitudes and behaviours: The situation at Technical Vocational Education and Training (TVET) colleges in South Africa. (<http://www.hsrc.ac.za>).

Shefer, T.; Kruger, L.; Macleod, C.; Baxen, J. and Vincent, L. 2015. "...a huge monster that should be feared and not done: Lessons learned in sexuality education classes in South Africa. *African Safety Promotion: A Journal of injury and Violence Prevention*. 13 (1): 71-87. (Accessed on the 11 Mar 2016).

Sidani, S. 2015, *Health Intervention Research, Understanding Research Design & Methods*, Sage Publication: Thousand Oaks.

Silverman, D. 2013. *Doing Qualitative Research*. (4th Ed), London: Sage.

Silverman, D. 2014. *Interpreting Qualitative Data*. Thousand Oaks: Sage.

Skinner, C. S.; Tiro, J. and Champion, V. L. 2015. Background on the Health Belief Model. *Health Behavior: Theory, Research and Practice*, p.75.

Slavin, R. E. (2012). *Educational psychology: theory and practice*. New York: Pearson.

Snider, S. 2014. U.S. news and world report. (Available Online): www.usnews.com/education/best-colleges/paying-for-college/articles/2014/09/08/3. (Accessed on the 20 March 2016).

Status Update. 2018. An HIV/AIDS Unit Initiative. Cape Peninsula University of Technology.

Steinberg, L. 2008. A Social Neuroscience Perspective on Adolescent Risk-Taking. *PMC: Dev Rev.* 28(1): 78-106. doi:10.1016/j.dr.2007.08.003.

Streubert, H. J. and Carpenter, D. R. 2011. *Qualitative Research in Nursing*. China: Wolters Kluwer Health Lippincott Williams and Wilkins.

Stewart, D.W and Shamdasani P.N. (2015) *Focus Groups Theory and Practice*, Third Edition, Sage Publication, Thousand Oaks.

Svanemyr, J.; Amin, A.; Robles, O.J. and Greene, M. E. 2015. *Creating an Enabling Environment for Adolescent Sexual and Reproductive Health: A Framework and Promising Approaches*. (<http://www.jahonline.org>).

Swaziland central Statistical Office and Macro International Inc. 2008. *Swaziland Demographic and Health Survey*. Mbabane: Swaziland Central Statistical Office and Macro International Inc.

Tarkang, E. E. and Zotor, F. B. 2015. Application of the Health Belief Model (HBM) in HIV Prevention: A Literature Review. *Central African Journal of Public Health*. Volume 1. Issue 1: 1-8. Doi: 10.11648/j.cajph.20150101.11.

Tretyakova, N.V.; Fedorov, V.A.; Dorozhkin, E. M.; Komarova, M. K. and Sukhanova, E. I. 2016. Student Readiness Formation for Activities Oriented to Health saving. *International Journal of Environment & Science Education*. 11 (15) 8281-8292.

Tung, W.; Ding, K. and Farmer, S. 2008. Knowledge, attitudes and behaviors related to HIV and AIDS among college students in Taiwan. *Journal of the Association of Nurses in AIDS Care*. 19 (5) 397-408. (Accessed 20 June 2016).

United Nations AIDS (UNAIDS). 2012. Report on the Global AIDS epidemic. http://www.unaids.org/sites/default/files/media_asset/JC2434_WorldAIDSday_results_en_1.pdf. (Accessed on 10 August 2016).

Tung, W.; Daniel M.; Cook, D. M.; Lu, M and Ding, K. 2015. A Comparison of HIV Knowledge, Attitudes and Sources of STI Information Between Female and Male College Students in Taiwan, *Health Care for Women International*, 36:8, 870-882, DOI:10.1080/07399332.2014.962136.

Turnbull, T.; van Schaik, P. and van Wersch, A. 2016. Sexual knowledge, contraception and assessing contraceptive methods among university students. *Health Psychology Update*, 25(1), 13-19.

United Nations AIDS (UNAIDS). 2012. Report on the Global AIDS epidemic. Available on http://www.unaids.org/sites/default/files/media_asset/JC2434_WorldAIDSday_results_en_1.pdf. (Accessed on 10 August 2016).

United Nations AIDS (UNAIDS). 2013. Report on the Global AIDS epidemic. (Available: http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Global_Report_2013_en_1.pdf). (Accessed on the 10 August 2016).

UNAIDS. (2013b). Global report: UNAIDS report on the global AIDS epidemic 2013. Geneva: United Nations Programme on HIV/AIDS.

United Nations AIDS (UNAIDS). 2014. The Gap Report 2014. Available on http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf. (Accessed on 10 August 2016).

United Nations AIDS (UNAIDS). 2016. Global AIDS update. Available on http://www.unaids.org/sites/default/files/media_asset/global-AIDS-update-2016_en.pdf. (Accessed on 10 August 2016).

Vember, H. F. 2010. Integration of HIV/AIDS into Higher Education curricula. Saarbrücken: Lambert Academic Publisher.

Vember, H. F. 2013. (PhD Thesis) An evaluation of the influence of an HIV/AIDS peer education programme at a higher education institution in the Western Cape. University of Stellenbosch.

Viljoen, L.; Thorne, M.; Thomas, A.; Bond, V.; Hoddinott, G. and on behalf of the HPTN 071 (PopART) team. 2016. A narrative analysis positioning HIV relative to personal (sexual) relationship challenges in an agony aunt column in the Western Cape, South Africa- aunty Mona's "love advice". *AIDS care*. 28(3) 83-89. DOI:10.1080/09540121.2016.1178957.

White, R. 2015. Academic Advising in Higher Education: A place at the core. *The Journal of General Education*. Volume 64. Issue 4: 263- 277. (<http://www.jstor.org/stable/10.5325/jgeneeduc.64.4.0263>) (Accessed 18 Jun 18).

Whitehill, J.M.; Rivara, F.P.; Moreno, M. A. 2014. Marijuana-Using Drivers, Alcohol-Using Drivers and Their Passengers: Prevalence and Risk Factors Among Underage College Students. 2013. *JAMA Pediatr*. 168(7)618-624. Doi:10.1001/jamapediatrics.2013.5300.

Wirtz, A. L.; Kamba, D.; Jumbe, V.; Trapence, G.; Gubin, R.; Umar, E.; Stromdahl, S.; Beyrer, C. and Baral, S. D. 2014. A qualitative assessment of health seeking practices among and provision practices for men who have sex with men in Malawi. *BMC*:doi: (10.1186/1472-698X-14-20).

Zimmerman, B. J. 1989. A social cognitive view of self-regulated academic learning. *Journal of Educational Psychology*. 81 (3) 329-339.

APPENDIX A: Research Information sheet and Informed consent

Title: Potential health risk factors amongst students at a Higher Education Institution (HEI) in the Western Cape with regard to sexuality and HIV/AIDS.

Principal Investigator: Nomzamo Peggy Tabata

E-mail: peggy.tabata@hotmail.co.za

Supervisor: Dr. Hilda F. Vember

E-mail: vemberh@cput.ac.za

Address: Faculty of Health and Wellness

Cape Peninsula University of technology

Nursing Department

Box 1906

Symphony way, Bellville 7535

South Africa

Contact number: 021 959 6911

Dear Participant

I am a postgraduate student at Cape Peninsula University of Technology. I am inviting you to participate in this research study, to identify the potential health risks factors in students at a Higher Education Institution (HEI) with regard to sexuality and HIV/AIDS. Please take as much time as you need to read the information presented to you. This information will explain the details of this study. It is very important that you clearly understand what the study entails, and you are welcome to ask me any questions that are related to this study. Your participation in this study is entirely voluntary. You are free to withdraw at any stage of the study, if you are uncomfortable.

What this research study is about

The aim of this research is to explore why students at an HEI indulge in health risk behaviours. This research is trying to explore the factors that may increase health risk behaviour and attitude in students at an HEI with regard to sexuality and HIV/AIDS.

Why you have been invited to participate

University students are a very important group in our communities. They are respected and viewed as future leaders. We cannot ignore the fact that university students have a social life. They are the most exposed group to sexuality issues and are proven by research to be the most vulnerable population to contract STI's and HIV/AIDS. That is why it is important to do this study, so that the researchers are able to identify these potential health risks factors. HIV positive students are also invited to participate, as an attempt is being made to assist them to live healthier lives and to reduce the risks of further infections. The research will be able to help to improve the quality and relevance of higher education policies regards to HIV/AIDS, STI and other health issues. Policy makers and educators may also take advantage of these insights to improve educational activities and communications

Will you benefit from taking part in this research?

The responses from participants will greatly add value to the research field of sexuality and HIV/AIDS issues in universities. You may also gain knowledge on how to reduce health

risk regarding sexuality, STI's and HIV/AIDS and how to change your behaviour and attitude regarding health risks.

Are there any risks involved in my taking part in this research?

The interviews will remain anonymous. The declaration form will be kept safe in a locked safe in the nursing department. If you feel any emotional discomfort because of the questions asked, you will be referred to the counselling unit of the university. You may also withdraw at any stage during the data collection phase, should you experience any degree of uncomfortability, with no negative consequences.

Will you be paid to take part in this study and are there any costs involved?

There will be no compensation offered to participate in this study and no direct cost to you.

DECLARATION BY PARTICIPANT:

I declare that:

I have read this information and consent form and that it is written in a language with which I am comfortable with and understand.

I was given a chance to ask questions and all my questions were sufficiently answered.

I understand that taking part in this study is voluntary and I have not been forced to take part.

I understand that I may withdraw from the study at any stage and I will not be penalized in any way.

I also consent that my information may be:

Used and kept for future research studies.....

used and discarded.....



Sign at.....On (date).....2017

Signature of participant..... Signature of witness.....

DECLARATION BY THE INVESTIGATOR

I, Nomzamo Peggy Tabata declares that, the information in this document has been explained to the participant.

I encouraged the participant to ask questions and provided adequate time to answer them.

I am satisfied that the participant adequately understands all aspects of the study, as discussed above.

Signed..... (Date).....2017

Signature of investigator.....Signature of witness.....

BRIEFING SHEET FOR INTERVIEW AND CONSENT TO AUDIO RECORD

It is highly appreciated that you are agreeing to take part in this interview. I am a student at the Cape Peninsula University of technology. I am doing Masters in Nursing Sciences. It is a requirement of my course to conduct a research study on identification of potential health risk factors in students at a higher education institution with regard to sexuality and HIV/AIDS. I have selected to conduct this study in this university.

Before we start, may I please have your permission to record our interview with an audio recorder? The recording will help me to remember the things we discussed, and your answers given. I will make a copy of this discussion available for you if you so wish to. If you are uncomfortable with the recording, I will respect that and only take notes during our discussion. Your personal details will not appear in any report and you will not be penalized if you are uncomfortable to answer any question, as it has been stated that the research is completely voluntary.

As we are going to start, our discussion will take 60 to 90 minutes of your time and you are welcome to stop the discussion any time if you are uncomfortable. At the end of our discussion I will transcribe your answers and send them to you, so that you can verify that it is a true reflection of your answers. If you are ready, we can start the interview.

I consent that the interview may be audio recorded:

Signed..... (Place).....On (date).....2017

Signature of participant.....

APPENDIX B: Permission approval letter



HIV/AIDS UNIT

Date: 20 January 2016

Dear Ms Peggy Tabata

Letter of support/approval to conduct a study through the HIV/AIDS Unit.

Study Title: "The identification of potential health risks factors in students at a higher education institution in the Western Cape with regard to sexuality and HIV/AIDS"

I hereby acknowledge your signed letter dated 28 August 2015 received 11 January 2016.

You are approved to conduct your study through the HIV/AIDS Unit pending receipt of your Research Proposal and CPUT Ethics approval. Kindly send us a copy as soon as you received approval.

I wish you all the best with your studies.

Regards



Melanie Marais
HIV/AIDS Coordinator

APPENDIX C: Request letter to conduct study

No 26 Shearer Green

Victoria Palms

Summer Greens

Milnerton

7441

28 August 2015

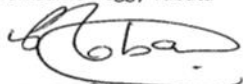
Dear Mrs. M. Marais

I am a master student who just registered with CPUT, under the supervision of Dr. Hilda Vember. I am doing masters in Nursing Sciences with the focus on social science. I am doing a project on "The identification of potential health risks factors in students at a higher education institution in the Western Cape with regard to sexuality and HIV/ AIDS". The project will take two years to finish. I will be doing interviews with students, it is a follow-up interview per student, and I will also be doing focus group discussions and everything will be confidential be it the focus group or individual interview. I would like to ask for permission, if I can do my research at CPUT.

Thank you

Kind Regards

Nomzamo Peggy Tabata



28 August 2015

APPENDIX D: Briefing sheet for interview and consent to audio record

Thank you very much for agreeing to participate in this interview. I am a Masters' in nursing student at the Cape Peninsula University of Technology. As part of my data collection, I will be conducting focus group interviews to identify HIV/AIDS risk factors and behaviour in students at a Higher Education Institution in the Western Cape.

Before we start, I would like your permission to record our discussion with an audio recorder. This recording will help me to remember the things we discussed, and your answers given. I will make a copy of the discussion for you if you want to have it. If you however, do not feel comfortable for your voice to be recorded, I will respect your wish and only take notes during our conversation. Your name will not appear in any recording or written report and you will not be punished if you do not feel comfortable to answer any question.

Our discussion will take 60 to 90 minutes and you can feel free to stop the discussion any time, if you feel uncomfortable. I will transcribe your responses at the end of our discussion and send it to you, for your verification that what is written is a true reflection of your answers. We can start the interview if you are ready.

I consent that the interview may be audio recorded:

Signed at (place).....On (date) 2017

Signature of participant.....

APPENDIX E: Letter from student counselling



Student Counselling Department

Date: 22 August 2016

Letter of support

Dear Madam

I hereby acknowledge your request for support from Student Counselling Department, CPUT. The Student Counselling department hereby agrees to provide a counselling service to students whom may feel emotional discomfort during the process of the research project: **Title: The identification of potential health risks factors in students at a Higher Education Institution (HEI) in the Western Cape with regard to sexuality, and HIV/AIDS.**

For any further request contact Student Counselling at ext 6513

Kind regards


Dr Charlene Petersen
Student Counselling

APPENDIX F: INTERVIEW GUIDE: Focus Group Discussion (FGD)

Title: Potential health risk factors amongst students at a Higher Education Institution (HEI) in the Western Cape with regard to sexuality and HIV/AIDS.

Principal Investigator: Nomzamo Peggy Tabata

E-mail: peggy.tabata@hotmail.co.za

Telephone number: 0742832612

Supervisor: Dr. Hilda Vember

Telephone number: 021 9596183

E-mail: vemberh@cput.ac.za

Address:

Faculty of Health and Wellness

Cape Peninsula University of technology

Post Nursing Department

Box 1906

Symphony way, Bellville 7535

South Africa

Thank you for agreeing to participate in this focus group which is my data collection tool for my research study, as indicated in the information sheet. Just a reminder, that I will need your written permission to audio record this discussion.

Aim

The aim of this study is to explore potential health risk factors amongst students at a Higher Education Institution (HEI) in the Western Cape with regard to sexuality and HIV/AIDS.

Could you please answer the following questions, to the best of your ability?

- What in your opinion are Sexually Transmitted Infections (STI's) and Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS)?
- Do you know what does the community think of people living with HIV/AIDS? And why?
- What is your role in the community with regards to HIV/AIDS?
- What do you understand by "health risks"?
- What do you think are the factors that may contribute to the increase of health risks to students at HEIs?
- Do you think students have enough knowledge regarding potential health risks relating to HIV/AIDS and other sexuality-related behaviours? Why?
- What are the attitudes that students at HEI's have towards health risks regarding HIV/AIDS and sexuality?
- What factors would influence young people to make informed decisions with regards to their sexuality and HIV/AIDS?
- Are you aware of the Institutional preventative strategies?
- What do you think of them?
- Do you think they are working?

- Do you have any suggestions how they can improve these strategies to minimise health risks?

Many thanks for your valuable input and participation in these discussions.

APPENDIX G1: Focus Group Discussion 2

Interview Date: 31 March 2017

Interview Type: Focus Group Discussion No 2

Audio Recording Length: 1:37:51

Interviewer Name: Peggy Tabata

Transcriber Name: Ntombomzi Mcanjana

Interview Language: English

Time of the interview: 14:00 p.m.

I= Interviewer

P= Participants

I would like to start by discussing in detail all these questions. Remember there is no right or wrong answer all I want is your opinion in each question. Please answer them to the best of your ability. My first question read as follows:

I: What is the perception of youth sexual health? Anyone can answer do not be shy anyone can start.

P: Can you please clarify what do you mean by perception?

I: To clarify that what do you think of sexual behaviour and the youth out there, what is your perception?

P: What I have notice is that today's youth are sexual active at a much younger age unlike before because you find that these kids that have sex at 12, 13, 14 years of age and you even get cases where a 12 year old child is pregnant with the child and you wonder how is she going to take care of the child because she is still a child. I think today's youth has been more reckless in terms of their conduct with respect to sex and whateverinaudible)

P: I would like to also add on that I feel like we brag about being sexual active I feel like it's a competition. You know back then it was more like an investment. These days it's like you are out of fashion, you not doing it so that is what I see.

P: As the first participant said, these past days I saw an article of a ten-year-old girl with a child, she is having a child and I was wondering a ten year old child with a child that means that the youth today is more reckless they just want to explore these things.

P: Yes I would also say that it is right people are reckless the way people are doing it the way they are reckless about it is not even try to be safelike the way to do it or whatever like basically it's like you just(4:56mns inaudible).....with anyone you do not know what the person will.....(5:01 inaudible). And also I do not know if you have noticed but most of the time if you listen carefully to our conversations of my age we always ask questions like "do you have a boyfriend or do you have a girlfriend, why don't you have or how many do you have". This shows like there is nothing it is more like a badge something like a boyfriend and a girlfriend actually taking part in sexual intimacy it is no longer embarrassing someone was saying that back then used to be embarrassing used to be like a hush- hush thing but now it's like everyone is like argh.....if you not doing ityou know.

P: I do not know if we are affected by TV or social media we all recently have seen the video of a 14 or 13 year old girl it is so sad and so sad we are reckless(06:20 inaudible).

I: Okay. Anyone else?

P: Then again yes fine we are saying that they are reckless and all of that we do not check what raises this kind of behaviour because we have social media that promotes like the TV. Back then when we grew up we used to watch TV with elders and if there is sexual

scene they will change it and if the age restriction is 16 and above you were told not to watch it. Now I think again the parents, social media because when these kids get home they very happy because at schools they use tablets and they go to social media they see all those things so social media has an influence in youth's sexual behaviour.

I: Okay thank you. Let's go to the next question. What are some of the risky sexual behaviours that young people engage in?

What are some of the risky behaviours that young people engage in?

P: In nowadays they get involved in group sex by actually think it's cool they get drunk in a group and do group sex and I do not think condoms, and everything is involved in that.

I: Did you say group sex?

P: yes

I: What do you mean by group sex?

P: Group sex is sex that involved more than two people

Group: It's kind of 3 some or 4 some (laughing)

P: I think that all of you guys are familiar with the movie called Shades (all laugh) where they usehave you guys watched it? (All laugh some said yes) they make use of things there and people like youth is watching it and they want to experiment they want to use things that they see there and they do not understand that.

P Just to make clarity on that because kids behaviour is like what they do.....so.....

I: What are some of the risky sexual behaviours young people engaged in?

P: I do not know but I think that blesser thing is part of a risky sexual behaviour because it is very risky because I watch this movie called Saint and Sinners there is a young girl that is abused by a blesser this girl has to leave class if the blesser is calling because he wants her now so it is very risky and it is tempting but very risky.

P To add on what she is saying now she is talking about blessers, if you realise everyone now is talking about blessers everyone want to be a blesser everyone want to have a blesser and everyone want to be a lessee. I recall (mentor Nathan) he mentors us as peer educators, she was giving a presentation during orientation week on statistics about the prevalence of HIV/AIDS in young girls between the ages 16-19 and in all the men starting from 19-30 and it turned out that all men were taking advantage of these young girls so that is how the transmission of this virus gets out there because you get girls have intimate relationship with older men not really romantic but some of.....(inaudible 11:36secs) it's more like an exchange not even cash or something they buy you something so having multiple partners or blesser as one of the behaviours that usually.....(someone clears the throat.....inaudible).

P: Also another risky behaviour you see in nowadays young girls they trust too much especially into long-term relationship so my boyfriend and I have been dating for 5 years so by now it is not a force to use condoms they claim "we have been together for years we trust each other by now" but they n\know that they do not lay eyes on them all the time I do not know what he is doing when he is away so they engage in sex and after that they go for testing and results are shocking because you are wondering why because you are only active with him but the boyfriend was busy dishing up from other pots and end up getting the bananas (HIV) that's one risky behaviour. Also the whole about sex it is risky I do not know because these kids even us the youth at schools they are talking about STIs but when we are in that position you know all those things fade you know guys we are in romance the music is cosy the red roses the sheets all of that banishes so that lot of people do bad things those things of symptoms and outcomes (group laugh) people who do that(group laughs and inaudible)

P: Also as she was talking about these kinds of behaviours the most risky one is the anal sex because we all know that anus is not made for sex it is made for its job but now if we engage anal sex there is a possibility that anus may tear they do not know the next person has HIV or what which is more risky more in terms of.....

I: Okay

P: Another thing that could be risky sexual behaviour is the thing of multiple partners not necessarily people you are engage in relationship with. People turn to just sleep with people they like casual I do not know what they call they call the one night stands or the cookies at the bash you see all those things I feel they are much more riskier chances are you are not in the right state of mind you do not even know who is this person you might never see him again and anything that might happen be pregnancy, STI or HIV you would be able to tell the person or to advise because you are left alone with this thing that you have so this thing of multiple partner or casual partner or friends with benefits and cookies at bashes is also very risky behaviour.

P: And also drinking alcohol for some when they are high they just want it (sex) and some when they drunk they are out they do not know their names or whenever they go to parties and guys spike their drinks no it's not good it's risky.

I: You mentioned STI's, what in your opinion are sexually transmitted infections and HIV in your opinion?

P: In my opinion I think sexually transmitted infections are infections nhe that people acquire during sex so what I discovered it is not like a severe disease there is treatment for them, but they are mostly external no guys I never experienced (laughs) they mostly external like those red blisters and all that so I what are the impetus in English?

P: Maggots

P: So, these maggots I did not even know about them, so you knowinaudible 17:53)

I: Anyone else?

P: I was also going to say that are the infections that you get from having unprotected sex with someone who has those STIs.

I: Are these sexually transmitted infections different for HIV?

P: Yes, they are different because STIs can be treated; HIV can be managed but not treated.

I: Okay

P: And also, HIV you not only getting it through sexual intercourse you can get it through blood transfusion or body fluids contact and there is a cut in your skin or the blood of someone who is HIV enters in your cut you can get HIV. STIs are mostly found in sexual intercourse.

I: So, are you saying STIs are not HIV?

P: NO

I: So, what is HIV?

P: HIV is a virus I kind of cannot explain beyond that (laughs).

P: Okay HIV is in the immune system and infections are not in the immune system.

I: What are your examples of sexually transmitted infections? Anyone who knows them what are they?

Group: Ghonorreas, Trichomonas, Syphilis, Pubic lice

I: There is no right or wrong answer anyone can answer.

P: I only know two

I: Which ones?

P: Ghonorrea and Syphilis

P: There are also warts **and** pubic lice. (There is a participant who is talking apparently asking an Interviewer a question about STI, but she is speaking very softly cannot hear exactly her words)

I: Before I can answer that, are you saying that HIV is not an STI, is that what you are saying?

P: I would say no because STI only affects reproductive sexual organs but when you look at HIV it affects your whole body and also HIV itself allows opportunistic infections like itself.

P: HIV is sexually transmitted, but you get child which means a child can get infected also.

I: I hear you. What was your question again?

P: Can all STIs be cured?

I: Can all STIs be cured, if I answer that question now I will be giving you answers to this

P: Okay we can talk after this

I: Yes, just remind me.

P: Trying to answer this question, some STIs can be cured but they are recurring let's say you have genital warts and they are cured and later they re-appear I would say some can be really cured depending when you practise safe sex.

I: Anyone who wants to answer the question, can STIs be cured?

- Group: Yes; yes

I: She is asking "Can all STIs be cured"?

P: Yes, but sometimes it depends at what stage the STI is. For example, if you get the..... (Inaudible 23:33) there is a place where itching.....and there is nothing you can do you see.....(inaudible) so it depends on what stage the STI is that is why they encourage that if you see something now go for medical help immediately

P: And again, that is why they always like to advise you at the clinic when they give you medication they ask you to finish medication because there might be something there so if you finish your medication you might be safe.

P: And if they come back again you get the same medication it does not help so now you must get something stronger because the bacteria re-appeared because it is clever it knows that this is what I got last time so yeah

P: The bacteria sort of adapts to the medication

I: Okay let us go to the next question. Whom do you think is at risk of contracting HIV? Anyone can answer. Whom do you think is at risk of contracting HIV?

P: Mostly the rural poor are the ones who are at risk they do not have access to better health facilities. Some do not have access to education like this one where they will be educated about HIV/AIDS still suffering from stigma attached to HIV/AIDS, STIs and some are afraid to go to the clinic or talk to somebody else who might help to HIV testing in fact they do not getand also the stage we are also in the stage where teenagers like to experience things.

P: I would like to add on what she said, mostly is the youth who are living in the rural areas, what I have noticed in the rural areas is that the service as compared to the service we receive in the city you could see that the service is not the same. For instance, here in Cape Town if you are staying around townships you can see that it is easy to get access to condoms but in the rural areas you find that the clinic is very far you have to travel a long distance so you do not have access to things like condoms they practise sex without safe protection.

P: And also some if they do have access to them because there is stigma so if there are condoms here the brother or the sister will be curious to know why condoms so you end up hiding things or you do not speak freely about sexuality based on (ukoyika) being scared.

P: Also, religion and culture play a part on that. Just to emphasize I was watching this video in Zimbabwe in rural areas and I forgot what the name of it and there was this kid and I forgot what the name of the kid in the video, (she is speaking very fast I cannot hear a word.....28:33-30:11) very lucky in Cape Town (group laughs).

I: Okay, whom do you think is at risk of contracting HIV?

P: Especially like the rural wives the husbands' works in the mines they leave in January and come back in December leaving the wife with the mother in law and the husband is having a casual partner and not just one you know in the mines, so women are at risk.

P: In my opinion I think that everyone who is sexually active is at risk that is how I see not necessarily say it is like this I see it as everyone who is sexually active being at risk of getting HIV because we can never be too sure about anything even the use of condoms can never be sure because anything can happen so everyone is at risk.

P: Also, the university students especially those who stays at res we know what happens there we know how exposed we are and today's youth want to experiment and experience everything so it goes back to the three some and what- what.

I: Anyone who would like to add?

P: Before we say that, yes we can say women are always at risk, where does she get it from because I am also at risk

I: Okay you going to leave it like that?

P: Yes

P: I want to add I want to agree with the lady who said everyone is at risk of contracting HIV and does not discriminate whether you are male or female it does notscare anyway anyhow and like she said that it is not the high prevalence on female species even men as well because the norm is that men are promiscuous and they have multiple partners and raises the high-risk of contracting HIV/AIDS because most of them they do not prefer the plastic which is the condom and whatever the case maybe. I would say (inaudible).....than we can even in children, if the child has a cut and depend..... (Inaudible) because children are taught to share in the playing ground they might get a cut and they exchange things and we do not know the child status, they might be positive or negative but there is a chance of HIV transference so everyone can contract HIV/AIDS.

I: okay let us go to the next question. What does the community think of people who are living with HIV/AIDS? Let's give the gentleman a chance.

There was silence.

I: While he is still thinking let's hear from anyone.

P: People are stereotyped they know you get HIV through sex like marital.....(inaudible). There are other people who believe that if you are HIV you got it through sex they forgot all other things that's what they believe in.

I: Anyone who wants to answer as well?

P: I think the communities now are well informed a lot of information and a lot of things now staff about HIV now they know a lot of things unlike before when it was first introduced while it was still new in our lives then everyone it was like a big.....because people were not getting anything but now we are moving on we are taking initiatives like Love Life they took their time and others like to indicate problems like these where people are perpetuating knowledgeso it's like now community is well informed unlike before they are aware of sexual staff but in terms of living together they know that they are treated so the members of the community know now they are more welcoming it is not like back in the days where it was not like that and I think education that came into play it has settled everything people are living in harmony in the community.

P: On my side I would still say the communities still do not have much knowledge on HIV because if we can say there is much knowledge of HIV/AIDS why the rate of people with

HIV is getting more increasing if there was a difference. I also think that there is only issue that people they view HIV in our communities as something..... (inaudible) even if I have it I will still have 20 more years to live and also there are so many diseases in our communities that makes us to say if there is diabetes for example, there is HIV so I choose to have HIV because Diabetes is more killing than HIV. HIV is a better disease than others, so what I am trying to say is that people do not see having a disease as something that is wrong because everyone seems to have disease it does not matter what type of disease so the issue of HIV is mostly in something that we like which is sexuality so people are saying it is better to have HIV than not to have sex.

P: In most communitiesrumours fled quickly even in varsity rumours spread like that even if you are on diet people will say oh okay so like rumours spread quickly people are always concerned what course are you doing where are you working so rumours spread like that. So if you know before you are HIV.....(talking very fast cannot hear her) even if you have TB just TB only people would say its HIV so people are not comfortable because other TB's for example are taking long and you lose weight and even if you are cured after that and gain weight still people will talk so people are not comfortable in communities because they are judged and treated like single man so it is different in our communities.

P: To add on what she is saying, people as she said that even if you had TB and it cured then you gain weight then people will say she is so beautiful because of the ARVs they are working in her favour, you see they still have that stigma that person has HIV even with us guys let's say a girl was skinny before but now she is got more flesh then you want to approach that girl and you will hear the guy saying are you not afraid of HIV so they still have that mind even if they date that person they know you won't get HIV because you are dating her sometimes there dates that they do not have sex or those they do [protected sex but if you date that person people will say ash he is got it.

P: I would also like to add, like she said that lot of our communities now are informed about HIV/AIDS, like not all communities are all informed about HIV education has not reached far end areas in our country some they do have knowledge but it is not enough, some they do but its decorative some do haveagainst HIV/AIDS in our communities. Like she said that once you have HIV it always go back to sexual morality that you are being promiscuous you are having multiple partners sleeping with everyone around that is why you have HIV/AIDS of which most of the time no but not really most of the time sometimes it's not really the case a nurse could prick you accidentally with the syringe she used before and there is a whole lot of scenarios on how you can get HIV. For example, from where I come from it is a small town but not everyone is educated about HIV some would judge you but you could tell even when you are walking people will pass comments like argh.....so you do not feel comfortable or welcomed you do not fit in the piece of the puzzle. Even though education is getting through it is not enough.

I: So stigma is there.

P: To add also, I would say this I will make an example of my father and his two brothers; all three of them are diabetic and High Blood Pressure. This other time, just as a joke, the other two are using injection to treat their diabetes and the other one is just using tablets. So the other two would say to each other "we have not yet injected", like you find that they are speaking freely with their diabetes and HBP. There is this other brother the fourth one, is HIV+ and TB(inaudible) so there is that stigma in the house that he was not behaving well he has a lot of girls and the comment that I got from one of the brothers is that, okay everyone who enters the house knows about this one's status, so I asked why do you say he is got AIDS he is taking pills for AIDS, he said no they will say I do not behave well which I still do not get why are certain diseases are given stigma.....that kind of thing.

P: I think HIV is associated with death that kind of thing is you have HIV they think you will die like they see someone on TV with HIV they will say the person will die or they find out that someone is in hospital they just think that person will die. Even on funerals when they are about to talk about the cause of death everybody comes in and be quiet because they heard rumours that the person was HIV+, so when the preacher start preaching everybody goes away they are only interested in the cause of death so they associate HIV with death.

I: okay. What is the role of the community with regards to HIV/AIDS? Since you were telling us about stigmas so what is the role of the community? Anyone?

P: I think our role as the educated youth is to break stigmas and stereotypes about HIV infections and everything surrounding it just to normalise this just like every illness that is around by just breaking stigmas and negative connotations.

P: I think also like to break stigmas is us talking about the dangers of it like talking about the general instead of talking about if you are HIV you will die those kind of stigmas are the ones that make people nervous you see.

P: Also like TB one of the family members was criticising virus I just explained to them that it is the same like any other disease out there so at least you know that you can.....

P: To add on what she said, there was a guy well known guy a politician, it was a very first time after a long time he was not appearing on TV, so when he appeared he was very slim and people were like he is sick you can see how slim he is only to discover that the guy is on diet and people were talking saying that he is sick and even though they do not specify what sickness at the back of their minds they are thinking about HIV.

P: I think our role is to educate people more about importance of health. It all goes with.....you know we can talk more about HIV and everything but also think about the most important thing is that people must keep themselves away from HIV to try and make a community that is going to make sure that the HIV infection is decreasing and also making community stay together not being judgemental to one another and if you have it they support each other so that this HIV cannot spread making sure that we love one another, so if we can create a society like that I think HIV will not spread.

P: Lastly also you can.....one of the kids from the drum.....(inaudible).....like parents listen to their kids like if a husband is abusive a kid will say you father you like to beat my mother and the parent will say oh my kid you know(inaudible).....how to avoid HIV.....(inaudible)

I: Do you have knowledge about HIV since you are talking about that we must educate them do you think students have enough knowledge regarding potential risks?

P: Yes I think at this stage we are knowledgeable about HIV we do know about how HIV is transmitted how to manage I have learned and I have seen what happened in the past.

I: I am not asking her alone anyone can answer.

P: I personally think as students yes we do have knowledge about HIV/AIDS but I feel like it is not enough because most of us when we speak about anything that is sexual related we do not pay much attention to it is as though we are saying like guys stop having sex which is unrealistic to say that to people because they will not stop having sex. So I feel like in most conversation we do not engage enough with them hence people are not having protected sex we always say that we do not have enough education we are still holding on what we have been taught in past grades there are programmes that are running about HIV and STIs for students so I do not think we dwell much on that hence we are reckless when it comes to sexual behaviour and stuff.

P: Sometimes especially we students.....we always take it for granted(she is talking very fast I cannot hear her 54:37)

P: Sometimes students know but there are social factors like poverty you know somebody would like in residence hungry and this guy would just come and you know I can buy you airtime here is 200 and you know you have been eating nothing you will just go buy yourself food so it will end up being like that because you want money for food and you know that HIV is there and all that but because of the situation.

I: So, factors, poverty, what are the factors that can influence young people to make informed decisions with regard to sexual behaviour?

P: Poverty, culture, tradition

I: Okay give us more

P: I did not get the question

I: She was talking about poverty, so I was asking what factors that could influence young people to make informed decision with regard to sexuality and HIV/AIDS?

P: Peer pressure sometimes, there is this person I know and.....(inaudible) I ask didn't you guys used condoms or protection and she said.....(inaudible) and I asked where did you get that condoms is the only way of protection whereas there are other ways of protection and then she said my friends told me so and I think peer pressure.

I: So, what are the factors that will influence young people to make informed decision? No 12?

P: I think the culture like we must create a culture or something that is going to be a norm if we do sex before marriage you are doing something wrong without creating a society or community that everyone is going to say the same thing if I am telling the next person that I like that girl I want to have sex the next person will say no sex we must wait do not do sex before marriage and when I go to the next one he will say the same thing. I think that can make them to have informed decisions.

I: Is it not available already?

P: But now then now if I go to my friends and we speak about sex if you do not have a girlfriend or you do not have sex you are seen as someone who is not in the right trend so all societies we are now living has improved that it is cool for you that you can have sex before go for it so we do not see or think you wrong in that.

P: I think as young people we already know what is wrong and what is right something like we know in our heads but it's something we have to do that's why(inaudible 100:15).

P: It80% I do not support the idea but 20% I support the idea that if you are HIV positive justI do not know if Zuma or who came with the idea that HIV positive people must be marked, there is that thing but still HIV rate increases so I mean you must look when you are in a relationship and tell your lover that my love do not be surprised when you see marks all over my body I think that will help and it's not like we are criticising them there were different reasons but now.....I think it is going to help.

I: Can you repeat that?

P: Just for the benefit of the next generation but we not judging them but there must be a mark at least even if it is in the forehead written HIV+ or just a mark so that from government..... (inaudible 1hr2mns40secs). But one can tell (inaudible).

I: So, you say they should be stigmatised?

P: I think judgement day is close Jesus Christ is coming the devil is at work (all laughing) I promise you.....exist.....(inaudible 1hr 03mins 48 secs).

P: To add up on that the decision we make is because of the influence, if the influence was good |I should not have started having sex at an early age. But because my friends and family said the same thing, in my family I am Dlamini (the clan name) and my dad had many girlfriends at one go and I was advised to have two when I had them when I am telling my brother he would say now you like your father, now you like your father. My

friends would say I have girlfriends you should also have one, so really, really if we can try and have a society that is going to support us making good decisions in life we can succeed in the issue of sexual intercourse and HIV.

I: Okay anyone?

P: Yes I also think that if we would have proper channels to follow we would make informed decisions like apparently I also myself do not know like if you one of those people who struggles financially as in like anything whatever there are places to go to make a provision for food even for money and I know of a girl from where I come from she does not have parents but she does not struggle financially and I am not sure which department she went to but it is managing her very well financially and if we have those kind of knowledge we would not resort to sort of like these rejected highly risk decisions just to make ends meet.

I: Anyone who would like to add?

Silent

I: Okay the next one is, what are the attitudes that students at higher education institution have towards risks regarding HIV/AIDS and sexuality? What are the attitudes that students at higher education institution have towards health risks regarding HIV/AIDS and sexuality?

P: According to what I have seen when you talk to youth regarding the experience of HIV/AIDS they like a tendency of being bored or something like as if they do not know what you are talking about when you talk about something they already know there is still that ignorance that they do not want to listen to someone who is talking about HIV when you approach someone about HIV/AIDS you can see the person from the face that the person is bored. So I do not know for me they have that mentality that they know everything about HIV/AIDS or something.

P: I would also like to agree with you in terms of ignorance when it comes to sexual behaviours ignoring that we might actually run the risk of contracting HIV/AIDS and the system we talked about that if my girlfriend is negative I am also negative of which is incorrect you cannot test by somebody else you have to go by yourself and find out that you are really negative so in that sense I would say that you really negative.

P: I heard before.....(inaudible 1:08:35) do not trust any guy you cannot commit serious relationship and all that so some people came here as adults like they engage in sexual relationships with someone you just met without using condoms knowing there are these things so this person is old and is got mind so if you come to me and you agree if I want to make sex with you that is your decision you are big enough to make a decision you the idea of freedom and you know the consequences of that you are aware of that(inaudible) experience so let us stop that attitude and know when you make decisions there are consequences that comes with it.

I: Okay, let us hear from you what do you think you madam? (Group laughs)

P: I agree with the speaker earlier like when you talk about HIV/AIDS you see people are bored because they have seen this on TV taught at school and now you are saying the same thing again no maan aha

P:it depends again on how the people will approach you about this topic of HIV/AIDS you do not just talk sexreally it gets boring.....(inaudible)

I: How do you suggest we do this flexi approach to students?

P: Maybe.....

I: I am asking anyone not just her she mentioned that students are tired maybe we need to change the approach.

P: I think we should make it more fun like we have activities and educational ones not too formal or serious also people if you approach them too seriously you already turning them

off then activities will make them have fun but also should be educational talking about HIV/AIDS I think that is the way at least they are not bored.

I: Do you want to say something brother?

P: Yes I want to emphasize what she said that approach is very important when you want to talk about HIV/AIDS you cannot go out and say hey do you know that if you have HIV you could die no you do not do that you just start small and discuss like eish.....(inaudible 1:12:43) whole lot of responsibilities try like go with an angle like as long as we know it comes with responsibilities and it will be really grateful if you take into account those responsibilities so that it may not be sort of a problem when they catch up with you.

P:(inaudible 1: 13:33) There was once an event at the student centre that was the most approachable event for HIV/AIDS and then maybe during that we have an activity or a session like this one I do not know but it was quite interestingand maybe we have these kind of seminars in that kind of environment.....individuals (Something is making a noise am not sure if it's a door or what - the participant is speaking very fast I cannot hear)

P: I would like to add from what she was saying yes we had an event and it was very fun they were trying to get it educational as well and we tried to get everyone involved which is what everybody likes to get involved but it's not like we had a questionnaire under HIV/AIDS and STIs..... (Participant is talking very soft I cannot hear) (More than one person is speaking I cannot hear.....they are all laughing)

P: Another thing that is.....not necessarily this is not(inaudible) but more of a thing that will make us take informed decisions see like the whole campaign "do you know your HIV status" I think it should be more of "do you know my status" so if someone wants you that will make you think I do not know this person's status and already I(inaudible) I think that will make somebody really think and make an informed decision.

P: You see the testing station for HIV(inaudible) (whole group is laughing) we different and of cause our reaction is different so immediately I scream after getting my results people would say obvious she has it.....(inaudible)so I do not know if the space sometimes is safe it was going to be more convenient if it was a room like this one person enters the door and it is completely closedam not very sexual active but I was like.....(inaudible)I do not think it is private eish.....I do not know.

P: Having those tents for testing it is not because they are trying to expose or something it is because of you guys don't have a time to go for test so they come to you so that you can test(inaudible) there is counselling as well (group is talking some are laughing).

I: Do you get counsellors?

P: Yes, there is counselling before and after but when the counsellor is counselling you after you cannot hear anything it's like now this is the end and you start counting how many you have slept with (whole group is laughing) you calling your partner's name while the counsellor is busy counselling you.

I: So where can you go if you have STIs when you are around?

P: At the campus clinic

P: Tjo the campus clinic is a problem I once go there you find no one and you are asked to make appointment

P: For family planning or sick leave?

P: For family planning and everybody isthis one there is madness therebut having to say that there is people waiting there to make appointments and you have to say what is wrong with you.

I: Do we all agree on that?

Group: Yes

P: And the thing you know you get there, and you are told no we are fully booked so you have to make the appointment and come back Wednesday because Monday we are fully booked and that is so embarrassing (whole group is talking)

P: Meaning our health facilities are not enough even if we go to another clinic there is this kind of thing so for example I had a flue so I know that if I do not come here but here they said that it is a we cannot help you because of spray or something and I knew if I go to Belhar I know it's too full

P: And sometimes when you want to go to Belhar you just do not know how to get there its risky you know they said there are gangs and we do not know.

I: So it is their facilities, so what are they doing to improve that?

P: They need to fix their attitude (group agrees with her)

P: I never tried to find the reason for this because the doctor that is there only comes for certain hours and she leaves so I think they must try and get a permanent person there for that post because I think that is the problem.

P: When you talk about doctors there are two doctors there male and female doctors and when the other one is busy with CPUT staffs and I do not know if the other one is permanent.

P: I think another one is a supervisor because he never sees patients there you know and it's not nice when they shout then you must fix that face it is not me who said you must do what and like everybody is sitting there and listening to this

P: I think really but I never been there, and I think but let us(inaudible) you understand because I am here to get help(whole group agrees)

P: I think the design of the clinic facility is also.....because and they ask you from the reception what is your problem.....instead of.....what if you really

P: I did not know this(inaudible)

P: (Inaudible)

P: (Inaudible)

P: Cause from what she said they say they see one consultation for one month so let us say if you fall sick again in a month you will have to pay R10.00 for each consultation which isand they will be seeing you for different stuffs

Group: (Inaudible)

P: They should also extend this to a night thing because most of the students get sick at night and there is nowhere to go you have to wait for an ambulance because they close there is no after-hours emergency.

P: they should at least close at nine and even in the morning you must be there at 7 and they take numbers.....(inaudible)

I: Are there any suggestion boxes there?

Group: There are suggestion box there

P: There is a suggestion box and I also feel that when you write something there and see you dropping it immediately they open it and see it's a student she said this and that so it is not confidential or anonymous so they should put it outside not inside so that when you outside you should write something and drops it there.

I: Okay we are done because you just answered the last question.

P: In that last question I just have a suggestion. If maybe government can focus more on families because this start at home because at home we are not well informed about issues of sexuality and HIV and that is giving the child good morals we were not given good morals thus why the issue of HIV otherwise we can get HIV because of rape and the rapist then all start at home meaning whom we do not have a good teaching with HIV that means government can try to have more education with young people even at tertiary level saying

that we must not look for our parents we must ask ourselves can this person be a good father to my children and the other one ask the same question and also the child that you give birth to must be the child that is going to help the community so at the country so I think having these family platforms to discuss issues can be more and more help.

P: (Inaudible)

I: Is the question related to this?

P: (She is eating I cannot hear what she is saying)

P: I just see it as any other disease it's like cancer or any other disease.

P: And also it depends to the motive why are they telling us are they telling us to do something or do you see us as a family so you want support or comfort unless you do not want comfort just randomly telling us.

P: But people whoabout it you know from Facebookyou know so and so was talking about me you know somebody busy bragging about status just try and educate people not to spread anything about their private life because telling other people that so and so slept with me last night not even knowing what the status of the person but you are bragging on Facebook it is not ion educate people about it.

P: That one depends on what interest I have(inaudible)

I: Thank you for your participation in this research.

APPENDIX G2: Coding Thematic Analysis

Name: Peggy Tabata

Transcriber Type: Focus Group Discussion No 2

Audio Recording Length: 1:37:51

Interviewer Interview Date: 31 March 2017 (CPUT Bellville Campus)

Interview Name: Peggy Tabata

Interview Language: English

Time of the interview: 14:00 p.m.

I= Interviewer

P= Participants

<p>I would like to start by discussing in detail all these questions. Remember there is no right or wrong answer all I want is your opinion in each question. Please answer them to the best of your ability. My first question read as follows:</p> <p>I: What is the perception of youth sexual health? Anyone can answer do not be shy anyone can start.</p> <p>P: Can you please clarify what do you mean by perception?</p> <p>I: To clarify that what do you think of sexual behaviour and the youth out there, what is your perception?</p> <p>P: What I have notice is that today's youth are sexual active at a much younger age unlike before because you find that these kids that have sex at 12, 13, 14 years of age and you even get cases where a 12 year old child is pregnant with the child and you wonder how is she going to take care of the child because she is still a child. I think today's youth has been more reckless in terms of their conduct with respect to sex and whatever(inaudible)</p> <p>P: I would like to also add on that I feel like we brag about being sexual active I feel like it's a competition. You know back then it was more like an investment. These days it's like you are out of fashion, you not doing it so that is what I see.</p> <p>P: As the first participant said, these past days I saw an article of a ten year old girl with a child, she is having a child and I was wondering a ten year old child with a child that means that the youth today is more reckless they just want to explore these things.</p> <p>P:like the way to do it or whatever like basically it's like you just (4:56mns inaudible).....with anyone you do not know what the person will..... (5:01 inaudible). And also I do not know if you have noticed but most of the time if you listen carefully to our conversations of my age we always ask questions like "do you have a boyfriend or do you have a girlfriend, why don't you have or how many do you have". This shows like there is nothing it is more like a badge something like a boyfriend and a girlfriend actually taking part in sexual intimacy, it is no longer embarrassing someone was saying that back then used to be embarrassing used to be like a hush- hush thing but now it's like everyone is like argh.....if you not doing ityou know.</p> <p>P: I do not know if we are affected by TV or social media we all recently have seen the video of a 14 or 13 year old girl it is so sad and so sad we are reckless(06:20 inaudible).</p> <p>I: Okay. Anyone else?</p> <p>P: Then again yes fine we are saying that they are reckless and all of that we do not check what raises this kind of behaviour because we</p>	<p>1 Do not understand</p> <p>2 Early engagement of sexual activities</p> <p>2 Teenage pregnancy</p> <p>2 Reckless behaviour</p> <p>3 Peer pressure</p> <p>2Virginity is fashionable</p> <p>2Teenage pregnancy</p> <p>2Exploring sexuality</p> <p>2No safe sex</p> <p>3 Peer pressures of having a partner</p> <p>2 fashionables to have sexual partner/s</p> <p>4 Social media influences youth behaviour</p> <p>4 impact of social media to youth</p>
---	---

<p>have social media that promotes like the TV. Back then when we grew up we used to watch TV with elders and if there is sexual scene they will change it and if the age restriction is 16 and above you were told not to watch it. Now I think again the parents, social media because when these kids get home they very happy because at schools they use tablets and they go to social media they see all those things so social media has an influence in youth's sexual behaviour.</p>	<p>4 Parents have no control over our use of internet and TV</p>
<p>I: Okay thank you. Let's go to the next question. What are some of the risky sexual behaviours that young people engage in?</p>	
<p>What are some of the risky behaviours that young people engage in?</p>	
<p>P: In nowadays they get involved in group sex by actually think it's cool they get drunk in a group and do group sex and I do not think condoms and everything is involved in that.</p>	<p>2 Alcohol and group sex leading to unsafe sex</p>
<p>I: Did you say group sex?</p>	
<p>P: yes</p>	
<p>I: What do you mean by group sex?</p>	
<p>P Group sex is sex that involved more than two people</p>	<p>2 Multiple partners</p>
<p>Group: It's kind of 3 some or 4 some (laughing)</p>	
<p>P: I think that all of you guys are familiar with the movie called Shades, (all laugh) where they usehave you guys watched it? (All laugh some said yes) they make use of things there and people like youth is watching it and they want to experiment they want to use things that they see there and they do not understand that.</p>	<p>4 Impact of social media to sexual experiences</p>
<p>P Just to make clarity on that because kids behaviour is like what they do.....so.....</p>	
<p>I: What are some of the risky sexual behaviours young people engaged in?</p>	
<p>P: I do not know but I think that blesser thing is part of a risky sexual behaviour because it is very risky because I watch this movie called Saint and Sinners there is a by a young girl that is abused blesser this girl has to leave class if the blesser is calling because he wants her now so it is very risky and it is tempting but very risky.</p>	<p>2 Dating older people</p>
<p>P To add on what she is saying now she is talking about blessers, if you realise everyone now is talking about blessers everyone want to be a blesser everyone want to have a blesser and everyone want to be a blessee. I recall (mentor X) he mentors us as peer educators, he was giving a presentation during orientation week on statistics about the prevalence of HIV/AIDS in young girls between the ages 16-19 and in all the men starting from 19-30 and it turned out that all men were taking advantage of these young girls so that is how the transmission of this virus gets out there because you get girls have intimate</p>	<p>2 Older men taking advantage of young</p>

<p>relationship with older men not really romantic but some of.....(inaudible 11:36secs) it's more like an exchange not even cash or something they buy you something so having multiple partners or blesser as one of the behaviours that usually.....(someone clears the throat.....inaudible).</p>	<p>2 Transactional sex</p>
<p>P: Also another risky behaviour you see in nowadays young girls they trust too much especially into long-term relationship so my boyfriend and I have been dating for 5 years so by now it is not a force to use condoms they claim “we have been together for years we trust each other by now” but they n\know that they do not lay eyes on them all the time I do not know what he is doing when he is away so they engage in sex and after that they go for testing and results are shocking because you are wondering why because you are only active with him but the boyfriend was busy dishing up from other pots and end up getting the bananas (HIV) that's one risky behaviour. Also the whole about sex it is risky I do not know because these kids even us the youth at schools they are talking about STIs but when we are in that position you know all those things fade you know guys we are in romance the music is cosy the red roses the sheets all of that banishes so that lot of people do bad things those things of symptoms and outcomes (group laugh) people who do that(group laughs and inaudible)</p>	<p>2 Time in relationship= no condom use</p> <p>2 Sex=Risk</p> <p>2 Romance</p>
<p>P: Also as she was talking about these kinds of behaviours the most risky one is the anal sex because we all know that anus is not made for sex it is made for its job but now if we engage anal sex there is a possibility that anus may tear they do not know the next person has HIV or what which is more risky more in terms of.....</p>	<p>2 Anal sex</p>
<p>I: Okay</p>	
<p>P: Another thing that could be risky sexual behaviour is the thing of multiple partners not necessarily people you are engage in relationship with. People turn to just sleep with people they like casual I do not know what they call they call the one night stands or the cookies at the bash you see all those things I feel they are much more riskier chances are you are not in the right state of mind you do not even know who is this person you might never see him again and anything that might happen be pregnancy, STI or HIV you would be able to tell the person or to advise because you are left alone with this thing that you have so this thing of multiple partner or casual partner or friends with benefits and cookies at bashes is also very risky behaviour.</p>	<p>2 Casual sex with multiple partners</p> <p>5Consequences of choices</p> <p>2 Friends with benefits</p>
<p>P: And also drinking alcohol for some when they are high they just want it (sex) and some when they drunk they are out they do not know their names or whenever they go to parties and guys spike their drinks no it's not good it's risky.</p>	<p>5 Alcohol and sex</p> <p>5 Spiked drinks</p>

<p>I: You mentioned STI's, what in your opinion are sexually transmitted infections and HIV in your opinion?</p> <p>P: In my opinion I think sexually transmitted infections are infections nhe that people acquire during sex so what I discovered it is not like a severe disease there is treatment for them but they are mostly external no guys I never experienced (laughs) they mostly externallike those red blisters and all that so I what are the impetus in English?</p> <p>P: Maggots</p> <p>P: So these maggotsI did not even know about them so you know(inaudible 17:53)</p> <p>I: Anyone else?</p> <p>P: I was also going to say that are the infections that you get from having unprotected sex with someone who has those STIs.</p> <p>I: Are these sexually transmitted infections different for HIV?</p> <p>P: Yes they are different because STIs can be treated; HIV can be managed but not treated.</p> <p>I: Okay</p> <p>P: And also HIV you not only getting it through sexual intercourse you can get it through blood transfusion or body fluids contact and there is a cut in your skin or the blood of someone who is HIV enters in your cut you can get HIV. STIs are mostly found in sexual intercourse.</p> <p>I: So are you saying STIs are not HIV?</p> <p>P: NO</p> <p>I: So what is HIV?</p> <p>P: HIV is a virus I kind of cannot explain beyond that (laughs).</p> <p>P: Okay HIV is in the immune system and infections are not in the immune system.</p> <p>I: What are your examples of sexually transmitted infections? Anyone who knows them what are they?</p> <p>Group: Gonorheas, Trichomonus, Syphilis, Pubic lice</p> <p>I: There is no right or wrong answer anyone can answer.</p> <p>P: I only know two</p> <p>I: Which ones?</p>	<p>1 Knowledge of STI's</p> <p>1 Not severe</p> <p>1 Blisters</p> <p>1 Maggots</p> <p>6 Unprotected sex</p> <p>1 Can be treated</p> <p>7 HIV knowledge blood transfusion</p> <p>7 Skin cuts</p> <p>7 Not only sexual contact</p> <p>7 HIV not STI</p> <p>7 Can't explain HIV</p> <p>7 Types of STIs</p>
--	---

<p>P: Ghonorrea and Syphilis</p> <p>P: There are also warts and pubic lice. (There is a participant who is talking apparently asking an Interviewer a question about STI but she is speaking very softly cannot hear exactly her words)</p> <p>I: Before I can answer that are you saying that HIV is not an STI, is that what you are saying?</p> <p>P: I would say no because STI only affects reproductive sexual organs but when you look at HIV it affects your whole body and also HIV itself allows opportunistic infections like itself.</p> <p>P: HIV is sexually transmitted but you getchild which means a child can get infected also.</p> <p>I: I hear you. What was your question again?</p> <p>P: Can all STIs be cured?</p> <p>I: Can all STIs be cured, if I answer that question now I will be giving you answers to this</p> <p>P: Okay we can talk after this</p> <p>I: Yes just remind me.</p> <p>P: Trying to answer this question, some STIs can be cured but they are recurring let's say you have genital warts and they are cured and later they re-appear I would say some can be really cured depending when you practise safe sex.</p> <p>I: Anyone who wants to answer the question, can STIs be cured?</p> <ul style="list-style-type: none"> • Group: Yes; yes <p>I: She is asking "Can all STIs be cured"?</p> <p>P: Yes but sometimes it depends at what stage the STI is. For example, if you get the..... (Inaudible 23:33) there is a place where itching.....and there is nothing you can do you see.....(inaudible) so it depends on what stage the STI is that is why they encourage that if you see something now go for medical help immediately</p> <p>P: And again that is why they always like to advise you at the clinic when they give you medication they ask you to finish medication because there might be something there so if you finish your medication you might be safe.</p> <p>P: And if they come back again you get the same medication it does not help so now you must get something stronger because the bacteria re-appeared because it is clever it knows that this is what I got last time so yeah</p>	<p>7 HIV don't affect sexual organs but the whole body</p> <p>7 Inadequate info about STI's</p> <p>7 STIs are recurrent if have unsafe sex</p> <p>7 Seek medical help ASAP</p> <p>7 Compliance to Rx</p> <p>7 Prevents resistance to medication</p>
---	---

<p>P: The bacteria sort of adapts to the medication</p> <p>I: Okay let us go to the next question. Whom do you think is at risk of contracting HIV? Anyone can answer. Whom do you think is at risk of contracting HIV?</p> <p>P: Mostly the rural poor are the ones who are at risk they do not have access to better health facilities. Some do not have access to education like this one where they will be educated about HIV/AIDS still suffering from stigma attached to HIV/AIDS, STIs and some are afraid to go to the clinic or talk to somebody else who might help to HIV testing in fact they do not getand also the stage we are also in the stage where teenagers like to experience things.</p> <p>P: I would like to add on what she said, mostly is the youth who are living in the rural areas, what I have noticed in the rural areas is that the service as compared to the service we receive in the city you could see that the service is not the same. For instance, here in Cape Town if you are staying around townships you can see that it is easy to get access to condoms but in the rural areas you find that the clinic is very far you have to travel a long distance so you do not have access to things like condoms they practise sex without safe protection.</p> <p>P: And also, some if they do have access to them because there is stigma so if there are condoms here the brother or the sister will be curious to know why condoms, so you end up hiding things or you do not speak freely about sexuality based on (ukoyika) being scared.</p> <p>P: Also, religion and culture play a part on that (sexuality). Just to emphasize I was watching this video in Zimbabwe in rural areas and I forgot what the name of it and there was this kid and I forgot what the name of the kid in the video, (she is speaking very fast I cannot hear a word.....28:33-30:11) very lucky in Cape Town (group laughs).</p> <p>I: Okay, whom do you think is at risk of contracting HIV?</p> <p>P: Especially like the rural wives the husbands' works in the mines they leave in January and come back in December leaving the wife with the mother in law and the husband is having a casual partner and not just one you know in the mines so women are at risk.</p> <p>P: In my opinion I think that everyone who is sexually active is at risk that is how I see not necessarily say it is like this I see it as everyone who is sexually active being at risk of getting HIV because we can never be too sure about anything even the use of condoms can never be sure because anything can happen so everyone is at risk.</p> <p>P: Also the university students especially those who stays at res we know what happens there we know how exposed we are, and today's</p>	<p>8 People in rural communities</p> <p>8 Poor health care services</p> <p>8 Don't want to test for HIV</p> <p>Teenagers (Puberty stage)</p> <p>8 Poor services in rural</p> <p>8 Urban areas- easy access to medical care</p> <p>8 Accessible condoms-uirban</p> <p>9 Stigma-</p> <p>8 Not being able to talk openly about sex</p> <p>8 Religion/ culture inhibits sex talks</p> <p>8 Wives (rural)- husbands at work in the city</p> <p>2 Casual partners</p> <p>2 Sexually active= risk</p> <p>Even with condoms</p> <p>2Students are at high risk</p>
--	---

<p>youth want to experiment and experience everything so it goes back to the three some and what- what.</p> <p>I: Anyone who would like to add?</p> <p>P: Before we say that, yes we can say women are always at risk, where does she get it from because I am also at risk</p> <p>I: Okay you going to leave it like that?</p> <p>P: Yes</p> <p>P: I want to add I want to agree with the lady who said everyone is at risk of contracting HIV and does not discriminate whether you are male or female it does notscare anyway anyhow and like she said that it is not the high prevalence on female species even men as well because the norm is that men are promiscuous and they have multiple partners and raises the high risk of contracting HIV/AIDS because most of them they do not prefer the plastic which is the condom and whatever the case maybe. I would say (inaudible).....than we can even in children, if the child has a cut and depend..... (Inaudible) because children are taught to share in the playing ground they might get a cut and they exchange things and we do not know the child status, they might be positive or negative but there is a chance of HIV transference so everyone can contract HIV/AIDS.</p> <p>I: okay let us go to the next question. What does the community think of people who are living with HIV/AIDS? Let's give the gentleman a chance.</p> <p>There was silence.</p> <p>I: While he is still thinking let's hear from anyone.</p> <p>P: People are stereotyped they know you get HIV through sex like marital.....(inaudible). There are other people who believe that if you are HIV you got it through sex they forgot all other things that's what they believe in.</p> <p>I: Anyone who wants to answer as well?</p> <p>P: I think the communities now are well informed a lot of information and a lot of things now staff about HIV now they know a lot of things unlike before when it was first introduced while it was still new in our lives then everyone it was like a big.....because people were not getting anything but now we are moving on we are taking initiatives like Love Life they took their time and others like to indicate problems like these where people are perpetuating knowledgeso it's like now community is well informed unlike before they are aware of sexual staff but in terms of living together they know that they are treated so the members of the community know now they are more welcoming it is not like back in the days</p>	<p>2 Experimenting</p> <p>8 Women more at risk</p> <p>8 HIV does not discriminate</p> <p>9 Promiscuity</p> <p>9 Rejection of condoms</p> <p>9 Children may also infect each other on play grounds as some maybe positive</p> <p>8 Stereotype</p> <p>1 More information on HIV than before</p> <p>4 Love life</p>
--	--

<p>where it was not like that and I think education that came into play it has settled everything people are living in harmony in the community.</p>	<p>1 Education has improved perceptions</p>
<p>P: On my side I would still say the communities still do not have much knowledge on HIV because if we can say there is much knowledge of HIV/AIDS why the rate of people with HIV is getting more increasing if there was a difference. I also think that there is only issue that people they view HIV in our communities as something..... (Inaudible) even if I have it I will still have 20 more years to live and also there are so many diseases in our communities that makes us to say if there is diabetes for example, there is HIV so I choose to have HIV because Diabetes is more killing than HIV. HIV is a better disease than others, so what I am trying to say is that people do not see having a disease as something that is wrong because everyone seems to have disease it does not matter what type of disease so the issue of HIV is mostly in something that we like which is sexuality so people are saying it is better to have HIV than not to have sex.</p>	<p>1 Lack of knowledge</p> <p>9 Ignorance</p> <p>2 Sex is a priority than HIV and other diseases</p>
<p>P: In most communitiesrumours fled quickly even in varsity rumours spread like that even if you are on diet people will say oh okay so like rumours spread quickly people are always concerned what course are you doing where are you working so rumours spread like that. So if you know before you are HIV.....(talking very fast cannot hear her) even if you have TB just TB only people would say its HIV so people are not comfortable because other TB's for example are taking long and you lose weight and even if you are cured after that and gain weight still people will talk so people are not comfortable in communities because they are judged and treated like single man so it is different in our communities.</p>	<p>9 Stigma in universities</p>
<p>P: To add on what she is saying, people as she said that even if you had TB and it cured then you gain weight then people will say she is so beautiful because of the ARVs they are working in her favour, you see they still have that stigma that person has HIV even with us guys let's say a girl was skinny before but now she is got more flesh then you want to approach that girl and you will hear the guy saying are you not afraid of HIV so they still have that mind even if they date that person they know you won't get HIV because you are dating her sometimes there dates that they do not have sex or those they do [protected sex but if you date that person people will say ash he is got it.</p>	<p>9 Stigma in communities</p> <p>9 Losing weight is associated with HIV/TB</p>
<p>P: I would also like to add, like she said that lot of our communities now are informed about HIV/AIDS, like not all communities are all informed about HIV education has not reached far end areas in our country some they do have knowledge but it is not enough, some they do but its decorative some do haveagainst HIV/AIDS in our communities. Like she said that once you have HIV it always go back</p>	<p>1 Lack of HIV education</p>

<p>to sexual morality that you are being promiscuous you are having multiple partners sleeping with everyone around that is why you have HIV/AIDS of which most of the time no but not really most of the time sometimes it's not really the case a nurse could prick you accidentally with the syringe she used before and there is a whole lot of scenarios on how you can get HIV. For example from where I come from it is a small town but not everyone is educated about HIV some would judge you but you could tell even when you are walking people will pass comments like argh.....so you do not feel comfortable or welcomed you do not fit in the piece of the puzzle. Even though education is getting through it is not enough.</p> <p>I: So stigma is there.</p> <p>P: To add also, I would say this I will make an example of my father and his two brothers; all three of them are diabetic and High Blood Pressure (HBP). This other time, just as a joke, the other two are using injection to treat their diabetes, and the other one is just using tablets. So the other two would say to each other "we have not yet injected", like you find that they are speaking freely with their diabetes and HBP. There is this other brother the fourth one, is HIV+ and TB(inaudible) so there is that stigma in the house that he was not behaving well he has a lot of girls and the comment that I got from one of the brothers is that, okay everyone who enters the house knows about this one's status, so I asked why do you say he is got AIDS he is taking pills for AIDS, he said no they will say I do not behave well which I still do not get why are certain diseases are given stigma.....that kind of thing.</p> <p>P: I think HIV is associated with death that kind of thing is you have HIV they think you will die like they see someone on TV with HIV they will say the person will die or they find out that someone is in hospital they just think that person will die. Even on funerals when they are about to talk about the cause of death everybody comes in and be quiet because they heard rumours that the person was HIV+, so when the preacher start preaching everybody goes away they are only interested in the cause of death so they associate HIV with death.</p> <p>I: okay. What is the role of the community with regards to HIV/AIDS? Since you were telling us about stigmas so what is the role of the community? Anyone?</p> <p>P: I think our role as the educated youth is to break stigmas and stereotypes about HIV infections and everything surrounding it just to normalise this just like every illness that is around by just breaking stigmas and negative connotations.</p> <p>P: I think also like to break stigmas is us talking about the dangers of it like talking about the general instead of talking about if you are HIV you will die those kind of stigmas are the ones that make people nervous you see.</p>	<p>9 HIV is associated with multiple partners</p> <p>9 Stigma because of lack of knowledge</p> <p>9 HIV is badly stigmatised than other disease</p> <p>2 Multiple partners</p> <p>9 HIV stigma in our communities</p> <p>1 Youth to educate communities</p> <p>1 Changing strategies of HIV education</p>
--	---

<p>P: Also like TB one of the family members was criticising virus I just explained to them that it is the same like any other disease out there so at least you know that you can.....</p> <p>P: To add on what she said, there was a guy well known guy a politician, it was a very first time after a long time he was not appearing on TV, so when he appeared he was very slim and people were like he is sick you can see how slim he is only to discover that the guy is on diet, and people were talking saying that he is sick and even though they do not specify what sickness at the back of their minds they are thinking about HIV.</p> <p>P: I think our role is to educate people more about importance of health. It all goes with.....you know we can talk more about HIV and everything but also think about the most important thing is that people must keep themselves away from HIV to try and make a community that is going to make sure that the HIV infection is decreasing and also making community stay together not being judgemental to one another and if you have it they support each other so that this HIV cannot spread making sure that we love one another, so if we can create a society like that I think HIV will not spread.</p> <p>P: Lastly also you can....one of the kids from the drum.....(inaudible).....like parents listen to their kids like if a husband is abusive a kid will say you father you like to beat my mother and the parent will say oh my kid you know(inaudible).....how to avoid HIV.....(inaudible)</p> <p>I: Do you have knowledge about HIV since you are talking about that we must educate them do you think students have enough knowledge regarding potential risks?</p> <p>P: Yes I think at this stage we are knowledgeable about HIV we do know about how HIV is transmitted how to manage I have learned and I have seen what happened in the past.</p> <p>I: I am not asking her alone anyone can answer.</p> <p>P: I personally think as students yes we do have knowledge about HIV/AIDS but I feel like it is not enough because most of us when we speak about anything that is sexual related we do not pay much attention to it is as though we are saying like guys stop having sex which is unrealistic to say that to people because they will not stop having sex. So I feel like in most conversation we do not engage enough with them hence people are not having protected sex we always say that we do not have enough education we are still holding on what we have been taught in past grades there are programmes that are running about HIV and STIs for students so I do not think we dwell much on that hence we are reckless when it comes to sexual behaviour and stuff.</p>	<p>9 Stigma</p> <p>9 Weight associated with HIV</p> <p>1 Youth to educate about health to reduce new HIV infections</p> <p>1 Talk about stigma so that communities can support each other</p> <p>1 Youth have HIV knowledge</p> <p>1 HIV knowledge is not adequate</p> <p>1 Lack of knowledge lead to careless behaviours</p>
--	---

<p>P: Sometimes especially we students.....we always take it for granted(she is talking very fast I cannot hear her 54:37)</p> <p>P: Sometimes students know but there are social factors like poverty you know somebody would like in residence hungry and this guy would just come and you know I can buy you airtime here is 200 and you know you have been eating nothing you will just go buy yourself food so it will end up being like that because you want money for food and you know that HIV is there and all that but because of the situation.</p> <p>I: So factors, poverty, what are the factors that can influence young people to make informed decisions with regard to sexual behaviour?</p> <p>P: Poverty, culture, tradition</p> <p>I: Okay give us more</p> <p>P: I did not get the question</p> <p>I: She was talking about poverty so I was asking what factors that could influence young people to make informed decision with regard to sexuality and HIV/AIDS?</p> <p>P: Peer pressure sometimes, there is this person I know and.....(inaudible) I ask didn't you guys used condoms or protection and she said.....(inaudible) and I asked where did you get that condoms is the only way of protection whereas there are other ways of protection and then she said my friends told me so and I think peer pressure.</p> <p>I: So what are the factors that will influence young people to make informed decision? No 12?</p> <p>P: I think the culture like we must create a culture or something that is going to be a norm if we do sex before marriage you are doing something wrong without creating a society or community that everyone is going to say the same thing if I am telling the next person that I like that girl I want to have sex the next person will say no sex we must wait do not do sex before marriage and when I go to the next one he will say the same thing. I think that can make them to have informed decisions.</p> <p>I: Is it not available already?</p> <p>P: But now then now if I go to my friends and we speak about sex if you do not have a girlfriend or you do not have sex you are seen as someone who is not in the right trend so all societies we are now living has improved that it is cool for you that you can have sex before go for it so we do not see or think you wrong in that.</p>	<p>5 Circumstance forces you to transactional sex</p> <p>3 Peer pressure</p> <p>1 Education about cultures, sex and values</p> <p>3 Societal pressures of having a partner</p>
---	--

<p>not resort to sort of like these rejected highly risk decisions just to make ends meet.</p> <p>I: Anyone who would like to add?</p> <p>Silent</p> <p>I: Okay the next one is, what are the attitudes that students at higher education institution have towards risks regarding HIV/AIDS and sexuality? What are the attitudes that students at higher education institution have towards health risks regarding HIV/AIDS and sexuality?</p> <p>P: According to what I have seen when you talk to youth regarding the experience of HIV/AIDS they like a tendency of being bored or something like as if they do not know what you are talking about when you talk about something they already know there is still that ignorance that they do not want to listen to someone who is talking about HIV when you approach someone about HIV/AIDS you can see the person from the face that the person is bored. So I do not know for me they have that mentality that they know everything about HIV/AIDS or something.</p> <p>P: I would also like to agree with you in terms of ignorance when it comes to sexual behaviours ignoring that we might actually run the risk of contracting HIV/AIDS and the system we talked about that if my girlfriend is negative I am also negative of which is incorrect you cannot test by somebody else you have to go by yourself and find out that you are really negative so in that sense I would say that you really negative.</p> <p>P: I heard before.....(inaudible 1:08:35) do not trust any guy you cannot commit serious relationship and all that so some people came here as adults like they engage in sexual relationships with someone you just met without using condoms knowing there are these things so this person is old and is got mind so if you come to me and you agree if I want to make sex with you that is your decision you are big enough to make a decision you the idea of freedom and you know the consequences of that you are aware of that(inaudible) experience so let us stop that attitude and know when you make decisions there are consequences that comes with it.</p> <p>I: Okay, let us hear from you what do you think you madam? (Group laughs)</p> <p>P: I agree with the speaker earlier like when you talk about HIV/AIDS you see people are bored because they have seen this on TV taught at school and now you are saying the same thing again no maan aha</p>	<p>9 Ignorance</p> <p>9 Youth is tired of being told about HIV</p> <p>9 Ignorance</p> <p>9 Rely on their sexual partners about their HIV status</p> <p>6 Unprotected sex</p> <p>5 Consequences of choices</p> <p>9 Boredom</p>
--	--

<p>P:it depends again on how the people will approach you about this topic of HIV/AIDS you do not just talk sexreally it gets boring.....(inaudible)</p> <p>I: How do you suggest we do this flexi approach to students?</p> <p>P: Maybe.....</p> <p>I: I am asking anyone not just her she mentioned that students are tired maybe we need to change the approach.</p> <p>P: I think we should make it more fun like we have activities and educational ones not too formal or serious also people if you approach them too seriously you already turning them off then activities will make them have fun but also should be educational talking about HIV/AIDS I think that is the way at least they are not bored.</p> <p>I: Do you want to say something brother?</p> <p>P: Yes I want to emphasize what she said that approach is very important when you want to talk about HIV/AIDS you cannot go out and say hey do you know that if you have HIV you could die no you do not do that you just start small and discuss like eish.....(inaudible 1:12:43) whole lot of responsibilities try like go with an angle like as long as we know it comes with responsibilities and it will be really grateful if you take into account those responsibilities so that it may not be sort of a problem when they catch up with you.</p> <p>P:(inaudible 1: 13:33) There was once an event at the student centre that was the most approachable event for HIV/AIDS and then maybe during that we have an activity or a session like this one I do not know but it was quite interestingand maybe we have these kind of seminars in that kind of environment.....individuals(something is making a noise am not sure if it's a door or what - the participant is speaking very fast I cannot hear)</p> <p>P: I would like to add from what she was saying yes we had an event and it was very fun they were trying to get it educational as well and we tried to get everyone involved which is what everybody likes to get involved but it's not like we had a questionnaire under HIV/AIDS and STIs(participant is talking very soft I cannot hear)(more than one person is speaking I cannot hear.....they are all laughing)</p> <p>P: Another thing that is.....not necessarily this is not(inaudible) but more of a thing that will make us take informed decisions see like the whole campaign "do you know your HIV status" I think it should be more of "do you know my status" so if someone wants you that will make you think I do not know this</p>	<p>1 Approach about sexual issues are important</p> <p>1 Youth want fun educational activities and flexible approaches to sexuality</p> <p>1 Strategic approach for youth will help</p> <p>1 Understanding the consequences and responsibilities</p> <p>1 Activities like focus groups are more needed</p> <p>1 Fun and educational events are needed</p> <p>1 New strategies, "Do you know my status" will</p>
---	---

<p>person's status and already I(inaudible) I think that will make somebody really think and make an informed decision.</p> <p>P: You see the testing station for HIV(inaudible) (whole group is laughing) we different and of cause our reaction is different so immediately I scream after getting my results people would say obvious she has it.....(inaudible)so I do not know if the space sometimes is safe it was going to be more convenient if it was a room like this one person enters the door and it is completely closedam not very sexual active but I was like.....(inaudible)I do not think it is private eish.....I do not know.</p> <p>P: Having those tents for testing it is not because they are trying to expose or something it is because of you guys don't have a time to go for test so they come to you so that you can test(inaudible) there is counselling as well (group is talking some are laughing).</p> <p>I: Do you get counsellors?</p> <p>P: Yes there is counselling before and after but when the counsellor is counselling you after you cannot hear anything it's like now this is the end and you start counting how many you have slept with (whole group is laughing) you calling your partner's name while the counsellor is busy counselling you.</p> <p>I: So where can you go if you have STIs when you are around?</p> <p>P: At the campus clinic</p> <p>P: Tjo the campus clinic is a problem I once go there you find no one and you are asked to make appointment</p> <p>P: For family planning or sick leave?</p> <p>P: For family planning and everybody isthis one there is madness therebut having to say that there is people waiting there to make appointments and you have to say what is wrong with you.</p> <p>I: Do we all agree on that?</p> <p>Group: Yes</p> <p>P: And the thing you know you get there and you are told no we are fully booked so you have to make the appointment and come back Wednesday because Monday we are fully booked and that is so embarrassing (whole group is talking)</p> <p>P: Meaning our health facilities are not enough even if we go to another clinic there is this kind of thing so for example I had a flue so I know that if I do not come here but here they said that it is a we</p>	<p>assist in informed decisions</p> <p>1 Getting new and strategic approaches</p> <p>8 Mobile clinics coming to students</p> <p>8 Counselling is available</p> <p>Appointments are misunderstood</p> <p>Booking</p> <p>8 More health facilities needed</p>
--	--

<p>cannot help you because of spray or something and I knew if I go to Belhar I know it's too full</p> <p>P: And sometimes when you want to go to Belhar you just do not know how to get there its risky you know they said there are gangs and we do not know.</p> <p>I: So it is their facilities, so what are they doing to improve that?</p> <p>P: They need to fix their attitude (group agrees with her)</p> <p>P: I never tried to find the reason for this because the doctor that is there only comes for certain hours and she leaves so I think they must try and get a permanent person there for that post because I think that is the problem.</p> <p>P: When you talk about doctors there are two doctors there male and female doctors and when the other one is busy with CPUT staffs and I do not know if the other one is permanent.</p> <p>P: I think another one is a supervisor because he never sees patients there you know and it's not nice when they shout they you must fix that face it is not me who said you must do what and like everybody is sitting there and listening to this</p> <p>P: I think really but I never been there and I think but let usinaudible) you understand because I am here to get help(whole group agrees)</p> <p>P: I think the design of the clinic facility is also.....because and they ask you from the reception what is your problem.....instead of.....what if you really.....</p> <p>P: I did not know thisinaudible)</p> <p>P: (Inaudible)</p> <p>P: (Inaudible)</p> <p>P: Cause from what she said they say they see one consultation for one month so let us say if you fall sick again in a month you will have to pay R10.00 for each consultation which isand they will be seeing you for different stuffs</p> <p>Group: (Inaudible)</p> <p>P: They should also extend this to a night thing because most of the students get sick at night and there is nowhere to go you have to wait for an ambulance because they close there is no after-hours emergency.</p> <p>P: they should at least close at nine and even in the morning you must be there at 7 and they take numbers.....(inaudible)</p>	<p>8 Students do not want to be embarrassed</p> <p>8 After hours clinic</p>
---	---

<p>I: Are there any suggestion boxes there?</p> <p>Group: There are suggestion box there</p> <p>P: There is a suggestion box and I also feel that when you write something there and see you dropping it immediately they open it and see it it's a student she said this and that so it is not confidential or anonymous so they should put it outside not inside so that when you outside you should write something and drops it there.</p> <p>I: Okay we are done because you just answered the last question.</p> <p>P: In that last question I just have a suggestion. If maybe government can focus more on families because this start at home because at home we are not well informed about issues of sexuality and HIV and that is giving the child good morals we were not given good morals thus why the issue of HIV otherwise we can get HIV because of rape and the rapist then all start at home meaning whom we do not have a good teaching with HIV that means government can try to have more education with young people even at tertiary level saying that we must not look for our parents we must ask ourselves can this person be a good father to my children and the other one ask the same question and also the child that you give birth to must be the child that is going to help the community so at the country so I think having these family platforms to discuss issues can be more and more help.</p> <p>P: (Inaudible)</p> <p>I: Is the question related to this?</p> <p>P: (She is eating I cannot hear what she is saying)</p> <p>P: I just see it as any other disease it's like cancer or any other disease.</p> <p>P: And also it depends to the motive why are they telling us are they telling us to do something or do you see us as a family so you want support or comfort unless you do not want comfort just randomly telling us.</p> <p>P: But people whoabout it you know from Facebookyou know so and so was talking about me you know somebody busy bragging about status just try and educate people not to spread anything about their private life because telling other people that so and so slept with me last night not even knowing what the status of the person but you are bragging on Facebook it is not on educate people about it.</p> <p>P: That one depends on what interest I have(inaudible)</p> <p>I: Thank you very much guys we are done, thank you.</p>	<p>8 Suggestion box should be outside the clinic</p> <p>8 Families should be involved in sexuality issues</p> <p>1 Lack of knowledge</p> <p>6 Rapes at home worsens the HIV</p> <p>1 Youth to assist education in families/communities</p> <p>4 Role of social media to youth</p>
--	---

APPENDIX H: Ethics Approval



HEALTH AND WELLNESS SCIENCES RESEARCH ETHICS COMMITTEE (HW-REC)
Registration Number NHREC: REC- 230408-014

P.O. Box 1906 • Bellville 7535 South Africa
Symphony Road Bellville 7535
Tel: +27 21 959 6917
Email: sethn@cput.ac.za

4 October 2016
REC Approval Reference No:
CPUT/HW-REC 2016/H23

Faculty of Health and Wellness Sciences – Nursing

Dear Ms Tabata

Re: APPLICATION TO THE HW-REC FOR ETHICS CLEARANCE

Approval was granted by the Health and Wellness Sciences-REC on 15 September 2016 to Ms Nomzamo Peggy Tabata for ethical clearance. This approval is for research activities related to student research in the Department of Nursing at this Institution.

TITLE: The identification of potential health risk factors in students at higher education institution (HEI) in the Western Cape with regard to sexuality and HIV/AIDS

Supervisor: Dr Vember

Comment:

Data collection permission is required and has been obtained.

Approval will not extend beyond 5 October 2017. An extension should be applied for 6 weeks before this expiry date should data collection and use/analysis of data, information and/or samples for this study continue beyond this date.

The investigator(s) should understand the ethical conditions under which they are authorized to carry out this study and they should be compliant to these conditions. It is required that the investigator(s) complete an **annual progress report** that should be submitted to the HWS-REC in December of that particular year, for the HWS-REC to be kept informed of the progress and of any problems you may have encountered.

Kind Regards

A handwritten signature in black ink, appearing to read "N. Naidoo".

Mr. Navindhra Naidoo
Chairperson – Research Ethics Committee
Faculty of Health and Wellness Sciences

