USING HIV/AIDS INTERVENTIONIST RESEARCH IN A UNIVERSITY CONTEXT TO IMPROVE WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH AWARENESS

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requirements for the degree

MASTER OF ARTS IN PSYCHOLOGY

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by

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DECLARATION

I declare that **Using HIV/AIDS interventionist research in a University context to improve women's sexual and reproductive health awareness** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

01/12/2019

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SIGNATURE DATE

(Nitasha Kida)

ABSTRACT

Background: Young women in South Africa are a vulnerable group, with HIV prevalence almost twice that of men, limited preventive behaviour, and many challenges in negotiating sex. However, there is a paucity of in-depth research to understand how these challenges play out and what can be done to promote positive sexual and reproductive health in this population.

Methods: To understand the effects of the Auntie Stella Activity card intervention (developed and used in Zimbabwe), this study used a mixed methods participatory action research design. Five focus group discussions among female Rhodes University students between the ages of 18-23 were conducted with the activity cards as a basis for engagement. Additionally, pre-and post-intervention sexual and reproductive health awareness levels were also measured by a customized questionnaire. Based on participants' responses to the cards and post-exposure reflections on their learning, possible impacts on behaviour change were explored. Thematic analysis of transcripts was used to draw out major themes in the qualitative data.

Results and conclusions: Themes that emerged were: 1) women's self-esteem; 2) lack of knowledge; 3) peer pressure and male dominance; and 4) alcohol and substance use. Results of the pre- and post- intervention questionnaire found a positive change in knowledge and behaviour amongst the participants. However, the intervention in its current format focused too much on teenage rather than adult scenarios. To make it more useful for this population, further modifications that account for the target age group are needed. Overall, the challenges in sexual and reproductive health faced by university-aged women in South Africa are deeply concerning, but this study's findings show that an intervention like the ASAC has the potential to be used widely in Southern Africa, if appropriately tailored.

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LIST OF ACRONYMS:

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
ASACs	Auntie Stella Activity Cards
AVT	Antiretroviral Therapy
FGDs	Focus Group Discussions
HAPS	HIV/AIDS Prevention Study
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
HSV-2	Herpes type 2
IMAGE	Intervention with Microfinance and AIDS and Gender Equality
IPV	Inactivated Polio Vaccine
MTCT HIV	Mother to Child Transmission of HIV
NGOs	Non-Government Organisations
PMTCT	Prevention of Mother-to-Child Transmission of HIV
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STI	Sexually Transmitted Infections
TARSC	Training and Research Support Centre
TB	Tuberculosis
UNFPA	United Nations Population Fund
WHO	World Health Organization

TABLE OF CONTENTS

CHAPTER ONE: INTRODUCTION

Throughout the world, sexual and reproductive health (SRH) and rights of women are being undermined. The World Health Organization estimates that 214 million women who want contraception are not receiving it due to lack of access, stigma, and fear (World Health Organization, 2018). The vast majority of these women live in developing countries (Africa and the Global South), where social and economic factors exacerbate the situation for them and worsen their access to care. While efforts are being undertaken to improve women's SRH and rights, these efforts are clearly insufficient.

During my undergraduate studies in psychology, informed by my coursework on social psychology, I increasingly found myself in the position of a pseudo-ethnographer: learning from my peers through their confiding in me about how they approached sex, negotiated condom use, and thought about their own SRH. I was surrounded by a highly educated group of young women and it has been a privilege to learn from them and build such a community. However, on the topic of sex, I would occasionally wonder if, as young women growing up in Africa, we had received appropriate and adequate education at school, and whether we had access to all the information we needed to empower and protect ourselves.

1.1 WHY IS SRH IMPORTANT?

"Good SRH is a state of complete physical, mental and social well-being in all matters relating to the reproductive system" (United Nations Population Fund, 2016). SRH means that people are able to have children if they please and are able to do so at the time of their choosing, whilst maintaining a good and safe sex life. Thus, both procreation and sexual issues are covered in SRH. People who do not have the power to make these kind of SRH choices are unable to control what happens in their futures (United Nations Population Fund, 2016). This final point highlights the important matters of control, power, and choice; all elements that impact particularly on women in the developing world.

1.2 WHY IS SRH IMPORTANT FOR YOUNG WOMEN IN SOUTH AFRICA?

New rights, laws and programmes focusing on women's SRH were put into place between the years of 1994 and 2004 in South Africa (Cooper et al., 2016, 2004). For these policies to have been introduced there had to have been an existing demand or need for improvement around women's SRH rights. The areas that the policies focused on were "contraception, maternal health, termination of pregnancy, cervical and breast cancer, gender-based and sexual violence, HIV/AIDS and sexually transmitted infections and infertility" (Cooper et al., 2004, p. 70). These are still the main concerns that women in South Africa are experiencing.

The new policies established between 1994 and 2004 are listed in the box below, retrieved from Cooper et al (2004, p 72).

1994 - Department of Health establishes partnerships to plan, process and review HIV/AIDS policy, focusing on the prevention of new HIV infections and treatment of AIDS-related opportunistic infections.

- Free public health services for pregnant women and children under six.

1995 – Government ratifies the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).

1996 – Choice on Termination of Pregnancy Act provides a legal framework for the provision of abortion services.

1997 – Maternal death made a notifiable condition; Standing National Committee for Confidential Enquiries into Maternal Deaths established.

- Patients' Rights Charter launched, giving patients the knowledge and right to address issues of quality in health care services.

1998 – New Population Policy introduced, delinked from population growth.

- South African National AIDS Council formed.
- Domestic Violence Act passed.

1999 – Prevention of Mother-to-Child transmission (PMTCT) of HIV programmes introduced in the Western Cape province.

2000 – National Guidelines for Cervical Screening Programme launched.

2001 – PMTCT programme introduced in Gauteng province.

2002 – Treatment Action Campaign and Children's Rights Centre win a court application ordering Government to implement a comprehensive PMTCT programme to prevent mother-to-child HIV transmission (PSTCT) and to roll out PMTCT services country-wide.

- National Contraception Policy Guidelines launched.
- Government approves the provision of HIV post-exposure prophylaxis to survivors of rape in public sector facilities.

2003 – Government approves plan to provide antiretroviral drugs to people with AIDS through public sector health services.

2004 – Sexual assault legislation under review to amend the definition of rape and enforce heavier sentences.

Even though the above policies were put into place by 2004 and there has been constant effort and interventions put in place since, today, sixteen years later, South Africa remains a vulnerable country for women and their SRH is at very high risk (Kmietowicz, 2019; World Health Organization, 2020)

I will be talking about the women's SRH matters that are relevant to the students who participated in this particular research project, which are: Contraception methods, abortion, HIV (including mother to child transmission of HIV), cervical cancer, sexual violence, gender-based violence, and intimate partner violence. I have chosen to speak about the aforementioned topics as these were brought up and debated about during the focus group discussions (FGDs) that were held during the course of this research project. As a result, I have collected the relevant data surrounding these topics to analyse and discuss at a later stage.

Young women in South Africa have reported difficulty accessing methods of contraception in rural areas due to inadequate health care services; and if contraception is available, some feel judged by the health care provider, since having sex before marriage is still stigmatised in parts of South Africa, some also have a fear that the healthcare provider may know them or their parents, compromising confidentiality (Cooper et al., 2016). This judgmental attitude from healthcare providers may prevent young women from obtaining methods of contraception, resulting in an increase in unwanted pregnancies and therefore an increase in the need for services to enable abortions (also frowned upon by some healthcare providers). The abortions may be obtained illegally and from untrained doctors, putting these young women and their SRH at additional risk (Woog, Singh, Browne, & Philbin, 2015).

Regardless of obtaining contraception methods from health care services, young women are still having unprotected sex, which is harmful to women's SRH. The reasons for this are complex and other pressures (such as financial dependency) may lead to a "deprioritisation of the self" in the challenge of negotiating safe sex practices (van der Riet, Sofika, Akhurst, & Daniels, 2018).

Having unsafe sex can result in the spread of the Human Papilloma Virus (HPV), sexually transmitted infections (STIs), as well as HIV/AIDS. Condoms are one of the chief methods of providing protection; and advice to use these has been part of a national strategy (Sonke Gender Justice, 2019), given the high HIV prevalence in South Africa. If used properly, and if there is no slippage or breakage, condoms can prevent the spread of the aforementioned. Condoms are also more easily accessible than other hormone contraceptives, which need to be obtained from health care services. In 2019, condoms and femidoms, are generally available in University men and women's bathrooms at no cost, but it may be more difficult to access them this easily in the rural and poor areas.

Throughout the world, HIV/AIDS is the main cause of death for women between the ages of 15 and 44 years, which is the reproductive age range (World Health Organization, 2020). Statistical research in South Africa suggests that HIV-preventative behaviour is limited in individuals between the ages of 15-24 and that unsafe sex is the main method of transmission in developing countries (Van Staden & Badenhorst, 2009; World Health Organization, 2020). Young women are a predominantly vulnerable group, with HIV prevalence being almost twice that of men (Simbayi et al., 2014). The number of women in Africa who die from HIV, tuberculosis, and maternal complications is higher than in other regions in the world (World Health Organization, 2020). In order to meet the goals of the National Strategic Plan 2012-2016 informed by the

UNAIDS vision ("zero new HIV infections, zero discrimination and zero AIDS-related deaths") there is a widespread need to improve education efforts.

1.3 PREVIOUS INTERVENTIONS THAT HAVE WORKED

In South Africa there have been successful outcomes from interventions that have occurred in the past (Harrison, Newell, Imrie, & Hoddinott, 2010). Harrison et al. (2010) comment on eight intervention programmes that were adapted for and carried out in South Africa. These interventions planned to raise awareness about HIV/AIDS and educate youths on how to avoid sexual risk behaviour, in order to hinder transmission rates. Similar content was presented about HIV/AIDS in each intervention, however the ways in which knowledge was conveyed were unique. Interventions were delivered by peer educators, teachers, and mentors, and were carried out at schools or in group settings. The positive results of these interventions indicated a decrease in the number of people engaging in risky sexual behaviour and as well as reductions in STI incidence. There were also positive effects, such as increased awareness and knowledge about HIV/AIDS, seen from activities being carried out in groups and by information being delivered by peer educators. However, it should be noted that peer educators did need a substantial amount of training prior to intervention onset.

From the reviews of the above interventions done by Harrison et al. (2010), some key recommendations can be made. For prevention interventions to be successful, they needed to address "HIV social risk factors, such as gender, poverty and alcohol; target the structural and

institutional context; work to change social norms; and engage schools in new ways, including participatory learning" (Harrison et al., 2010, p. 1). Another recommendation would be to include developing methods that keep in mind age, gender, and sexual status. The research to be described in this thesis has features that include the aforementioned recommendations for successful HIV prevention interventions. According to Kelly and Ntlabati (2002, p. 42) "behavioural prevention is today's HIV vaccine!" Behavioural prevention methods are vital in preventing HIV transmission.

1.4 AUNTIE STELLA ACTIVITY CARDS: TEENAGER'S TALK ABOUT SEX, LIFE AND RELATIONSHIPS

There has been a past emphasis on various HIV/AIDS education and prevention initiatives, however more is needed to aid vulnerable groups affected by HIV/AIDS such as those in South Africa. The Auntie Stella Activity Cards (ASACs) were first developed in Zimbabwe in 1997 and have been widely used since, being modified in 2005 (TARSC, 2006). The cards tackle the issue of HIV/AIDS education differently, since the approach is based around group discussion and includes sharing of information, as opposed to having a didactic approach. Through this research I hope to ascertain if this form of HIV/AIDS preventative education enables an alternate response to HIV risk taking behaviour amongst female university students. The material to be utilised as the basis of discussions is indicated by the title: Auntie Stella activity cards: *Teenagers talk about sex, life, and relationships*. The activity cards contain typical personal and social scenarios including points of debate and a separate "answer" card to provide factual guidance (TARSC, 2006).

1.5 MOTIVATION FOR ENGAGING IN THIS STUDY

Having lived both in Zimbabwe and South Africa, where HIV prevalence is high as well as highly stigmatised, it saddens me that some people who are HIV positive feel that they cannot access Antiretroviral Therapy (ART) purely because of the fear of being judged, if people knew they were HIV positive. They put their chances of living a normal healthy life second to the fear of people finding out their HIV positive status. I have also seen first-hand how women, especially those from the rural areas, are seen as inferior to men and the substantial amount of gender-based violence that takes place in Southern Africa, which may also put pressure on women from their male partners to engage in unsafe sex. Furthermore, in order to help decrease the prevalence of young women contracting HIV, there needs to be better education on the prevention of HIV/AIDS, STIs, how to look after their SRH, as well as empowering women to be able to make informed choices and assert their rights.

My interest in educating young women about cervical cancer only developed at a later stage, during the course of this research project through one of my FGDs. Initially, my main aim was to concentrate on increasing awareness of HIV/AIDS in order for young women to have a better understanding on how to protect themselves from contracting HIV/AIDS. Due to the lack of knowledge in other areas of women's SRH that arose in the FGDs, as well as in the research carried out for the literature review; I gained increased awareness of the extremely high numbers of women dying from cervical cancer in South Africa, due to lack of access to SRH information and resulting from irregular screening. My interest, as well as knowledge, of the need to significantly improve women's SRH overall, not merely concentrating on HIV/AIDS, greatly increased. The death rate of women due to cervical cancer is extremely high in South Africa, and

cervical cancer is one of the most easily treatable cancers if caught early enough (Perlman et al., 2014). I found this knowledge gap alarming given that all the participants had supposedly been exposed to sex education classes during high school, and it is expected that young women should have learnt about regular pap smears, as well as mammograms at some point in their lives. If not learned at school, when are young women supposed to learn how to take care of their own SRH? There seems to be a gap in the provision of this information.

1.6 AIM OF THIS STUDY

Broadly, given the knowledge gap that I have observed anecdotally and which is also reflected in some of the literature, this study aims to understand the features of female students' sexual and reproductive behaviour, especially striving to answer the question of why educated young women attending university engage in unprotected sex.

On a more pragmatic level, this study also aims to evaluate the acceptability and possible utility of the Auntie Stella Card intervention in a university context. This research will trial the AS educational tool pack, in order to ascertain whether it has an impact on the improvement in and maintenance of good SRH amongst young university women in South Africa. Further, the content and process of using the ASACs is of interest for its potential to be rolled out more widely as a peer education measure. Given the overall higher levels of education in a university context, where the majority of students have received some school-based input on SRH, this

study also seeks to understand if and how the ASACs could be modified to make them relevant for this setting.

1.7 THESIS STRUCTURE

Having laid the groundwork and motivations for this study in this introduction, Chapter 2 will review the relevant literature surrounding SRH for women, with a focus on South Africa. It will explore the prevalence of HIV/AIDS in young people, factors that promote unsafe sexual behaviour, and discuss condom use and negotiation. Next it will explore some of the theory linking risk and self-esteem: elements that may be critical drivers for women's sexual practices. Finally, it introduces the ASACs intervention.

Chapter 3 is focused on the methodology employed in order to answer the research questions. It will outline the research questions, the mixed methods research design, and rationale for the decisions taken. Given the sensitive nature of the content discussed during focus groups, this chapter includes a discussion of the ethical considerations for this study.

In the fourth chapter, I describe in detail the study findings. The findings, based on thematic analysis, are divided into four broad themes: 1) women's self-esteem; 2) lack of knowledge; 3) peer pressure and male dominance; and 4) alcohol and substance use. Then I present specific data related to the process of the ASACs intervention, including participant reflections on how the intervention could be modified.

The final discussion chapter links the study findings to the literature, including the theoretical underpinnings. It also discusses some of the more surprising findings from the study. Finally, I explain the study's limitations, and implications both for policy and for future research.

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL BASIS

2.1 INTRODUCTION

In this chapter, I will review the relevant literature on HIV and sexual behaviour amongst young people in South Africa. First, I will explore the prevalence of HIV and risky sexual behaviour amongst South African youth. Next, I will detail some components of sexual behaviour amongst this demographic, including a discussion of condom use and factors that promote unsafe sexual practices, with a focus on two specific populations: women and university students. Finally, I will explain the Auntie Stella (AS) intervention in the context of other HIV interventions in South Africa. Considering this review, it is necessary to define young people, youths, and adolescents. The World Health Organisation (WHO) defines "Adolescents" as individuals between the ages of 10 – 19 years, "Youths" are defined as individuals between the ages of 15-24 and lastly "Young People" also cover the range of 10 – 24 years (SEARO, 2019).

The prevalence of HIV/AIDS in South Africa continues to be of growing concern. According to statistical research, about 60% of all new HIV/AIDS infections are among individuals between the ages of 15 and 24; and this same age group also has the highest prevalence of sexually transmitted diseases (Simbayi et al., 2014). In Africa, AIDS is still the most prominent cause of death amongst young people (AVERT, 2015). AIDS-related deaths in the youth increased by 50% between 2005 and 2012, concurrently there was a 30% decrease in those already living with HIV/AIDS (AVERT, 2015). The South African government has made great strides in the

provision of antiretrovirals (ARVs) in order to prolong life, as well as improve existing HIV/AIDS education programmes to increase awareness levels regarding transmission (Mensch et al., 2015). However, it is clear that in young people, HIV-preventative behaviour is limited. Young women are a predominantly vulnerable group, with HIV prevalence almost twice that of men (Simbayi et al., 2014). Factors limiting HIV-preventative behaviour in young women are particularly structural, such as lack of education, poverty, and the high prevalence of gender inequality in South Africa (Pettifor et al., 2016). The UNAIDS (2015) vision is "zero new HIV infections, zero discrimination and zero AIDS-related deaths," therefore there is a need to improve efforts to reach these young women.

In general, all racial and cultural groups in South Africa have beliefs concerning gender roles, and most are based on the premise that women are less important, or less deserving of power, than men (Dunkle et al., 2004). Gender discrimination is part of tradition in many communities in South Africa and many women themselves abide by this, making it difficult to attain gender equality in South Africa (Hutson, 2007). Research has shown that gender discrimination has played an important role in the discrimination against women and prevalence of HIV/AIDS (Hutson, 2007; Jewkes, Dunkle, Nduna, & Shai, 2010).

In a study conducted amongst South African students, the role of the relationship between gender and cultural factors and their impact on sexual behaviour that may impact SRH were studied (Van Staden & Badenhorst, 2009). Results from the study revealed factors that put students' SRH at risk for contracting HIV, were: "male dominance vs female submissiveness; age of first sexual encounter; financial status; and myths" (Van Staden & Badenhorst, 2009, p. 19). Some male students consider risk-taking as a way of portraying themselves as more masculine, in order

to maintain the status quo of "masculinity" and consequently they engage in unsafe sexual behaviour, increasing the risk of HIV/AIDS infection as well as STIs. Female students may be expected to be subordinate to their male counterparts and are at increased risk of HIV-infection: this is because often male students decide whether or not the sexual activity will involve the use of a condom.

Students becoming forced into unsafe sexual behaviour without providing consent, is a major concern in South Africa for HIV/AIDS, with the high prevalence of rape being closely associated with male-dominant culture (Jewkes, Levin, & Mbananga, 2002; Van Staden & Badenhorst, 2009). In certain African cultures it is believed that not wearing condoms can improve one's social status as a male (Eaton, Flisher, & Aaro, 2003; Jewkes et al., 2010; Macphail & Campbell, 2001). In addition, risk could be exacerbated because female students may choose a method of contraception that does not prevent HIV-infection, because they are more worried about an unwanted pregnancy than contracting HIV/AIDS (Van Staden & Badenhorst, 2009).

2.2 WOMEN AND SEXUAL REPRODUCTIVE HEALTH

2.2.1 ABSTINENCE

Abstinence is one of the key ways to avoid HIV/AIDS according to Nhamo, Campbell, and Gregson (2010). However, very few young people in South Africa have the intention to refrain from having sex until marriage (Eaton et al., 2003). The few adolescents that are willing to do

this are usually female and refrain for religious reasons. In contrast, a fair number of men think of monogamy as being almost as unwanted as abstinence. The promotion of abstaining from sex until marriage as way of preventing HIV-infection is therefore not an option for some individuals (Eaton et al., 2003). It can be seen that religion, culture, and context needs to be taken into consideration when looking at prevention methods.

2.2.2 CERVICAL CANCER AND PAP SMEARS COMPARED TO THE DEVELOPED WORLD

Developing countries have much higher rates of women dying from cervical cancer compared to developed countries (Francis, Leser, Esmiont, & Griffith, 2013). Among women in developing countries, cervical cancer is responsible for the most deaths among all other cancers. Cervical cancer is the second major cause of mortalities among women in South Africa. In comparison, the number of deaths of women in the United States of America (USA) as a result of cervical cancer is much lower (Francis et al., 2013). This is largely owed to the health care services in the USA, where there is much greater accessibility to pap smears. Therefore, owing to regular pap smears, cervical cancer is detected at an early stage and is treatable, resulting in fewer women developing the cancer to an untreatable stage. Knowledge and awareness levels of cervical cancer and pap smears are relatively low in South Africa (Francis et al., 2013). As a result of this, there is a low self-perception of risk amongst women in South Africa. Further education efforts to improve South African women's knowledge and awareness of cervical cancer are needed.

According to Botha and Dreyer (2017), in South Africa cervical cancer is a significant cause of death in females. In 2016 it was recorded that 4248 women, were dying annually from the disease in South Africa (Jordaan, Michelow, Richter, Simoens, & Bogers, 2016). Cervical cancer rates are high due to often late diagnosis and relatively poor treatment. Many patients in South Africa do not react positively to treatment, due to repeated infection of the cervix from HPV. Currently national cervical cytology smears account for three sessions per lifetime of the individual, starting from the age of 30 for 10-year intervals. Patients with HIV/AIDS infections require more frequent testing than this. With correct implementation and regular cervical screening, it is likely that mortalities caused by this disease could be significantly reduced.

2.2.3 WOMEN AND HIV/AIDS IN SOUTH AFRICA

As mentioned earlier, gender discrimination is part of the tradition in some communities in South Africa and women themselves accede to this, making it difficult to attain gender equality in the country (Hutson, 2007). Research has shown that gender discrimination has played an important role on the prevalence of gender-based violence and HIV/AIDS (Hutson, 2007; Jewkes, Dunkle, Nduna, & Shai, 2010).

"Power, virility and domination of women in sexual relationships" are the main characteristics of masculinity in much of South African culture and are characteristics of "a real man" (Chikore, 2000, p. 39). Some male students consider risk-taking as a way of portraying themselves as more masculine in order to maintain the status quo of "masculinity" and consequently engage in unsafe

sexual behaviour, increasing the risk of HIV/AIDS infection and STIs (Van Staden & Badenhorst, 2009) Other expectations of "masculinity" in parts of South Africa are "having several sexual partners, engaging in casual sex, unprotected sex, demonstrating negative attitudes toward condom use, having control over women, and owning expensive accessories" (Selikow, Zulu, & Cedras, 2002, p. 24). Female students are expected to be subordinate to their male counterparts and are at increased risk of HIV-infection as the male students decide whether or not the sexual activity will involve the use of a condom (Van Staden & Badenhorst, 2009).

2.3 HIV AND YOUNG PEOPLE IN SOUTH AFRICA

Bearing in mind that the country exhibits one of the highest populations of HIV/AIDS globally and young people are more exploratory and adventurous when it comes to sex, South African Universities comprising mainly of young people are a context of concern (van der Riet et al., 2018). It is important for Sub-Saharan Africa to take the context and tradition of young people into consideration when conducting HIV/AIDS research, including intervention implementation due to the relationship of gender inequality and the practice of safe sexual behaviour (Van Staden & Badenhorst, 2009). Gender inequality and financial insecurity have an impact in this vulnerable group; given that around 6000 new HIV/AIDS infections transpire on average per day (van der Riet et al., 2018). It is necessary to place more emphases on improving current HIV/AIDS interventions in order to decrease the prevalence in young South Africans, and to consider information regarding community and social factors that influence transmission of the epidemic.

Eaton et al. (2003) noted that no less than 50% of South African adolescents become sexually active by the age of 16, and this was confirmed in 2004, when South African adolescents were regarded worldwide to be a "high risk" population for transmitting HIV/AIDS (Leclerc-Madlala, 2004). During this time at the largest provincial hospital in Durban, more than 80% of the AIDS patients that were bedridden fell between the ages of 15 to 24, and these were in particular young women (Leclerc-Madlala, 2004). A study done by Richter (as cited in Leclerc-Madlala, 2004) showed that the average age for South African youth to become sexually active was between 13-15 years old and, in Durban. More recently it was reported that South Africa is still at the centre of the HIV epidemic, with over 6.4 million people in the population living with the infection (Cooper et al., 2016). Young members of the population are most at risk of HIV/AIDS with 15-24 year olds having a 7.1% infection level, and 25 – 49 year old people having a 25.2% infection level (van der Riet et al., 2018).

Young people in South Africa increase their risk of HIV infection by not practicing safe sex and by having many sexual partners (Eaton et al., 2003). According to Leclerc-Madlala (2004), during adolescence the person's sexuality is formed and develops, hence sexual debut often occurring at this time. It is therefore vital for researchers to understand how early sexual encounters happen and what triggers them in order to design successful interventions in the future (Kelly & Ntlabati, 2002). These findings are the reason why more research in this area is needed. Despite knowing that HIV is a prevalent epidemic and how to prevent it, young people are often more likely to take this risk, rather than risk social exclusion and being left out by their peers by not engaging in risky sexual practices (van der Riet et al., 2018).

Young people are often generalised as a “homogenous group”, which has implications for research done with adolescents (Macphail & Campbell, 2001). Some young people will not follow societal norms in the same way as others, whilst other adolescents find it difficult to resist societal norms as influenced by their peers (Macphail & Campbell, 2001). The sexual behaviour of young people varies in many ways. Some of these include parental upbringing, religious beliefs, societal norms, community norms, financial status, gender inequality, peer pressure, social status, survival (Eaton et al., 2003; Hartell, 2005; Leclerc-Madlala, 2004; Macphail & Campbell, 2001). There is a large volume of quantitative research on sexual behaviour amongst young people and their sexuality in developed countries, but such data are more limited in developing countries (Macphail & Campbell, 2001). As noted earlier, youth aged between 15 to 24 are vulnerable, with 60% of new HIV/AIDS infections happening within this age bracket (Simbayi et al., 2014). This age group also has the highest prevalence of sexually transmitted infections (STIs). The death toll for HIV/AIDS related incidents increased by 50% from 2005 to 2012 but since then, due to the availability of ART, there are less people living with HIV/AIDS (30% decrease – 2015) (AVERT, 2015).

2.4 FACTORS THAT PROMOTE OR PERPETUATE UNSAFE SEXUAL BEHAVIOUR IN YOUNG PEOPLE

There are three main areas into which the unsafe sexual practice of adolescents fall (Eaton et al., 2003). These are personal factors, the proximal environment, and the distal environment. Personal factors include issues with self-confidence and low perception of risk while proximal and distal environment factors relate to issues within a person’s home and the environment

beyond. Proximal factors could include issues of peer pressure, alcohol, and drug abuse as well as gender-based violence against woman. While distal factors in the environment could include issue of poverty and culture.

In a study done amongst undergraduate students at the University of Nairobi by Othieno, Okoth, Peltzer, Pengpid, and Malla (2015), poor mental health had an effect on the sexual behaviour of adolescents. Results from this study revealed that there was a positive correlation between students who have depressive symptoms and taking risks in sexual behaviour. These risks included partaking in sexual behaviour with more than two partners and not consistently practicing safe sex. This may be due to possible low self-esteem and self-efficacy in depressed students. It is possible that they do not care about themselves and the numbers of risks they take are higher than if they did not have any depressive symptoms. When looking at future HIV/AIDS intervention programmes, it is important that this factor is taken into consideration (see section 2.5 for further discussion of self-esteem in this regard).

According to a more recent study conducted in South Africa, some common reasons that people engage in sexual activity at a young age include, sexuality being a source of identity, for social or partner acceptance, masculine virility and men regarding sexual satisfaction as a right (van der Riet et al., 2018). Many young people do not see themselves to be at risk for HIV-infection, even though they are aware of the severe effects of the disease, and therefore continue to engage in risky sexual behaviour with more than one sexual partner (Onoya, Zuma, Zungu, Shisana, & Mehlomakhulu, 2015; Pitpitan et al., 2016).

2.4.1 CONDOM USE

In South Africa, Hartell (2005) reported that condom use amongst adolescents was inconsistent and more than half of the sexually active adolescents did not use condoms at all, while less than 10% used condoms consistently in sexual activity. Reasons for the irregular use of condoms, if used at all, include: peer pressure, poor negotiation skills, low self-perception of risk, and impairment of one's judgment to use condoms after drinking alcohol (Hartell, 2005). In more recent studies it has been suggested that HIV/AIDS infections in youths, again, are likely to be linked to inconsistent condom use and unprotected sex with multiple partners (Othieno et al., 2015).

Males have been known to report that contact sex is preferable and in some South African communities virility was seen to be obstructed by condom use (van der Riet et al., 2018). It is common for people who are sexually active, who have both had sex with and without a condom, to report pleasure loss in sexual intercourse with condoms. This could affect decisions to use condoms, putting them at higher risk to HIV infection. Condom use is less favoured than the oral contraceptive in preventing pregnancy, which is seen as more of a concern for women than HIV/AIDS transmission (Cooper et al., 2016). More recently, development of different brands of condoms have taken the "skin on skin" factor into consideration, and have manufactured condoms that are thinner in order to feel similar pleasure as "skin on skin" intercourse, but with the added benefits of being protected of HIV infection, sexually transmitted diseases, as well as unwanted pregnancy (Higgins & Fennell, 2013).

In some African cultures, it is common in rural areas for young women to have to prove their fertility to men, because traditional young African men also have the need to prove their virility by being a father. In a study conducted in seven east and southern African countries in rural settings, it was noted that masculinity was strongly related to sexual virility and virility was proven through being sexually active and having multiple sexual partners (van der Riet et al., 2018). Women thus rarely have a say in condom use, and 45% of young men in a study reported the use of condoms as being a "waste of sperm" (Eaton et al., 2003, p. 158). In South Africa many young woman are fearful of rejection from men, so that they do not question condom use, or prioritise safe sexual behaviour, in effort to keep the relationship (van der Riet et al., 2018).

However, young people in urban areas tend to not have the desire to have children at a young age (Macphail & Campbell, 2001). Those who do want to use a method of contraception in order to avoid becoming pregnant feel that hormonal contraceptives will be more effective than condoms, as noted above. Knowing their partners' status before would be an ideal way of preventing HIV-infection in such cases.

Previously it was noted that there were many misconceptions around condom use in South Africa and that a proportion of 70-90% of a sample were aware that HIV/AIDS could be prevented by condoms (Eaton et al., 2003). This showed a need for education in the area. It has also been seen that with groups that were aware that condoms could prevent HIV/AIDS, there was still limited use of them for protection. This literature reveals that in some places, HIV-awareness levels and prevention strategies are relatively high, though this does not change risky sexual practices. It also shows that in some groups there are still myths and misconceptions about condom use, which is problematic in trying to reduce the spread of HIV/AIDS.

2.4.2 PEER PREESURE

Peer-pressure to engage in early sexual intercourse amongst South African adolescents is high and is one of the reasons that their average age for first sexual encounters is so young (Eaton et al., 2003; James et al., 2004; Kelly & Ntlabati, 2002). Young men are pressured to demonstrate their masculinity, which involves engaging in sexual intercourse, and to have multiple sexual partners. People are also pressured into sexual activity because of societal factors (van der Riet et al., 2018). It is noted in the aforementioned study amongst young men that identity is more socially, than biologically constructed with socially arranged activities helping them come to understand themselves. Sexual activity, being a part of these social arrangements, therefore plays a big part in young men's identification of the self. They therefore feel pressured into these activities in a search to find our identity amongst others in society. Woman's social status is also centred around having a male partner, resulting in acquiescing to their partners' desires, which may at times put their SRH at risk. This can be seen as something beyond peer pressure and is now rather centred around the need to invest the self "in a particular kind of social reputation" (van der Riet et al., 2018, p. 14).

2.4.3 PERCEPTION OF SELF-RISK AND HIV/AIDS STIGMATISATION

Eaton et al. (2003) noted that many adolescents in South Africa did not see themselves as being at risk for HIV-infection, which affected their decisions to practice safe sex. Perceptions of contracting HIV amongst sexually active adolescents were very low and these individuals did

not practice safe sex due to this perception. There are things that affect these low self-perceptions of risk that were found through qualitative studies. These are that people do not want to believe that there is a risk of contracting HIV within their community because they think they know the people in their community, and none appear to have HIV. This is especially the case in the rural areas of South Africa where the stigma attached to HIV/AIDS is extremely high. Not perceiving oneself to be at risk for HIV infection affects decisions such as consistently using condoms as well as having more than one sexual partner without knowing their status (Anderson, Beutel, & Maughan-Brown, 2007).

People living with HIV/AIDS in South Africa experience discrimination due to the stigma attached to HIV (Anderson et al., 2007). If a person perceives themselves to be at risk to HIV infection it also may make them think that they are part of a group that is highly discriminated against and stigmatised (Macintyre, Rutenberg, Brown, & Karim, 2004). This is said to result in South African youth having low perceptions of risk, to avoid being part of a stigmatised group. It can be said that they do not want to admit their vulnerability because HIV is so frowned upon and they do not think the people they associate with in sexual encounters belong to such a discriminated group.

There is also a connection between young individuals who perceive themselves as at high or low risk of HIV infection and age of first sexual intercourse (Anderson et al., 2007). Adolescents who see themselves as being at high risk for HIV infection may be more inclined to postpone their first sexual intercourse than those who do not see themselves at risk to HIV/AIDS (Macintyre et al., 2004). Individuals may also be uncertain of their own ability to consistently practice safe sex. The majority of the studies done on HIV risk behaviour in South Africa have

looked at how often people practice safe sex and how many sexual partners they have (Eaton et al., 2003; Hartell, 2005; Macphail & Campbell, 2001), but little research has looked at perception of HIV risk and first sexual debut (Anderson et al., 2007). There have been some gender differences in perception of risk of HIV amongst those who are sexually active (Simbayi, Chauveau, & Shisana, 2004). Risky sexual behaviour is a major concern as explained by Harrison et al. (2015) and highlights the need for improvement in education about safe sex and HIV/AIDS transmission.

2.4.4 ALCOHOL AND RISKY SEXUAL BEHAVIOUR

Alcohol consumption has an influence on risky sexual behaviour (Kalichman, Simbayi, Kaufman, Cain, & Jooste, 2007). South Africa, having the highest HIV-infection rate amongst adolescents, also consumes a great amount of alcohol (Kalichman et al., 2007). Areas in South Africa with a significant alcohol consumption are those that are at most risk for HIV-infection (Kalichman et al., 2007). Statistics reveal that roughly 40% of South African men and 15% of South African women consume alcohol, and a great number of these drink heavily.

The number of times that people drink alcohol is associated with increased risky sexual behaviour (Campbell, Williams, & Gilgen, 2002). However, a study done by Morojele et al. (2004) found that the number of times men and women consume alcohol is not directly related to HIV status, but the amount of alcohol drank by men and women was related to having more

sexual partners. The use of condoms has been seen to decrease with alcohol and substance abuse which increases unsafe sex rates as well as HIV/AIDS risk (Harrison et al. 2015).

The risk of HIV transmission in South Africa is related to alcohol consumption in any quantity and frequency (Kalichman et al., 2007). In a study in Kwazulu Natal Waxman, Humphries, Frohlich, Dlamini, and Ntombela (2016) have also reported that increased alcohol consumption led to women being more vulnerable to abuse and consequently gender based violence. Individuals who consumed a large amount of alcohol have said that they used condoms less in sexual activities, as well as having multiple sex partners, which shows how alcohol consumption can increase the risk of HIV-infection as it impairs the judgements of people to have protected sex (Dunkle, Jewkes, Nduna, Jama, & Levin, 2007; Kalichman et al., 2007).

2.5 SELF-ESTEEM AND PERCEIVED SELF-EFFICACY AS FOUNDATIONAL FACTORS

The way in which people see themselves and the beliefs they have about their abilities that affect their behaviour is known as “perceived self-efficacy” (Bandura, 1994). This controls the way in which people are motivated to perform tasks in everyday life and it is done through four processes: cognitive, motivational, affective, and selection.

Having a good sense of perceived self-efficacy plays an important role in being successful and accomplishing personal goals throughout their lives (Bandura, 1994). Instead of avoiding

challenging tasks and seeing them as intimidating, an individual with a high level of perceived self-efficacy will approach these with the intention to learn, improve the current skill set, and gain experience from the task. If they fail at a task, they do not dwell on their setback but rather see where they went wrong and attempt to understand how to approach the task in an improved manner. Having a high level of perceived self-efficacy and approaching situations in this manner is proposed to reduce anxiety and depression.

On the other hand, people with low levels of perceived self-efficacy tend to avoid challenging tasks as these tasks may come across as intimidating (Bandura, 1994). Individuals with low perceived self-efficacy struggle to stay committed to a task if it presents as difficult and will dwell on their failures and struggle to pick themselves up again. They tend to give up easily when presented with something difficult rather than attempting to learn how to be successful in that given situation.

Perceived self-efficacy is not something that individuals are born with but is developed over time and through experiences (Bandura, 1994). There are four main ways in which self-efficacy is developed by an individual. The first way in which self-efficacy can be developed is through mastering a skill which allow the person to become confident about performing that skill. This is the most effective way of building up a high level of self-efficacy.

The second way in which one can gain self-efficacy is through seeing other individuals who have a similar skill set to themselves succeed in the desired activities, making them feel that they too possess the ability to do so (Bandura, 1994). Thirdly, individuals develop self-efficacy through

the verbal encouragement of people around them, also known as social persuasion. This boosts self-efficacy by allowing them to believe they have the ability to complete and succeed in the task at hand. Lastly, people may rely on their emotional reactions to performing a task, when it comes to self-efficacy. If they experience an increase in stress levels and anxiety when they do not perform well in a particular task, they may be discouraged from facing that task again in order to avoid the feeling of discomfort.

The level of individuals' perceived self-efficacy has an impact on their behaviour, their thought processes, and their feelings (Schwarzer & Warner, 2013). People who have high levels of self-efficacy have the ability to view difficult situations or tasks as challenges, as opposed to anxiety provoking threats. On the other hand, individuals with low levels of self-efficacy have trouble dealing with difficult situations as they doubt their abilities and lack the confidence to carry out the task. People with low levels of self-efficacy tend acknowledge and put more emphasis on their failures and do not praise themselves enough for their successes. An individual's self-efficacy beliefs may persuade them to think they are incapable of performing a certain task, but this does not mean the individual does not possess the ability to successfully carry out the task.

Low self-esteem has been shown to have an influence on condom use (Eaton et al., 2003). Individuals with low self-esteem may find it difficult to negotiate condom use because they do not want to disappoint their sex partner. Individuals with low self-esteem may want to please their partners, but they do not know the faithfulness of their partner either, and so their safety is not guaranteed.

Negotiating the use of condoms is usually more difficult for women in South Africa opposed to men, due to the dominant male culture that places the men in control in sexual situations (Dunkle et al., 2004; Nesoff, Dunkle, & Lang, 2015). Many women often do not have a choice to practice safe sex, because they are scared of being abused or rejected by the man as a result (Manzini, 2001). It is common for South African men to have multiple sex partners, increasing the risk for HIV-infection for women further (Eaton et al., 2003; Hartell, 2005; Macphail & Campbell, 2001; Van Staden & Badenhorst, 2009).

Women with low self-esteem may not even consider condom use, depending on what the partner wants, "going with the flow" in order to ensure her partner receives pleasure from being with her, which may temporarily improve her self-esteem and make her feel more important. Harrison et al. (2015) explain that low self-esteem and poor mental health are also commonly linked to increased substance abuse, which can result in an increase in sexual risk-taking behaviours including not wearing a condom.

It is not unexpected for young adults to engage in risky sexual behaviour especially during their years of tertiary education, and is it acknowledged that there is a link between safer sexual behaviour and having a higher self-efficacy (Ajayi & Olamijuwon, 2019). The link between self-efficacy and sexual behaviour is known as "sexual self-efficacy" and can be defined as "one's belief in his/her ability to handle a sexual context well", meaning that people who have higher levels of sexual self-efficacy tend to practice safe sexual behaviour on a more regular basis as opposed to people with low levels of sexual self-efficacy (HSU, YU, LOU, & ENG, 2015, p. 125). Sexual self-efficacy plays an important role in one's SRH health since emphasis is placed on whether they engage in risky sexual behaviour or not (Assarzadeh, Bostani Khalesi,

& Jafarzadeh-Kenarsari, 2019). Individuals with low sexual self-efficacy have a higher risk of contracting STIs, HIV/AIDs, or falling pregnant unintendedly.

Having high levels of sexual self-efficacy is vital for the maintenance of good SRH. There have been interventions that measure self-efficacy, empowerment and SRH decision-making abilities in order to increase the sexual self-efficacy of women (Robinson et al., 2017). It was found that empowerment-based interventions were useful in this area, leading to increased use of condoms during sexual intercourse.

A major setback in increasing the sexual self-efficacy of women in lower-and-middle-income countries such as South Africa is the lack of provision of information on women's SRH needs (Desrosiers et al., 2020). The most important time to receive SRH knowledge for women is when they are adolescents and are at a reproductive age.

2.6 SEXUAL BEHAVIOUR AND ATTITUDES AMONGST UNIVERSITY STUDENTS IN SOUTH AFRICA

University life is a chance for many students to try out new behaviours that are daring and adventurous, such as experimenting with drugs and alcohol, which may impair their judgements to make safe sex choices (Van Staden & Badenhorst, 2009). It is undeniable that universities are sexualised places and there is a lot of pressure placed on individuals to experiment and become sexually active (van der Riet et al., 2018). According to van der Riet et al. (2018) men feel that it is their right to make decision regarding how a sexual encounter plays out and young woman looking for approval by men often go along with these desires in the hope of acceptance, opposed to prioritising non risky sexual behaviour.

University students in South Africa are particularly at risk for HIV-infection compared to other countries worldwide (Heeren, Iii, Mandeya, & Tyler, 2007). Students have been known to be pressured/forced into unsafe sexual practices without giving their consent is a major issue in South Africa. (Jewkes, Levin, & Mbananga, 2002; Van Staden & Badenhorst, 2009). The high prevalence of rape in South Africa, estimated to be over one and a half million rapes every year, is closely associated with the male stereotype and male dominant culture which pressure woman into threatening sexual behaviour (Van den Berg & Van Rooyen, 2007). South African gender based violence is a big concern, with the country having extremely high rates and woman under the age of 18 being particularly vulnerable (van der Riet et al., 2018). These high rates of gender based violence are a reflection of South Africa's interpersonal and community violence which is a big concern for the public health sector (Harrison, Colvin, Kuo, Swartz, & Lurie, 2015).

Not using a condom is believed to improve the social status with male sexual partners for female students from an African cultural upbringing (Jewkes et al., 2010). In addition, risk could be exacerbated because female students may choose a method of contraception that does not prevent HIV-infection due to the fact that they are wrongly more concerned about an unwanted pregnancy than contracting HIV (Van Staden & Badenhorst, 2009).

2.7 PREVIOUS HIV/AIDS INTERVENTIONS

Chandra-Mouli, Lane, and Wong (2015) noted that the 1994 International Conference on Population and Development (ICPD) gave some recognition to SRH needs and concerns relating to teenagers in low to middle income regions. Through the ICPD it was noted that young people were not receiving correct education on sexuality, reproduction and SRH, at home, school or from their community. These communities did not openly recognise sexual behaviour in adolescents as well as their right to SRH, and SRH programs at the time were primarily centred, rather, around adult woman. However, since 1994 there has been much done to recognise these SRH rights for adolescents and a number of interventions have taken place to promote understanding and action in this area.

Previous HIV/AIDS interventions amongst South African youth have been shown to have positive outcomes (Harrison et al., 2010). Eight intervention programmes have been studied, that were designed or adapted for the South African context. The studies had the same objectives, which was to raise HIV/AIDS knowledge and awareness amongst youth in South Africa and

teaching them how to avoid sexual risky behaviour; in order to lower their chances of contracting the infection. In all eight interventions the content surrounding HIV/AIDS that was taught was similar, but the ways in which it was delivered to the youth differed. The interventions were either school or group-based, with information delivered through peer educators, teachers, and mentors.

The results of the study done by Harrison et al. (2010) show that after these programmes, there was a decrease in STI occurrence as well as a decrease in the number of people who reported engaging in unsafe sexual behaviour. It was also found that group-based methods of providing knowledge and awareness had a more positive effect on the youth, as did the provision of this information by peer educators, though it was stated that the peer educators did require a substantial amount of training in order to do so.

Based on the results of the review, key recommendations were established for future HIV/AIDS prevention interventions. These recommendations consist of "addressing HIV social risk factors, such as gender, poverty and alcohol; target the structural and institutional context; work to change social norms; and engage schools in new ways, including participatory learning" (Harrison et al., 2010, p. 1). The proposed research has features that relate to these successful HIV prevention interventions.

Previous sub-Saharan attempts to initiate HIV/AIDS programs for adolescents have been poorly planned out and reported little influence on sexual behaviour (Jewkes et al., 2008). However, two interventions that have demonstrated successful results have been the Stepping Stones and

LoveLife programs initiated in Southern Africa. I will now detail the research on these two successful initiatives followed by initiatives that have not been as successful.

2.7.1 LOVELIFE INTERVENTION

LoveLife was a campaign funded by the Kaiser Foundation (USA), initiated in 1999 and aimed to prevent the prevalence of the epidemic effecting adolescents in South Africa (Thomas, 2004). The campaign targeted youth populations through high-powered multimedia initiatives (billboards, TV advertising, print media and radio), health services centred on SRH, as well as nation-wide support programs and community outreach (Pettifor, MacPhail, Bertozzi, & Rees, 2007). The initiative has been criticised for its public media strategy which came across as superficial and impertinent to the population, often sending confusing messages about idealised life situations (Thomas, 2004). LoveLife aimed to encourage the reduction in HIV risk behaviour and encourage positive lifestyle choices centred around topics of condom use, having many sexual partners and gender roles in society (Pettifor et al., 2007).

It was noted that determining whether the campaign had any effect on HIV transmissions or sexual behaviour was complicated, however, there were some relevant findings from the campaign (Pettifor et al., 2007). In a survey conducted in 2003 there was a rise in awareness levels reported due to the LoveLife campaign, and in some areas youth were more likely to report the use of a condom in recent sexual interactions. Some participants noted that they were more comfortable in speaking about HIV and many noted optimism and empowerment through

focussing on bettering themselves and their futures. Overall the program was hard to evaluate due to being on such a large scale and having many inter relating elements that make it difficult to assess effect in a specific region (Harrison et al., 2010).

Thomas (2004) notes that whilst interviewing people in areas targeted by the campaign, women acknowledged condom use as a prevention method for contracting HIV, however, they explained that they did not use condoms with their male sexual partners due to their economic dependence on them, or issues of pleasing their partners in transactional sex. A limitation of the campaign was that it failed to address issues of homosexual sexual interactions, only displaying images of heteronormative sexual scenes (Thomas, 2004).

It is necessary to address issues on sexual violence, transactional sex, cross-generational sex, and sex work, since LoveLife did not succeed in these areas (Thomas, 2004). Bearing in mind that LoveLife was aiming to create ideas of new relationships, the campaign would have benefitted from demonstrating a variety of alternative representations of sexuality, as opposed to relying on images depicting the stereotype. Such images only credit current relationships. The initiative could have also benefitted from providing access to practical information on getting treatment for HIV, as well as dealing with discrimination against people living with HIV. Moreover it is necessary that a competent, well-functioning and accessible medical and public health infrastructure is established that can provide early prevention and satisfactory medical care, before such initiatives are put in place, which is where South Africa is restricted (Thomas, 2004).

2.7.2 STEPPING STONES INTERVENTION

This approach, initially introduced in Uganda as a HIV prevention programme, makes use of role play, critical reflection and active learning methods to counter gender based sexual violence and generate more understanding, stronger and equal relationships amongst men and woman (Jewkes, Wood, & Duvvury, 2010). The program aimed to combat HIV and STI infection as well as address relationships and gender equality as a means to counter risky behaviour/vulnerabilities in the first place. Specific topics covered included love and sex, unwanted pregnancies, reasons for sexual behaviours and working on communication skills. The initiative was carried out in rural South Africa and included 3-hour intervention sessions taking place for individual genders – male or female groups of 20 people. These sessions were carried out by a trained peer facilitator.

This intervention has shown potential, according to Gibbs, Jewkes, Sikweyiya, and Willan (2015), particularly for South Africa. In one particular case the randomised controlled trial (RCT) carried out reported that there was "a 33% reduction in herpes simplex type 2 incidence among woman and men", with a lower number of reported IPV incidences by males after two years, as well as a reduction in drinking related sexual risk taking and transactional sex incidence (Gibbs et al., 2015, p. 210).

In the findings from the Stepping Stones intervention, Jewkes et al. (2010) show a significant influence on many aspects of subjects' lives, including HIV related risk behaviour. The most

notable influence was that on communication, with participants reporting more confidence in addressing issues around sex and relationships, as well as empowering individuals and aiding in self-identification. In relation to HIV and risky sexual behaviour, in the male participants it was noted that a new idea of which risks were involved had surfaced, and there was intention to avoid these instances in future interactions. In carrying out the initiative aims to reduce IPV's, the case-studies suggest this was plausible along with reconsideration and analysis of power and relationships – an indication for change (Gibbs et al., 2015).

This improved behaviour was notable and said to be due to exercises in critical reflection for these males (Jewkes et al., 2010). Women demonstrated some HIV risky behaviour reduction but did not show as impressive signs of perceptions of risk and intent to avoid it. This was because women found it hard to have concerns over things that they believed they had no control over, due to prevalent gender inequalities. It is highly plausible that the Stepping Stones initiative failed to impact as much on HIV incidence in woman because of these perceptions.

2.7.3 OTHER INTERVENTIONS

There have been many other, less extensive, interventions that have occurred in HIV prevention. According to an analysis conducted by Harrison et al. (2010), in South Africa there have been another seven interventions that demonstrated steps forward in preventing HIV transmission and risky sexual behaviour. The eight interventions reviewed by the study included;

- **HAPS [HIV/AIDS Prevention Study]** introduced in Kwazulu Natal that aimed to decrease the amount of alcohol related sexual risk taking.
- **HealthWise** introduced in Cape Town that aimed for reductions in substance abuse, STI/HIV transmission, and better use of spare time.
- **Mpondombili Project** introduced in Kwazulu Natal to encourage safer sex practices and work on gender equality and challenging gender norms.
- **Adolescent Livihoods** introduced in Kwazulu Natal, which aimed to reduce people engaging in activities that could put them at risk for contracting HIV, as well as allowing for discussion places.
- **SATZ** which took place in Cape Town's Northern suburbs and aimed at creating school programmes for sexual health centred around correct condom use and abstinence.
- **Stepping Stones** (covered above)
- **Tshwane Peer Education and Support Programme** in Pretoria, which aimed to encourage correct information relay regarding the HIV epidemic and addressing friend relationships and creating a space for psychological support for sex and relationships.
- **IMAGE – Intervention with Microfinance and AIDS and Gender Equality,** which aimed to assess the impact of microfinance and training intervention on risk behaviour in relation to HIV.

From the above interventions it was noted that in many cases there was limited impact on sexual risk taking behaviour and biological outcomes (Harrison et al., 2010). There were, however, common effects that could be discerned on secondary outcomes. These included an increased emphasis was placed on one or more sexual risk factors (e.g. alcohol and gender); increased exercise of group-based work as a means to counter social norm; and there was a need for

additional staff to relieve educators of the duty of carrying out interventions; and targeting interventions at institutions as well as individuals. From all eight studies some specific cases of positive impact on knowledge, attitudes and social conventions were recorded. Some of these included: more positive attitudes to condom use, increased perspective on condom availability, decrease in unprotected sex, decrease in sexual partners, decrease in transactional sex, decreased rates of depression, increased self-esteem, comfort in discussing sex at home, an increase in HIV testing, as well as a higher perceived risk of contracting HIV (Harrison et al., 2010).

All the interventions described above, as well as LoveLife, illustrated that such interventions confirm the possibility to change risk behaviours that are related to HIV/AIDS (Harrison et al., 2010; Jewkes et al., 2010; Thomas, 2004).

2.7.4 LESSONS FROM INTERVENTIONS

From the above interventions we can note some important lessons:

[1] the main message from these interventions was an emphasis on moving from measures of an individual's knowledge and psychology to addressing larger social structures of society that underpin HIV risk behaviour (Harrison et al., 2010). It is important to consider addressing all factors, be they individual, social, or institutional.

[2] the importance of change in individual values and gender ideology in affecting the structural context of HIV risk taking behaviour. Many of the studies demonstrated ways in which structural approaches can influence participant behaviour.

[3] It is critical to challenge social conventions in relation to HIV risk taking and prevention. This can be done through group activities involving critical thinking and building individual empowerment. This is not seen in school-based interventions and it should be encouraged that schools take a less didactic approach to education on HIV risk and prevention in favour of group-based, more interactive learning.

[4] Finally, delivery should be conducted by trained personnel other than educators. It was also seen through the interventions that peer education did not have the ability to impact participants. Peer educators are seen as less effective in classroom situations and struggled with the authority required to run a class. It could therefore be beneficial to have advisors who were older.

2.7.5 WHAT DID NOT WORK

In considering SRH awareness and effectiveness it is necessary to consider the literature on previous interventions that have not worked, in order to ensure such issues are not ignored or repeated. Peer education, as seen above, along with youth centres and public meetings which take place without follow ups, have not been seen to be successful in enabling young people access to SRH services as well as changing normative behaviour (Chandra-Mouli et al., 2015).

In South Africa, the above- mentioned interventions faced many struggles in consistency due to absenteeism of both educators and pupils, recurrent violence and disruptions (Harrison et al., 2010).

A number of recent publications have commented that ineffective interventions and intervention delivery mechanisms continue to be used widely (Chandra-Mouli et al., 2015), while interventions that have shown a positive impact are often being delivered unsuccessfully. This means that there has been major resource investment without affirmative results, raising the question about the worthiness of carrying out such SRH strategies. There is also evidence from the interventions that the youth are not actually receiving these services intended for them: that the intervention is rather accessed primarily by older, literate youths.

Youth centres serve as a friendly meeting place for young people to go and receive SRH information. Though they have been seen to be popular they have not always been effective (Chandra-Mouli et al., 2015). These centres were only used by a small percentage of the population, being visited for recreation and there was limited impact on use of SRH services, not to mention a high beneficiary cost. Peer education schemes were another ineffective intervention. Here, information was shared regarding SRH, however, there was a limited impact on putting into place healthy behaviours and the educators seemed to benefit more from the program than the intended beneficiaries. Peer education could work as part of holistic intervention where peers act more as a source to refer to expert services. High-profile public meetings were another intervention that failed to make an impact on SRH. These events have no follow ups to reinforce behaviours and are simply just well publicised spectacles aiming to address issues with little reinforcement.

Although none of the interventions initiated in South Africa could be considered entirely successful, there had been substantial intervention efforts over the 20 years prior to this article being written (Chandra-Mouli et al., 2015). There are still gaps in knowledge on the subject, however we now have a better idea of what is needed in these low to middle income areas as well as what is effective. Stopping the transmission of HIV and new infections is vital to restricting the epidemic (Cooper et al., 2016). The goals of the National Integrated Strategy on HIV, STIs and TB (Tuberculosis) for South Africa have not been achieved (Burman, Aphane, & Delobelle, 2015). This strategy aimed to reduce HIV occurrence by 50% and there are still high levels of youths aged 15-24 contracting new HIV infections with young woman being at greatest risk have eight times the likelihood of contracting the infection as opposed to young males.

2.7.6 GAPS IN THE RESEARCH SINCE THESE INITIATIVES

As highlighted by Germain, Sen, Garcia-Moreno and Shankar (2015), since initial interventions such as Stepping Stones and LoveLife there has been a gap in SRH information and services, accountability mechanisms and medical standards to effectively combat the HIV/AIDS epidemic.

From the onset of democracy in South Africa there has been great progress in improving SRHR legislation, however, disorganised policy delivery has meant little progress in preventing HIV infections (Cooper et al., 2016). A more comprehensive approach to SRHR is necessary. International donors to South African HIV health care have only contributed to initiatives for

HIV/AIDS care and ART, with SRH education and HIV prevention having a small part of these contributions. There have also been problems with significant SRHR Non-Government Organisations (NGOs) closing down or having financial difficulties. Lee, Kapogiannis and Allison (2019) notes that in the USA, HIV transmission rates among the youth have not improved and prevention services and risk-reduction interventions are required. Initiatives such as Stepping Stones that aim to promote SRH and other prevention methods need to be put in place in educational institutions as current young people struggle to make connections between sexual education in class and actual sexual experiences (Cooper et al., 2016).

2.8 AUNTIE STELLA ACTIVITY CARDS: TEENAGER'S TALK ABOUT LIFE, SEX, AND RELATIONSHIPS

Although South Africa has made progress in improving existing HIV/AIDS education programmes, outreach efforts to particularly vulnerable groups need to be improved further. The *Auntie Stella activity cards (ASACs)* take a different approach to HIV/AIDS education because the approach is discursive, based on group sharing of information rather than didactic. The cards have been widely used, and were first developed in Zimbabwe in 1997, followed by a modified form that was released in 2005 (TARSC, 2006). Through this research we hope to explore whether this form of HIV/AIDS education enables a different response to HIV risks and prevention amongst female university students. The role of this form of HIV/AIDS education will be explored in the proposed research, and if found to be successful, recommendations for refining of the material and wider implementation of the cards will be disseminated.

The material will be utilised as the basis of discussions as indicated by the title: *Auntie Stella activity cards: Teenagers talk about sex, life and relationships.* The activity cards contain typical personal and social scenarios including points of debate and a separate "answer" card to provide factual guidance (TARSC, 2006). The cards include a question, based around common misconceptions or troubling topics, that can be posed in group sessions. On the other side of the cards there are Action Points which promote discussion around the topic. For example, the 12th card poses the question "I pay for lunch, don't I deserve sex?" – a potential male assumption that brings up issues of transactional sex or sex in exchange for money or goods. The Action Points for this question include discussion points around if it is acceptable to ask for sex for money and if woman feel pressured to have sex with men if they buy them things. Some cards include scenes of common interactions between people regarding these issues which help to place the cards' issues in realistic situations. Other questions cover topic on cervical cancer and peer pressure to have sex.

2.9 RATIONALE FOR THIS STUDY

The financial status of female university students has an influence on HIV/AIDS and is an important determinant of unsafe sexual behaviour (Zembe, Townsend, Thorson, & Ekström, 2013). Many young women are unable to negotiate safer sexual practices when it comes to transactional sex due to the dominance of patriarchal culture. Numerous students move from small towns to larger ones to study at university, impacting their financial status and increasing their exposure to HIV (Van Staden & Badenhorst, 2009). These students are at the highest risk for HIV infection because they are at a financial and social disadvantage. As a result of their

poor living conditions, female students may engage in sexual relationships merely to gain financial benefits from their partners (Van Staden & Badenhorst, 2009; Zembe et al., 2013). Lack of security and understanding could also put these people at a social disadvantage.

There has been a substantial volume of research that has focused on cognitive decision-making about safe sex practices (Aarø et al., 2014; Harrison et al., 2010; Smith et al., 2008). Previous HIV/AIDS interventions amongst South African youth have been shown to have positive outcomes (Harrison et al., 2010). This research has features that relate to these successful HIV prevention interventions.

Although South Africa has made progress in improving existing HIV/AIDS education programmes, in order to meet the National Strategic Plan 2012-2016, outreach efforts to particularly vulnerable groups need to be improved further. Compared to other programmes, the *Auntie Stella activity cards* take a different approach to HIV/AIDS education because the approach is discursive, based on group sharing of information rather than didactic.

Through this research we hope to explore whether this form of HIV/AIDS education enables a different response to HIV risks and prevention amongst female university students. The role of this form of HIV/AIDS education will be explored in the proposed research, and if it found to be successful, recommendations for refining of the material and wider utility of the cards will be disseminated.

CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter outlines the aims of the research (including the research questions) and the methodology used, including discussion of the appropriateness of these, in order to conduct this research project. The chapter will provide a brief overview of blended methods with an emphasis on what qualitative research design entails, in particular, thematic analysis. It will discuss how the participants involved in the research were recruited, as well as the criteria they had to meet in order to participate in the research. Furthermore, the chapter entails an in-depth discussion of how the data for the research was collected and then analysed in order to answer the research questions. Lastly, any limitations and ethical concerns that need to be taken into consideration will be discussed.

3.2 RESEARCH AIMS

The aim of this study was to determine whether a particular set of educational tools (ASACs) can help improve women's SRH awareness in a university context. It can be assumed that young women at university are educated to some extent about how to protect their SRH by reducing their risks of contracting HIV/AIDS, STIs (for example, through the use of condoms), and developing cervical or breast cancer by going for regular pap smears and mammograms. One of

the main concerns of the researcher is the continuance of some young women partaking in risky sexual behaviour given the high prevalence of HIV/AIDS in South Africa (Heeren et al., 2007; Van Staden & Badenhorst, 2009). Therefore, this research aims to trial the Auntie Stella educational tool pack in order to ascertain whether it has an impact on the maintenance of good SRH amongst young university women in South Africa.

3.3 RESEARCH QUESTIONS

The broad questions framing this study are as follows:

- Why do young women at university still engage in unsafe sex given the high prevalence of HIV/AIDS in South Africa?
- How do the participants respond to the content of the ASACs, what were their reflections on the use of them, and what were the personal impacts of their use expressed in the group discussions?
- How might the ASACs be modified further for the South African University context?

3.4 RESEARCH TOOLS

Although South Africa has made progress in improving existing SRH education programmes, outreach efforts to particularly vulnerable groups need to be improved further (Harrison et al., 2015). The material utilised as the basis for discussion in the focus groups as indicated by the title: *Auntie Stella activity cards: Teenagers talk about sex, life, and relationships*. The activity cards contain typical personal and social scenarios including points of debate and a separate "answer" card to provide factual guidance (TARSC, 2006). The ASACs take a different approach to education on SRH as the method is discursive, based on group sharing of information rather than didactic. The cards have been widely used, and were first developed in Zimbabwe in 1997, followed by a modified form that was released in 2005 (TARSC, 2006). Through this research we hope to explore whether this form of SRH education enables the maintenance of good SRH amongst female university students in South Africa. The role of this form of education is explored in the research, and recommendations for refining of the material and wider implementation of the cards will be disseminated.

3.5 QUALITATIVE RESEARCH DESIGN

It is important to describe the type of research design and the methods taken in order to allow the reader to understand how the researcher progressed to the findings at the end of the study (Braun & Clarke, 2006).

Qualitative research designs tend to be more flexible and ask "open-ended" questions which allow participants to express themselves in further detail providing rich data sets, as opposed to a quantitative approach, which is far less flexible and involves more "closed-ended" questions. Quantitative research designs generally do not permit participants the opportunity to explain the reasons for their responses, whereas the qualitative approach allows the researcher to gain a better understanding of the "why" in participant's responses.

Since this study is based on the trialling of an educational tool that is discursive and involves group sharing of information, a qualitative approach was found to be suitable. The research used a mixed methods qualitative interventionist research design (M. Campbell et al., 2000) including the collection of focus group data, questionnaires, and an individual interview. Qualitative methods were used in order to achieve a more complete explanation and description of the data obtained (Bryman, 2012; Hussein, 2009).

3.6 THEMATIC ANALYSIS

Thematic analysis is a method of qualitatively analysing data that involves the recognition of recurring themes (also considered as patterns) across the data corpus by the researcher (Braun & Clarke, 2006). This method of analysis allows the researcher to arrange and classify the data into different categories (which is known as "coding"), condensing the relevant data and making the analysis process more straightforward. The coding process allows the researcher to focus merely on the data items that relate directly to the research questions at hand, whilst discarding irrelevant

data that would not be valuable to the aim of the study. This permits the researcher to provide a more in-depth analysis specifically relating to the purpose of the research without being clouded and bombarded with large amounts of unconnected data. A thematic analysis generally consists of data collection, coding of the data corpus into themes, and then analysing the data within the identified themes.

The central focus of the research is to trial material in the hope that it will improve women's SRH. Using a thematic analysis is a well-suited method in this case as the researcher is looking for commonalities within the reasons for young university women either maintaining, or not maintaining, good SRH.

Furthermore, the use of a thematic analysis was deemed appropriate as it can be used as an essentialist or realist method, which takes into consideration the "experiences, meanings and the reality of participants" (Braun & Clarke, 2006, p. 9). The interventionist educational tool at hand required group sharing in which experiences, opinions, and questions would be discussed amongst peers. In this instance, where the research will be looking at sexual behaviour and reproductive health maintenance of the participants, it is important to take into consideration past SRH experiences, as well as the reasons and outcomes for them. The participants may be able to draw from other's unique experiences, and as certain important elements may be missed without disclosure of other's experiences, this group sharing is foreseen as a valuable learning method. The sharing of experiences in a group environment is beneficial to the outcome of the study as it gives the researcher insight to components that need to be taken into consideration in order to further improve and develop educational tools in this area of research. The research will additionally seek to explore whether reasons for participants engaging in unsafe sex are due to

authentic decision-making, peer pressure, the influence of alcohol and other substance use, or any other motives that will be discussed further in the analysis chapter.

When it comes to coding the data set, there are two main techniques that a researcher can use to identify themes in the data collected (Braun & Clarke, 2006). Searching a data set for information that relates directly to the research questions is one way of identifying themes in a study; this is called a theoretical thematic analysis. Another approach is known as an inductive thematic analysis, whereby; themes or patterns emerge unintentionally and strike the researcher's interest. In an inductive thematic analysis, the researcher does not attempt to fit the data into previously determined categories, but rather allows the data to categorise itself.

3.6.1 LIMITATIONS OF THEMATIC ANALYSIS

A thematic analysis takes place when an analyst begins to pick up patterns of meaning in an area of interest in a particular set of data (Braun & Clarke, 2006). This is then reported on and narrowed down to themes which identify common patterns in the data collected. There are, however, limits to this method of analysis. Many disadvantages are a result of badly carried out analysis or unsuitable research questions than on the techniques themselves. The flexibility of a thematic analysis is troublesome as this allows for a substantial span of analytical approaches which means a diverse number of different conclusions can be drawn from a data set. This is a disadvantage as in some cases it is hard to "develop specific guidelines for higher-phase analysis" and it can become difficult individuals to choose what to centre their research on

(Braun and Clarke, 2006, p. 27). If thematic analysis is not used within an established theoretical framework it has restricted interpretative ability beyond merely being descriptive. Thematic analysis is also critiqued as being an approach taken by a researcher who has no knowledge of any other, more advanced method like grounded theory.

3.7 SAMPLING

Participants in the study were students who volunteered for a series of five focus group discussions using the ASAC as a basis for engagement. The criteria for the recruited participants were that they should be female tertiary students between the ages of 18-25. Since the project took place at Rhodes University in South Africa, an advertisement was placed on the University Facebook page in order to recruit participants. There was a total of 15 students who met the aforementioned criteria and contacted the researcher in the interest of partaking in the study. However, only 6 of these students followed through with the participation in doing the pre- and post-questionnaires, and the focus group discussions. The researcher spoke to the 6 existing participants regarding the recruitment of potential participants, and through the method of snowballing (Streeton, Cooke, & Campbell, 2004), a further 4 participants were recruited, therefore, leading to a total of 10 participants in the research project.

3.8 DATA COLLECTION

Research data were obtained using a pre-and post-intervention measure of participants' SRH related knowledge in the form of two questionnaires. The main purpose of the pre- and post-questionnaire was to determine whether or not the intervention had a significant impact on the participants' knowledge, awareness, and behaviour around the topic. Furthermore, it demonstrates the significance of the intervention at hand (Menna, Ali, & Worku, 2015). The focus group discussions were enabled using a relevant selection of the *ASACs,* and the discussions were audio-recorded and then transcribed. Focus groups have the potential for social norms to be formed by debate amongst individuals (Macphail & Campbell, 2001). Understanding individuals' different views, and how they feel about particular situations is one of the main purposes of the focus groups (Krueger & Casey, 2014).

The researcher ensured the creation an environment where participants felt comfortable enough to discuss the topics at hand. In this research, the *ASACs* aided in creating this environment, and the provided points of action and debate facilitated conversation after the scenario had been conveyed. Permission to audio record and transcribe data was obtained from the participants beforehand and their anonymity was ensured (Burman, 1994). The reasons for recording and transcribing the discussions were explained to the participants.

The data from the post-exposure questionnaire, explored their reflections on the cards, what the participants have learned from the cards, as well as the impact that the intervention had on their behaviour. At the end of the focus group discussions, after 5 weeks had passed, the participants

were given the option of engaging in an individual interview with the researcher, describing their thoughts on the intervention and the impact it had on them. This option was provided in case participants felt the need to share relevant experiences and thoughts about the intervention that they were unable to disclose in the group discussions for unknown reasons. There were 3 out the 10 participants that opted for this opportunity, however, only 1 participant followed through with the individual interview. The 2 participants who did not partake in individual interviews gave the same reason of not having enough time due to upcoming examinations at the university. Important data that was not conveyed in the focus groups, for the reason of individuals not being comfortable enough in the group to share such personal experiences, was obtained in one individual interview. This individual interview was semi-structured (Bryman, 2012).

In preparation for the focus group discussions, the researcher chose a selection of the ASACs that related best to the topic of women's SRH. Since the ASACs were developed as an educational tool for the teenage population in more rural areas, the researcher found that particular modification of the cards was necessary before the start of the FGDs. However, after the start of the project, although there was previous modification of the cards in attempt to fit the age group of young women in university, it was clear that further modification was needed. This area will be discussed further in the analysis chapter. The topics of the selected ASACs that were used as a basis for discussion in the focus groups are as follows:

- "I pay for lunch, don't I deserve sex?"
- "I want to have sex like all of my friends"
- "My church says condoms are wrong"
- "Must I tell her about my STI?"

- "My sugar daddy is treating me badly"
- "I'm worried about cervical cancer"
- "I'm HIV positive and pregnant"
- "How do ARVs work?"

Some of the Auntie Stella card titles, and parts of the card content, was modified in consultation with the supervisor in order to cater for this particular group of participants. The table below shows the Auntie Stella card number, the modified title of the card (if it was changed), as well as the number of the focus group in which that particular card was discussed.

Table 1: Table representing the order of the Focus Group Discussions, the number of the Auntie Stella card, as well as the title of the card

Focus group number	AS Card number	Card title
1	12	*I pay for everything; don't I deserve sex?* (modified title)
	6	*I want to have sex like all of my friends.*
	33	*My church says condoms are wrong*
2	22	*Should I tell him I'm HIV positive?* (modified title)
	36	*My sugar daddy treats me badly*
3	36 cont.	
	15	*I'm worried about cervical cancer*
4	40	*I'm HIV positive and pregnant*
5	19	*What are antiretrovirals?*

3.9 DATA ANALYSIS

The data collected from the focus group discussions underwent a thematic analysis as aforementioned in this chapter (Braun & Clarke, 2006). There was thorough reading and re-reading through the transcripts of the focus group discussions in order to identify the reasons for female students engaging in unsafe sexual behaviour, maintaining, or not maintaining good reproductive health, and to discuss the content of the ASAC. The researcher carefully selected and used only relevant data by recognising the main themes through the process of coding (Braun & Clarke, 2006). Themes are frequent patterns in the transcriptions of the focus group discussions (Bryman, 2012). A thematic analysis was appropriate for this study as it identified commonalities in the answers to the proposed research questions. An analysis comparing the pre- and post-intervention questionnaires was done to identify the changes in the participant's responses after exposure to the activity cards. The thematic analysis of the focus group discussions and individual interviews reflected on the utility and limitations of the content and process of using the cards.

Before the inception of the FGDs, I thoroughly read through all the Auntie Stella cards in the tool kit. I then carefully selected the cards that I found most relative to women's SRH and any factors affecting this, such as male partners insisting on no condom use. Once these cards were chosen, I looked for ways to modify them without completely changing the scenario, in order for it to be more suited to a university context, as opposed to a high school context so that my participants would be able to gain some knowledge and contribute in the FGDs that were to come. Major modifications included adding extensive theory about cervical cancer, Mother to Child Transmission of HIV, and the use of Antiretrovirals.

The data that I am presenting is an integration of both the qualitative and quantitative data that I have collected. The quantitative data was retrieved via pre and post questionnaires, and the qualitative data consisted of the transcriptions from the FGDs that took place. All of my data has undergone a thematic analysis, but due to the large volume of data, I have had to be selective and condense the data in order to answer the research questions.

According to Silverman (2000) in qualitative research it is essential that findings are based on thorough investigation and analysis of all relevant data to come up with truthful conclusions. Findings should not be based off few selected sources and conflicting information must be considered. Points to be proven should be set aside and an objective approach should be taken in order to prevent the drawing of incorrect conclusions. Validity and reliability have been adapted to standards to assess qualitative research keeping in mind reliability. This authenticity is based on credibility – dependent on resources studies; transferability – based on the degree to which findings can be transferred to other contexts; and dependability – based on the consistency of results if study was replicated.

Authenticity is based on a fair representation of sample data which helps participants to have understanding of their social worlds where researchers acknowledge other contributors. Bryman (2012) notes most importantly that with authenticity research has the ability to empower people to take action. According to Silverman (2000), tape-recordings and transcribed data is less credible due to difficulties in relating seemingly trivial parts of conversation and it is therefore essential to make use of recognised transcription methods to avoid such pitfalls. It is therefore necessary to take steps to ensure findings are believable, consistent, applicable, and credible for other readers.

Triangulation is essential for this, where multiple sources of data are relied on, opposed to only focus group material. Thus, exceptional care in transcribing data, using a recognised method, is essential. Ensuring a well-defined context and noting of unexpected changes is advised to allow for readers who have interest in recreating the study to have sufficient information to do so. It is also advised to keep records of information and research processes to ensure utmost credibility in confirming authenticity of data by others.

This also includes the regular supervision of information to counter bias in data analysis.

3.10 ETHICAL CONSIDERATIONS

The Rhodes University Psychology Department's Research Projects Ethics Review Committee has approved this research. This ethics approval included permission from the Training and Research Support Centre (TARSC) based in Harare, to trial and modify the material. Since young women are a predominantly vulnerable group of HIV infection, this will be stated clearly as the purpose for recruiting female students only. Informed consent regarding audio- recording, the involvement of human subjects, and the participants' consent was obtained. The participants were given the option to withdraw from the research at any time if they were uncomfortable with the focus group discussion. The researcher assured the anonymity of all participants involved in the research and kept the data collected from the participants confidential and protected from the access of other persons (Bryman, 2012). The researcher understood that this is a sensitive area of research. Therefore, all students engaging in this research received a pamphlet containing the phone numbers for the Rhodes University HIV/AIDS centre, that offers testing and counselling,

as well as the details of the student counselling centre, should any experiences of distress be provoked by the content of the cards or the discussions.

CHAPTER FOUR: FINDINGS

In this chapter, I will be presenting the pertinent results that were carefully selected after undergoing a thorough thematic analysis. Firstly, I will present the results that give insight to student's sexual and reproductive behaviour, as well as reasons for their continuous engagement in unsafe sexual behaviour given the high HIV/AIDS prevalence in South Africa. These results will be divided into five key themes: women's self-esteem; low self-perception of risk; peer pressure and male dominance; alcohol and substance abuse; and lack of knowledge. Next, I will be talking about how the participants respond to the content of the ASAC. Finally, I will provide the reader with participant perceptions of the Auntie Stella cards, including how they may be modified for the South African university context.

I will present the data retrieved from the FGDs which has undergone a thematic analysis. I thoroughly familiarised myself with the data from the transcriptions of the FGDs and the individual interview. During this process, there were a number of codes that were common ideas I synthesised into particular codes were then grouped into broader themes.

4.1 THEMES

The main themes that emerged throughout the FGDs that provide insight to the earlier proposed research question 'Why do young women at university still engage in unsafe sex given the high prevalence of HIV/AIDS in South Africa?' are:

- women's self-esteem
- low self-perception of risk
- peer pressure and male dominance
- alcohol and substance abuse
- lack of knowledge

4.1.1 WOMEN'S SELF ESTEEM AS A RESULT OF MALE DOMINANCE: 'I'VE GOT THE POWER OVER YOU'

Though I noticed this particular group of participants seemed to have a strong belief in feminism, women's rights, and gender equality when compared with the average woman, it became clear later on during the FGDs that one of the most prominent reasons for young female university students engaging in unsafe sex is due to women's low self-esteem in what is still perceived as a male dominated world. This showed me that although one may strongly believe in all of the

aforementioned, the heteronormative-dominated society in South Africa, still has a major influence on their actions.

Young women put the pleasure felt by male partners during sex before their own SRH. They would rather risk compromising their SRH than depriving males of sexual pleasure. This choice demonstrates how much these young women have the urge to please and impress their male partners, and in doing so, lowering their self-worth, and putting their health at risk.

In the FGDs, when the participants who had unsafe sex with their male partner were asked if they trusted him, all except for one had said they fully trusted that their male partners did not have HIV/AIDS, STIs, and were not sleeping with other women. This illustrates that most of the young women in my FGD have succumbed to the pressure of having unsafe sex with their male partners despite the risk of affecting their SRH.

Some participants agreed with the notion of a reason for not insisting on condom use and giving in to the pressure of not using a condom from their partner, is because it is common knowledge to women that there is pleasure loss from condoms for males during sex, and they do not want to ruin the sexual experience for their male partner by insisting on condom use. In the pre-questionnaire, 30% of the participants reported having felt pressured to have unsafe sex by their sexual partners, and in the FGDs it was confirmed verbally that this feeling of being pressurised to have sex without a condom, resulted in just that.

In the individual interview that was done, the participant expressed the reason she felt at risk to contracting HIV/AIDS or STIs as she was currently having unprotected sex with someone who she knew was having unprotected sex with other people. More importantly, the participant shared that her partner had engaged in unsafe sex with a female who recently found out that she was HIV positive, but the participant's partner has refused to go for an HIV test and still insists on having sex without a condom. She expressed that her partner is someone very close to her and her family, foresees a future with him and is giving him time to mature. The participant felt the need to have an individual interview as she was unable to share this information in the FGD due to certain associations with other participants. She was aware that it was vital for the research project that her circumstances were noted since she was not looking after her SRH and taking a risk for her male partner in the hope that they have a future together. Her interview showed that she acknowledges the risk of contracting HIV/AIDS due to the fact that her partner's prior sexual partner is HIV positive, that she does not trust her sexual partner, and yet she continues to put herself at risk by engaging in unsafe sex with him. This individual interview strongly demonstrated the power that men still have over women.

> *I mean, I have told him that I would like to use protection and he agrees, well, he agrees at the time, but when we actually do have sex it's always a different story, like, he says things like "but you're on the pill", and "it's so nice without a condom, just one last time", and I do it. It's happened so many times. And I know he's cheating on me, I know what I'm doing is dangerous, but I just can't seem to say no to him you know?* (Participant 3).

The above excerpt is extracted from the individual interview conducted with the participant who was unable to speak freely in the FDGs. This illustrates the points about the unequal distribution of power in these relationships, as described earlier.

4.1.2 LOW SELF PERCEPTION OF RISK

"Trust" in this study refers to a female expecting and assuming that their male sexual partner does not engage in unsafe sex with others, and believes him when he tells her he does not have HIV/AIDS or STI's, and if he did, he would share this information with her.

In the pre-questionnaire 87.5% of the sexually active participants reported having engaged in unsafe sex in the past year or are currently engaging in unsafe sex. After the inception of the FGDs, this percentage was reduced to 50%, leaving the remaining 50% of sexually active participants reporting having not engaged in unsafe sex since the inception of the FGDs.

At the inception of the FGDs, only 30% of the participants had been tested for HIV/AIDS in the past year, whilst 80% of the participants were sexually active, and 87.5% of the sexually active participants had engaged in unsafe sex. Reasons given during the FGDs for not having been for an HIV/AIDS test were due to low self-perception of risk.

> *"Well I haven't really thought I've needed to go for one you know, because I know who I've slept with and I just haven't felt like it would be an issue"* (Participant 5).

The above excerpt is from the person who in the pre-questionnaire stated that she had engaged in unsafe sex with two male partners, both under the influence of alcohol as well as being sober.

Post-questionnaire results revealed that 60% of the participants had been tested in the past year, demonstrating a 30% increase in the number of participants who reported been tested for HIV/AIDS since the inception of the FGDs. Participants were asked if this had to do with the FGDs and those who had been tested recently admitted it was because of what they had learned from the FGDs. This shows the participants acknowledged that they were at risk of contracting HIV/AIDS more so than they may have thought and took a step further towards looking after their SRH by knowing their status. The FGDs appeared to increase self-perception of risk.

Participants were asked in the pre-questionnaire before the start of the FGDs if they perceived themselves as being at risk of contracting HIV/AIDS and STIs, 20% answered "yes", 70% answered "no", and 10% answered "sometimes". One participant who felt that they were at risk of contracting HIV/AIDS and STIs commented further by saying:

> *"I am having unprotected sex with someone who is constantly sleeping with other people,"* (Participant 3).

It can be seen in the pre-questionnaire results that even though 87.5% of the sexually active participants had engaged in unsafe sex, only 20% of all the participants perceive themselves as being at risk of contracting HIV/AIDS and STIs. This emphasises a low self-perception of risk amongst these young female students who engage in risky behaviour.

In one of the FGDs, when discussing the Auntie Stella card "My sugar daddy treats me badly", where a young woman had begun a relationship with an elder wealthy man because he had promised her a certain way of life. She started to feel unsafe having sex with him with the use of

a condom, and when she asked him if they could start using condoms, he refused and told her if she wanted anything from him, that was how it would be.

The group of participants were annoyed with this scenario, some of their responses are quoted below.

> *"That is just pure blackmail, that's all they do, they just blackmail you into doing the things they want you to because they know you have nowhere else to go, and he doesn't even respect her enough to consider condom use, that's really unfair"* (Participant 3).

> *"And she said that he actually hurt her that night whilst having sex after she asked to use a condom, it's like him saying to her "I've got the power over you" without having to say those words"* (Participant 8).

After asking the participants why they think women stay in this kind of relationship, one of the participants responded:

> *"You can just become used to being treated badly, it can happen very easily, soon you don't know what you're actually supposed to be treated like, it's happened to me"* (Participant 3).

The above excerpt brought about an element of surprise amongst the group, surprise that someone in the room had admitted to currently being mistreated. It was noticeable that participant 3 was upset/emotional whilst sharing this with the group. The room was silent for a few seconds, and then another participant responded:

> *"I also think it's very easy to fall into a routine of accepting bad treatment from men, and also about the condom thing, it's happened to me before, and I'm sure a lot of us, where we have the intention to use a condom but they always have some comment that we fall for, but we can't carry on like this"* (Participant 9).

The above excerpt shows the participants were starting to realise the importance of condom use as well as not allowing their male sexual partners to talk them out of using a condom.

> *"I, as a virgin, think it should be a rule at the start of every relationship that you both agree to use protection all the time, and not just go with the flow, that's certainly what I am going to do when that time comes after hearing how some men can be so manipulative just to not use a condom, it's awful"* (Participant 7).

The aforementioned Auntie Stella card seemed to have brought more awareness to the group about how easy it is to be talked out of using a condom as well as how mistreatment from their male partners may be commonplace for and perhaps even taken as the norm by some young women may be commonplace for and perhaps even taken as the norm by some young women.

When asked after the FDGs if they perceived themselves as being at risk of contracting HIV/AIDs 40% answered "yes", 30% answered "no", and 30% answered "sometimes". The participants who do not see themselves as being at risk of contracting HIV/AIDS and STIs justified their answers. Some of these were "*I've never had sex before*", "*I always practice safe sex*", "*my partner and I get tested regularly*", "*I was at risk before, but now I see myself as being asexual, so there is a very low possibility of me engaging in any sexual activities*".

Those who answered "sometimes" explained that "*everybody is at risk because you never know if your partner is lying to you or not*", "*I thought oral sex without protection was ok, but now that I know there is still a risk of transmission I think, it makes me question if I've been exposed or not*". The participants who agreed that they were at risk stated the following "*I was previously raped, so there is a possibility, but, I do get tested regularly*", "*I have slept with someone who has had unprotected sex with an HIV positive person (we both did not know until recently)*". The results show an increase in self-perception of risk with contracting HIV/AIDs after the gaining knowledge from the FGDs, as well as an increase in self-esteem (referring to the participant who talks about trust and not knowing if your partner is lying to you or not).

Data from the FGDs reveal that one of the main worries for young women at university in South Africa is falling pregnant from having unprotected sex, thus it was not contracting HIV/AIDS, STIs, or impacting their SRH in other harmful ways.

> *"I also think that girls here at University don't really think of using condoms to protect their sexual health like you mentioned earlier with the cervical cancer, I feel that most of them only use condoms if they are not on the pill so that don't get pregnant, because that would be like, just the end of everything"* (Participant 6).

Another issue is that people either get tested very rarely, or they don't get tested at all, so most do not know their status. This results in a cycle of people believing they are not HIV positive and so they don't get tested, they don't know their status, and then they have unprotected sex with another person who they believe would/could not have HIV/AIDS due to their physical appearance or social status. The excerpt below demonstrates subconscious awareness of other people's status.

"I mean, I don't really sleep with people who would be HIV positive and stuff, I'm very careful about who I sleep with" (Participant 5).

This illustrates the common phenomena of the virus being often associated as being prevalent mainly in the rural and poor areas. Due to these misconceptions, young people at university often assume they do not interact or associate with people living with HIV/AIDS. This low self-perception of risk of contracting the virus results in people in urban and university settings still engaging in unsafe sex. This is compounded by people living with HIV/AIDS in wealthy or urban areas being ashamed, embarrassed, and afraid to disclose their status to anyone and therefore they try and hide it as much as possible.

4.1.3 PEER PRESSURE AND MALE PRESSURE

In this study, peer pressure refers to individuals feeling obligated to carry out certain actions solely due to the pressure asserted by the people in their social setting, and not because they as an individual want to do so. Peer pressure can lead to one feeling out of place in society if they do not adhere to the perceived "norm" from the people in their social setting. Examples of peer pressure are bullying, teasing, mocking, and emotional abuse that often results in individuals doing things they wouldn't normally do had it been up to them entirely. Male pressure in this study refers to the pressure men put on women in order to have their way and show their power over women. This refers to men buying things for women in the hope of having sex with them, as well as pressurising them into having sex when they do not want to, and lastly talking women out of using a condom. In this section, I will present the data on peer and societal pressures first, followed by data on male pressure.

In an advice seeking scenario to Auntie Stella card number 6 *"I want to have sex like all of my friends"*, a young man at University seeks a long-term girlfriend but is worried about the fact that he has never had sex before, and asks Auntie Stella if he should have a one night stand beforehand to get some sexual experience. He is afraid he will embarrass himself and disappoint his girlfriend. Furthermore, he states that his male friends tease him for being a virgin and not sleeping around as they say that is not fulfilling the characteristics of a true man.

This scenario was rather difficult for the participants to approach as they understood the young man's, but also stated he should be more confident in his choices and not let the peer pressure get to him, which some participants said was really difficult.

> *"His friends are making him feel like he isn't a 'true man' just because he doesn't sleep around, no one should feel that way, and he shouldn't have to prove himself to them or the girl he loses his virginity to because it's his life"* (Participant 3).

> *"Well that's a tough one hey, because he sounds like he has good intentions, and he wants to love and be loved too, but I totally get that he's a bit nervous to have sex for the first time with a girlfriend who has had sex before, yeah and especially because his friends make him feel worse about the situation he's in which has a knock on his confidence"* (Participant 4).

The participants in the FGD strongly felt that this scenario was unnecessarily caused merely by peer and societal pressure, and it is something that needs to be avoided. The above excerpt reveals two complications for the young man; the first being that he is a virgin and is

inexperienced, and the second is the pressure from his friends by mocking him for his sexual inexperience, which results in a decrease in the young man's self-confidence. Another participant added:

> *"He feels this way because sex is such a casual thing nowadays and to be honest it is terrifying when you're still a virgin and you don't want to disappoint your partner on your first time"* (Participant 7).

The above excerpt shows understanding and relation to the situation that the young man finds himself in, and agreement that it is a distressing situation to be in. The above excerpt also highlights the commonplace acceptance of casual sex amongst some people, but that it is not always so due to differences in prior decisions, opportunities, experiences, and upbringing. This can lead to additional stress being experienced by some people who change contexts (e.g. from a sheltered school and protective home to the more liberal university setting). Another participant adds:

> *"I just think that his friends are boasting way too much. There's that very patriarchal toxic masculinity coming out, and the problem with that sort of pressure is it inevitably ends up in a male pressurising a female, because his friends are pressurising him. It's an awful cycle that pushes people to do things that are not emotionally prepared for, so it's just very toxic. If he wants to be in a long-term relationship with a good woman, he should expect this woman to be fine or even happy that he's inexperienced, I would personally be happy with an inexperienced man because most men have slept with so many women these days"* (Participant 2).

Participant 2 suggests that the friends of the young man may be exaggerating about the number of women they have sex with, causing unnecessary worry for the young man. The participant explains that male attitudes about sex, such as in this case, start the cycle of people having sex when they do not want to, or are not emotionally ready to. This kind of peer pressure feeds the male dominated competitive society, causing males to behave in a certain manner to feel socially accepted. The participant also points out that this young man should not feel ashamed, but rather proud that he is sexually inexperienced as it shows that sex is meaningful to him which a woman may appreciate. The group discussion evolved to participants feeling sorry that the young man has found himself in this position, but also stating that he needs to have more of a "backbone" and stand up for himself, as well as realising everyone has sex for the first time at some point in their lives and his girlfriend should understand that if she is the appropriate long-term girlfriend he seeks.

The next few paragraphs will refer to data collected on male pressure put on women. In the pre-questionnaire, 12.5% of the sexually active participants reported having been successfully talked out of using a condom by their male sexual partners. The post-questionnaire results after the FGDs revealed an increase in number of participants who reported being successfully talked out of using a condom during sex to 16.5%. This increase either reinforces the idea of women having low self-esteem and still feeling pressured to have unsafe sex by their male partner due to the male dominated society that people live in in South Africa, and despite the emphasis placed on women living up to male expectations in the FGDs the knowledge and awareness that was conveyed may have been overlooked by some still felt pressure from male sexual partners regarding condom use. Or, this increase may be due to the participants being more open and honest in their post-questionnaires after the FGDs after gaining a deeper understanding of the

value of this research. In the FGDs it was confirmed verbally that the feeling of being pressurised by male sexual partners to have sex without a condom had an impact on the use of condoms.

> *I mean, I have told him that I would like to use protection and he agrees, well, he agrees at the time, but when we actually do have sex it's always a different story, like, he says things like "but you're on the pill", and "it's so nice without a condom just one last time", and I do it. It's happened so many times. And I know he's cheating on me, I know what I'm doing is dangerous, but I just can't seem to say no to him you know?* (Participant 3).

The above excerpt is extracted from the individual interview conducted with one of the participants who felt that she could add valuable information to the research project but was unable to speak freely in the FDGs as her boyfriend's sister was a part of them.

In a FGD where the Auntie Stella Card that was being used (card number 12, *"I pay for everything, don't I deserve sex?"*) I asked the participants if they think that men expect a woman to have sex with them if they pay for things such as lavish meals, drinks at a bar, and buy them gifts.

> *"I mean they probably do, but he chooses to pay, and he doesn't have to, the girl hasn't agreed to have sex with him if he pays for everything"* (Participant 9).

This excerpt was followed by another participant stating that it is a different kind of pressure and the hopes of the male are not necessarily conveyed to the female but are expected to some extent:

> *"It's a silent pressure I think, not an obvious pressure that you think about as being pressurised, but its more in your subconscious"* (Participant 3).

The above excerpts show that sometimes women feel pressurised without anything being articulated, because they have a sense that this is being expected of them.

Participant 7 shared a story, a younger girl from her hometown in Durban and when they were out partying one night the younger girl shared her thoughts on the topic by stating that if a guy buys a girl a drink she feels they have to "hook up" with him after that.

Discussion around these excerpts showed that the participants think that men should not expect to have sex with women because they pay for things or buy them gifts and that they wouldn't feel pressurised in an instance like this, but, they admit that it does happen and some young women do engage in sex with men as a result of the man paying for things.

> *"Majority of guys pay for things in the hope that you will have sex or hook up with them, like buying you drinks and getting you a bit more drunk, even presents and stuff, it makes you more susceptible for you to be nice to them. Some girls just feel bad and give into it"* (Participant 7).

A debate between the participants arose when one suggested that some young women give into this silent pressure of being expected to have sex with their male partner who pays for everything, to have sex with him, so not to lose the treatment she is currently receiving due to the fear of losing this current lifestyle.

> *"But she's not really entitled to, there's no written rule that says when a man pays for things there's an expectation to have sex with him, and if she's worried about not being treated the same then obviously she is with the wrong guy?"* (Participant 10).

> *"I was just saying that maybe she'll feel guilty when he's doing all this stuff for her and then she doesn't give him anything back in return"* (Participant 7).

But then the discussion becomes more nuanced, as follows:

> *"All he giving her is materialistic things that she didn't ask for, and yes maybe he is giving some emotion or love or whatever, but that doesn't mean she needs to repay him physically by having sex with her, I mean unless they had some kind of mutual agreement beforehand that says she will have sex in return for all these things, but otherwise she should be strong enough to know that it's her body, not his, he can't buy if from her without her agreeing to sell it to him, you know? If she feels guilty she should speak to him rather than jumping into bed with him, tell him she feels this pressure and if he doesn't understand or his intention was just about sex then he should get kicked to the side of the road, sorry"* (Participant 10).

The above comments seem to refer to some sort of "rational" agreement that implicitly relates to a transaction-like exchange. In addition, the participant implies that the female has a sense of the value of her body and agency in consenting. It highlights an ideal of women being able to engage in clear communications in these situations. It further seems to suggest that the woman has power and control: "*Tell him she feels this pressure*" and then more a more extreme expression of her rejecting his advances in "*he should get kicked to the side of the road*". Whilst

these suggestions give examples of how a woman could respond, the next participant returns to the subtle pressures asserted societally in much of what is unspoken:

> *"but it also has to do with society, the way we've established society , so for the guy its ingrained in him to be a gentleman in order to get something back, and it's programmed in the girls mind that if a guy does something nice for you, you need to give something back, it's a societal construct, sort of getting the relationship to an equal level like give and get back"* (Participant 8).

This example appears to defend men who expect sex when they pay for things. Thus, the participant refers to pressures from expectations of behaviour that are constructed societally (becoming schemas "programmed" into thinking of sex as some form of exchange by a variety of sources) referring to it as "norm" in the society we live in, and that men cannot be blamed for what society has taught them. This comment was responded to by another participant who explained that we should not be living in that kind of society and we should change the way we view things and not expect what society tells us to:

> *"That's so heteronormative and it's so frustrating. The thing is that if he needs sex that's ok, some people need sex and some don't, but he shouldn't expect anything from her and he should just cut it off before feelings are developed, but obviously he doesn't feel for her, he can treat her like a blesser but only if she agrees, otherwise he should go get a new girlfriend who has the same expectations that he does"* (Participant 2).

The above excerpt demonstrates the annoyance experienced by this participant when men have certain expectations of women in a society where some of the women are trying to make a change and fight for women's rights and gender equality.

Other participants suggested the opposite, that some young women purposefully restrain from having sex with their partner so as to "*keep him interested"* and "*not give it up*" in case this ruins the excitement and results in him becoming bored of her once they have had sex.

> *"And then you get those girls who make sure they don't sleep with the dude to keep in interested, you know that saying, what is it, something about it being all about the chase and then once they've had it and the chase is all over they get bored and move onto someone else"* (Participant 4).

This conversation gave insight to the lengths some young women go to in order to please men and how more about pleasing the man rather than attaining what they, as women, really want for themselves. The responses demonstrated that men probably expect sex after these deeds, but it is up to the woman whether she wants to have sex with him or not.

4.1.4 ALCOHOL/ SUBSTANCE USE

The pre and post questionnaire data, as well as the transcribed data captured from the FGDs showed that alcohol and substance use were other factors influencing the practice of unsafe sex. University is often a students' first time living away from home without the rules of parents or guardians. It is a time where they have independence and responsibilities for the first time. It is also a chance for young women (I state as this study focuses on women, although it provides this for young men too) to go out to bars and parties, test their boundaries with alcohol and drugs, without having a curfew or even having to return home.

The survey showed that from the sexually active participants, 87.5% reported having a "one-night stand" after partying and drinking alcohol at university. Of those who had engaged in unsafe sexual practices, 50% reported being under the influence of alcohol at the time. This shows that amongst the participants, alcohol has played a major role in the decision-making of practicing safe sex. Even if women do ask for condom use before engaging in sex whilst under the influence, the pressure from a man to have unsafe sex may seem higher, resulting in the woman to just "let it go" and engage in unsafe sex.

The following excerpt demonstrates a young woman who has asked her boyfriend to have safe sex on many occasions. Even though he agrees beforehand, his words do not translate into behaviour. The overuse of alcohol and other substances inhibits one's perception and can affect decision-making, such as the decision to practice safe sex. When one is under the influence, their judgment is impaired, and they may make different decisions as to when they are sober.

> *"Most of the time I'm really insistent, and he respects that, and we use a condom and all, but then sometimes after going out and drinking and stuff it just happens without a condom"* (Participant 9).

The above quote from the FGD shows that when alcohol is involved, there may be an increased risk of engaging in unsafe sexual behaviour.

Alcohol and substance abuse play a major role in the spread of HIV/AIDS, STIs, unwanted pregnancies, and poor decision-making such as having sex with someone in the first place which would not have happened in sober conditions, later resulting in an overall feeling of low morale.

4.1.5 LACK OF KNOWLEDGE

Lack of knowledge of women's SRH was one of the themes that emerged from the data. I found that many young women in my FGDs were not aware of all the risks associated with unsafe sex, mainly cervical cancer. Participants associated unsafe sex primarily with unwanted pregnancy and HIV/AIDS, but few knew of other implications affecting their SRH. Furthermore, although participants appeared very aware of the relation between unsafe sex and HIV/AIDS, they did not seem to know much about the virus, how it affects the body and how antiretroviral treatment (ART) works.

4.1.5.1 CERVICAL CANCER

In the questionnaires, participants were asked if they were aware of cervical cancer and how it is caused. Initially, 40% responded "yes" and 60% responded "no". However, it was discovered during the FGD on cervical cancer that most participants were not aware of the most important aspects of the cancer, and just knew of its existence.

The scenario (Auntie Stella card 15, *"Im worried about cervical* cancer") by a 21-year-old young woman writing to Auntie Stella who sought information about cervical cancer such as, how one gets this particular cancer and whether or not it could be prevented. After reading this scenario out to the participants, I asked them to share any knowledge about the cancer they had with the group. None of the participants knew more about the cancer besides that it is cancer of the cervix and that it involves HPV.

> *"I know it's got to do with something called HPV, human pap something, and that obviously it's in the cervix part of a woman"* (Participant 2).

They did not know of any preventative measures or that it was an easily treatable cancer if caught early enough. None of the participants knew that a preventative measure of cervical cancer was to have safe sex. I explained what cervical cancer was, how it could be prevented, and how it is treated.

> *"So, if there's a vaccine for this HPV thing that is linked to cervical cancer why don't our GP's just give it to us?"* (Participant 9).

> *"Yeah exactly and how are we supposed to know about it, I mean, who would ever think that there is a link between having unprotected sex and CANCER, and now there's some vaccine no one here has even heard of"* (Participant 3).

> *"Why did we not learn about this in school? I feel like we should have learned this in sex education or something? But if we did learn about it, why do I not remember anything?"* (Participant 1).

Participant 6 responds to the above excerpt on sex education classes:

> *"Those sex education classes were useless. The only thing that was ingrained in us was that sex is bad. And this was in grade 11 when most of the class were already having sex"* (Participant 6).

The rest of the participants were all in agreement with the above excerpts demonstrating concern about the lack of knowledge and awareness of the cancer and its prevention methods, additionally revealing the urgent need for the inclusiveness of vital sexual and reproductive information in the sex education classes in schools. This concern shows the participants consider

this information as important and would most likely follow prevention methods if they were aware of them.

In the post-questionnaire, after the FGD that consisted of over an hour's conversation about cervical cancer, 100% of the participants reported that they knew what cervical cancer was and how it is caused, and what preventative measures can be taken to avoid the risk of getting cervical cancer. This shows an increase in knowledge and awareness on the disease due to information conveyed in the FGD.

In the pre-questionnaire, participants were asked if they had ever been for a pap smear before, 20% answered "yes" and 80% answered "no". In the FGD, the importance of pap smears was conveyed to the participants and further conversation about pap smears revealed one of the main reasons some of the participants have not been for a pap smear, and why those who have had the procedure are reluctant to experience it again, was due to the invasiveness discomfort of a pap smear.

In the post-questionnaire these responses increased to 60% of the participants reported having had a pap smear and the remaining 40% had still not been for a pap smear. One of the participants made the effort to comment in the post-questionnaire when answering the question "Have you ever been for a pap smear?" stating the only reason she went for a pap smear (for the first time) was because of the knowledge she had gained from the FGDs, and that she was unaware of the importance of it. There was thus a promising 40% increase in the number of participants who had been for a pap smear since the inception of the project.

4.1.5.2 FEMALE CONDOMS

A method of protecting oneself and engaging in safe sex that was brought up in the FGDs and was not mentioned in the pre and post questionnaire was the use of female condoms. Some of the participants had heard of them, and one sexually active participant had used them. Their knowledge level on the appearance and how to use female condoms was low.

> *"What do they even look like? I've never even seen one before"* (Participant 1).

> *"Ok we definitely weren't taught about female condoms in those sex ed classes, I remember like a normal condom and a banana demonstration, like how to put it on and all, but nope, nothing about female condoms"* (Participant 6).

Questions about female condoms posed by the participants in the discussion led to the education on how to use them and what the benefits were. During the discussion, I, as the researcher conducting the FGDs educated the participants how the female condom works. I informed them how useful the female condom could be, especially, if women know they are going out drinking alcohol, as it can be inserted a few hours before sex. Some participants felt that if they had this knowledge prior to their sexual experiences they may have not found themselves in the position of engaging in unsafe sex.

The participants found the idea of using female condoms promising so not to depend on their male sexual partner always having male condoms, and that it provided them with more agency to have unsafe or safe sex, as opposed to leaving it up to the male to have as well as put on male

condoms prior to sexual intercourse. They noted that it may be easier to not adhere to the pressure from their male partner to have safe sex as they wouldn't have to ask or expect them to use a condom.

Another interesting topic that falls under the theme of "lack of knowledge" is Mother to Child transmission of HIV/AIDS. Again, participants had poor knowledge on this matter, and most/all participants were under the impression that if an HIV positive mother fell pregnant the baby would then contract HIV. They were unaware of the preventative measures HIV positive mothers could follow in order to prevent the baby from contracting HIV, as well as how high the chance of the baby not contracting HIV could be. Most participants were under the impression that the only options are to raise an HIV positive child or have an abortion.

> *"I didn't think it was possible for an HIV positive mother to have a baby, well I mean obviously it's possible, but what I mean is like, for them to have a baby that won't be HIV positive you know"* (Participant 6).

4.2 PARTICIPANTS' RESPONSES TO THE CONTENT OF THE AUNTIE STELLA CARDS

In this section I will be presenting data related to the participants' thoughts about the content of the Auntie Stella cards. More positive responses from the participants appeared to be related to cards:

- 15- *I'm worried about cervical cancer*

- *40- I'm HIV positive and pregnant*
- *19- What are Antiretrovirals?*

Some negative responses from the participants appeared to be related to cards:

- *6- I want to have sex like all of my friends*
- *12- I pay for everything, don't I deserve sex?*
- *36- My sugar daddy treats me badly*
- *33- My church says condoms are wrong*

4.2.1 "I'M WORRIED ABOUT CERVICAL CANCER"

This was one of the cards presented in the FGD's that evoked a valuable discussion. Though it may seem the obvious answer for the young woman would be to research cervical cancer, since the Auntie Stella cards were being used as a basis for discussion amongst participants. I found that few of my participants were fully aware of cervical cancer. They did not have much to say about the scenario presented to Auntie Stella as they did not have much knowledge about cervical cancer themselves.

Auntie Stella's reply explains what cervical cancer is, and when a woman is at greater risk of developing cervical cancer, as well as that it is easily treatable if found early enough. The

participants felt that Auntie Stella shared a valuable amount of information and understood it well.

> *"Yeah, I think that is a good explanation and good advice from Auntie Stella, I don't think there's much more she can say,"* (Participant, 2).

My participants and I found this card highly relevant given the amount of knowledge they obtained from this FGD.

4.2.2 "I'M HIV POSITIVE AND PREGNANT"

The participants showed interest in the questions posed in this scenario where a pregnant woman wanted to have an abortion as she recently found out she was HIV positive, but the doctor had told the baby won't necessarily be HIV positive if precautions are followed properly. The participants had little knowledge on Mother to child transmission of HIV and were unaware of preventative measures that could be taken in order for the baby to be born healthy.

> *"I didn't think it was possible for an HIV positive mother to have a baby, well I mean obviously it's possible, but what I mean is like, for them to have a baby that won't be HIV positive you know"* (Participant 6).

None of the participants were aware that there was not 100% chance the HIV positive mother passing HIV onto the unborn baby, resulting in the baby having HIV when it is born.

Auntie Stella's reply to the woman explains ways to lower the risk of the baby contracting HIV from her. She goes on to explain the drugs administered before, during, and after labour, as well as the drugs Andrea will need to take for the rest of her life from now on. Auntie Stella gives Andrea advice about breastfeeding, formula, and advises that she should make an appointment to visit her doctor soon so that he can explain all of the medical terms properly to her. The participants found Auntie Stella's reply very informative and gained a vast amount of knowledge from this card and scenario.

> *"Well considering that most of us, if not all of us, I'm assuming all because no one really said anything when Nitasha asked us if we knew of any preventative measures that could be taken so that the kid doesn't catch HIV from the mother, I think that her reply, Auntie Stella's reply was good and I honestly learned interesting stuff from it"* (Participant 8).

They were shocked that none of them knew there was any chance of survival for an unborn baby with an HIV positive mother, never mind that the chance was so high. The participants were impressed with how much they learned from Auntie Stella in this FGD and found this card highly relevant.

4.2.3 “WHAT ARE ANTIRETROVIRALS?”

This card is about a young woman who seeks Auntie Stella’s knowledge on what ARVs are and how they work since she has recently found out her best friend is HIV positive and wants to help her to the best of her ability.

In the pre-questionnaire participants were asked if they knew what antiretroviral therapy was, 90% responded “yes”. During the FGD it was found that the participants knew what ARVs were, but merely the fact that they are given to individuals who are HIV positive. They did not know how they worked, and some participants were unaware that when Antiretroviral therapy is followed properly, an HIV positive individual can live a normal healthy lifestyle.

> *“I knew that the ARV’s couldn’t heal people with HIV, but I thought they would still get more and more sick, kind of like terminal cancer and chemo, I didn’t realise that they could help a person with HIV that much and that they could stay healthy if they took the meds properly, that’s pretty shocking to me but wow, that’s cool”* (Participant 6).

In the post-questionnaire, 100% of the participants said they knew what antiretroviral therapy was and how it worked.

4.2.4 “I WANT TO HAVE SEX LIKE ALL OF MY FRIENDS”

This card describes the setting of a young man at university with no sexual experience and is ready to engage in a long-term relationship. The concern that he expresses to Auntie Stella is that the girl he will find will have sexual experience, and he will end up disappointing her when that time comes. Furthermore, his friend group teases him about being a virgin, and not having one-night stands like they do. They say that this means he is not a “true man”, which deepens his sexual inexperience insecurities. He is considering having a one-night stand before he finds a girlfriend to ensure he has some level of sexual experience and to avoid any embarrassment with a future girlfriend. He seeks Auntie Stella’s advice about this.

The participants understand the young man’s sexual inexperience concern and showed empathy towards the young man.

> *“His friends are making him feel like he isn’t a ‘true man’ just because he doesn’t sleep around, no one should feel that way, and he shouldn’t have to prove himself to them or the girl he loses his virginity to because it’s his life”* (Participant 3).

Those who had had sexual intercourse before expressed their first time to the other focus group participants. They explained it to be an anxiety provoking experience as their partner had previous sexual experience. They also shared the same feeling as the young man, the feeling of not wanting to disappoint their sexual partner who had prior sexual experience, but not to the extent of considering a one-night stand.

> *"I mean everyone has sex for the first time anyway, it's not like some us were born non virgins, I mean my first time was really scary because he wasn't a virgin, but then it ended up being ok you know"* (Participant 3).

> *"Yeah and like he definitely shouldn't go have a one-night stand, he'll just feel crappy about it, I mean especially because he seems like a decent guy, and then imagine if he goes and has this one night stand and gets some disease, yeah it's just a bad idea"* (Participant 6).

The participants also felt that the young man felt some pressure to fit in with his friend group and may have a fear of being excluded. Their advice for this young man is to trust the right girl will not judge him for being sexually inexperienced and may even appreciate that in a young man these days. They may find it respectful instead of judging him for it.

They found this was very relevant as they feel this attitude is common amongst the young men that they came into contact with, almost as if it were a competition, and found it refreshing for a young man to want this kind of relationship with a young woman.

> *"Somebody needs to tell this poor guy there are few men like him and so he definitely shouldn't go throw himself away, this competition of oh I've slept with this many girls blah blah blah needs to stop, it's horrible to girls too, I don't know about you but I don't want a guy whose slept with thousands of girls"* (Participant 1).

This card was important as it raised the societal pressure to have sex (even when one is not ready), as well as the heteronormativity that being a "true man" is having many sexual partners and one- night stands, which adds on to the spread of HIV/AIDS if protection is not used.

Auntie Stella's reply was that it is great he is ready for a long-term relationship; however, it happens naturally, and not merely when one decides to have a partner (unless some arrangement is agreed upon). She emphasises that he should not worry about what his friends say as they may not be telling the full truth about their sexual experiences. She encourages him to continue focusing on his studies and stay happily single until the right girl comes along.

Some of the participants agree with Auntie Stella's reply about waiting to be ready, especially with the fact that she encourages John (the young man) to focus on his studies at University for the time being. Participant 7 agrees with Auntie Stella's reply.

> *"I like the fact that Auntie Stella told John when you do find love, experience with sex won't matter, and when you are with the right partner you don't care about that, whether either of you is experienced or not, it's about the special moment"* (Participant 7).

Other participants thought that she may feel this way because she is supporting waiting for marriage to have sex, which could be a factor to take into consideration. They felt that Auntie Stella may not fully understand the anxiety that comes with having sex for the first time if she doesn't plan on having sex anytime soon. Opposingly, one of the participants noted that Auntie Stella's advice was difficult to follow. She stated that:

> *"If he is concerned enough to write to Auntie Stella, I don't think Auntie Stella's advice on concentrating on his studies and forgetting it all for now is the right answer, or what I mean is I don't think he'll be able to just do that"* (Participant, 3).

Participant 3 feels that if the young man had thought so much about this scenario it will be difficult to just put his insecurities aside and take Auntie Stella's advice because it has such a

big impact on him. In the end of the FGD, participants agreed that Auntie Stella's advice was not helpful enough for John.

4.2.5 "I PAY FOR EVERYTHING, DON'T I DESERVE SEX?"

The scenario in this card consisted of a young man writing to Auntie Stella expressing his concern that his girlfriend has not had sex with him yet, despite the fact that he has been paying for everything, such as meals, hotel bills, and buying her gifts.

This card brought about a fair amount of anger and frustration amongst the participants as the scenario is translating that a young man is under the impression that women should be obligated to have sex with men if they spend money on them, and treating the relationship as transactional without prior communication about such an agreement with the woman.

> *"Oh my God how can he even ask that kind of a question? That's just disgusting"* (Participant 4).

> *"Yeah because all of us women just have sex with any guy that buys us anything, idiot"* (Participant 5).

All of the participants strongly felt that they were not obliged to have sex with their partner or date, merely because he pays for things such as meals, hotels, and buys them gifts. They felt that having sex with someone is a personal choice despite what she has received from the man, and that she is not entitled to have sex with him if there was no prior transactional arrangement.

In Auntie Stella's reply, she mentions that young women are unhappy when men treat them like property. The participants of the FGD strongly greed with this comment from Auntie Stella. Auntie Stella advised the young man not to pressurise her into having sex which the participants agreed was a good recommendation.

> *"Well yeah I should hope that would be her advice, somebody needs to put him in his place"* (Participant 2).

The thing that Auntie Stella mentioned that really stood out to the participants was that "some people still treat girls differently to boys, but this attitude is changing now. They should be treated as equals. Have the courage to treat your girlfriend as your equal". Here, Auntie Stella is emphasising gender equality. This quote was well respected by the participants in the FGDs and appreciated as Auntie Stella was attempting to implement gender equality. They all hoped that he would understand what she meant, and her advice would not be discarded. Overall, participants felt that this was an appropriate response from Auntie Stella and that it focused on respecting the young woman's choices, and that there was no need for modification in Auntie Stella's reply.

4.2.6 "MY CHURCH SAYS CONDOMS ARE WRONG"

This card describes the scenario of a young man at university who says he has recently become very religious. He is not a virgin and his pastor has told him not to have sex until marriage, but he says he will definitely marry his girlfriend and wants to have sex with her to show her how much he loves her. He therefore believes in his situation sex before marriage is fine. Furthermore,

his church has said that condoms have tiny holes in them that allow HIV to pass through and they will not provide any protection. He asks Auntie Stella if this is true and when he pursues his girlfriend for sex, if he should use a condom or not.

This card brought about fury and annoyance amongst the participants because they felt the young man portrayed himself to be in a difficult situation when his main problem was that he had recently become religious and his church preaches no sex before marriage, and he wanted to have sex with his girlfriend. A participant brought up that he was being hypocritical in not wanting to use a condom because his church says they are wrong, but he wants to have sex even though his church says it is wrong, so he is willing to break one rule and follow the others in order to suit him.

> *"Ok now this is one hypocritical guy, first he sleeps around, then he converts fully and goes to church and stuff, then he wants to break the rule of ACTUALLY having sex, but he wants to follow the rule of not using a condom? Is this guy mad?"* (Participant 8).

> *"Maybe it's because he's had sex before and just can't like, not have sex, but really, the condom part is silly, if he wants to have sex he should but there's no need to bring religion into this condom situation"* (Participant 3).

Some participants suggested it may be because he had several sexual partners before. One of the participants brought up that he mentioned the reason he wanted to have sex with his girlfriend was to show her how much he loves her- this participant puts emphasis on the fact the fact that sex is not a way of showing your love for someone, all the other participants agreed.

It was also suggested by a participant that there is a problem within the church as well in terms of having sex and condom use. It was understood that the church preaches not to have sex until marriage, but the participants all agreed that it is wrong for them to talk about condom use in this manner, especially given the high HIV/AIDS prevalence in South Africa at the moment. When this point was brought up, some participants had a clearer understanding as to why the young man is conflicted whether to use a condom or not when the time comes. They said that it is a widely known religious belief to wait until marriage to have sex, but not many young people do this nowadays, and maybe he is trying to follow some rules from his church, especially because he has already had sex before. The Auntie Stella talking point card contained the following quote:

> *"Abstinence before marriage and faithfulness to a single partner within a stable marriage- obviously these are key to good living and to avoid infection. However, the church ministers in the real world should give people all the options, one of which is to use a condom, not as a contraceptive, but to prevent transmission of a death-dealing virus".*
>
> *"Ok yes I get it, I am a catholic as well and I am familiar with this quote, and I wholeheartedly, I like, understand the catholic church doesn't agree with condoms but I completely agree about protecting your health if you're going to have sex"* (Participant 7).

Another participant conveyed her annoyance with all his talk about him definitely going to marry her, wanting to have sex with her to show his love, seeking Auntie Stella's advice about condom use, when he should be talking to his girlfriend about all of these things as maybe she does not feel the same way.

> *"How does he even know he's going to marry her? Firstly, how does he even know SHE wants to marry him? I think he should be talking to his girlfriend about all of this not Auntie Stella, God, or his pastor"* (Participant 9).

This point underlined how some men do not take their female partners' choices into consideration and feel that all of the choices are up to them.

Auntie Stella's reply highlights that although churches encourage people to abstain from having sex until they are married and do not encourage the use of condoms, she says that people in all religions are starting to change and believe in condoms in order to prevent HIV/AIDS contraction. Auntie Stella explains the health advantages of using a condom and emphasises there are no holes in condoms that HIV can pass through. Furthermore, she suggests they both have an HIV test and look at other contraception methods if they both decide to sleep together.

The participants were happy with Auntie Stella's reply as she explained how condoms worked, how they differed to other contraceptive methods, and that he should speak to his girlfriend and make these choices together. They were liked that she encouraged them both to go for HIV tests even though the statistics for HIV testing amongst the participants were low.

4.3 WHAT ARE THE PARTICIPANT'S REFLECTIONS ON THE USE OF THE AUNTIE STELLA CARDS AND WHAT WERE THE PERSONAL IMPACTS OF THEIR USE IN GROUP DISCUSSIONS?

4.3.1 IMPLEMENTATION OF AUNTIE STELLA ACTIVITY CARDS

Feedback from the participants regarding the use of the ASACs was positive. Participants reported that they learned a considerable amount of new information regarding women's SRH.

> *"Yeah I thought they were good, I mean hell we sure did learn a lot about cervical cancer, and that there are actually things we can do to like, prevent it"* (Participant 8).

> *"I certainly learned a lot over the past few weeks by coming to these discussions. Like about female condoms and yeah definitely cervical cancer stuff, also on how babies don't necessarily contract HIV from their mothers"* (Participant 2).

They reported the cards being beneficial to them and that they have had an impact on their sexual decisions since. The information participants reported as interesting was that regarding the use of antiretroviral treatment, and how this can make the virus manageable, if adherence to medication is good and if treatment is started at the necessary stage. Furthermore, none of the participants were aware of reinfection in PLWH already.

> *"I didn't know if you had like HIV and AIDS you could get it again, like you mentioned the reinfection and that even if two partners were HIV positive they still have to have protected sex, that was really interesting"* (Participant 4).

It was new and crucial knowledge for them to know that two HIV positive people should not engage in unprotected sex due to the possibility of each individual having different strands of the virus, could then result in the infection worsening.

As mentioned earlier, participants found the FGD on mother to child transmission especially interesting, because, most of them were under the impression that if a pregnant woman were infected, the baby would indefinitely be HIV positive too. The researcher explained the different breastfeeding techniques on how the mother can prevent transmission to the baby.

Participants reported that if it were not for the FGDs, some of them would not have had an HIV test, a pap smear or been aware of the importance of both tests. From the FGDs, I noticed that participants had very little knowledge on cervical cancer, the prevalence of the cancer, and how easily it can be treated if caught at an early stage, hence the importance of regular pap smears and safe sexual behaviour.

There were only positive comments from the participants regarding their overall experience of the FGDs in the post-questionnaire. Participants reported how enjoyable they found the discussions and that they would look forward to attending each FGD.

> *"I mean I didn't think I'd actually look forward to coming to these group discussions, no offense or anything, but meeting new people and sharing ideas and learning all this stuff, I think it's been great!"* (Participant 10).

> *"I just can't believe how much I thought I knew when actually there was so much about cervical cancer and like, the female condoms, I mean I don't think I would know if they existed still, and yeah it was nice to feel comfortable around people I never knew before"* (Participant 2).

Most of the participants reported that it was a safe and comfortable environment to be open and honest about their thoughts and experiences. Other participants stated that if it were not for the FGDs, they're not certain when and if they would gain the knowledge that they did during the project. Comments about the topics discussed in the focus groups not being in everyday conversations allowed them to think more critically and understand others' experiences and how to tackle these.

Recommendations from the participants were to further modify the cards to suit a university context where some of the scenarios in the ASACs did not apply to them, and answers to some of the cards seemed obvious to the participants.

The participants learned mostly from the action points, which the researcher attempted to modify as much as possible to ensure important knowledge was conveyed and discussed during the FGDs. All of the participants agreed that the ASACs could be a good educational tool for female university students, and more so once recommended modifications are made. There was positive feedback on the actual use of the Auntie Stella cards as a teaching tool as they found they learned a vast amount during the FGDs. Overall, feedback from the participants demonstrated that they all enjoyed attending the FGD's using the Auntie Stella cards as a basis for discussion.

The post-questionnaire results show that the use of the Auntie Stella cards had positive personal impacts on the behaviours of the participants. There was a reported decrease in the number of participants having unsafe sex, as well as in those who felt pressured to have sex by their partners. Hopefully this is due to the impact of the FGDs, but this cannot be proven as it is merely a response in the post-questionnaire. There was a reported increase in the number of participants who had been for HIV test, and an increase in overall knowledge of women's SRH as well as HIV/AIDS.

4.4 HOW MIGHT THE CARDS BE MODIFIED FOR THE SOUTH AFRICAN UNIVERSITY CONTEXT?

It must be mentioned I found the young female university students who took part in this study to believe in feminism, women's rights, and gender equality more so than the average young female university woman. I came to this deduction as overtime I compared their responses on women's rights and gender equality to those of people whom I socially interacted and conversed with. I feel that a major reason for this "above average feminism" is that the participants were all studying Psychology, whereas other students I conversed with were enrolled for Business or Science degrees. It seems that the latter two disciplines do not put much emphasis on feminism, women's rights, and gender equality.

As the researcher, I noticed some apprehensiveness amongst the group after reading out some of the scenarios from the ASAC, as these in particular were more suited for a high-school setting,

not a university setting. Nonetheless, the participants put in effort to partake and ask questions, allowing the FGD to evolve into useful and educational conversation about SRH related topics, as well as facilitating the development of the FGDs into somewhat of a safe learning space.

As some of the Auntie Stella cards were found to be monotonous, and the university students had trouble relating to the "less mature high-school" scenarios, further modification is necessary. In order for the ASAC to be a useful educational tool in a university context, the scenarios need to be developed in a more thought-provoking and stimulating way. For example, an increase in their complexity is recommended as participants reported Auntie Stella's answers to some cards as being too "simple" or "obvious". Although I had previously made modifications to the cards as I found them not complex enough for university students, further modification would have been increasingly beneficial.

CHAPTER FIVE: DISCUSSION AND CONCLUSION

This study is a follow-through study from my team's work (van der Riet, Akhurst, & Wilbraham, 2019). Together with that study, this research is, to my knowledge, some of the first in South Africa to examine the drivers for undergraduate female university students to engage in unprotected sex. The findings demonstrate that knowledge of HIV is widespread, yet prevalence of unsafe sex is high. Women's perceptions surrounding this disconnect were divided into five main areas: women's self-esteem; low self-perception of risk; peer pressure and male dominance; alcohol and substance use; and lack of knowledge.

Poor self-esteem among women is a world-wide problem due to societal expectations of them to constantly look thin, beautiful, be a good housewife, look after their male partner and do as they are told by him in most circumstances; resulting in physical abuse, emotional abuse, mental illnesses, as well as other illnesses such as eating disorders, and in this case, transmission of HIV and AIDs, and STIs. Though times are changing in South Africa, this heteronormative belief is still ingrained in most young men and women (Eaton et al., 2003; Othieno et al., 2015).

When an individual has a low perceived self-efficacy it has an impact on their behaviours, for example, whether they engage in risky sexual behaviour or not (Schwarzer & Warner, 2013).

In the study, 12.5% of participants had been talked out of condom use just before sexual intercourse. This can be due to low self-esteem, low self-perception of risk, as well as poor condom negotiation skills. It is common for females to want to please their male counterpart as much as possible, resulting in these risk-taking behaviours.

It is seen in the literature that the use of condoms is not tolerated in some religions and cultures (Jewkes, Dunkle, et al., 2010; Nesoff et al., 2015). However, despite the religion, race, and gender of the participants, 100% of the participants agreed that the use of condoms as a way of protection during sexual intercourse was acceptable in both the pre- and post-questionnaires. This poses an interesting disconnect between what is generally stated in the literature and the findings of this research study. The most likely explanation for this difference is that this study is poorly representative of the larger South African population because we sampled highly educated students in tertiary education. According to statistics tertiary educational attainment in South Africa is the lowest among G20 countries with only 7% of adults attaining a tertiary education (the average among G20 countries is 38%) (Organisation for Economic Cooperation and Development, 2019). Therefore, we are sampling a very select group of the population in this study, who likely have quite different exposures to sex education and social and cultural frameworks for approaching sex and negotiating condom use. It is therefore, not unexpected that the acceptability of condom use is high among our participants – likely because they have been trained as educated individuals, and members of more families and communities from higher socioeconomic backgrounds, adhering to somewhat more progressive views on condoms, at least at the surface level.

Having said that, interestingly, the data from the questionnaires show inconsistent condom use amongst the participants, since 87.5% reported having unsafe sex with "some" of their partners. So, even though participants in this study had good *theoretical* acceptability of condom use – likely because they have been acculturated to "say the right thing" – the reality of their sexual practices is that they do not practice what they preach. This terrifying reality confirms literature by Hartell (2005) who found that condom use amongst young people in South Africa is inconsistent. The difference between the participants' outward projection of their images compared to their practical realities is concerning for current approaches to sex education in schools and universities. What we learn is that, while well-educated people are taught what to say and how to act, that this often does not translate into behaviour change in sexual practices. This study, therefore, provides invaluable data on the barriers faced due to this disconnect between teaching and practice, which are critical for future policymakers and educational administrators in the design of sex education programs.

Somewhat reassuringly, none of the participants reported having unsafe sex with "all" of their sexual partners, i.e. none of the participants constantly engaged in unsafe sex. Reasons for the inconsistency in condoms use amongst these participants have been a result of both male pressure and alcohol consumption. This finding backs up literature by Kalichman et al (2007) who stated that alcohol consumption has an influence on risky sexual behaviour.

Methods for prevention of HIV, STIs and pregnancy used by the participants consisted of condoms only, or both condoms and hormones (the pill) simultaneously. This is a positive finding and may challenge some of the literature stating that women from urban areas are more

concerned about pregnancy than contracting HIV or STIs, resulting in them taking hormones only (Morrison et al., 2015; Van Staden & Badenhorst, 2009).

Despite the well-known existence of gender inequalities still in South Africa, all of the participants agreed that women do and should have a say in decisions regarding their sexual practices, and whether it is safe or unsafe sex. This is a positive result as these particular participants feel that they are able to make safe sex decisions regardless of their gender.

Probably the most striking finding in this study, both for the researchers and participants, was the limited knowledge surrounding cervical cancer and female condoms. The participants were astounded that as young educated women, they did not have adequate knowledge on such an important part of women's SRH, and if preventive measures for cervical cancer are taken, or if cervical cancer is caught early enough it can be completely treated. They were unaware of the prevention methods for cervical cancer such as safe sex, the HPV vaccination, and regular pap smears. Furthermore, it was evident that the participants were eager to gain more knowledge about the disease, which demonstrates their interest and desire to look after their SRH.

Additionally, results from the FGDs revealed the little knowledge that participants had on the use of female condoms. Only one of the participants had ever used a female condom, and most of them did not know what they looked like. This is an important prevention method that needs to be made more accessible, as well as further education on the use of female condoms. This limited understanding of cervical cancer and female condoms is striking for a couple of reasons:

1) these are issues that only affect women, and 2) they do not form part of the current discourse surrounding HIV/AIDS.

A possible explanation for the knowledge gap in cervical cancer and female condoms is that current sex educational materials are focused on limiting sexually transmitted infections that affect both men and women (e.g. HIV/AIDS, gonorrhoea, or syphilis), however, when it comes to public health issues that affect ONLY women (likely cervical cancer), these have been de-emphasised in public health campaigns and sex education. This is yet another example of heteronormative dominance creeping even into the way that safe sexual practices are conveyed in education and the media. While issues that affect both men and women are well-known, issues that affect women primarily (e.g. breast or cervical cancer) are poorly represented (Ginsburg, 2013). This finding is consistent with a much wider literature on women's health research. Overall, no matter the issue, women are historically underrepresented and underfunded in health research. I imagine, somewhat provocatively, but also with backup from previous scholars, that the reason for this is that women are undervalued by male-dominated societies and governments and therefore there is low political will to engage in activities that only help women (Fisk & Atun, 2009).

5.1 THEORETICAL FRAMING

Amongst the participants that took part in the FGDs, it was agreed that women do and should have a say in whether they practice safe or unsafe sex, though the gender inequality in South

Africa is renowned. This is an encouraging response as it shows that these participants are able to make the decision to look after their SRH irrespective of their gender.

When asked if it was normal to have sex with your partner even though you do not want to, in the pre-questionnaire, 10% answered “yes” and 90% answered “no”. The explanation for the 10% who answered “yes” was “unfortunately our society has a stigma of relationships and even though we shouldn’t, we still feel the silent pressure to please our male partner, all of my friends have said they’ve had sex with their partner even though they didn’t want to”. The other participants explained that this was “classified as rape”, “being in a relationship with someone does not mean you are entitled to have sex when they want to”, and “women need to learn not to be submissive to males, even in relationships”. The post-questionnaire revealed that 100% of the participants reported having sex with your partner when you don’t want to is not normal. This shows a change in attitude from the 10% who previously answered “yes”.

Previous work of Mackinnon portrays the author’s opinion on pleasure derived from sex for women (MacKinnon, 1989). She explains that because women have always been viewed as inferior to men, and with the existence of pornography, that women will never know if they want to engage in sexual intercourse or if they do consent to it due to the impact of society. Through the lens of liberalism, a popular framework for thinking about choices that women make is the idea of authentic vs. adaptive autonomy. While liberalism respects the choice of others because these choices are assumed to be reflective of what is good for the person, adaptive autonomy or preferences are those that people develop based on the social situations to which they have previously been exposed (Levy, 2005). Gill (2007) argues that women who engage in their sexualisation are positioned as either cultural victims (as a form of false consciousness) or as

agentically engaged in their own liberation – which is a decidedly a post-feminist perspective. This is referred to as the agency pendulum (Gill, 2007).

Therefore, to take the findings of this study even further, by embedding a theoretical framework on agency, the real question is: for the 90% of participants in the study who answered "no" – how many are "authentically" able to make that choice by themselves? Furthermore, while they state "no," how often are they truly able to say "no" and when are they saying "no" because they really mean it? Levey (2005) explores the extent to which women's choices are truly their own and the extent to which these choices are adapted preferences that have been exposed to women. Unless the world is completely free of all oppression of women, it is difficult to know what these women's preferences actually are. Women may think they have freedom of choice in terms of the way they portray themselves, however, the social expectations of women have an effect on the autonomy of women, again showing how the autonomy of women is mostly adaptive. MacKinnon states, "for the female, subordination is sexualised in the way that dominance is for the male, as pleasure as well as gender identity, as femininity" (Mackinnon, 1989, p. 7).

5.2 LIMITATIONS

This study has several limitations, some of which have been mentioned above. They are, principally: 1) the specific population studied, 2) the small sample size, 3) the qualitative nature of the research. All three of these limitations affect the study's generalisability, or external validity. Because I studied women who are highly educated, with greater exposure to sex education and public discourse around SRH, the findings in this study are poorly generalisable to women in South Africa more broadly, since most women in this country do not have the

opportunity to attend tertiary education. Given this fact, we need to be cautious in interpreting the implications of the findings and how they apply to the South African population at large. It is unfair to consider these findings as relevant among, say, a rural South African population, where education levels are much lower and contemporary notions of SRH are not similarly matched with urban areas and university settings.

However, I would go on to say that the fact that we studied this specific population, while limiting generalisability to the wider South African population, is actually a strength of the study. Prior to this study, there was limited data on the sexual practices of university-going female students. Knowledge of these practices are critical because they help us understand the failings of current public health and sex education campaigns. Put alternatively: if the most educated women in South Africa still have knowledge gaps and barriers to good SRH, then the answer is not just that we need *more* sex education, but that we need *better* and *different* sex education, because even those receiving the best education have incomplete knowledge. In many ways, understanding this sub-set of the population gives us understandings of how to improve sex education for all South African women.

The small sample size and qualitative nature of the research study might also be viewed as limitations on the study's external validity. It is true that in this study we do not have a representative sample, nor did we have a sample size that is large enough to be powered for making broad generalisations. However, I would argue that this was not the goal of the study to begin with. In qualitative research, we are not trying to achieve a "representative" sample. Instead, we seek information-rich cases to try and understand complex phenomena (such as why highly educated women still engage in unsafe sex practices). Finally, the mixed-methods design

also ended up being a strength of this study, because quantitative findings from the survey were triangulated with qualitative explanations for what was going on.

5.3 IMPLICATIONS

There are several important and far reaching implications of this study. On a practical and granular level, the misrepresentation of cervical cancer and female condoms needs to be rectified. It is unacceptable that the country's most educated women have not been adequately taught about the serious public health consequences of cervical cancer, or about the availability of and agency provided by female condoms. From a cervical cancer standpoint, educational materials in schools and universities need to have parity with HIV/AIDS and other STIs. This is especially in light of the dramatic global advances in the provision of antiretroviral therapy and strong health systems surrounding HIV/AIDS. We have gotten to the point where HIV/AIDS is becoming a chronic disease, controllable almost like diabetes. Therefore, we need to start working on the adjacent issues that both optimise HIV/AIDS care, and can also benefit from the momentum gained by the HIV/AIDS movement in destigmatising issues such as SRH. From a community awareness standpoint, some ways in which cervical cancer education could be improved is by including it early and frequently in education materials at the primary and secondary levels and via media campaigns that highlight its importance.

On a health-systems level, cervical cancer screening needs to be routinised into primary care for young women of sexually reproductive age. University life is fraught with the complexity of

transitioning to adulthood and societal expectations surrounding sex, alcohol, and drug use. However, universities are also a unique touchpoint for helping women to access healthcare and there is currently a missed opportunity to integrate screening programs into university settings. I would recommend that as part of starting as a new student at university we should create opt-out systems that embrace women's health with pap smears at clinically recommended intervals, STI screening, and educational empowerment on how to navigate sex in the new (often scary) setting of university. If this process were done in a standardised way, it would become "normal" for all female students and would also help reduce stigma and empower women.

The Auntie Stella cards are an effective way of engaging young women as they start university and throughout their university process. It was clear that the material in the Auntie Stella cards was informational and helpful to participants, so at least they demonstrate fairly good acceptability among university-going women. However, we learn from this study that in order for the cards to succeed in the university setting, they also need to be adapted for this population. The participants found the cards too monotonous and often too simple or obvious. Some ways to improve the intervention for this population would be to brighten up the conversations by adding some more provocative topics that push women to think about their roles in society at large and the power of heteronormative dominance on all the decisions that they make. Practically speaking: increasing the complexity of the cards will also help university students engage with some of the more complicated topics, such as cervical cancer, that are often missed in high school or public education campaigns.

On a much broader and philosophical level: what has become clear throughout the analysis of data from this study, is that women's health and especially SRH are constantly undermined and

understudied. Outside of HIV research, in South Africa, and likely other Sub-Saharan African countries we need far more nuanced and specific research targeting women's sexual practices. While this study was able to provide some hypotheses for common barriers to unsafe sex in this specific population, much more work still needs to be done. We need large-scale, nationwide population health studies that seriously reckon with women's sexual health: not just as an afterthought of men's health, or folded into HIV research, but rather targeted and empowering research that is designed to help women.

Over my years of studying women's sexual health both as an undergraduate and as a graduate student, I have been astounded by the historical underpinnings for the position of women in society. Women have been suppressed for millennia, and this suppression persists today, and is pervasive. In the health sector, these effects might initially be invisible for political or cultural reasons that favour the male agenda. However, when you look beneath the surface the consequences for women are terrifying and tragic. Women's SRH is an emergency, and the time to act is now.

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22 March 2016

Dear Jacqui,

Re: Research proposal from Nitasha Kidia

This is to certify that Nitasha Kidia's Masters by Thesis proposal is related to the project that was granted ethics approval by the RPERC on 17 February, tracking number PSY2016/02 entitled 'Young people's sexual and reproductive health: adaptation and modification of group discussion material'.

Yours sincerely,

Jacqui Akhurst

(Prof.) Jacqueline Akhurst

Rhodes University — Department of Psychology

USE OF TAPE RECORDINGS FOR RESEARCH PURPOSES
—
PERMISSION AND RELEASE FORM

Participant name & contacts (address, phone etc)	
Name of researcher & level of research (Honours/Masters/PhD)	NITASHA KIDIA, MASTERS
Brief title of project	USING HIV/AIDS INTERVENTIONIST RESEARCH IN A UNIVERSITY CONTEXT TO IMPROVE WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH AWARENESS
Supervisor	JACQUI AKHURST

Declaration

(Please initial/tick blocks next to the relevant statements)

1.	***The nature of the research and the nature of my participation have been explained to me***	verbally	
		in writing	
2.	***I agree to be interviewed and to allow tape-recordings to be made of the interviews***	audiotape	
		videotape	
3.	***I agree to take part in and to allow tape-recordings to be made.***	audiotape	
		videotape	
4.	***The tape recordings may be transcribed***	without conditions	
		only by the researcher	
		by one or more nominated third parties:	
5.1	***I have been informed by the researcher that the tape recordings will be erased once the study is complete and the report has been written.***		

Pre-questionnaire: women's sexual and reproductive health, as well as HIV & AIDS awareness research

Thank you taking the time to participate in this study! Please fill in this questionnaire before the first focus group discussion takes place. Please note that this information will only be seen by the researcher, kept in a safe place, is confidential, and any information used from this study will be completely anonymous. Please try to provide as much detail as possible in your answers to this questionnaire, if necessary, please answer N/A to any questions that do not apply to you. This will allow the researcher to have more accurate findings at the end of the study. Your participation in this study is much appreciated and could be very important for improving women's sexual and reproductive health as well as reducing the risk of HIV-infection in the future.

Date:…….

Name:……..

Sex:

Male	Female	Other

Sexuality:

Heterosexual	Bisexual	Homosexual	Other

Age:…….

Race:

Black	White	Coloured	Indian	Other (specify)

Religion:……

Have you ever been or are currently in a sexually active relationship?

Yes	No

If yes, did your first sexual encounter entail safe sex practices?

Yes	No

If you have never had sexual intercourse, is there a specific reason why?
……
……

Do you ever feel pressured to have sex by your friends or partner?

Yes	No	Sometimes

Have you ever engaged in unsafe-sexual practices?

Yes	No

If yes, were you under the influence of any substances? (alcohol, drugs etc.)

Yes	No

Do you believe that using condoms is wrong?

Yes	No

If yes, please explain why.
……
……
……

Some young people have “one-night stands”, perhaps after a party or after drinking? Has this ever happened to you?

Yes	No

How many sexual partners have you had in the past year?

NONE	ONE	More than one	More than five

How many of these sexual encounters involved unsafe sex?

NONE	ALL OF THEM	SOME OF THEM (number)

What methods of contraception have you used?

Condoms	Hormones (the pill)	Other (specify)

Have you ever tried to negotiate condom use with your partner but have been talked out of it?

Yes	No

Sexual intercourse	Blood transfusion	Sharing needles for drugs	HIV+ve mother to baby	Oral sex	Other (specify)

Have you ever received any education on sexual and reproductive health and HIV/AIDS?

Yes	No

If yes, was this information helpful and do you practice with it in mind? Please comment further if you would like to.

Yes	No

……
……

Do you feel you are at risk for contracting STI's? Please explain your answer briefly.

YES	NO	SOMETIMES (specify)

What do you think the main cause of HIV-transmission is?

Is abstinence from sexual intercourse an option for you in order to prevent early pregnancy, STI's, and HIV/AIDS?

Yes	No

Do you think you are at risk for contracting HIV? Please explain your answer briefly.

YES	NO	SOMETIMES (specify)

Do you know what antiretrovirals are?

Yes	No

Do you know what makes antiretrovirals effective?

Yes	No

Would you tell your sexual partner if you were HIV-positive or if you had an STI?

Yes	No

Would you expect your partner to tell you if they were HIV-positive or had an STI?

Yes	No

Do you think women have a say in relationships in terms of when to have sex and whether it will be safe sex or not? Please explain further if you wish to.

Yes	No

Have you, or anyone you know, ever experienced any form of sexual or gender-based violence?

Yes	No

Do you think having sex with your partner in a relationship even when you don't want to is normal? Please explain why.

Yes	No

Have you ever had sex in exchange for gifts, money, or anything?

Yes	No

Are you aware of cervical cancer and how it is caused?

Yes	No

Have you ever had a pap smear?

Yes	No

How often do you think young women (18-25 years old) should have a pap smear?

Once a year	Twice a year	Never unless there is a visible problem

Are you happy with your current sexual behaviour?

Yes	No

Please comment if you wish.
……

Post-questionnaire: women's sexual and reproductive health, as well as HIV & AIDS awareness research

Thank you taking the time to participate in most of the focus group discussions! Please fill in this post-questionnaire and return it to the researcher as soon as possible. Please note that this information will only be seen by the researcher, kept in a safe place, is confidential, and any information used from this study will be completely anonymous. Please try to provide as much detail as possible in your answers to this questionnaire, if necessary, please answer N/A to any questions that do not apply to you. This will allow the researcher to gather more accurate findings of the impact of the focus group discussions.. Your participation in this study has been much appreciated and could be very important for improving women's sexual and reproductive health as well as reducing the risk of HIV-infection in the future. Please fill in this questionnaire taking into consideration the focus group discussions and anything that may have changed during the past months (any differences in your opinions and knowledge). Please also indicate if any of the below questions have changed as a result of the focus group discussions.

Date:…….

Participant number:……

The following questions were all asked in the previous questionnaire. If your answer or thoughts on any of these have changed since you started participating in the focus groups, please comment in the space below the list. If nothing has changed, please answer with N/A.

Have you become involved in a relationship since the inception of this project?

Yes	No

If yes, did your first sexual encounter entail safe sex practices?

Yes	No

Do you ever feel pressured to have sex by your friends or partner?

Yes	No	Sometimes

Have you ever engaged in unsafe-sexual practices?

Yes	No

If yes, were you under the influence of any substances? (alcohol, drugs etc.)

Yes	No

Do you believe that using condoms is wrong?

Yes	No

Some young people have “one-night stands”, perhaps after a party or after drinking? Has this ever happened to you?

Yes	No

How many sexual partners have you had in the past year?

NONE	ONE	More than one	More than five

How many of these sexual encounters involved unsafe sex?

NONE	ALL OF THEM	SOME OF THEM (number)

What methods of contraception have you used?

Condoms	Hormones (the pill)	Other (specify)

Have you ever tried to negotiate condom use with your partner but have been talked out of it?

Yes	No

……..……
……

Were the focus group discussions helpful in terms of educating you on sexual and reproductive health and HIV/AIDS?

Yes	No

If yes, please list some of the things you learned from the discussions that you were unaware of before.

……
……

Do you feel you are at risk for contracting STI's? Please explain your answer briefly.

YES	NO	SOMETIMES (specify)

What do you think the main cause of HIV-transmission is?

Sexual intercourse	Blood transfusion	Sharing needles for drugs	HIV+ve mother to baby	Oral sex	Other (specify)

Is abstinence from sexual intercourse an option for you in order to prevent early pregnancy, STI's, and HIV/AIDS?

Yes	No

Do you think you are at risk for contracting HIV? Please explain your answer briefly.

YES	NO	SOMETIMES (specify)

Do you know what antiretrovirals are?

Yes	No

Do you know what makes antiretrovirals effective?

Yes	No

Please comment on whether the focus group discussions have helped you have a better understanding about what makes antiretrovirals effective.

……
……
……

Would you tell your sexual partner if you were HIV-positive or if you had an STI?

Yes	No

Would you expect your partner to tell you if they were HIV-positive or had an STI?

Yes	No

Do you think women have a say in relationships in terms of when to have sex and whether it will be safe sex or not? Please explain further if you wish to.

Yes	No

……
……
……
……

Do you think having sex with your partner in a relationship even when you don't want to is normal? Please explain why.

Yes	No

Have you ever had sex in exchange for gifts, money, or anything?

Yes	No

Are you aware of cervical cancer and how it is caused?

Yes	No

Have you ever had a pap smear?

Yes	No

How often do you think young women (18-25 years old) should have a pap smear?

Once a year	Twice a year	Never unless there is a visible problem

Are you happy with your current sexual behaviour?

Yes	No

Please comment if you wish.

Do you think the Auntie Stella cards can be used as an educational tool among female university students in the future?

Yes	No

Do you have any advice regarding the content of the cards or the process in which the cards were used that the researcher could take into consideration for future use?

……
……

Do you have any further comments about the focus group discussions and what you have learned? Did you enjoy the discussions, and what did you like or dislike about them?

……
……