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# To 'test' or not to 'test'? : an exploratory study of WITS students' responses to Voluntary Counselling and Testing (VCT).

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# TO 'TEST' OR NOT TO 'TEST'?

An exploratory study of WITS students' responses to Voluntary Counselling and Testing (VCT)




**By**

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A research report submitted to the Department of Sociology- School of Social Sciences, the Faculty of Humanities at the University of the Witwatersrand, Johannesburg, South Africa.

In partial fulfilment of the requirements for the degree Master of Arts by Coursework and Research Report in Health Sociology.

**DECLARATION**

I, Priya Buldeo, candidate number 0609653R, hereby declare that this report, *To 'Test' or not to 'Test'? : An exploratory study of WITS students' responses to Voluntary Counselling and Testing (VCT)*, is my own unaided work except where it has been acknowledged and fully cited by means of complete references. It is to be submitted hereof as part of the requirements for the degree Master of Arts in Health Sociology by Coursework and Research Report at the University of the Witwatersrand, Johannesburg, South Africa.

It has not been submitted for any other degree or for examination purposes at any other University.

Signed:  Date: 17th April 2012

Miss Priya Buldeo

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**ABSTRACT**

The health of University students is important as these individuals are central to the future economic sector. Since HIV/AIDS is a major public health threat in South Africa (SA), it is vital to develop health initiatives that aim to reduce the HIV prevalence rate among youth and to promote positive health behaviour. Voluntary Counselling and Testing (VCT) is one such initiative. The National Department of Health (NDoH) recently implemented the 'First Things First' campaign that aims to promote VCT among youth. In line with the NDoH's initiative, this study explored the factors that shape attitudes towards VCT among first year students at the University of the Witwatersrand (WITS).

This study was conducted using a combination of quantitative and qualitative research methods. The respondents included 195 first year students out of approximately 220 who participated in a survey and two key informants in the field of HIV/AIDS whom I interviewed. With regards to ethical considerations, the study protected the respondent's rights by maintaining anonymity of all survey participants and exercised care that the human rights of individuals and the reputation of WITS as an institution were safeguarded.

Based on conceptual models of health behaviour, the study identified factors that shaped students responses to VCT. The results of this study indicate that youth at WITS go for VCT mainly to know their HIV status. This is being triggered by them knowing someone who has either; been for VCT, is living with HIV or passed away due to AIDS. In addition, the free availability and easy accessibility of VCT services on campus and the positive influence of peers through social mobilisation were regarded as key motivations for students accessing VCT. However, some students seem to not access VCT services due to personal fears of rejection, blame and discrimination if they were to be found HIV-positive. The gendered dynamics and nature of clinics together with the poor attitudes of some health service providers were also major barriers to VCT uptake among youth.

The findings conclude that many students know that VCT is a necessary and beneficial process. It also found that there are multiple factors that work together in complex ways to shape the reasons why youth choose to 'test' or not to 'test' for HIV.

## LIST OF ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| ABC | Abstain, Be Faithful, Condomise |
| AIDS | Acquired Immune Deficiency Syndrome |
| CCDU | Careers and Counselling Development Unit |
| CHWC | Campus Health and Wellness Centre |
| HBM | Health Belief Model |
| HCT | HIV Counselling and Testing |
| HE | Higher Education |
| HIV | Human Immunodeficiency Virus |
| HREC | Human Research Ethics Committee |
| IDU | Injection Drug User |
| MSM | Men who have Sex with Men |
| MTCT | Mother-To-Child-Transmission |
| NDoH | National Department of Health |
| PLWHA | People Living With HIV/AIDS |
| PSE | Psycho-Socio-Environmental |
| SA | South Africa |
| SRC | Student Representative Council |
| SSA | Sub-Saharan Africa |
| STI | Sexually Transmitted Infections |
| TS | Transactional Sex |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| VCT | Voluntary Counselling and Testing |
| WHO | World Health Organisation |
| WITS | University of the Witwatersrand |

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## INTRODUCTION

HIV/AIDS is a major public health threat in the worldwide context as it impacts on the individual and society at large (D'Adesky, 2004; Barnett and Whiteside, 2006). It is a well-documented fact that SA has the largest AIDS epidemic worldwide (UNAIDS, 2010). In the year 2008, the national HIV prevalence estimate among all South Africans was 10.6% whereby approximately 5.2 million people of the total population were HIV-positive (Shisana et al., 2009). More recently, in 2009, there has been an estimated 5.6 million people living with HIV/AIDS. The prevalence rate has been 17.8% among 15-49 year olds with some groups particularly more affected than others (UNAIDS, 2010). In order to address this high prevalence rate, it is important to target the youth (Njagi and Maharaj, 2006) and to focus on their attitudes and behaviours with the hope of turning the tide against HIV/AIDS (Shisana et al., 2009).

Despite studies that show high levels of HIV/AIDS awareness, many youth still participate in risky behaviours such as; alcohol drinking, drug abuse and early, multiple sexual encounters which increase their vulnerability to HIV (MacPhail and Campbell, 2001; Ettorre and Miles, 2002; Ndinga-Muvumba and Pharoah, 2008; Shisana et al., 2009; Poulson et al., 2010). As a result, these have serious negative short-term and long-term effects on their overall health and well-being (Granich and Mermin, 1999; MacPhail et al., 2008). HIV/AIDS is also associated with stigma, prejudice and discrimination which have psychological, emotional and cultural consequences that form part of a wider milieu of health (Fako, 2006; Herwitz, 2006; Nettleton, 2006; Njagi and Maharaj, 2006; MacPhail et al., 2008) and impact on VCT uptake among youth.

The South African NDoH recently drew attention to the promotion of VCT uptake among youth by implementing the First Things First campaign in various schools and Universities across SA. The First Things First initiative inspired this study which was conducted at WITS, an institution that is also affiliated with the NDoH and the First Things First campaign. The reason for focusing on first year University students is because this population of youth are regarded as the most at-risk population for contracting HIV (UNAIDS, 2006; Shisana et al., 2009). This might be due to the transition into the freedom of adulthood where parental structures may not be available. As such, the engagement in risky behaviours may be the outcome of lack

of social support and agency in terms of their decision-making capacity about health and well-being (Abraham et al., 2002; Harrison, 2005; HEAIDS, 2010).

This study therefore focused on the health behaviours of first year students as the literature confirms that youth's patterns of consumption represent a manifestation of their experience of health behaviours and identity (Ettorre and Miles, 2002; Nettleton, 2006; UNAIDS, 2006; Campbell et al., 2005). Thus, there is a need to understand the level of awareness among youth at University regarding HIV/AIDS and their attitudes towards VCT. This understanding is important in order to examine the underlying factors that either motivate or pose barriers to VCT uptake among youth which is imperative in turning the tide against HIV and AIDS (Shisana et al., 2009). A key aspect to this entails knowing how youth perceive HIV-positive people, how they react to them and whether or not they recognise the benefits of VCT.

Some of the benefits of VCT involve provision of psycho-social support to help those who are HIV-negative to remain negative and those who are HIV-positive to deal with the anxieties and to understand and accept the implications of their results (UNAIDS, 2001; Van Dyk and Van Dyk, 2003; Fako, 2006; Van Dyk and Van Dyk, 2008). VCT is based on the principle that, on the one hand, those who test and are found to be HIV-negative should receive counselling in order to identify and reduce high risk behaviours (UNAIDS, 2001; UNAIDS, 2004; Shisana et al., 2009). On the other hand, those who test HIV-positive should receive proper medical care, counselling, treatment and support in order to make informed decisions about their status and thereby reduce the chances of transmitting HIV to others and to also protect their own health (UNAIDS, 2001; UNAIDS, 2004; Njagi and Maharaj, 2006; Shisana et al., 2009).

Yet, there is little information about the HIV prevalence statistics among University students and the factors that motivate them to go for VCT and those that pose barriers. There is however agreement in the literature that VCT awareness must be promoted effectively among youth to help them identify their HIV status and prevent risky sexual behaviours in order to maintain a normal and productive life (UNAIDS, 2001; Njagi and Maharaj, 2006; Shisana et al., 2009; Fako, 2006). For the reasons mentioned thus far, it is of significance to focus on the attitudes, perceptions and health behaviours of youth at University. This is important in order to curtail the

spread of the epidemic by conveying acceptable messages about the dangers of risky behaviours and sexual practices and thereby encourage VCT uptake (Aggleton, 1996; Shisana et al., 2009). In addition, the meanings youth attach to their health are fundamental in the sociological explanations of health behaviour because it shapes their reasons to 'test' or not to 'test' for HIV.

In order to examine the sociological explanations of health behaviour, this research uses the constructs of the Health Belief Model (HBM) as a point of reference to explore and understand the health behaviours among first year students. The constructs of the HBM tie in with the focus on the factors that shape attitudes towards VCT. It also draws on the Psycho-Socio-Environmental (PSE) model and the ecological model to help explore how the social context affects health behaviours. This is vital in initiating and recommending new strategies that can be adopted by the NDoH with the aim of reducing infection rates.

In as much as this will be a difficult task, overtime such interventions can primarily be driven by theory, thereby making it easy to evaluate. Therefore, this research has relevance beyond a South African context as it appeals to the entire global population infected and affected by HIV/AIDS. In this appeal, it suggests that such research and theory are building blocks to knowledge creation and interventions. These may lead to positive change through a multidisciplinary approach when society works together in targeting and dealing with specific issues that begins by addressing the youth. It is against this backdrop that this research aimed to examine the factors that shape attitudes towards VCT among youth in SA which is necessary as the future of the epidemic will be shaped by their health behaviours.

Recent research on HIV/AIDS highlights many factors that contribute to the utilisation of particular health services such as VCT. Some of the factors include; age, gender, race, geographical location, social networks, stigma, fear of discrimination, socio-economic status and level of education while other factors comprise accessibility of contraception and quality of health care information and services (Ingham and Aggleton, 2006; Njagi and Maharaj, 2006; Ndinga-Muvumba and Pharoah, 2008; MacPhail et al., 2008; Shisana, 2009, MacPhail, et al., 2009; Mathews, 2010). Arguably, in SA these factors combine to affect VCT uptake among youth, however, there may be other intervening factors between individuals and

society (Airhihenbuwa and Obregon, 2000; Boswell and Baggaley, 2002). This study therefore sought to explore some of these factors in order to better understand the attitudes towards VCT among first year students. This knowledge is of importance in the struggle against HIV/AIDS.

As indicated in the literature, an important question of how society encourages the development of HIV awareness in targeting the youth remains a social, cultural and political question (Abraham et al., 2002; Lindsey, 2011; Lehr, 2008; Leclerc-Madlala, 2002). The Joint United Nations Programme for HIV/AIDS (UNAIDS) has documented that VCT is an important tool for detecting and preventing HIV infection as it allows youth to evaluate their behaviours and the consequences thereof (UNAIDS, 2001; 2004; 2006). Hence, knowing one's HIV status is a path to behavioural change and offers prevention benefits (Boswell and Baggaley, 2002; Njagi and Maharaj, 2006; Shisana et al., 2009).

Following the aim of the study, the main research question was:

What are the factors that shape attitudes towards VCT among WITS students?

Subsidiary questions were:

What factors shape health behaviour?
What factors shape help-seeking behaviour?
What are the perceptions of HIV and VCT?
What motivates/encourages uptake of VCT?
What issues pose barriers to VCT?

## LITERATURE REVIEW

This review of literature explores theory and research that have been developed with regards to youth and health behaviour. It further identifies and operationalises key concepts that have been established in order to discuss the major elements of this study in relation to VCT and HIV/AIDS. The purpose is to present information about VCT knowledge in addition to the access and utilisation of VCT services by youth at WITS. As such, it addresses the existing research that has been conducted on the topic of HIV/AIDS in both the local and global context (Airhihenbuwa and Obregon, 2000; D'Adesky, 2004; Njagi and Maharaj, 2006; Ndinga-Muvumba and Pharoah, 2008; MacPhail et al., 2008; Shisana, 2009; Lindsey, 2011; Campbell et al., 2005). However, it reveals that there has not been much research into the factors that shape attitudes and behaviour towards VCT among youth in SA, particularly those who attend University. The literature review therefore discusses health behaviour among youth in University with reference to the HBM. However, it does not probe into the causal effects proposed by the HBM as it is beyond the aim and scope of this study.

Nonetheless, the focus of this study is on the need to understand what motivates youth to go for VCT and what issues pose barriers towards it. To begin with, it is important to mention two words on the terminology used in this report. Firstly, the term 'students', 'youth', 'respondents' and/or 'participants' are used interchangeably to refer to the first year students who participated in the survey while the term 'interviewees' refer to the experts who were interviewed. Secondly, the term VCT refers to the 'voluntary' aspect of HIV-testing but this term has been replaced by a newer term 'HCT' which refers to HIV-testing and Counselling whereby the emphasis is not on the voluntary aspect.

Despite the fact that the term 'HCT' reflects the more recent thinking about HIV testing, for the purposes of this study, VCT is a preferred term as it focuses on the motivations and barriers or willingness and/or unwillingness to go for an HIV test. As such, VCT is not used interchangeably with HCT. Reason being, this study focuses on the 'voluntariness' as VCT it is client-based, whereby it involves individuals actively seeking out an HIV test or counselling. HCT however is primarily provider-initiated which is usually recommended by health care providers to anyone

attending a health care facility as a standard component for medical care and support.

Against this elucidation of terminology, an exploration of the factors that shape attitudes towards acceptance and/or rejection of VCT among WITS students are of main concern in this study. This is useful in addressing the key aspects of HIV/AIDS and the reasons why youth at University adopt certain health behaviours.

**Health Behaviour**

Health behaviour is “the activity undertaken by persons who believe that they are healthy, for the purpose of preventing or detecting disease in an asymptomatic stage” (Gilbert et al., 2010: 13). From an HIV/AIDS perspective, this means that regardless of whether or not people are infected, they adopt certain health practices based on information derived from society in order to ensure good health and avoid the possibility of contracting the disease and to maintain a healthy life. As such, VCT is an optimal initiative for positive health behaviour because it allows one to take responsibility to know their HIV status and to adopt the necessary precautions and treatment if necessary (Boswell and Baggaley, 2002; MacPhail et al., 2008; Njagi and Maharaj, 2006; UNAIDS, 2001; Francis, 2010). Disease and illness is not only an individual lived experience but is a social experience too. This implies that society has the moral duty to support the unwell whereby the beliefs they conform to may be a result of cultural upbringing and social norms (Airhihenbuwa, 1995; Petersen and Wilkinson, 2008).

There is evidence to suggest that many HIV/AIDS prevention initiatives, community health care services as well as parents and teachers have difficulty discussing issues of sexual behaviour and HIV with the youth which greatly impact on their views on the epidemic (Granich and Mermin, 1999; Ingham and Aggleton, 2006; Petersen and Wilkinson, 2008; MacPhail et al., 2008; Lindsey, 2011; Leclerc-Madlala, 2002; Kalipeni et al., 2004). This further problematises the task of developing appropriate health behaviours which are conducive to HIV prevention. Therefore, there is a need to make reference to the HBM in understanding youth’s health behaviours and attitudes towards VCT.

**Health Belief Model (HBM)**

There have been various health models applied to safer sexual and health behaviour, however, the HBM is regarded as useful as it is a psychological model which attempts to explain and predict health behaviours by placing emphasis on the attitudes and beliefs of individuals. Hence, the HBM is of greatest relevance to this study as it suggests that preventive action occurs when people, in this case the youth, hold certain beliefs about recommended action (Becker, 1974; Gochman, 1997; Airhihenbuwa and Obregon, 2000; Redding et al., 2000; Glanz et al., 2002). The following table sums up the key aspects of the HBM which is useful for this research in ways that will be discussed thereafter.

| **Constructs** | **Descriptions** |
|---|---|
| Perceived Susceptibility | One's evaluation of chances of getting a condition. |
| Perceived Severity | One's evaluation of how serious a condition, its treatment, and its consequences would be. |
| Perceived Benefits | One's evaluation of how well an advised action will reduce risk or moderate the impact of the condition. |
| Perceived Barriers | One's evaluation of how difficult an advised action will be or how much it will cost, both psychologically and otherwise. |
| Cues to Action | Events or strategies that increase one's motivation. |
| Self-efficacy | Confidence in one's ability to take action. |

Figure .1.1. Health Belief Model Constructs (adapted from Redding et al., 2000: 182)

The usefulness of the HBM's constructs in attempting to explore the factors that shape attitudes towards VCT among youth is because it proposes that those who seek medical help are motivated to take action by the perception of symptoms and their relation to the perceived risk (Redding et al., 2000; Peterson and DiClemente, 2000; Becker, 1974). For example, this may include acceptance that they are susceptible to a preventable risk such as HIV and that recommended preventative action such as contraception use is effective and has positive outcomes.

However, the HBM has been critiqued on many grounds, particularly in its causal explanations (Peterson and DiClemente, 2000) as well as its focus on the individual

and the perceived severity of a health ‘condition’ (Redding et al., 2000). As such, the perceptions may be exaggerated and a ‘negative’ label is attached to an undesirable identity (Kelleher and Leavey, 2004; Aggleton et al., 2006; Njagi and Maharaj, 2006). In addition, the HBM comprises assumptions that present limitations to its use which are important to mention at this point in order to evaluate its overall usefulness in this study nonetheless.

One of the critiques brought forth is that the HBM assumes that a person will adopt the necessary health related action, such as condom use, if s/he feels that a ‘negative’ health condition such as HIV can be avoided (Conner and Norman, 1996; Glanz et al., 2002; Redding et al., 2000). As such, it is necessary to help individuals acknowledge that they have the potential to avoid a health condition that will present them with a negative identity. This can only be done if one is aware of the problem and only through health promotion and health education strategies can one be able to take the relevant action (Becker, 1974; Aggleton, 1990; MacDonald, 1998; Lucas and Lloyd, 2005; Campbell, 2003; Njagi and Maharaj, 2006; Clarke, 2010; McCoy et al., 2010).

Another critique on the HBM is that it takes for granted that a person will be motivated enough to take action against a ‘negative’ health condition if s/he has an optimistic expectation that by taking action, such as using condoms, they will prevent a ‘negative’ health condition (Glanz et al., 2002) such as HIV. This implies that the person needs to fully understand the benefits that s/he will gain from practising positive health behaviours such as going for VCT. However, if youth fail to see the benefits of VCT for example, it becomes difficult for them to take the necessary cues to action.

Lastly, the HBM further assumes that a person takes the health-related action based on their subjective cognisance or agency in recognising the seriousness of a health condition and thereby believes that s/he can successfully take a recommended action (Becker, 1974; Conner and Norman, 1996; Glanz et al., 2002). Hence, it requires the person to feel confident that s/he has the necessary agency or self-control to make use of the health services or use condoms comfortably and consistently that are provided to them and to make the relevant changes to their health behaviours (Redding et al., 2000; Glanz et al., 2002). This further implies that

there is a need to ensure that a person has the necessary knowledge and skills and supportive structures within an accepting social environment in order to carry out the required action/s. In sum, the HBM presupposes that knowledge of the seriousness of, for example, HIV is the ultimate pathway to behavioural change, treatment, care, support and prevention benefits; however, behavioural change is a multilayered and complex task that needs to unfold overtime.

Despite the critiques advanced thus far, the HBM informs this study mainly since it utilises a descriptive approach that does not probe into the causal effects proposed by the HBM, which is beyond its scope. In this study, the HBM acts as a useful analytical tool that enables the identification of the factors relevant in this context. A pre-requisite for seeking medical care is the individuals' recognition that they are susceptible to certain 'risks' such as HIV and/or sexually transmitted infections (STIs) or an unwanted pregnancy. As such, they must perceive that the severity of the condition is worth avoiding (Peterson and DiClemente, 2000; Redding et al., 2000).

Moreover, the HBM postulates that help-seeking behaviour is influenced by a person's perception of a threat posed by a particular problem and that the values associated with actions are aimed at reducing the threat (Redding et al., 2000; Peterson and DiClemente, 2000; Gochman, 1997). This notion is most relevant in the context of this study that explored why the youth are willing to go for VCT, or more specifically, who among them is more likely to do so. For example, the ones' who either knew people who are HIV-positive, who have been for VCT or someone who has passed away due to AIDS. As such, their increased perceived susceptibility was one of their motivations for their willingness to test. This thereby demonstrated how their help-seeking behaviours are shaped not only by their perceived susceptibility but the perceived severity of how serious HIV and AIDS are and how it constitutes a threat to their life.

**Help-seeking behaviour and other models of health**

Help-seeking behaviour refers to "the decision-making process leading people to seek professional healthcare... [as a result of] how symptoms are perceived and interpreted" (Gilbert et al., 2010: 13). With this in mind, an appropriate model used to contextualise this understanding is the PSE model which places emphasis on the

role of people's behaviours in their social context in determining their health status (Gilbert et al., 2010). As a result, this model offers a macro-sociological perspective of health and the meanings and experiences society attaches to illnesses and diseases (Gilbert et al., 2010) such as HIV/AIDS. This implies that the PSE model in relation to the HBM has a tremendous influence on how people understand their health. Thus, the constructs of the HBM; perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action and self-efficacy (Redding et al., 2000) are vital to understanding the factors that shape attitudes towards VCT and the health behaviours involved. Indeed, the adoption of the PSE model as a guiding framework in this study counteracts the potential critique against the use of the HBM since it facilitates the understanding of individual human behaviour within its larger social context.

As evidenced in the array of literature, it becomes clear that there is a relationship between the data collected on VCT and the analyses presented by the HBM in relation to help-seeking behaviours (Redding et al., 2000; Airhihenbuwa and Obregon, 2000; Peterson and DiClemente, 2000; Gochman, 1997). For example, the combined advantage and disadvantage of this model is that even when an individual recognises personal susceptibility they may not always take action unless they perceive the seriousness of illness (Redding et al., 2000; Airhihenbuwa and Obregon, 2000; Peterson and DiClemente, 2000). Thus, the individual's subjective assessment of their health situation is an important variable in the utilisation of health services like VCT (Njagi and Maharaj, 2006). As such, various aspects to VCT in relation to the HBM prove that there are a range of factors that together shape attitudes towards VCT which depends on the regulation of cognitive and social skills required to manage and negotiate sexual interaction within the youth's social network (Abraham et al., 2002; Pettifor et al., 2004; Njagi and Maharaj, 2006; MacPhail et al., 2009; Leclerc-Madlala, 2002; Lindsey, 2011).

Due to the fact that HIV/AIDS is usually contracted through sexual intercourse it often provokes strong negative images in people's minds (Abraham et al., 2002; Njagi and Maharaj, 2006; Lindsey, 2011; Airhihenbuwa, 1995; Ankrah, 1991; Fan et al., 2007). As a result, an infected person is subjected to various stereotypes of blame (Ndinga-Muvumba and Pharoah, 2008; MacPhail et al., 2008; Scambler,

2009; Gilbert et al., 2009) that affect decisions to seek, or not to seek medical help which usually has a gender dimension to it (MacPhail et al., 2009; Deribe et al., 2009), a topic that will be discussed later. For the purposes of the present discussion and in line with this gendered thinking, Ingham and Aggleton (2006) propose an ecological model to emphasise for example, how gender norms related to sexual behaviour are internalised by the individual through the interaction of factors such as peer groups, intimate partners, familial relations and access to and quality of social services and support networks.

Thus, gender ties in with help-seeking behaviours which are either promoted or hindered by the messages that are transmitted within the structures of social capital (Goldin, 1994; Mane and Aggleton, 2001; Jewkes et al., 2003; Njagi and Maharaj, 2006; Mathews, 2005) and may affect VCT uptake among youth in Higher Education (HE) in particular. Like the HBM and PSE model, the ecological model is also useful for a macro-sociological understanding of the factors that shape attitudes towards VCT. All three of these models place emphasis on the inner workings of the social context, particularly the impact of social capital and its influences on how one lives their life.

**Social Capital**

The concept of social capital has implications that are important to health and life chances as it shapes both positive and negative ideas about the world and health behaviour in particular (Poortinga, 2006). As such, there is a contested nature embedded in the meaning and practical implications of social capital on individuals and communities. “Social capital refers to the rules that reflect community values and norms and which provide for various coping strategies, durable networks, marriage, kinship networks, extra familial support structures and secular and religious community institutions” (Kelleher and Leavey, 2004: 142). Using this definition as a backdrop it can be said that social capital shapes attitudes towards health-related issues among youth whereby ones’ risky behaviours are usually frowned upon and limited by discourses of control (McElroy and Jezewski, 2000; Preston-Whyte, 2004; Rassjo et al., 2007).

These discourses are usually imposed upon by elders, peers in opposition to such behaviours and society at large **(**Granich and Mermin, 1999; MacPhail et al., 2008; Petersen and Lupton, 1996; Wight et al., 2006; Soroses, 2006) and thereby pose barriers to access of health information and services. This implies that social capital is both an individual and collective resource. The contestation however arises when social capital, in relation to health, poses simultaneous unfavourable and favourable conditions for individuals and society (Poortinga, 2006). These conditions lay a platform to considering how structure and agency both shape health behaviour along two dimensions of social capital; bonding and bridging which underline the existence of power relations that work through a range of mechanisms which determine access to resources and material goods (Ferlander, 2007; Siegrist and Marmot, 2004). Hence, there is much variation between groups regarding access to different social capital which further impacts their health; in positive and negative ways depending on the quality and quantity of their social networks (Turner, 2003).

To build on this, MacPhail et al. (2009) found that when communication about HIV and testing are ignored, the chance of seeking a test is low. However, when testing has been done, youth fear disclosing their status to their parents in avoidance of bringing shame to their family and loved ones (MacPhail et al., 2009; Yep, 2000; Deribe et al., 2009). Also, disclosure of their status renders simultaneous acknowledgement of their sexual relations which further add to their emotional burdens (Granich and Mermin, 1999). Moreover, due to the negative influence of social networks such as peer pressure, personal health concerns about the risk of HIV infection and self-protection may appear as unimportant and may become secondary goals (Harrison, 2005; Hart and Carter, 2000; Jeeves and Jolly, 2009). This may make self-protective action such as contraception use less probable as it implies a risk-conscious approach to intimacy among youth (Abraham et al., 2002).

To emphasise the contestation embedded in social capital, Siegrist and Marmot (2004) and Dahl and Malmberg-Heimonen (2010) highlight the positive and negative impacts of social capital. In a positive light, access to ‘good’ social capital enhances life chances and longevity which is important for self-rated ‘good’ health outcomes because social capital acts as a shield against disease contraction such as HIV/AIDS. In a negative light, where the quality of social capital is poor, there is

deterioration in health and the increase of disease prevalence due to an increased participation in sexual risk behaviour.

Nonetheless, literature mainly points out the positive influence of social networks whereby knowing people who have been for an HIV test and those who use contraception motivates others to get tested themselves and make use of contraception as well (Takyi, 2003; Maxwell, 2002; Taylor et al., 2007; Van Zyl; 2006). It is however noted that social capital has a combined effect on people. For example, continuous support by peers, parents and other family members may be perceived as crucial in coping strategies and the prevention of suicide (MacPhail et al., 2009). In addition, the positive effects of social capital may be linked to health promotion initiatives among certain groups of people such as youth whereby social capital may be a driving force to students embracing positive health behaviours such as willingness to access VCT (Mathews, 2005; Njagi and Maharaj, 2006). This is because their decisions could have been shaped by their peer community within a circle of mutual help and support with an increased level of trust among peers (Maxwell, 2002).

But, due to the general considerations of stigma and fear of discrimination, youth are less likely to disclose their status to their partner if; they never discussed HIV, if they were unaware of their partner's HIV status or if they did not recognise the relationship as stable (Deribe et al, 2009; Carlisle, 2001; Deacon et al., 2005; Gilbert and Walker; 2009). Thus, of sociological importance of social capital are the combined consequences that are embedded in a situation whereby attitudes and behaviours are shaped by the environmental situation, social networks and personal biography (Airhihenbuwa, 1995; Kelleher and Leavey, 2004; Nettleton, 2006; Hart and Carter, 2000). To relate these phenomena from a classic sociological standpoint, Mills (1959) suggests that in order to understand any aspect of societal needs there must be a close examination of the individuals' biography and shared history of the society at large. Thus, the usefulness of studying HIV/AIDS and VCT in a macrocosm is based on Mills' (1959) notion of the 'sociological imagination' which implies that there is no specific way of interpreting the happenings in the world as it is ever-changing. This therefore links in with Durkheim's (1895) proposition of a 'social fact' which, like Mills (1959), cannot be understood in isolation because of the

fluid nature of the world and its processes in knowledge creation which differs per individuals' biographical, social and environmental context.

However, these authors are different in their approach in studying society; on the one extreme, Durkheim (1895) places emphasis on societal-level measures of individual behaviours; on the other extreme, Mills (1959) favours history and biography in examining the ways in which society functions. Using the propositions of these theorists, this study finds significance in undertaking a holistic view of exploring the factors that shape attitudes towards VCT. The significance is based on the need to study societal responses to HIV/AIDS through a macro-sociological lens as it sheds light on the ways in which risks, identity, behaviour and lifestyle is created which thereby impacts on the utilisation of health services such as VCT especially among youth (MacPhail and Campbell, 2001; Njagi and Maharaj, 2006).

One of the barriers to the utilisation of health services such as VCT among youth at University is that they form their own youth culture as an expression of their identity. As such, they participate in various lifestyle choices in order to be socially accepted among their peers, however, these choices may put them at an increased risk of contracting HIV (Kelleher and Leavey, 2004). Harrison (2005) thereby suggests that "[c]ertain social and structural factors are most commonly associated with HIV infection in young South Africans" (p. 262). For example, "[e]vidence points to associations between HIV infection and a partners age, school attendance and completion, parental absence, participation in community and sports organisations and other measures of social capital" (ibid.). These factors thus bring into focus the notion of health promotion and health education in relation to behavioural choices among youth in SA which is important to consider in relation to understanding VCT.

**Health promotion and education: its links to HIV prevention and VCT uptake**

Health promotion is a complex notion of which its conceptual, theoretical and operational meanings are multilayered and dynamic (Aggleton, 1996; Naidoo and Wills, 1994). As such, there have been many debates on health promotion as health education is embedded in it; however, the two are neither mutually exclusive nor interchangeable (MacDonald, 2008). Health promotion is "the process of enabling people to increase control over, and to improve their health" (Clarke, 2010: 357)

whereas health education is to “acquaint people with the facts of what health is in explicit and identifiable terms” (MacDonald, 2008: 11) and which “promotes health or illness related learning” (Tones, 1990; cited in Naidoo and Wills, 1994). However, there is no one definition as these concepts have an elastic quality (Clarke, 2010). As such, there is a fine line between health promotion and health education but there are major differences in the ways in which they are understood in theory and practice (Naidoo and Wills, 1994; Lucas and Lloyd, 2005). Against the backdrop of the HBM, this is useful to discuss in order to examine the factors that shape attitudes towards VCT and HIV/AIDS.

There are key characteristics of health promotion mentioned in *The Ottawa Charter for Health Promotion* (1986), cited by Clarke (2010), which highlights how preventing disease is one aspect of health promotion and it “emphasises the importance of helping people, either as individuals or in groups, to gain control over their health and adapt to the environments in which they find themselves” (p. 357). This links in to the ecological model brought forth earlier in this review of literature as it recognises that people’s health is beyond an individual responsibility but that health promotion is not based purely on the health care sector because social and environmental factors can affect health too (Aggleton, 1996; Aggleton et al., 2006). Much literature emphasise public health approaches that promote abstinence, condom use, and faithfulness which may not be effective because it ignores existing gender inequalities that have become a product of SA’s historical past (Abdool-Karim and Abdool-Karim, 2005; Cullinan, 2010; Gilbert et al, 2010; Mathews, 2010).

Thus, a better understanding of such dynamics and how they act as prevention barriers is needed especially with the focus on youth and their attitudes towards VCT and the barriers and motivations for it. Thus, health promotion needs to be understood within a wider context of public policy (Lucas and Lloyd, 2005; Clarke, 2010; Naidoo and Wills, 1994). Lucas and Lloyd (2005) point to the multifaceted understandings of health and how definitions of health promotion are challenged. The contestation arises in terms of its conceptual, theoretical and operational difficulty in exploring the ways in which HIV prevention efforts are impeded or facilitated.

This is important to note from a SA standpoint as there is a dire need to target specific population groups in order for facilitating effective prevention. Although, behaviour change is not an easy task and does not necessarily work (Jeeves and Jolly, 2009) which may thereby impede HIV prevention efforts. Thus, regardless of the magnitude of HIV/AIDS awareness initiatives by government and society in SA, HIV prevention still has negative effects on public health (Jeeves and Jolly, 2009; Njagi and Maharaj, 2006; Naidoo and Wills, 1994). McKinlay (1979), as cited by Naidoo and Wills (1994:74), highlighted the need to refocus *'upstream'* approach that centres on the social and physical environments that either promotes or hampers good health and well-being. As such, the upstream approach emphasises the promotion of health; to change the aspects that are harmful to health and prevent disease/s in larger groups in society. For example, using Naidoo and Will's (1994) concept of the 'New Public Health threat', it can be argued that alcohol use among youth for instance, is labelled as a warning and a driving force to HIV prevention whereby alcohol labels warn people of its negative effects on health.

In linking this with HIV prevention efforts in SA, alcohol use is a risk factor to HIV transmission as it alters human behaviour and makes a person more prone to engage in risky sexual practices which may lead to them contracting HIV. Thus, in SA and across the globe, there are multiple messages of health promotion in a single campaign that is linked to HIV prevention, such as alcohol, smoking and unsafe sex. In line with this, Jeeves and Jolly (2009) and Mathews (2010) show that many factors at the community level as well as personal, interpersonal, cultural and structural factors point out efforts to prevent HIV, including knowledge about STIs as well as access to treatment which thus blurs ideas of health promotion and health education as they both work together to shape health. Thus, a purely biomedical or social approach is problematic. Hence, this study focuses the lens on a macro-sociological account of the factors that work together to possibly shape attitudes towards HIV/AIDS and VCT uptake among youth.

There has not been much emphasis in health promotion initiatives to address the social aspects of health-related issues among youth at a collective level in SA which seriously needs to be altered to prevent HIV (Jeeves and Jolly, 2009). Hence, there is a need for a multidisciplinary approach (Carter, 2010) from social scientists,

medical doctors, public health professionals and policy and economic analysts to work together to facilitate a shift from individual to community levels. A multidisciplinary approach to health promotion with a focus on the social aspects means that there will be a focus beyond a purely biomedical approach which is important for effective efforts to prevent HIV in SA. For example, using what Gilbert and Walker (2009) refer to as the 'fault lines of society'; gender, age, race, geographical location and socio-economic status, health promotion and health education is a response to the fears and prejudices of individuals and communities. However, theoretical and practical understandings of health promotion as an umbrella term is useful as it offers insights into how and why HIV/AIDS prevention efforts for youth are developed and is maintained in different social contexts within SA, such as those across social and cultural norms (Jeeves and Jolly, 2009).

Thus, understanding the factors that shape the ways in which efforts to prevent HIV unfolds in SA provides information on the social epidemiological context of which health promotion and health education manifests itself (Tenkorang et al., 2009). Harrison (2005) suggests that when discussing health promotion in relation to youth, it is important to consider "[i]nterventions with potential to reduce the number of new infections in youth include 100% condom promotion, youth-friendly services, voluntary counselling and testing, income generation....and protecting sexual and human rights" (p. 263). Thus, an adequate and nuanced understanding of the social perspective to HIV prevention efforts needs to be discussed using the PSE to analyse the context specific situation of which the epidemic and health promotion unfolded in SA (Gilbert et al., 2010). The 'Social and Political Structure' proposed by Gilbert (2008, cited by Gilbert et al., 2010), is useful for discussing the dimensions that play a role in health promotion in SA and health education initiatives. It points to the fact that social injustices are mirrored in the state of health of the people and the services available to them (Gilbert et al., 2010).

Hence, personal risk awareness, resistance to condoms, problems of stigma and disclosure are important to understand in the spread of HIV/AIDS and the impediment on HIV prevention efforts (Abdool-Karim and Abdool-Karim, 2005; Gilbert and Walker, 2009; Njagi and Maharaj, 2006; Yep, 2000; Van Dyk and Van Dyk, 2003). However, "young people often do not perceive themselves to be at risk,

preventing them from accessing or using prevention when needed" (Harrison, 2005: 264). Thus, the extent to which health promotion is shaped by efforts to prevent HIV is not straightforward. Nonetheless, health promotion is spatially patterned and geographic location affects health and disease (Tenkorang et al., 2009). As noted by Carter (2010), behaviour change programmes had little impact on HIV incidence amongst women and girls in poor countries and that the development of female-controlled biomedical methods of HIV prevention such as microbicides has been disappointing. In addition, HIV prevention for women and girls now relies on behaviour change such as delayed sexual intercourse and a reduction in the number of partners- which has not been successful (Jeeves and Jolly, 2009; Tenkorang et al., 2009; McCoy et al., 2010**).**

In tying all that has been mentioned thus far, Naidoo and Wills (1994) succinctly sums up by noting that there are different approaches to health promotion; medical/prevention, behaviour change/lifestyle, educational, social change and empowerment. It is argued that SA's efforts to prevent HIV is primarily on health education as interventions are concerned with changing behaviours on an individual level rather that health promotion at a collective level which is problematic. Jeeve's and Jolly (2009) propose that prevention efforts can only be effective if one takes into account the complex socio-cultural aspects HIV prevention. However, again, there is a need to focus on the macro-sociological aspects to understanding the debates on health promotion and subsequent efforts to prevent HIV in SA. Also, as Harrison correctly points out, "non-use of contraception by those who have recently become sexually active means that opportunities for counselling regarding condom use and dual protection against HIV and pregnancy are missed" (2005: 268). As such, health promotion strategies need to account for the correct use of condoms rather than merely promoting condom use among youth.

There is no comprehensive picture of health promotion in terms of HIV prevention as it varies considerably. As suggested by Harrison (2005), while more youth make the transition into adulthood and into tertiary education to live on their own for an extended period of time away from familial and parental structures "the needs for youth-focused programmes have been more apparent" (p. 264). This is due to the fact that youth is a time of experimentation and risk which often leads to increased

vulnerability as young people make an important transition to social and psychological independence. “Peer pressure, socio-cultural norms and expectations are social factors that influence the process” (Harrison, 2005: 264) of youth at University as their social network increases as well as their “emotional and physical development, age, inexperience and financial dependence” (Harrison, ibid.). As a result, within a University environment, students may then form their own youth culture (Maxwell, 2002; Leclerc-Madlala; Poulson et al., 2010; O’Sullivan et al., 2003) and resist healthy lifestyle choices and moral behaviour. These ideas have been taken onboard in the analysis of the data collected in this study and will be discussed later on. For now though, the issue of the newfound youth culture and lifestyle choices are important to discuss so as to set a platform to understanding the complexities inherent in reasons for and against uptake of VCT.

**Youth Culture and Lifestyle**

McElroy and Jezewski (2000) suggest that culture is understood as “a system of learned and shared codes... for perceiving, interpreting, and interacting with others and the environment” (p.191). Within this, youth culture unfolds in the consumption of risky health practices such as unsafe sexual behaviour, alcohol use and intravenous drug usage. These practices represent an area where the youth construct lifestyles within which they live and feel free to discuss aspects of the risk society with their peers who also engage in such activities (Selikow et al., 2002). Lifestyle is a concept that refers to people’s styles of living, which in turn are shaped by their patterns of consumption (Ettorre and Miles, 2002; Nettleton, 2006). “In relation to health, this refers to eating, the use of legal and non-legal drugs, smoking, leisure and sporting activities, sexual activity and aspects of body maintenance” (Nettleton, 2006: 33-34). These activities are significant as they are regarded as potential risk factors associated with health status (Nettleton, 2006: 34).

Also, “since levels of infection are so high in the general population, simply being sexually active places young people at high risk. Further, unique characteristics of sexual partnerships for many South African youth, predispose them to acquisition of HIV” (Harrison, 2005: 263). As a result, the health needs of youth are shaped by the changing patterns of their risky social contexts and health-related behaviour (Ettorre and Miles, 2002). In many ways, youth represent a population group that is

important to target as they are in their formative stage of life of which they are making their transition into adulthood (Harrison, 2005) and thus their experiences are important to account for as effective messages about HIV/AIDS has the possibility of turning the tide against HIV/AIDS (Shisana et al., 2009).

Also, youth are regarded as 'pathological' and assumed to be unhealthy by implication of their identity due to their lifestyle choices which predispose them to negative health conditions (Ettorre and Miles, 2002; Kelleher and Leavey, 2004). As a result of this, youth may experience psychological and emotional instability such as feelings of low self-esteem and self-efficacy (Kelleher and Leavey, 2004). This implies that to a certain extent, the relationship between youth culture and lifestyle is an expression of their positioning within the risk society which affects their health and pose barriers to VCT uptake, which is at the centre of this study.

**Barriers to VCT uptake**

The literature reveals two main barriers to VCT; on one level, the internal individual obstacles such as the fear of death and an inaccurate personal risk perception (Njagi and Maharaj, 2006), on another level, external societal obstacles of stigmatisation, prejudice and discrimination by social networks (Boswell and Baggaley, 2002; Campbell, 2003; Deacon et al., 2005; Njagi and Maharaj, 2006; Gilbert et al., 2009; Goldin, 1994; Glanz et al., 2002; Lindsey, 2011; Leclerc-Madlala, 2002). According to Goffman (1963), as cited by Gabe at al., stigma is a "negatively defined condition, attribute, trait or behaviour conferring 'deviant' status, which is socially, culturally and historically variable" (2004: 68). The concept of stigma is applied to any condition that symbolically categorises a person as inferior which indicates the idea of shame, rejection and blame which in turn alters an individual's identity (Kelleher and Leavey, 2004; Scambler, 2009; Nettleton, 2006).

Prejudice also arises when an individual in a group is suspected of being at risk for HIV. Prejudice is understood as a biased attitude toward a person or a group of people that arises from negative perceptions in people's minds that are associated with specific individuals (Airhihenbuwa and Obregon, 2000; Fan et al., 2007). Whereas prejudice relates to attitudes, another closely related aspect that poses a barrier to VCT is discrimination. Discrimination is understood as any behaviour

toward an individual based solely on the individual's affiliation in a particular group that is usually thought of in a negative light (Nettleton, 2006, Fan et al., 2007; Petersen and Wilkinson, 2008; Ndinga-Muvumba and Pharoah, 2008).

From a societal perspective, stigma, prejudice and discrimination are key aspects to exploring the barriers towards VCT uptake, especially among youth (Fan et al., 2007; HEAIDS, 2010). As such, these negative images are created among people in their close social networks such as peers and therefore the commonly held attitudes and norms in a community affect how those with HIV/AIDS are treated and how HIV is, or is not prevented (Njagi and Maharaj, 2006; Fan et al., 2007). A common thread in the literature is the nature of sexual relationships among youth at University in the form of power dynamics between the couple involved, as well as their social networks such as family members or peers who may influence the process of certain relationships. Studies in SSA have shown that violence and coercion perpetrated by men on their female partners are part of sexual intercourse for many, especially with respect to patriarchy and power (Rassjo et al., 2007; Preston-Whyte, 2004; Takyi, 2003; Pick and Cooper, 1997; Lehr, 2008; McCoy et al., 2010). Young women, for example, often report that they are unable to refuse sexual relations with their partners who desire unprotected sexual intercourse due to the fear of violent consequences and the label given to them as being prostitutes and HIV-positive (Cleland and Ferry, 1995).

As Harrison (2005) points out, "[s]ocial barriers to contraceptive use also exist, particularly among young people, often including communication difficulties between [youth] and parents and avoidance of responsibility for contraception by male partners" (p.273). These negative views further add to the complexity inherent in the barriers towards VCT which needs to be sociologically analysed within a broader macrocosm of how society functions which can either promote or hinder VCT uptake among youth. Hart and Carter (2000) propose that an adequate analysis of the way society functions requires analyses on three levels; macro-, meso- and micro-sociological levels. These authors suggest that macro- analysis refers to societal level, meso- analysis refers to organisational issues and micro- analysis explores individual and social meanings of behaviours deemed to be risky (Hart and Carter, 2000). This is useful to gain a more nuanced understanding on the factors that pose

barriers towards VCT uptake because of the multi-level approach to studying HIV/AIDS in relation to VCT uptake in a macrocosm. Such analyses focus on the interpretations of risk and which thereby provides insight to social and cultural norms which then shape people's views, beliefs and actions (Durkheim, 1895; Nettleton, 2006). Thus, if youth are to develop agency in relation to their sexual practices and risky behaviours they need to be encouraged in order to be aware about how such perspectives affect their health and sexual interaction (Abraham et al., 2002).

Some other reasons why youth may avoid going for VCT include the fear of; the status outcome, lack of confidentiality, being sexually inactive, losing a relationship and using condoms consistently (MacPhail and Campbell, 2001; Abraham et al., 2002; Boswell and Baggaley, 2002; Ettorre and Miles, 2002; Njagi and Maharaj, 2006; HEAIDS, 2010). Further barriers to VCT among youth are the perceived lack of availability and accessibility of VCT services, long waiting times, high costs, pressure by health staff to notify partners, inaccurate risk perception and inadequate responses from healthcare providers, including counsellors to effectively meet the HIV prevention, care and support needs for them (Boswell and Baggaley, 2002; Njagi and Maharaj, 2006; HEAIDS, 2010). Therefore, there is a huge challenge facing VCT uptake among youth in HE as health care services have to be targeted depending on a range of factors. These factors include geographical location, level of societal stigma, access for hard to reach groups and supportive legal and policy environments (Boswell and Baggaley, 2002; MacPhail et al., 2008; Barnett and Whiteside, 2006; Airhihenbuwa and Obregon, 2000).

Addressing these factors is a means of targeting the ways in which the youth deal with health-related issues and the reasons why they adopt risky behaviours. "Age puts young people at risk, in terms of inexperience and inability to negotiate the terms of relationships" (Harrison, 2005: 264) as well as "[c]ertain biological or developmental factors also confer risk, as does the broader social context" (Harrison, ibid.). Furthermore, initiation of sexual intercourse puts young people in a high risk position for HIV and other STIs as well as unplanned pregnancy (Tenkorang et al., 2009; Steinberg et al., 2006; Selikow et al., 2002; Leclerc-Madlala, 2002). Thus, within the context of youth and HIV/AIDS the age of sexual debut becomes a focal point as it is a marker of risk because it determines length of exposure to infection

whereby those who become sexually active at a younger age are more likely to have a greater chance of infection than those who delay (Tenkorang et al., 2009; Harris, 2005).

In addition, the characteristics of patterns of sexual networks are essential to consider as the age differentials and type of partners as well as the numbers of partners all contribute to the risk of HIV infection (Leclerc-Madlala, 2002) and the reasons for and against VCT. The general literature demonstrates that, for example, young women who have partners that are approximately three to five years older than themselves pose a major risk factor for HIV infection. Likewise, young men's decisions to engage in multiple sexual partnerships sometimes concurrently are a major underlying risk factor for HIV infection (Selikow et al., 2002; Taylor et al., 2007). Thus, there is an important need to study the risk behaviours among youth at University in order to explore what factors further pose barriers to VCT uptake, as was done in this study.

**Risk behaviours**

The fact that youth are mostly regarded as risk-takers is largely generalised to the entire population which fails to acknowledge that not everyone in the youth group is sexually active or submissive to risky behaviour (Rutter and Quine, 2002). As a result, youth are viewed as irresponsible and passive in life decisions. For example, the focus has always been on youth as "risk-takers; smokers, drinkers, drug users, sexual experimenters" (Ettorre and Miles, 2002: 177) whereby their experience of health is portrayed as deviant. Therefore, central to the literature on health behaviour among youth in SA is the notion of risk. Petersen and Wilkinson (2008) suggest that risk is sociologically understood as an organising principle of society and an important coordinate of personal identity. Thus, health can be promoted and HIV/AIDS can be prevented by identifying and controlling risk factors (Hart and Carter, 2000; Abraham et al., 2002; Campbell et al., 2005). For example, of prime concern among youth in HE is the fact that unsafe sexual practices increase their risk of HIV/AIDS (Cleland and Ferry, 1995; Abraham et al., 2002; HEAIDS, 2010). As pointed out by Harrison (2005), "sexual risk is influenced by multiple social, behavioural and situational factors" (p. 264) which thereby increases youth's vulnerability to HIV/AIDS.

Some of these risky sexual practices include unprotected vaginal and anal sex that puts the sexual partners at greater risk of contracting HIV and other STIs (Fan et al., 2007; HEAIDS, 2010; MacPhail, 2001). However from a practical perspective the degree of risk exposure and frequency of these practices may differ which cannot be categorised in terms of the specific level of risks. From a theoretical perspective, the riskiest sexual practices are those in which HIV-infected blood, semen or cervical-vaginal secretions from an infected person comes in direct contact with the bloodstream or mucous membranes of another person (Fan et al., 2007; Granich and Mermin, 1999; O'Sullivan et al., 2003). These practices include vaginal intercourse between a man and a woman, anal intercourse between a man and a woman and anal intercourse between two men which are activities that may be commonly practiced among youth in their developmental stages (Granich and Mermin, 1999; Campbell et al., 2005; HEAIDS, 2010) and a topic that will be discussed shortly.

Thus, what further complicates the relationship between risky behaviours and health is the various levels of contact between different risk groups. For example, injection drug users (IDU), heterosexual contact, homosexual or bisexual men whereby youth may be curious to explore different sexualities in finding their identity (Fan et al., 2007; Kelleher and Leavey, 2004). "Other risk factors for HIV infection in young people include infrequent or inconsistent condom use, as well as high levels of fluidity and mobility in relationships and high levels of sexual coercion, particularly around sexual initiation" (Harrison, 2005: 263). Thus, these factors are particularly important to understand within the context of HE as many first years may be sexually coerced into unfavourable sexual practices that may seriously endanger their health. As briefly mentioned before, much literature focuses on the reasons for risk-taking among youth despite their knowledge of HIV and its transmission outcomes, which has a gendered dimension to it- a topic that will now be discussed.

**Gender**

Gender, according to Mensch et al. (1998) and as cited by Ingham and Aggleton (2006) is defined as "the socially constructed roles, identities and attributes of men and women... [and is] a key issue for understanding the sexual behaviour and vulnerabilities of young people" (p. 61). This highlights how gender characterises a

complex interplay of contextual and individual factors that pose challenges and opportunities for young men and women in terms of their sexual identity and related health risks. To elaborate on this, Rassjo et al. (2007) note that where sex is used to obtain money and material goods, young women turn to older men in the form of 'sugar daddy' relationships whereas young males resort to multiple sexual partners to gain a popular identity. In addition, these sexual relations may also involve sexual violence and subordination in the form of gendered power relations whereby safe sex is not a given option (Rassjo et al., 2007; Taylor et al., 2007; Ingham and Aggleton, 2006; HEAIDS, 2010; Selikow et al., 2002).

More notably, Harrison (2005) points out that in SSA, "HIV/AIDS is an epidemic of young people, especially women" (p. 263). This is important to note as gender is an important factor and driving force in the epidemic in SSA in general which has the implication of, for example, incorrect use of condoms which has the outcome of unintended pregnancy among youth and may lead to gender-based violence from older male partners which also has socio-cultural dimensions. For example, a young girl may face alienation from her family and community if she has to fall pregnant before marriage and before completing her studies (Ndinga-Muvumba and Pharoah, 2008; Abdool Karim and Abdool Karim, 2005). These factors also have grave consequences on the sexual and reproductive health of young women in particular as their bodies may not be ready for childbirth and thus they may suffer negative health conditions (Kalipeni et al., 2004). In addition, "[y]oung women are also biologically vulnerable with the immature genital tract and cervix providing increased opportunity for the transmission of infection" (Harrison, 2005: 265). Therefore, the issue of agency over ones sexual and reproductive health is important when discussing the health behaviours of youth and will be discussed shortly.

However, literature points out in general that both young men and women are vulnerable but it is the young women who represent the most vulnerable population group in relation to HIV/AIDS and women represent the majority of those living with HIV/AIDS in SSA. As such, gender roles and norms contribute to the gap between HIV awareness and practices and the social processes that may influence youth, or a young woman's disproportionate risk for HIV (Takyi, 2003; Wight et al., 2006; Rassjo et al., 2007; Lindsey, 2011). Therefore, youth in particular may suffer

emotional, psychological and social setbacks as a result of these negative aspects and they may also avoid going for testing (MacPhail et al., 2008, MacPhail et al., 2009; HEAIDS, 2010). The non-use of condoms for example has important symbolic dimensions, whereby, using or not using a condom is beyond a physical act but it has social meaning in terms of the level of trust between sexual partner/s (Ingham and Aggleton, 2006; HEAIDS, 2010). Another dimension of symbolism is the value placed on multiple sexual partners among males which is perceived by them as a sign of potency and manhood (Rassjo et al., 2007; Ingham and Aggleton, 2006). Thus, the reasons for unsafe sexual practices are primarily due to curiosity and insecurity (Campbell et al., 2005).

As a result, gender affects sexuality for both heterosexual and homosexual men and women in terms of gender socialisation and sexual roles. For example, common in the literature is the emphasis on men who have sex with men (MSM) which puts them at greater risk of contracting HIV as MSM is also categorised as risky behaviours (HEAIDS, 2010). Furthermore, to a vast degree MSM are subjected to stigmatisation which can lead them to practice their sexuality secretly and prevent them from seeking sexual health information and services which further add to their vulnerability to HIV and STIs (HEAIDS, 2010). Moreover, in such cases a major reason for not getting tested is due to the underestimation of personal risk whereby the perception that they are at risk is not taken seriously (Campbell et al., 2005; HEAIDS, 2010). This is then reflected in their risk behaviours which lead to them ignoring the messages presented by HIV/AIDS campaigns and initiatives for social change. Kelleher and Leavey (2004) highlight how youth respond differently to social change and adopt risky behaviours that are socially unacceptable within their familial settings but acceptable among their peers.

These may all pose a formidable challenge to VCT uptake especially among youth in HE whereby first year students in particular have to deal with the transition from school to University where they lack the experience to make risk-aware decisions about sexual encounters, drug and alcohol use (HEAIDS, 2010). The spread of HIV among youth in general highlights the biological threats inherent in risky behaviours with particular focus on sexual behaviour and attitudes and perceptions towards health care interventions (Abraham et al., 2002; MacPhail et al., 2009). Also, youth's

risky behaviours can be regarded as an extension of the type of youth culture they adopt when they socially include themselves within like-minded youth and simultaneously socially exclude themselves from the dominant adult culture they find themselves in (Leclerc-Madlala, 2002; O'Sullivan et al., 2003; Ettorre and Miles, 2002; Selikow et al., 2002; Nettleton, 2006). Within this new found youth culture, HIV/AIDS awareness is challenged in terms of accuracy of the information they receive from various members of society (Granich and Mermin, 1999). This then contributes to the multiplicity of factors and/or structures that shape their agency in terms of health behaviour such as VCT uptake.

**VCT: Structure and Agency**

In the context of health behaviours and sexuality among University students, there is a profound debate concerning the nature of which structure and agency shape decisions to test, or not to test for HIV. As such, the ontological question of the role structure and agency plays in the attitudes and behaviours among youth comes into focus. Arguably, when youth know better they ought to do better but this is not necessarily the case depending on social circumstances (Leclerc-Madlala, 2002; O'Sullivan et al., 2003; Shisana et al., 2009; D'Adesky, 2004; MacPhail et al., 2008; HEAIDS, 2010). Hence, even though the targeted population of youth in this study are University students whose social relations are shaped by society and their institution of study, their levels of awareness with regard to VCT may differ (Boswell and Baggaley, 2002) due to the interplay of multiple factors.

Similar to youth culture, lay health beliefs also become important to explore in relation to the meanings attached to HIV/AIDS and VCT in terms of the quality of education and information received among youth. Aggleton (1990) points out that lay beliefs refer to people's understanding and interpretation of health and the actions that pertain to health. In discussing perceptions of HIV, many youth wrongly understand that testing is only for those who show signs of illness which thereby prevents those who feel healthy to get tested (MacPhail et al., 2009). From this standpoint, even though broader knowledge about HIV may be common among students of HE, deeper knowledge and accurate awareness show gaps which may lead to youth refusing to get tested (Steinberg et al., 2006; Francis, 2010; Njagi and Maharaj, 2006; Taylor et al., 2007). Thus, research into the factors that shape

attitudes towards VCT among University students is important to understand because it provides insight into the ways in which they identify themselves within a larger sociological arena.

Given the negative societal attitudes towards HIV/AIDS, there is a need for parents, teachers and other members in a community to openly discuss sexuality with the youth in order for decisions to be made about the implementation of effective HIV prevention programs (Fan et al., 2007; Ingham and Aggleton, 2006; Lindsey, 2011). Some studies now reveal that sociological and popular conceptions of youth portray young people as active negotiators of the relationship between structure and agency in terms of their individual decision-making capacity on sexual practices (Ingham and Aggleton, 2006; Petersen and Wilkinson, 2008; Shisana et al., 2009). Nonetheless, the problems associated with youth consumption focuses on youth as risk-takers (Plant and Plant, 1992 as cited by Ettorre and Miles, 2002), for example, youth's consumption of risky health practices represents an active negative expression of their relationship with social structures (Ettorre and Miles, 2002). Hence, there is a relationship between structure and agency among youth in University whereby various structural factors have fundamental implications for gender-specific vulnerabilities such as those that were discussed earlier and which will later be considered in the analysis of findings.

There have also been challenges and contested debates about the access to, as well as the lack of socio-economic opportunities, health care services and social policies to deal with youth specific outcomes of individual risky behaviours (Rutter and Quine, 2002; Shisana et al., 2009; HEAIDS, 2010). For example, ethnographic studies that were conducted in an Eastern Cape township in SA have suggested that the lack of economic and recreational opportunities for youth has led to sexual relations being used as a means of gaining social status (Wood and Jewkes, 2001 cited by Ingham and Aggleton, 2006). Importantly, while poverty has drastic negative impacts on the health and behaviours of youth in SA and SSA, its impact is tenfold on young women who have less access to information and less negotiating power for decision-making and protecting themselves from HIV (MacPhail et al., 2008; Shisana et al., 2009; HEAIDS, 2010).

Literature reveals that the economic vulnerability of which youth are exposed to also have serious gender dimensions. For example, some young women in University sometimes exchange sex for money and material goods in the form of transactional sex (TS) or sugar daddy relationships (HEAIDS, 2010; Rassjo et al., 2007). This therefore increases their likeliness to gender-based violence which further prevents them from leaving a relationship they perceive to be risky and poses a barrier to them gaining access to formal support services and support groups (Ingham and Aggleton, 2006; Cleland and Ferry, 1995). It can however be argued that the notion of agency in sugar daddy relationships on campus acts as a means of power and resistance. For example, the young women may have agency which is exercised through her sexuality within relationships that involve TS and is therefore seen as a means of claiming power that challenges traditional socio-cultural norms and practices (Selikow, 2002).

However, these young women may also not have the agency necessary to resist their partner/s risky demands for unprotected sexual activities which further add to their vulnerability to HIV and also prevents them from seeking medical assistance or making use of health services such as VCT (Boswell and Baggaley, 2002; Deribe et al., 2009). Against this backdrop it becomes important to bring forth the fact that many studies in SA show that youth who are sexually active report that they have a regular boyfriend or girlfriend. Therefore, within such relationships, condom use maybe disregarded because it is perceived to be an infringement of trust (McCoy et al., 2010).

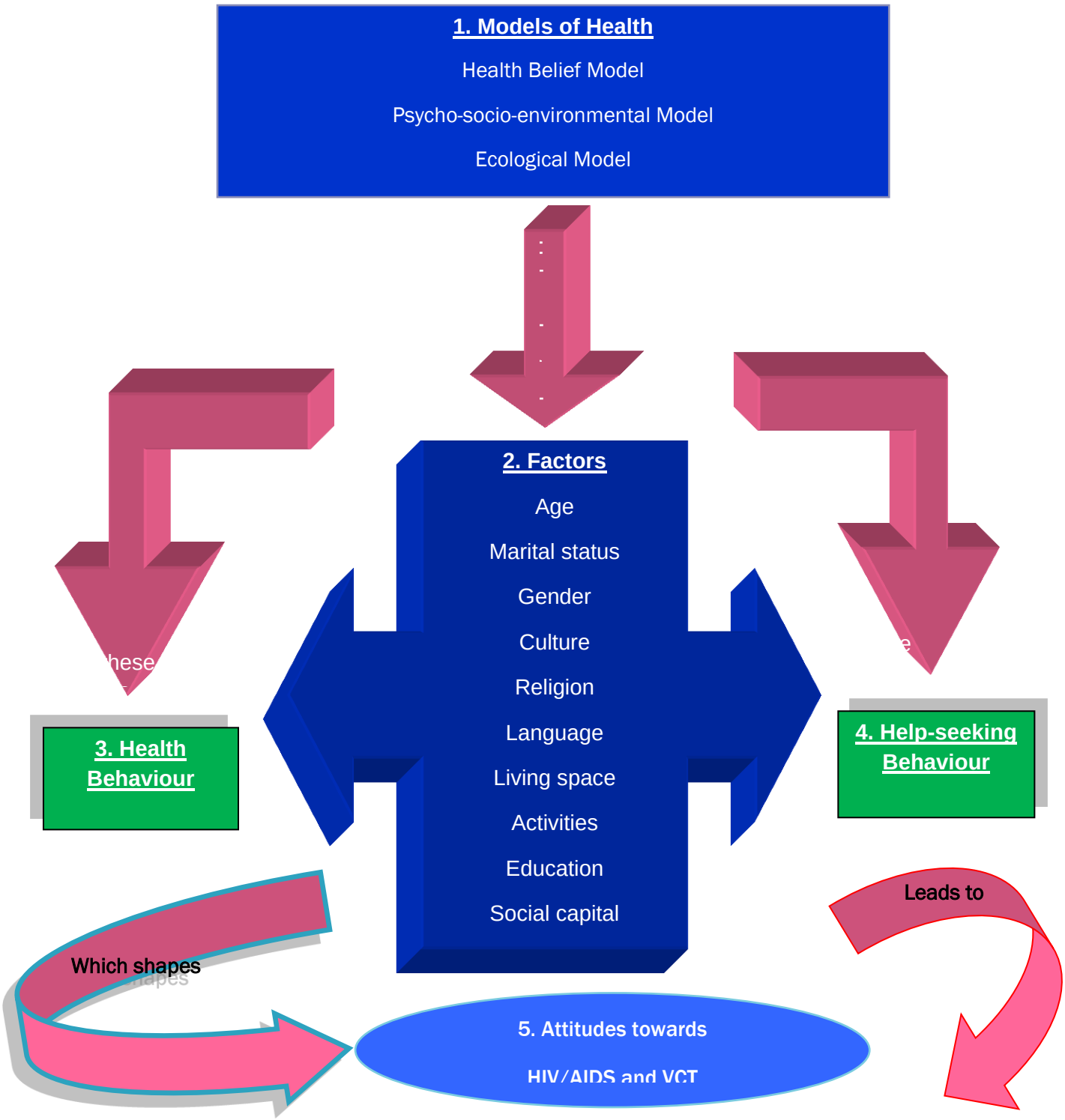
With all these notions in mind, there is a complex relationship between youth's perceptions and attitudes towards HIV/AIDS and VCT within their social structures in HE. For example, the socio-cultural and economic structures that led to transactional sexual relationships may simultaneously create power and constraints for the young woman's agency (Hart and Carter, 2000; McCoy et al., 2010) in the form of gendered power relations. Hence, literature points out that there is interplay of factors that promote and hinder access to the necessary health information and services (Jeeves and Jolly, 2009; Mathews, 2010; HEAIDS, 2010) such as VCT which then affects the level of agency youth have in their health behaviours. As such, these factors all shape youth's decisions to test, or not to test for HIV.

## Conceptual Framework

This study has tried to reflect the influence of not only individual factors relating to the responses to HIV/AIDS and VCT among youth but also the influence of broader social structures and processes such as those mentioned in the review of literature. These individual, social and societal factors operate simultaneously to influence decisions to test and not to test for HIV which thereby plays a role in maintaining and creating a social order among youth. As such, it must be noted that the aim of this study was not to statistically test causal relationships but rather to highlight the relevant factors at play.

For illustrative purposes, the relevant themes discussed in the literature review forms the basis of this study and are consolidated in Figure 1.2. on the next page. This is done in order to show the possible relationships between different factors and to gain a nuanced understanding of the associations between them.

The concepts and relationships depicted in the figure inform my study by illuminating some of the issues that pertain to the factors that shape attitudes towards VCT among youth. In so doing, the key concepts are brought forward as an attempt to understand the factors and to show how this study has been conceptualised and what the concepts and theories are that guide it.




| 6. Motivations for VCT uptake | 7. or Barriers against VCT uptake |
|---|---|
| Knowing someone who: has been for VCT, is HIV-positive or passed away due to AIDS. | Incorrect/ No risk perception |
| Positive peer influence & social mobilisation | Fear of stigma and discrimination |
| Youth friendly staff ethos & confidentiality | Gendered stereotypes about HIV-testing |
| Free counselling and Testing | Silence/ secrecy at home about sex & sexuality |
| HIV/AIDS prevention campaigns on campus | Individualistic, societal, familial barriers (psychological, emotional, physical , social, economic) |
| Awareness of the benefits of VCT | |

Figure .1.2. Conceptual Framework

## METHODOLOGY

This study was conducted using a combination of qualitative and quantitative research methods. Both these research methods explored a range of possible factors that shape attitudes towards VCT among first year Sociology students at WITS. The study respondents included first year students who participated in the survey and two interviews with key informants; a VCT counsellor at Campus Health and Wellness Centre (CHWC) and the HIV Coordinator at the Counselling and Careers Development Unit (CCDU).

This was an exploratory study that involved 195 students out of a total sample of approximately 220 which is regarded as being representative of the general student population as the response rate was 88.6%. In order to infer generalisability of a sample population, Burns and Grove (2001) mention that there should be a response rate of >50%. As such, the response rate in the study implies that the study was generalisable. The study paid attention to the descriptive associations between the factors that were evidenced in the survey and interviews and was also partly empiricist in nature because the factors needed to first be quantified in order to be qualitatively analysed thereafter.

The study entailed the use of self-administered questionnaires to the first year students. The data received from the open-ended questions were colour coded and thematised for purposes of analysis and the closed-ended questions were coded and tabulated for purposes of statistics. Thereafter, comparative data analysis was done using the Microsoft Excel 2007 computer software programme which also assisted in creating charts for purposes of graphical representations.

### *Research methods*

This study gathered useful data from the survey which enabled an assessment of the factors identified in the literature to explore attitudes towards HIV/AIDS and VCT among youth. These factors allowed for quantification in relation to the data obtained from the expert interviews. This therefore brings focus to the qualitative aspect of this study. The qualitative component of the study enabled a more in-depth exploration of the factors that work together to shape attitudes towards both, HIV/AIDS and VCT among youth at WITS and further allowed the study to probe into the reasons for and

against willingness to test. In addition, the models of health behaviour served as a basis for examining the role society plays in the decisions to test or not to test, which go beyond an individual level to a societal level.

The usefulness of utilising a qualitative research method was that it allowed for the analysis of the quantitative data in words in order to gain a more nuanced understanding of the topic of study. Strauss and Corbin (1990) argue that qualitative research "can refer to research about persons' lives, stories, behaviour, but also about organizational functioning, social movements, or interactional relationships" (p.17). This understanding is core to this study as the lives of youth in University was studied with a particular focus on their health behaviours and the interactional relationships they have within the context of University and society.

As part of qualitative research, this study made use of in-depth expert interviews which were thematically analysed. Thematic analysis of the open-ended survey responses was examined in relation to the literature. In addition, the study found the need to present a review of the WITS HIV/AIDS Policy as a backdrop to understanding the attitudes towards HIV/AIDS and VCT among youth. However, in order to make sense of the data, there was relevance in understanding the statistical findings of the survey first and therefore quantitative research methods were also used.

Quantitative research refers to a "broad area of investigation and application which uses data with a distinctive quantitative nature" (Greenstein et al., 2003: 10). With this in mind, survey research was conducted in order to gain statistics of the factors that shape attitudes towards VCT. Therefore, the study combined qualitative and quantitative methods by way of triangulation. Triangulation, or what Bryman (2004) refers to as multi-strategy, is "research that combines quantitative and qualitative research" (p.451). According to Bryman (2004), the approach to multi-strategy research occurs when the researcher makes use of a method drawn from either research strategy. As such, this study placed primary emphasis on the responses of the first year students in order to quantify what factors shape attitudes and perceptions towards VCT. The results of the survey were then used as the basis for qualitative analysis in order to probe into the relevant issues that concern this study.

### *Research design*

Greenstein et al. (2003) note that a "[r]esearch design is a plan that outlines the elements of the research, and how they are related to each other" (p.14) which must be done before data collection and analysis. DeVaus (2001) suggests that "[t]he function of a research design is to ensure that the evidence obtained enables us to answer the initial question as unambiguously as possible" (p.9) in order to ensure internal validity (p.28). With regards to quantitative research, DeVaus (2001) and Greenstein et al. (2003) suggest that a key characteristic is that it begins with hypotheses about how variables are related which shape its design.

Qualitative research findings, as argued by Strauss and Corbin (1990), may assist in clarifying and illustrating "quantitative findings, build research instruments, develop policy, evaluate programs...as well as for more scientific purposes such as the development of basic knowledge" (p.21). The usefulness of this is that research into the factors that shape attitudes towards VCT among youth at University may prove useful in policy development to target future generations and help alleviate the incidence and prevalence rate of HIV. Thus, this study found relevance in a mixed-method approach as survey research was undertaken in order to gather statistics on the factors that shape attitudes towards VCT and the findings were then qualitatively analysed.

### *Site and period selection*

Data collection through questionnaires was conducted at WITS during the months of August 2011 and September 2011. The questionnaires comprised of both closed-ended as well as open-ended questions. Thereafter, the in-depth expert interviews were conducted at the CHWC on Main campus and CCDU on West campus. These time-frames were selected, and strictly adhered to in order to complete data collection before the end of September 2011. This was in order to allocate sufficient time for data analysis and write-up during the months of October, November and December 2011.

### *Sampling techniques*

A sample refers to a subset of a population selected to participate in a research study (Polit and Hungler, 1999). The population in this study included one first year Sociology class in which questionnaires were administered to students in their lecture venue. This was done because of the likeliness of a greater response rate, improved validity of data and access to all the students at once. The selection of first year students as the primary unit of analysis is based on the NDoH's initiative to target first year students on their knowledge of HIV/AIDS as part of the First Things First campaign which WITS is affiliated with.

This group of students were also easily accessible and forms part of a non-random subset of the target population. The sampling approach to this study is that of non-probability sampling because it entails the participation of the most conveniently available individuals (Punch, 2000; DeVos, 1998) and assists in obtaining rich data. For this reason, the responses obtained from the 195 students provided sufficient and relevant material for the analysis due to the high response rate.

### *Data collection strategies*

Firstly, the quantitative component of this study was conducted through a survey that comprised of a structured questionnaire, of which all survey participants are anonymous. The questions in the questionnaire were formulated in relation to the recent literature on health behaviour, HIV/AIDS and VCT and consisted of a list of pre-determined answers from which the respondents could select. In addition, there was an option of 'other (please specify)' in order for respondents to freely choose an answer they felt best. Also, there were many open-ended questions that probed into the responses to the pre-determined or close-ended questions. This allowed for greater depth in understanding the topic under study and helped answer the research question. The questions aimed to verify the nature of responses towards health behaviour, HIV/AIDS in general and VCT more specifically so as to explore the ways in which the factors identified in the literature have relevance among youth in a University context.

Secondly, because quantitative research uses structured procedures and formal instruments for data collection (Greenstein et al., 2003); structured interview schedules were used to collect data from the experts. To gain a more nuanced understanding of the VCT process and why attitudes and perceptions among students differ, the study conducted in-depth interviews with two key informants in the field of HIV/AIDS and VCT at WITS; who both chose to remain anonymous. Nonetheless, with the permission of the interviewees, the interviews were both tape recorded and transcribed soon thereafter and later thematically analysed and examined in relation to the survey results and the literature.

Thirdly, the study found relevance in reviewing the WITS HIV/AIDS Policy in relation to the findings gathered from both, the survey and the interviews. The reason for the WITS HIV/AIDS Policy review was to understand the HIV/AIDS prevention initiatives and communication among staff and students on campus. This helped in gaining a more nuanced insight into the dynamics of society by the principles governing individuals (Sewell, 1996) in terms of their health behaviours. Also, because this research aimed to study human thoughts, perceptions, attitudes and behaviour, the Policy review was used as an analytical tool for understanding the literature and data collected through surveys and expert interviews. It also helped explore some of the reasons for the positive attitudes among youth at WITS as a possible result of health promotion initiatives on campus and social mobilisation.

### *Ethics appraisal*

The study protected the respondent's rights by maintaining anonymity of all survey participants. To ensure anonymity, the names and personal details of students was not requested in the questionnaires. For the experts, an option of anonymity was provided; who both chose to remain anonymous. The study also exercised care that the human rights of individuals and the reputation of WITS as an institution were safeguarded. It is understood that VCT is a human rights matter and that HIV/AIDS is a sensitive topic therefore the study was not used to gain statistics of youths' HIV status. As noted by Weiss (1995), the questions in the interview schedules and questionnaires should not be insulting, judgemental or embarrassing in any way. This was insured by not asking personal questions on a respondent's intimate life or

sexual behaviours. As such, the study did not ask personal questions on people's HIV status and therefore did not foresee any risks for them.

The confidentially of all study respondents were also taken into consideration and the research intentions were clearly stated in the participant sheet to avoid any misunderstandings (Babbie and Mouton, 2001). The study honoured the participants' privacy, dignity and overall welfare by being honest in the conducting of research and sensitive to the respondents' views (Weiss, 1995; Punch, 2000; Babbie and Mouton, 2001). In addition, the participants also had the right to withdraw from the study at any point they wished to and also the right to refuse answering the questions they were not uncomfortable in answering. In addressing all these ethical considerations, the interviewer submitted an ethics proposal to the Faculty of Humanities and the Human Research Ethics Committee (HREC-non-medical) of WITS. The proposal also included a copy of the questionnaire, interview schedule, participant information sheet and participant consent sheet which was done for ethical clearance from the University. The ethics proposal was passed and approved unconditionally by the Faculty and the HREC non-medical committee on the 3-08-2011; clearance certificate protocol number H110719.

***Limitations of the study***

Schurink (1998) points out that a qualitative strategy is a pre-requisite for quantitative strategies and therefore qualitative research requires that the data collected be rich in description rather than wholly representative of the population under study. Against this backdrop, the results cannot be generalisable beyond the respondents who participated in it. Another limitation is that the study initially planned to select an age group of 18-24 years old but once data collection and analysis was completed it found that in some instances the students were below and above this age group. Thus, there is a possibility that some segment of the population may have been over or under represented which means that the results may not be entirely generalisable. But, since this is a relatively modest exploratory study, it does not aim to be representative of the total WITS student population but merely examines the factors that play an important role in shaping attitudes towards VCT. A final limitation is that there may have been instances of social acceptability biases in the response rate by students because of their desire for non-judgemental attitudes towards them.

## ANALYSIS OF FINDINGS

This chapter presents the findings and analysis of the study of which the evidence gathered during the research process has been closely analysed and explained. The findings are organised thematically to help understand the factors that shape attitudes towards VCT among first year WITS students. In so doing, the factors are explored by providing evidence from the survey results and interviews against the background of the literature reviewed in chapter two. These validations are crucial in answering the research question as well as the subsidiary and primary questions brought forward in the introduction.

### Socio-demographic factors and health behaviour

*Age*

The age group of the first year participants in the study is considered to be representative of the population of youth at WITS. This is because the data revealed that most students are between 17 to 25 years of age. In addition, the study also included participants that were between 26 and 33 years old. This inclusion added an interesting dimension to the results of the study as it encompassed a broader age group. This links in well with the literature in that the youth most at-risk are within this age group (Harrison, 2005). Drawing on the survey results, the cohort of youth that were studied provided useful information which assisted in understanding how age is an important factor that either motivates or poses barriers to VCT uptake (Harrison, 2005; Fako, 2006; UNAIDS, 2006; Mathews, 2010). However, during an interview with the VCT counsellor, it was noted that it is difficult to say which age group is more likely to be willing to go for VCT because they [CHWC] "*do see a pretty even spread*" (02; 26/08/11). This highlights a complex dynamic to age being an important factor in reasons for and against VCT uptake among youth at WITS.

Nonetheless, age is an important factor that may put first year students at risk in terms of their transition into adulthood and inexperience and inability to negotiate the terms of their relationships (Harrison, 2005; Poulson et al., 2010). However, the evidence in this study shows that the students demonstrate immense agency in terms of their health and well-being and are taking the necessary precautions to

prevent HIV transmission. As a result, they seem highly conscious about the negative impacts of HIV/AIDS and are thereby socially mobilising to become actively involved in HIV prevention campaigns on campus in order to motivate their peers to go for testing. This relates to the constructs of the HBM; perceived susceptibility, perceived severity, perceived benefits, cues to action and self-efficacy and excludes perceived barriers (Redding et al., 2000).

To explain this, the study showed that youth on campus realise their susceptibility to HIV infection and the severe consequences if they were to get infected. As such, some of them acknowledge the benefits of VCT such as finding out their HIV status and adopting the necessary cues to action. Against this backdrop, age is an important factor as youth are the leaders of the future and it is only through positive social mobilisation to VCT acceptance among peers within a University context and thereafter society as a whole, can the epidemic be normalised over time. With regards to the findings and most worthy to mention is the delay in sexual onset and the revelation that many of the students do not have any sexually experience. This is important as it links into the general literature on HIV/AIDS within a global context as the age of sexual debut has always been a focal point and used as a marker of risk because of it being a determinant of the length of exposure to infection (Ingham and Aggleton, 2006; Wight et al., 2006; Mathews, 2010).

As proposed by Harris (2005), those who become sexually active at a younger age are more likely to be infected compared to those who delay sexual onset. Based on this, the first year students seem to be doing well in sexual abstinence which, if true, is an important determinant in stemming the tide against HIV/AIDS (Shisana et al., 2009). In a discussion about age and gender, the VCT counsellor mentioned that in as much as age is a crucial factor when it comes to VCT, "*where things differ is not so much age, but gender"* (02; 26/08/11). This implies that there is a relationship between the two factors; gender and age, which may both work together to shape attitudes towards HIV/AIDS as well as VCT among youth. The findings of the survey as well as the interviews are largely consistent with the literature on age and gender among youth. For now, it is important to turn the lens to a discussion on gender and the significance of it in terms of understanding the health behaviours of youth and the gendered perceptions that shape willingness and/or unwillingness to VCT.

*Gender*

As discussed in the review of literature, gender is an important factor to explore as gender roles and norms contribute to the gap between HIV awareness and practices and other social processes that may influence youth's health behaviours.

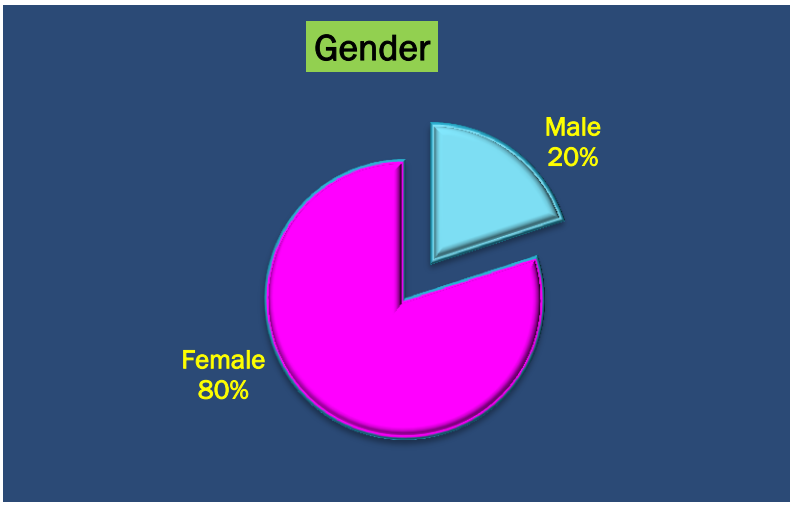



Figure .1.3. Students' gender

The study consisted of 80% female students and 20% male students which may not be reflective of the demographics of the student body due to the possibility that more females attend lectures. However, this is not regarded as problematic as the quality of data received is worth analysing in relation to the health behaviours of students.

As will be discussed later, female students are more willing to go for VCT than their male counterparts. Adding onto this, the VCT counsellor mentioned that CHWC sees "*a predominately female cohort at the testing site*" (02; 26/08/11). Hence, the findings of this study are consistent with findings from other studies on HIV testing (Soroses, 2006; MacPhail et. al., 2009) as well as studies that deal with other STIs (Jeeves and Jolly, 2009). One of the primary reasons why males shy away from VCT, as explained by the HIV Coordinator is because "*males struggle to seek out assistance for STIs and sexually related issues medically from female caregivers*" (03; 02/09/11). As such, understanding the barriers men face regarding VCT is important for future HIV/AIDS initiatives that may prove fruitful in the decline of HIV/AIDS prevalence rates; albeit overtime. This highlights the gender dynamics embedded in reasons for and against VCT uptake.

The VCT counsellor further explained that there seems to be a problem with the nature of SA's clinics whereby "*it is very difficult for a young, black male to discuss sexuality with an older black woman... and [this] across the board is a very important barrier...*" (02; 26/08/11). This barrier will receive additional attention later, but for now, beyond the nature of clinics the HIV Coordinator mentioned that it is uncertain if *"men feel that they are more invincible... if it comes from the stereotype that women are more susceptible to HIV, [and] whether or if it is because men are more scared of testing for HIV"* (03; 02/09/11). In addition, what was widespread in the interview and survey responses were that *"one of the things that are [common among students] is that women are used as an indicator for the test results of males"* (03; 02/09/11). This is also in accordance with the literature in SSA as men tend to believe that it is a women's responsibility to get tested and if she is HIV-negative then her HIV status renders simultaneous acknowledgment of his status (Campbell et al., 2005; Deribe et al., 2009).

Among other factors that shape males rejection of VCT, the study highlighted the fear, ignorance and denial that men feel which shows that many of them are largely unconcerned in adopting 'good' health behaviours. This is a common phenomenon that exists across age groups of men and is explained well in the book *Three-Letter Plague: A young man's journey through a great epidemic* (2010) by Johnny Steinberg. The topic of gender will be explored in greater depth later on in as there is much complexity embedded in understanding youth's attitudes towards VCT and their subsequent health behaviours. However, to summarise the key points mentioned thus far and a general occurrence on campus is that *"[help]-seeking behaviour is seen as gender appropriate for women... [help]-seeking behaviour in guys is seen as a weakness... because there is this gendered idea [that] clinics are for girls...*" (02; 26/08/11). This means that guys not only perceived that girls are willing to go for VCT much more than them but also that the women are more responsible for their health and well-being and that of society as a whole.

Even though an in-depth exploration of gender is beyond the scope of this report, it is an important factor to examine because it has been explored in many studies around the globe and a characteristic that was confirmed in this study as well. This is noteworthy as various studies have occurred overtime; even in the

twenty-first century in the era of globalisation (Barnett and Whiteside, 2006) and in the transition from tradition to modernity. Another aspect to build on in relation to gender is how marital status shape attitudes towards VCT among students based on ideologies that are generated within their social networks.

*Marital status*

There was an interest in understanding the impacts marital status has on health behaviour and was therefore a factor probed in relation to age and gender in order to gain a more nuanced understanding on reasons for and/or against VCT uptake among youth.

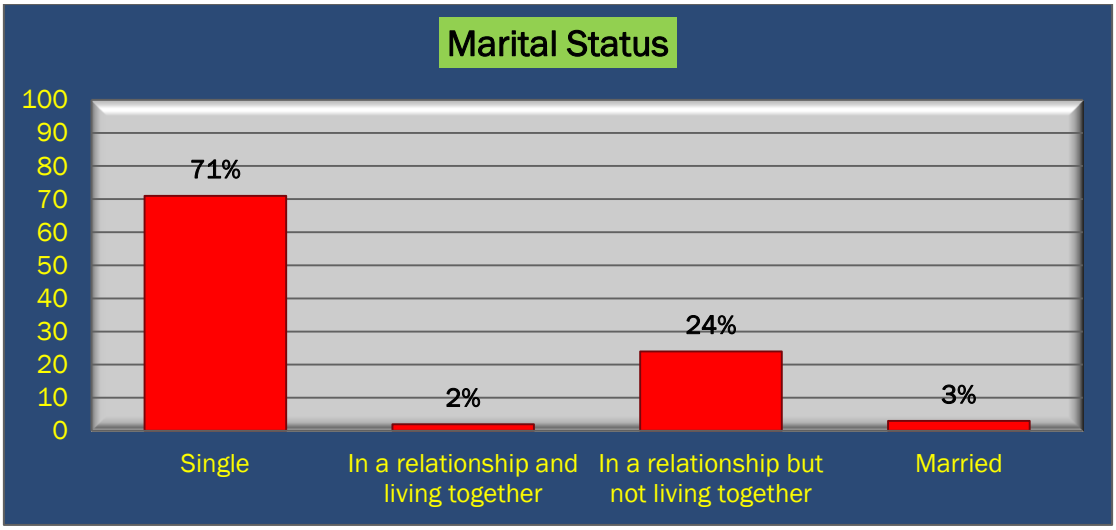



Figure .1.4. Students' marital status

The study found differences in marital status percentages of youth who participated in the study. Most striking is that 71% were single, 2% were in a relationship and living together, 24% were in a relationship but not living together and 3% were married. This is important to mention as marital status may be an important factor in reasons for and against VCT uptake (Soroses, 2006). Also, it may be a determining factor in the participation in risky behaviours among those students who are in a serious relationship and those who may have multiple partners (MacPhail and Campbell, 2001; Steinberg et al., 2006). To problematise this further, because the survey did not include questions on ones' sexual practices, even though many students claimed to be single, it is unclear whether or not those who are not in a serious relationship are engaging in casual sex.

The literature reveals that youth who are in a serious relationship may not place importance in condom use (Selikow, 2002) which may increase both partners risk in contracting an STI or it may even lead to unplanned pregnancy and drop-out from University. In addition, youth may then become dependent on their parents which in turn negatively impacts on their self-esteem (Harrison, 2005). Thus, VCT uptake may intentionally be avoided in fear of what society, family and friends may think of them if they were to be infected (Boswell and Baggaley, 2002). This characteristic was revealed in the study as youth feared the uncertainty about societal responses towards an HIV-positive status or a family member knowing that they had gone for VCT, which is another barrier to testing. Hence, youth fear the unknown and "*the root of this fear is that a lot of the AIDS education is incredibly negative reinforcement based*" (02; 26/08/11) which perpetuates further stigmatisation of, not just the disease, but the behaviour (Matjila, 2011).

However, the study found very little negative reinforcement among youth themselves but it was inherent in the youth's perceptions of how their families will react. Therefore, for those students who are sexually active, "*fear and guilt and shame... are problems [youth] have in terms of accessing, not just VCT but contraception, morning after pills, treatment for sexually transmitted infection... so the whole reproductive health space is neglected because of shame, and guilt*" (02; 26/08/11). As such, the health behaviours of youth are disapprovingly shaped as a result of negative reinforcement from society. On one level, this is worthwhile emphasising as marital status then becomes an important factor to understanding youth's health behaviours and risk perceptions, or lack thereof. In relation to the HBM, this was evident as there was in some instances the lack of perceived susceptibility of contracting HIV. For example, some students claimed that they were definitely not at risk as they make use of relevant protection and avoid much engagement in risky behaviours.

On another level, the literature reveals that the young women, who do engage in sexual relations, with older men for example, may face violence from their partners if they were to suggest condom use and therefore not all women have agency to decide on the types of sexual practices they engage in (MacPhail et al., 2008). However, this was neither evidenced in the study, nor was there a sense of lack of

agency as the females seemed empowered to negotiate condom use and agency over their sexual and reproductive health. However, in a study by Maharaj and Cleland (2005) it became evident that there is a newfound sexual culture of condom use that is occurring in Durban whereby youth are making use of condoms as a new sexual norm and choosing not to abstain. This contrasts with the findings in this study which showed that youth are claiming to abstain from sexual relations until they are married. Thus, marital status and sexual practices within relationships are important factors in understanding reasons why some youth may want to test and why others may not. As such, because of SA's social history, race may also be regarded as a confounding factor that shapes decisions to test for HIV.

*Race*

The study found the need to explore racial differences in relation to attitudes towards HIV/AIDS and VCT uptake among youth. This is because 'race' is a factor that is linked to SA's demographic population, its social history and HIV/AIDS-related death rates and prevalence figures (Whiteside and Sunter, 2000). The history of HIV and AIDS in SA has been controversial and laden with examples of government inaction, political conflict and conflict among AIDS organisations and scientists (Van der Vliet, 2004). Hence, the after effects of counterproductive policies by the past government are still being felt today in SA; a country with the world's largest HIV epidemic (Van der Vliet, 2004; Whiteside and Sunter, 2000). As such, race is a factor to explore in relation to attitudes towards HIV/AIDS and VCT uptake.

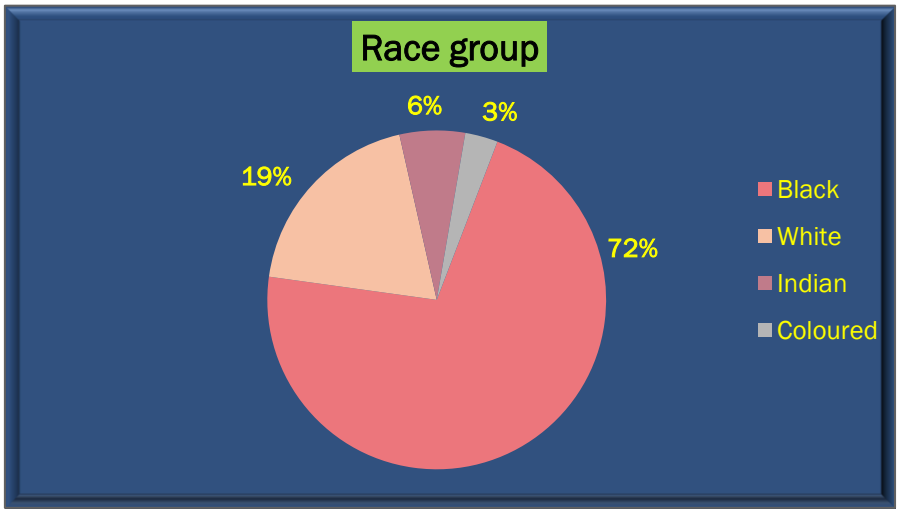



Figure .1.5. Students' race group

The results of the survey showed that all race groups were accounted for and was thereby largely representative as it included Black, White, Indian and Coloured students. The study revealed however that race was not a primary factor to shape attitudes towards VCT. This is evidenced by an interview with a VCT counsellor who mentioned that "*the demographics that [CHWC] gets of students testing is very similar to the demographics of the overall University population*... *so it's not seen as a 'black disease' or 'a poor disease'...*" (02; 26/08/11). With this in mind, and beyond racial categorisations, it is understood that, "*there is an incredible awareness that it is everybody's disease"* (02; 26/08/2011). This implies that there are not only individual and social, but also societal factors and characteristics that shape attitudes towards VCT as well.

However, what became evident from the interview with the HIV Coordinator is that "*in terms of the ratio that is being tested, Black students generally seek out testing much more than other race groups" (03;* 02/09/11). This may be attributed to the awareness of HIV/AIDS among Black communities which acts as a driving force to testing. A great majority of Black students, as opposed to other race groups, knew of someone who is HIV-positive, who passed away due to AIDS or someone who has been for VCT. This is recognised by the fact that there is a higher prevalence of HIV among the Black community as well as HIV/AIDS-related deaths and therefore there is a greater risk perception (Whiteside and Sunder, 2000; Van der Vliet, 2004; Sher, 1989; UNAIDS, 2010). To link this to the HBM, the cues to action such as the acceptance of VCT may be accounted for in terms of the awareness of HIV/AIDS impacts within youths' social networks. As such, the results show that positive social mobilisation among peers' leads to increased motivations to know ones' HIV status because of the perceived susceptibility and perceived severity of HIV/AIDS. Beyond race, it is culture and religion that was significantly focused on by students in the study.

*Culture*

Cultural backgrounds and diversity in traditional beliefs were a focal point in many responses to the open-ended survey questions. It was regarded as being a barrier to discussions about sex and sexuality in the household which thereby relates to what was mentioned in the review of literature. In line with the topic of culture, the VCT

counsellor highlighted how "*cultural backgrounds are incredibly diverse. In traditional African culture, sex and sexuality is a no-go zone at home... you do not discuss sex with elders*" (02; 26/08/2011). This was also a common thread in the study whereby participants mentioned the discomfort surrounding discussions of sexual matters as it is still regarded a taboo subject.

The VCT counsellor went on to explain that should sex be a taboo subject, it "*places students at an incredibly high risk of; pregnancy, HIV, STIs, misinformed sex and even sexual harassment...*" (02; 26/08/2011). However, the study did not find any links to such experiences among students as they seem to be very informed about HIV/AIDS and the risks of certain behaviours even though sex is considered a taboo subject in some of their homes. In addition, "*family discourses [and] the culture of silence... promote secret sex...*" (02; 26/08/2011) and this may create problems for effective health promotion and health education. The taboos of sex and its relation to secrecy were noted in the survey responses when some students said that secrecy within their households pose a barrier to discussions about sex with family members. As such, sex and secrecy is a topic that draws attention to the impacts of one's social environment in relation to the quality of social capital (O'Sullivan et al., 2003; Kelleher and Leavey, 2004; Deribe et al., 2009; Gilbert et al., 2010; Preston-Whyte, 2004). It also helps understand the multilayered complexity embedded in reasons for and against VCT uptake.

The social environment was an important factor evident in the study and will be discussed in greater depth later when this report examines some of the motivations and barriers to VCT uptake among WITS students. It became clear that in as much as race is not a separate factor in relation to gender and culture, there was evidence to suggest that youth's religious affiliation and quality of social networks may have a 'protective' effect on their health (Seballo, 2007; Takyi, 2003). This means that there are array of factors that work together to shape attitudes towards VCT among youth at WITS which simultaneously include motivations and barriers embedded in one's decisions about VCT. In line with this is the association with the prevention of HIV infection as well as promotion of better health behaviours. For these reasons, this study also focused on the role of religion in relation to the health behaviours of youth because it was clear that Christian affiliations were predominant in the study.

Hence, religion is a factor that was worthy of exploration in relation to attitudes towards HIV/AIDS and VCT.

*Religion*

Literature reveals that religion plays a positive role in shaping health behaviour (Parker et al., 2002; Alfonso, 1994). For example, the religious beliefs such as those embedded in Christianity (Wight et al., 2006; Lehr, 2008) were found to play a critical role in promoting ‘good’ health behaviour among youth and reducing sexual risk taking.

The study found evidence to suggest that religion was an important factor that shapes attitudes towards HIV/AIDS and VCT. Against the findings of sexual abstinence, it is noted that religion may be a protective factor (Seballo, 2007) to ‘good’ health behaviours such as the prevention of HIV among youth at WITS and may also act as a ‘protection’ to their health. This may be attributed to the finding that majority of students are Christian females who mentioned their familial beliefs in the Bible as well as the importance of sexual abstinence. Against this backdrop, religion is a confounding factor to attitudes about HIV/AIDS and VCT. This brings to light the relationship of religion and health complicated by the factor of gender; which will be discussed shortly.

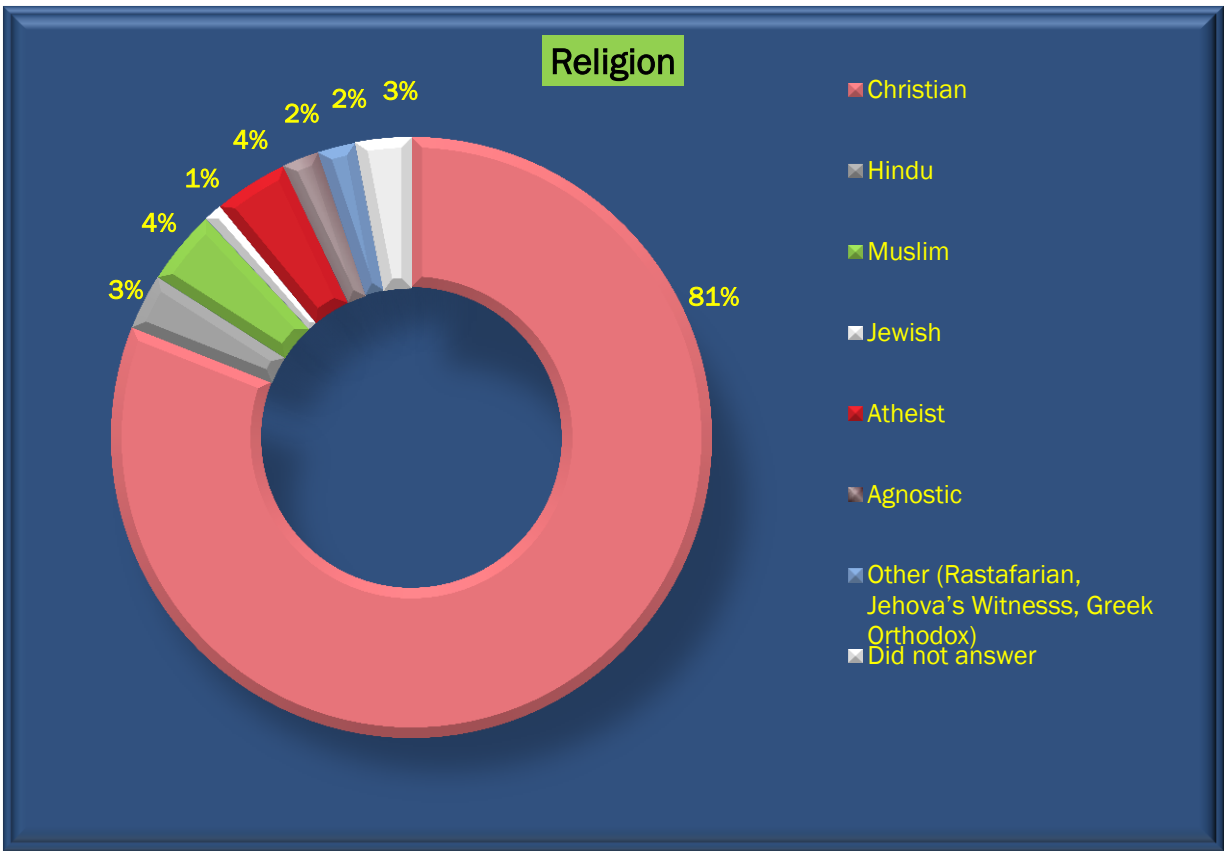



Figure .1.6. Students' religion

The survey highlighted that majority (81%) of students is Christian, which may or may not be an explanation why many of them admitted to not having sexual experience. These explanations may be based on religious beliefs like sexual abstinence (Wight et al., 2006; Seballo, 2007; Lehr, 2008). In addition, many females claimed that they do not perceive themselves at risk for HIV because they have not engaged in sexual relations. Against this background, it is argued that religion may also be a protective factor against HIV/AIDS among youth (Seballo 2007; Poulson et al., 2010) and is a factor that shapes 'protective' or preventative behaviours.

However, it cannot be generalised that religion is an overall factor that shapes attitudes towards VCT as the results were unclear. Students may have made these claims with the expectation that it is what must be said. Nonetheless, when looked at holistically by looking at the socio-demographic and underlying factors explored in this chapter, it becomes clear that religion does have a complex role to play in terms of attitudes towards HIV/AIDS and VCT. With regards to race, culture and religion,

language is also a factor to consider in relation to communications about sex and sexuality.

*Language*

In general, the study brought to light the lack of communication about sexual matters with parents and siblings within some students' households but occur more frequently and freely within peer social networks. As such, language is a factor that is important to explore as it shapes the ways in which interactions between, for example, males and females occur (Granich and Mermin, 1999; Airhihenbuwa and Obregon, 2000; Kalipeni et al., 2004). It also helps gain insight into generational differences of communication (Lindsey, 2011) such as tradition versus modernity or the newfound 'youth culture' (Selikow et al., 2002) that unfolds among youth at University.

In associating language to religion and culture, language becomes a factor that may characterise decisions for and against decisions to seek VCT as it shapes discussions on sexual matters within ones' living space. When asked "what is your primary home language?" only 34% of students said that they speak English at home. This may be problematic if there are conflicts of language, or language barriers within the household sphere. To touch on the 'intergenerational' aspect of communication mentioned earlier, it seems that youth today feel more comfortable in discussing sex with their peers at University because their elders, depending on geographical location (rural/urban) may talk in another language. This makes it difficult to converse in discussions on sex, sexuality and other related sexual matters which may be a common experience for the migrant population of students who go back home during the holidays.

As a result, these may lead to frustration and uneasiness and therefore youth may avoid these talks, which increases the silence on HIV/AIDS (O'Sullivan et al., 2003; Campbell at al., 2005). Clearly, there are multiple barriers youth face in relation to sexual matters which may exacerbate their chances of contracting HIV. For instance, youth may participate in risky behaviours as a result of the silence and level of discomfort that surrounds HIV/AIDS in some instances (Airhihenbuwa, 1995; Deribe et al., 2009). However, as will be discussed later, selective sharing of information

became evident which shows that it is not so much the level of discomfort that students are concerned about, but rather, the fear of what their family and community members will think. This thereby emphasises the need to consider the living space of youth as language and living space are two factors that may encourage or discourage VCT uptake simultaneously.

*Living space*

The study pointed out that majority of students live with their parents, siblings and other family members and/or friends whereas 14% live alone and only 4% live with their partner or spouse. This is important because it highlights how living space, like religion, may also have a 'protective' effect on youth. For example, if they live with their parents for a prolonged period of time the availability of parental structures may have a greater potential to enforce 'good' behaviour but the lack of these support systems may lead to participation in risky behaviours (Rutter and Quine, 2002; Petersen and Wilkinson, 2008).

According to the HIV Coordinator, "*The First Year Experience is specifically targeted at first years to ensure that students understand the risks that exist... and that living at res without parental structure allows so much more latitude but that there are risks associated with that"* (03; 02/09/11). This relates strongly to the literature on the benefits of parental structures as a 'protective' factor to good health behaviour. In relation to social capital, the type of living space may also be a determinant of the type and quality of social interactions between individuals and society which may either positively or negatively shape attitudes towards VCT. The results of the study reveal that the students' living space has an influence in how they consider HIV/AIDS. Majority of students explained that they live with both their parents, grandparents and siblings. In some instances, students mentioned that they live with a step-parent, aunt or uncle.

Interestingly, when the socio-demographic findings were compared to the responses of the open-ended questions of the survey, it was found that those students who lived with their family participated less in risky activities such as alcohol drinking, clubbing and smoking. Yet, those who mentioned that they live alone, with friends or with their partners engaged in these activities. Again, like religion, the quality of

familial relations and religiosity may have a simultaneous protective effect on students (Takyi, 2003; Seballo, 2007). As such, living space either shapes positive or negative attitudes towards HIV/AIDS or is a related factor to the activities the students engage in within their social context. When explored in parallel, living space and the activities youth participate in may either positively or negatively impact on VCT uptake.

*Extramural activities*

Based on ones' familiarity with their social environment and/or living space, the types of activities students engage in may either pose a risk to their health or act as a protective barrier to negative social influences (Rutter and Quine, 2002; Petersen and Wilkinson, 2008). When the answers were combined and examined individually, the study showed that majority of students participate in more than one activity simultaneously such as; exercise/sports, study groups, social networking and prayer (75%). Only 1% of students chose not to mention what activities they engage in while the remainder of students also participate in other activities such as smoking, alcohol drinking and/or clubbing.

However, there is much complexity inherent in these findings because there were overlaps between the type of activities students engage in and the impact of their social environment in terms of the health behaviours they adopt. On the one hand, those students who may participate in 'good' behaviours such as those mentioned in the 75% may in turn experience some sort of 'protection' to their health by engaging in these 'positive' health behaviours. On the other hand, those who participate in what the literature regards as 'bad' behaviours may simultaneously engage in 'good' behaviours which may or may not necessary shape attitudes towards HIV/AIDS and/or VCT.

These patterns of activities may be problematic as the literature points out that excessive alcohol drinking, for example, provide fertile ground for sexual risk taking which increases ones' vulnerability to contracting HIV (Rutter and Quine, 2002; Ettorre and Miles, 2002). However, the literature also shows that sexual behaviours and attitudes among youth are changing (Shisana et al., 2009; HEAIDS, 2010; McLea; 2011). The most recent news headlines (The Times, 30.11.2011) add onto

this understanding that sexual norms among youth are changing for the better as they are keen on adapting positive health behaviours. In the article, McLea quotes the LoveLife CEO Grace Matlhape to explain that there is “some measure of comfort that young people are much more responsive to the [awareness] initiatives” (p.5.). A day before World AIDS Day, this article revealed however that even though youth are more responsive to awareness initiatives, it is the unfaithfulness of husbands within married couples that continues to drive the epidemic.

In addition, husbands are to be blamed for the upward trend of HIV prevalence among older women and therefore there is a gendered dynamic to HIV/AIDS and men need to be targeted (McLea, 2011) to encourage them to have more agency over their health. Nonetheless, there is complexity embedded in reasons for and against VCT uptake among youth in general whereby positive and negative attitudes towards HIV/AIDS and VCT co-exist. Thus, health promotion and education among youth and exploring the factors that impact on decisions to test or not to test is vital as youth are the future leaders and therefore targeting men in their youth is important (Mane and Aggleton, 2001) for the future of the HIV epidemic in SA.

However, with regards to the gender ratio and the activities of youth (80% females and 20% males) and when analysed in terms of age, race, religion and activities, it becomes clear that most of the participants who engage in alcohol drinking, clubbing and smoking are female. These kinds of behaviour may put them at a greater risk of engaging in irresponsible sexual relations (Deribe et al., 2009; MacPhail et al., 2009; Preston-Whyte, 2004). What further complicates it is due to the well-known fact that females are biologically more susceptible to HIV (McCoy et al., 2010; Abdool-Karim and Abdool-Karim, 2005; Pick and Cooper, 1997). However, as mentioned before, females placed a strong emphasis on sexual abstinence and the taboos of sexual relations embedded in Christianity. This again highlights the possibility that in as much as there is a social transition from tradition to modernity, the value placed on sexual abstinence is an important factor for the reasons young women are willing to go for VCT and take social responsibility.

It also means that they are aware of the risks involved in certain behaviours and, as literature pointed out, women are the ones who practice ‘good’ health behaviours; a characteristic that came through strongly in the study. What is more unusual is that

many females said that they are virgins yet they are willing to go for VCT to ‘know their status’, as will be discussed later. For now however, this means that just because the females in this study participate in smoking, alcohol drinking and clubbing, it cannot be generalised that they are irresponsible. In fact, their level of agency in terms of health behaviour confirms this as most of the female participants have either gone for VCT or are willing to go in the near future.

Against the early discussion on language and the level of communication about sexual matters with peers, what was clear in this study is that youth are both openly or secretly engaging in good health behaviour. This means that even though there is secrecy surrounding sex and sexuality, health behaviours may also be taking place in silence so as to avoid negative misjudgements from society. Even though an in-depth exploration of this is beyond the scope of this report, it was a characteristic evident in responses to the question “do you think your family or friends will think differently of you if you go for VCT?”. This means that students may be engaging in sexual relations and adopting the necessary health behaviours in private but somehow felt the need to share it with me as I did not know anyone of them personally.

Hence, the responses given by students demonstrated their ‘voluntariness’ in discussing their sexual behaviour in the open-ended questions of the survey and making known that they are aware of what ‘good’ health behaviours are. This implies that, based on the fact that all participants are anonymous, they may have felt at ease discussing sexual matters to me, a stranger to them, even though some participants mentioned that they will not talk about their sexual behaviours with someone they did not know. Hence, there was a level of complexity in the responses provided but helps to understand the general findings in relation to the socio-demographic factors and health behaviour among youth.

**General findings on socio-demographic factors and health behaviour**

The study revealed that students are adopting 'good' health behaviours to protect themselves from HIV infection and maintain good health. In light of this, the VCT counsellor highlighted that:

> "*contrary to popular 'media', students do tend to be incredibly health conscious. I do see a lot of [help]-seeking behaviour, I see a lot of preventative health being used... so the student body in general, especially those that use the clinic do show incredibly good attitudes and uptake of health behaviours*" (02;26/08/11).

This aspect was evident in the study therefore the level of education and autonomy in youth's decision-making becomes significant factors to discuss in relation to VCT uptake. Also, youth nowadays seem to be making a transition away from tradition and/or religion and are thereby creating their own youth culture (Selikow et al., 2002; Ettorre and Miles, 2002). There is complexity embedded in this finding because even though there is a generational gap in communication about sexual matters within a household realm, students are maintaining the religious aspects to their identity and thereby adopting the necessary health behaviour. On the one level, there is a contemporary youth culture within a University environment that may perpetuate risky behaviours but on another level there is a culture of maintaining traditional and/or familial beliefs such as sexual abstinence that act as a protection to students' health.

The study found that; age, gender, marital status, race, culture, religion, language, living space and activities are all important factors that shape health behaviour within different social environments which thereby either positively or negatively impact on attitudes towards HIV/AIDS and VCT. However, the responses varied widely and to a large extent challenges much of the literature on youth in SSA. This is because the youth in this study seem to be well informed and empowered into making the 'correct' lifestyle choices. This is further evidenced in health behaviours of youth who have the agency to negotiate condom use in their sexual relationship. However, in McLea's (2011) article, SA's Health Minister, Dr Aaron Motsoaledi said that "although the whole country knew the "A, B, C" motto to "abstain, be faithful and condomise", the country needed to revisit that message" (p.5.). In addition, the Health Minister

went on to explain that condoms are working but it is a question of unfaithfulness that drives SA's HIV/AIDS epidemic. Therefore, the factors explored in this study cannot be thought of as a 'one-size-fits-all' strategy to understanding health behaviour because their impacts unfold differently in different social contexts.

Nonetheless, the study findings provide a solid basis to understanding the reasons for and against VCT uptake among youth. Against the social models of health behaviour, the study explored the factors in a nuanced way by linking them together and analysing them against each other in order to show the complexity of how health behaviours differ in different social settings. Nonetheless, what is common again is that youth seem informed about the dangers of engaging in risk taking, how HIV can be prevented and/or treated, why knowing their status is important and how avoiding promiscuity is an entry point to HIV decline overtime. This is evidenced in an article by Matjila (2011) who notes that promiscuity in SA is murdering its citizens. This alludes to the fact that health prevention messages need to be reconceptualised with, again, a focus on 'faithfulness'. However, the results of this study show that the 'good' health behaviour of University students is useful to examine in relation to the constructs of the HBM in order to gain insight into why youth adopt positive health behaviours.

Firstly, it shows that youth have a high level of perceived susceptibility in terms of their evaluation of their chances of getting HIV through risky behaviours such as unprotected sexual intercourse. Even though many students claimed to be abstaining from sex, those who are sexually active have a greater risk perception of them becoming infected.

Secondly, youth take cognisance of the perceived severity of HIV with regards to recognising the physical, psychological and social effects resulting from the development of the disease and the serious consequences of; altered social relationships, pain and suffering and even death. This may be attributed to them knowing someone who is HIV-positive or died as a result of AIDS (Macintyre et al., 2001). This may explain why some students mentioned that AIDS is stigmatised because of its link to sexual promiscuity and morality; something they do not want to be a part of and therefore they avoid 'bad' behaviour in order not to be judged by their family and community members.

Thirdly, the acceptance of VCT and positive attitudes towards willingness to test and the subsequent acknowledgment of the benefits of VCT emphasise cues to action imply that youth are motivated to engage in 'good' health behaviour and thereby taking the necessary action to know their HIV status. Again, this links into their level of perceived susceptibility.

Lastly, in their cues to action, youth seem to place emphasis on their individual agency in terms of self-efficacy which means that they have a strong perception in their ability to take action and prevent HIV infection. Also, this finding positively contrasts some of the available literature regarding the agency youth have over their sexual and reproductive health. These show that the acceptance of VCT and the positive change in sexual norms are beneficial to the decline in HIV prevalence rate in SA overtime as youth are taking cognisance of the impacts of HIV/AIDS.

In sum, many of the constructs of the HBM became clear in the findings of the study which demonstrates the relationship between the structure and agency of youth that exists within a University environment. Interestingly, there was no evidence of the perceived barrier of accessing VCT and the subsequent monetary costs. However, many did acknowledge other barriers such as the social, societal and individual barriers to VCT uptake and/or becoming HIV-positive; which will be discussed later.

**Understanding HIV/AIDS in a University context**

*Knowledge about HIV and AIDS*

As reflected in the literature, knowledge about HIV/AIDS plays a vital role in shaping positive health behaviour, such as VCT uptake (MacPhail et al., 2009; Boswell and Baggaley, 2002; Njagi and Maharaj, 2006; Fako, 2006). However, what is worth mentioning is that students were ambivalent about their familiarity of issues regarding health. For example, when asked "do you think you are familiar with issues regarding health?" 74% of students answered yes, 22% mentioned that they were somewhat familiar, 2% was not sure and 2% did not answer the question. When probed further to provide the full meaning of the acronym "HIV" and "AIDS" there was discrepancy in the responses. To evidence this, on the one hand, in providing

the full words for HIV, only 28% were correct, 4% did not answer and a massive 68% had the answer incorrect. On the other hand, in providing the full words for AIDS, 66% were correct, 5% did not answer and 29% were incorrect. This means that even though there is much awareness raising in terms of HIV/AIDS prevention, the basic foundation such as knowledge about what the acronyms mean is problematic. Thus, youth need to be targeted in terms of learning the basic terms.

Also, it seems as if HIV and AIDS has become a codeword that is used interchangeably among youth without a deeper level of knowledge about the differences between the two. As such, it is considered as something to be avoided because it causes 'bad' death. In relation to culture and tradition, bad death is regarded as the unnatural or premature death of an individual because of the view of witchcraft or a punishment, rather than death from natural causes (Pool, 2003). Therefore, what can be understood from this is that, in general, students' imagination of a person with HIV/AIDS varies as there is a co-existence of the biomedical and social model of health and disease. This is worthy to mention against the constructs of the HBM as it provides a nuanced understanding of students' health behaviours and how their social environment impacts on their decisions to test or not to test. To explore this nuanced understanding, when asked "what images come to mind when you hear the words "HIV-positive"?, most respondents placed emphasis on a biomedical explanation such as medication, blood, physical appearance, hospitals, and being bedridden.

A great majority place value on death, religion and gender. This links into the social model of health because death could be the result of cultural explanations based on the issue of 'im/morality' (Airhihenbuwa, 1995; McElroy and Jezewski, 2000). The cultural connotations may also be attributed to religious beliefs and gender differences as primary indicators for infection whereby women are regarded as polluted and transmitters of infection (Airhihenbuwa, 1995; Deribe et al., 2009; Jewkes et al. 2003; Gilbert et al., 2010). This links into the biomedical explanations that woman are physiologically more susceptible for HIV infection (Abdool-Karim and Abdool-Karim, 2005). However, even though religion was a factor in shaping attitudes towards HIV/AIDS and VCT uptake, making use of traditional medicine was not strongly emphasised, neither were traditional healers mentioned. This is an

interesting point to consider as it could be that contemporary attitudes are positively changing, resembling the shift away from cultural understandings of the disease to contemporary acceptance. Nonetheless, there is still a dominance of the biomedical model in treatment and prevention of HIV.

Even so, the co-existence of a biomedical and social understanding of HIV/AIDS is important to explore from a cultural standpoint as it was used as a tool for elaborating on the death of family member, friends and/or others in their community. Also, because many students knew someone who had passed away due to AIDS, negative images about AIDS were made reference to and seen as something to avoid. This means that students simultaneously link, what can be termed 'imagined death' to that of 'bad death'. As such, the HBM is a point of reference in analysing such responses as it shows that the perceived severity of HIV/AIDS and youth's evaluation of how serious the condition is and what the consequences would be. However, drawing on the problematics with definitions that were provided for the acronyms 'HIV' and 'AIDS', a cause for concern is that many students did not know what the acronyms mean. Hence, there is a dire need to question the quality and type of education youth were exposed to at school level as it impacts on their attitudes towards HIV and AIDS and subsequently on VCT uptake.

*Education and HIV/AIDS awareness initiatives at WITS*

The quality and type of education youth are exposed to during their developmental stages is important to consider in relation to their health behaviours and help-seeking behaviours. According to the literature, education is a key factor in shaping attitudes towards VCT. In relation to the HBM, Redding et al. (2000) propose mediating factors such as demographic and social variables like educational levels in order to show how it assists in understanding health behaviour. These mediating variables are thought to "indirectly affect behaviour by influencing an individual's perception of susceptibility, severity, benefits and barriers" (Redding et al., 2000:182-183). Against this, the study found that education is an important factor in reasons for and against, not only VCT uptake but also contraception use.

With regard to contraception use and VCT uptake, the VCT counsellor highlighted that "*the students that seek contraception tend to be incredibly well educated,*

*empowered, and therefore contraception and getting HIV tests seem to be behaviours that are very strongly linked*" (02; 26/08/11). Adding onto this point, the HIV Coordinator mentioned that "*students [who] are filtering through to higher education obviously have a fair amount of knowledge... to some extent even exhausted...*" (03; 02/09/11). However, the evidence gathered from the survey shows that the quality of education youth were exposed to in their school-going years is one to question because acronyms like HIV, AIDS and VCT were incorrectly defined and understood even though they are aware of its social, societal and individual implications.

In addition, the VCT counsellor expressed that young people "*come out of a high school system that's very loaded in terms of HIV education but the type of education is incredibly generic... so there's a lot of myths [and] misconceptions that come out of our school system. But, they've heard the word AIDS so often that they are sick of it*" (02; 26/08/11). Therefore, CCDU and CHWC work together to send out the correct messages among youth and first year students in particular. As the HIV Coordinator described, both these facilities "*target the curriculum [and] work with different Faculties and Schools in terms of inclusion of HIV issues [to] broaden the speck... It's not just biomedical... It's also looking at social issues; gender, cultural issues etcetera*" (03; 02/09/11) which assists with HIV/AIDS and VCT awareness. This implies that HIV and AIDS needs to be regarded as a social disease that affects everyone and therefore the correct measures need to be taken into account in order to convey correct messages to youth. Hence, the social models of explanations for health behaviour are useful in understanding the array of factors that work together to shape attitudes towards, not just HIV and AIDS, but also VCT among youth.

The importance is the awareness raising among students, regardless of their year of study, because it is important for social mobilisation of youth to encourage their peers and other students to get tested. To assist with such progress, the HIV Coordinator explained that:

> "*in terms of the prevention programme, there's campaigns that are consistently run throughout the year... Condom Week, World AIDS Day, Candlelight Memorial etcetera and other awareness campaigns that take place in between that... we also invite and partner with other stakeholders*

*in the HIV programme like Department of Health, Health for Men and Gender Health so we bring on external role players as well to create a sense of education to students on campus*" (03; 02/09/11).

These initiatives are important in spreading informed messages to students which can further be branched out via social mobilisation which may assist in 'normalising' VCT and de-stigmatising HIV/AIDS. For example, there are a few campaigns that focused on healthy living and the importance of knowing ones' status. In terms of HIV testing, the NDoH's First Things First initiative was a tremendous success at WITS which was "*excellently tendered by students....students were actually in queues to get tested"* (03; 02/09/11) which demonstrates the positive change in attitudes towards VCT.

On another level, the recent Smart Moves Campaign "*was about empowering students to make critical choices. So it was speaking to specific issues around gender... alcohol use... sexual orientation etcetera and empowering students to make responsible choices...*" (03; 02/09/11). In relation to the study, these aspects need to be focused on to ensure that more youth are empowered into taking control of their health in the future. In commenting on the relationship between CCDU and CHWC, the HIV Coordinator said that "*in terms of health promotion, or awareness raising [they] work quite well together* (03; 02/09/11) which is a major driving force in creating the youth-friendly environment that is required to assist youth make the correct choices.

With the constructs of the HBM in mind if, for example, VCT occurs in a non-friendly environment youth may perceive barriers such as psychological or material costs which then impacts on decisions not to go for VCT (Redding et al., 2000). This was not a finding in the study as students did not perceive psychological or financial barriers. Importantly, youth need to realise the perceived effectiveness of VCT in that they need to acknowledge the benefits of protective behaviour. However, those who do not acknowledge the importance of VCT or those who fail to see the relationship between risky behaviours and the perceived susceptibility of getting infected with HIV are unlikely to engage in 'good' health behaviours such as VCT as they may believe that it will not protect them against the disease.

But, to add on, the HIV Coordinator remarked that "*there is a sense of awareness that it is an important aspect of well-being... whether they see themselves at risk, that's the question... so VCT might not be a priority aspect for them" (03; 02/09/11).* In this regard, the study also revealed that there were 47% of students who claimed that they knew VCT well whereas 40% said that they are somewhat familiar with VCT, 8% was not sure what VCT is and 5% did not have any idea what VCT is. These percentages are important because it means that even though literature points out the social expectation of youth to be familiar with issues around HIV and AIDS, again, only 74% perceived themselves to be familiar with issues relating to health.

Nonetheless, there was a great level of awareness of where to get tested for HIV, both on and off campus, which shows that youth are in fact more familiar with issues relating to HIV/AIDS than they perceive themselves to be which may explain their decisions not to engage in risky behaviours and to abstain from sexual practices.

*Risk behaviours*

As pointed out in the literature, 'risk behaviours' among youth in general are closely related to their views on health and HIV/AIDS. According to the VCT counsellor, there is a newfound culture among youth that develops on campus that consists of risk taking such as "*alcohol use and abuse*" whereby "*first year students [in particular] come onto campus... they're embracing their adulthood... and that is when unplanned, unprotected sex happens*" (02; 26/08/2011) in some instances. The notion 'youth culture' was also common in the literature on youth and health behaviour (Selikow et al., 2002; Leclerc-Madlala, 2002). To further understand this culture that occurs within a University environment, the HIV Coordinator explained that *"[first-year] students are at a particular age [of being] 'rebellious' as part of this culture, as part of this developmental stage to rebel against normative societal rules"* (03; 02/09/11). Due to the possible lack of familial support, CCDU has put in place the First Year Experience initiative to assist students in making informed decisions about adjusting to the transition to campus life, taking care of their health and well-being and being aware of the implications of risky behaviours.

The positive impacts of such initiatives was greatly focused on in the study as many students related to this experience and were empowered into making the correct decisions about their health. Importantly, the VCT counsellor asserted that "*the perceptions are that 'youth are promiscuous, high-risk takers... [but] the reality is that these kids are incredibly well informed, switched on, aware, terrified of getting AIDS*" (02; 26/08/11) and therefore risky behaviours cannot be generalised to the entire youth population. The findings of this report therefore challenges literature that consider youth to be irresponsible and high-risk takers (Ettorre and Miles, 2002; Petersen and Wilkinson, 2008). Therefore the problem with any discussion of youth's health behaviour however is that not much attention is paid to them as positive consumers of health provision such as contraception use and other health-related practices (Rutter and Quine, 2002) such as their willingness to go for VCT.

To elaborate on this, the VCT counsellor mentioned that "*the first years that [are tested]... are not sexually active... They are virgins*" (02; 26/08/11). This is evidenced in the open-ended responses to the survey whereby many students claimed that they do not place importance on VCT because they are not sexually active and neither do they engage in any forms of risky behaviours that may place them at risk for HIV but they are however willing to 'know their status'.

In addition, some of them mentioned that they do not perceive themselves to be at risk and will only consider VCT when they plan on getting married. This finding is problematic as what youth say and what they do are not always similar. Also, because this study did not focus on the sexual practices youth engage in, there is no solid evidence to suggest that sexual abstinence is the case among these first year students. With regards to sexual abstinence, there is a supposed newfound stigma that occurs on campus- the stigma of the virgin. Although this was not a finding in the survey responses, it must be explored in relation to attitudes among youth regarding HIV/AIDS and VCT.

*Stigma, discrimination and the social environment*

As discussed in the review of literature, stigma is an important factor embedded in the AIDS epidemic and is a driving force that shapes the ways in which people think about the disease. This is because it is associated with immoral behaviour and

sexual engagements. To place it in the context of this study, the HIV Coordinator explained that *"there's a general stigmatisation still brought on by the students... stigma still exists, students don't want to be picked out, don't want to be seen as HIV-positive, don't want to be seen as sick, don't want to be seen as people with loose sexual morals..."* (03; 02/09/11). The study brought this to light one's fears of their family and society finding out that they went for VCT or that they may be HIV-positive. However, even though stigma will most probably always be linked to HIV/AIDS, when asked about the incidences of stigma on campus, the VCT counsellor mentioned that there is another type of stigma; the stigmatisation of a virgin:

> "*the stigma is not just about HIV, it's about perceptions of promiscuity, it's about another stigma... that 'poor virgin' and all of her friends are saying to her, what's wrong with you?*"... [so] "*stigma is a very complex issue on campus*" [and] "*there is more stigma around sexuality... then there is around HIV*" (02; 26/08/11) which is the biggest challenge to deal with on campus.

It also became evident in a talk with the HIV Coordinator that, in terms of this newfound stigma, *"students are more afraid when they engage in sexual relations about falling pregnant than actually becoming HIV-positive and that is a big concern for us, because then the use of condoms etcetera is largely for prevention of birth, or pregnancy as opposed HIV..."* (03; 02/09/11). The results of the survey study challenges what was mentioned in the expert interviews as the students mentioned that virginity was regarded as something to be proud of. But again, the problem is embedded in what students claimed; how truthful their responses were is highly questionable. The fear of discrimination was evident in the study as most of the students mentioned that they may be treated differently if they were to be found HIV-positive.

However, as the VCT counsellor explained:

> "students' *DO disclose [their HIV-status] to friends, they're incredibly supportive. We've never had a case of discrimination by peers around HIV. But, where the discrimination <u>does</u> come in is <u>self discrimination</u>; that people perceive HIV so negatively that if I'm positive I'd never tell anybody*

*because everybody will reject me, even though everybody is saying... I'd still love my friend if they were HIV-positive*" (02; 26/08/11).

This links in to the results of the survey as many students said that they would disclose their status to their friends but not to their family members because of the negative treatment they may receive. This shows that even though HIV is accepted within a University community, external barriers to testing co-exist which creates complexity in understanding reasons for and against VCT uptake among youth. Therefore, as noted in the review of literature, what became evident throughout the study was the importance of social capital among youth which plays a key role in shaping attitudes towards VCT and 'normalising' HIV and AIDS.

Building on this, the VCT counsellor mentioned that, "*positive peer pressure plays an incredibly important role in getting people" [to test as a result of] ... social mobilisation*" where students say, "'all *of my friends were talking about it and I was the only one in the whole group who hasn't tested so I thought, well...why not'* " (02; 26/08/2011). To reiterate what has been mentioned before, what was unusual to note was that even though many students placed emphasis on sexual abstinence, they were motivated to go for VCT. This again ties in with the constructs of the HBM in terms of their perceived susceptibility to HIV, the perceived severity of HIV/AIDS and the perceived benefits of VCT and therefore they are motivated to take the necessary cues to action; which is seeking VCT.

In relation to the survey results, most of the students were comfortable discussing sexual matters with their friends and were willing to test because of the positive messages that surrounded ideas of VCT. In addition, the ways in which VCT is offered on campus is welcomed by students as *"sometimes.... mobile testing... is available on the lawns as well"* (03; 02/09/11). In line with the literature on social capital, this implies that the social environment and the quality of one's social capital is a strong factor that shapes the ways in which youth think about HIV/AIDS and whether or not they accept VCT. In addition, social mobilisation within a University context further shapes attitudes towards HIV-positive people.

**Students' attitudes towards HIV-positive people**

The study pointed out that there are no feelings of discrimination towards HIV-positive people as their status is not something to be judgemental about since the person could have been infected in ways beyond promiscuity. In general, majority of the respondents stated that HIV-positive people are no different to others but they simply need to monitor their lifestyle choices more than others. There were positive responses in terms of acceptance of VCT and youth's willingness to test. This links into the constructs of the HBM in that in order to go for VCT, youth need to acknowledge their risks and the perceived susceptibility to HIV as well as the severity of AIDS. As such, many students may be willing to go for VCT because they acknowledge the consequences of HIV/AIDS and realise the benefits of knowing their status and thereby adopt the necessary cues to action. Again, this may be attributed to knowing people who are HIV-positive, passed away due to AIDS or someone who has been for VCT.

Overall, the findings showed that there are positive attitudes towards those infected. Many consider HIV-infected people to be 'normal' which may help understand the transition from AIDS being regarded as a death sentence to AIDS being understood as a manageable chronic disease. However, the 'bad death' discussed earlier challenges this finding and highlights the simultaneous existence of positive and negative feelings towards HIV-positive people.

*Positive attitudes towards HIV-positive people*

On the whole, there was broad-mindedness and non-judgemental attitudes towards people with HIV as it was not linked primarily to sexual practices. Rather, attention was focused on innocent victims of rape and mother-to-child-transmission (MTCT) and only in some cases due to promiscuity. There was a tremendous sense of inclusion of those with HIV within the social environments of the respondents.

Indifferent

Many respondents confirmed their acceptance of HIV-positive people by saying; "I don't feel anything negative towards them" (P17), "I have nothing against them.

It takes a strong person to be able to live with the virus amidst the stigma attached to it" (P84) and "in some cases it's not their fault that they got it" (P50). These responses show the overall broad-mindedness among youth towards HIV-positive people.

Acceptance

The most common responses were that HIV-positive people are still human-beings who need to be treated with love and respect. A great majority of students said; "I feel like they need more love and care rather than blame and segregation" (P11), "we are all the same. The only difference is that they have a disease" (P18) and therefore "they should be treated as they were before their status despite how they got infected... they are still humans with feelings" (P21). Other students mentioned that HIV-positive people "are to be respected as if they were HIV-negative" (P25). In addition, one must "accept them in society and support them" (P120).

'Normal'

In addition to indifference and acceptance of HIV-positive people, many students "feel it's an issue that has to be an open subject to people of all ages, race, gender, status and economic status" (P24) as "they are no different to anybody else living with a chronic disease" (P85). In 'normalising' HIV/AIDS, many respondents said that they do not have anything against HIV-positive people as they have personally lived with an infected person. For example, one student expressed that she "got nothing against them, maybe because [she] lived with one for a while" (P122) and another student mentioned that she usually "feel[s] happy when [she] see[s] someone living a full positive life with the disease" (P33).

Non-Judgemental

Overall, there was a tremendous sense of non-judgemental attitudes towards those with HIV. For example, some of the responses were; "I do not judge them because I don't know what led to their status" (P178); "I do not judge them because I understand that anyone can get the virus and still live a healthy life" (P185).

These responses tie in with acceptance and feelings of indifference towards HIV-positive people which is important for normalising the disease.

Sympathy

There was a general level of sympathy among youth towards HIV-positive people. This means that some of them may accept an HIV-positive person because of the sympathy they feel towards them. For example the respondents said; “I feel sorry for them like they are going to die” (P41), “I feel somewhat sorry for them” (P19); “I feel sorry for them... to know you are living with a disease that is going to kill you must be terrible” (P55). These responses highlight responses to HIV/AIDS that may explain acceptance of HIV as a chronic condition.

However, in as much as there seemed to be much acceptance towards HIV-positive people, there were also negative and mixed attitudes which add to the complexity in understanding the factors in isolation. However, there were also feelings of non-acceptance and blame attached to those infected and this was embedded in negative responses given by students during the study.

*Negative attitudes towards HIV-positive people*

Apart from the general acceptance of HIV-positive people, there were minor cases of rejection whereby feelings included blame, shame, pity and sadness. In extreme instances, some respondents mentioned that those who are sexually promiscuous deserve getting infected as a punishment for their irresponsible behaviour.

Non-acceptance

Even though many students claimed to accept HIV-positive people, some students admitted that they are weary about being in the company of an HIV-positive person. For example, common responses were; “I am extra careful around them” (P101), “I am somewhat tentative to be in contact with the infected person” (P69), “they must be responsible to not infect others” (P61) and “I feel bad because it can be very disabling to them and society” (P106). All these negative reactions show that HIV is embedded within power dynamics whereby it takes power to stigmatise and create the ‘Other’ (Steinberg, 2010).

Blame

A large number of respondents expressed that HIV-infected people; “could've been more careful sexually” (P28), “if a person got AIDS because of promiscuity then they deserve it” (P114) and “for those who knew about the disease I feel disgusted about them” (P63).

These negative responses are important as it is attitudes such as these that create barriers to VCT uptake, not only among youth but in society as a whole. Also, because of the barriers it poses to VCT, HIV/AIDS may not be ‘normalised’ for as long as negativity exists. To further emphasise the complexity embedded in the responses from students it was clear that, in general, mixed attitudes towards HIV-positive people exists as well.

*Mixed attitudes towards HIV-positive people*

However, complexity in feelings towards HIV-positive people arose when based on moral judgements that were subtly embedded in mixed emotion responses which mean that just because the respondents are aware that those infected need to be treated equally; it does not mean that they are.

Ambivalence

In some instances, respondents were unsure how they felt about HIV-positive people. As one participant expressed, “I feel remorse for a person that has HIV because they might have been through a lot of obstacles but I also admire HIV-positive people because they don't give up on life, they still have sense of hope in them” (P160). Another participant mentioned that “it’s complicated because I feel sorry for those who got infected through birth/cheating spouse or partner... I feel angry towards those who could have prevented getting infected” (P132). While others asserted; “HIV/AIDS is still a taboo subject in my society” (P156) and “it’s bad to be HIV-positive but I treat every person the same. My friend with AIDS is still my friend. There's nothing wrong with them” (P163). This challenges the finding in the interview with the VCT counsellor in that even though students may disclose their

HIV status to their friend, not everyone will accept them and this was a common fear found in the survey responses.

The attitudes towards HIV-positive people as discussed thus far can be explained in terms of knowing someone who is HIV-positive or passed away due to AIDS and that person's relation to the student. Most respondents expressed acceptance of people who are HIV-positive and this may be because 63% of students know someone who is HIV-positive whereby 37% claimed that they did not know anyone who is HIV-positive or passed away as a result of AIDS. This is interesting to explore because, on the one hand, the general attitudes towards the acceptance of an HIV-positive person may be explained in terms of the percentage of students who personally knew an HIV-positive person. On the other hand, those who did not know anyone who is HIV-positive or anyone who has passed away because of AIDS may be the students who showed mixed emotions in their responses.

Interestingly, 53% of the students who know an HIV-positive person confirmed that the person is a family member whereas others were close friends or co-workers. In addition, 65% admitted that they knew someone who passed away due to AIDS. These responses mean that the level of proximity of personal relations shape attitudes towards HIV/AIDS which may in turn influence decisions to seek medical assistance or go for VCT. Thus, it becomes important to examine how respondents imagine and feel about HIV-positive people as it is an underlying factor to reasons for and against VCT. Hence, student's feelings towards HIV-positive people thereby provided insight into how they imagine those infected and why they have a greater perceived susceptibility to HIV infection.

With the constructs of the HBM in mind, this is important to discuss in order to understand the health behaviours of youth as it explores how they think about HIV/AIDS and VCT. As a result, it helps examine what barriers they face and/or what shapes motivations to VCT uptake, what their cues to action are and what their level of self-efficacy is in terms of preventing HIV infection and maintaining 'good' health. Also, it sheds light into their knowledge and awareness of how HIV may be transmitted and prevented.

## Awareness of HIV transmission and prevention

By and large, there was a great amount of awareness in terms of the ways in which HIV can be transmitted and prevented. This means that there is much education and awareness that surrounds HIV/AIDS which is necessary in stemming the tide against HIV/AIDS among youth. However, the incorrect definitions provided for the acronyms 'HIV' and 'AIDS' and the uncertainty of HIV transmission that were embedded in some responses are cause for concern. Thus, the type and quality of education youth are exposed to and the myths and misconceptions in relation to transmission and prevention that surround the epidemic are important to explore in order to understand health behaviour and attitudes towards VCT.

*Transmission*

In order to understand the attitudes towards VCT and its subsequent acceptance and/or rejection, it is important to know how youth think of the disease. Those who participated in the study seemed very well informed about the ways in which HIV can be transmitted and prevented. Their understanding therefore links to their positive attitudes towards VCT uptake and their willingness to engage in 'good' health behaviour. This is in order to know their HIV status and subsequently take the necessary precautions. Overall, one of the primary modes of HIV transmission that were emphasised was transmission through unprotected sexual practices with an HIV-infected partner.

The unsafe sexual practices commonly referred to by the students were; vaginal, anal and oral sex. Interestingly, even though oral sex is not on the traditional continuum of sexual behaviours, it is a risky behaviour that occurs among youth as to avoid the 'real thing' and may nonetheless lead to unprotected sexual intercourse (Mckay, 2004). Thus, the fact that the students considered oral sex a risk factor for HIV transmission is worth noting. Literature points out that youth do not always acknowledge the risks inherent in the engagement in oral sex even though the chances of HIV contraction through oral sex are minimal (Granich and Mermin, 1999; Mckay, 2004). However, they do recognise the risk of contracting an STI if the giver of oral sex has an open wound in their mouth and the receiver is HIV-positive (Mckay, 2004).

Other means of transmission dealt with the risks involved when one comes in direct contact with the blood of an HIV-positive person, needle prick injuries, using contaminated syringes or razor blades and the risks involved in having multiple and concurrent partners. In addition, many respondents highlighted that a person may get HIV through a blood transfusion, during childbirth through MTCT, breastfeeding and by drug users sharing needles. These correct associations with HIV transmission demonstrates that there is a great level of education and awareness on HIV and AIDS-related issues in terms of accurate risk perception and the simultaneous acknowledgement of the risks involved when one engages in certain behaviours. The study found that youth are generally well aware of the dangers involved in risky behaviour and their increased susceptibility to HIV and the severity of the outcome of infection. Again, and as discussed earlier, the constructs of the HBM are useful as the findings revealed that youth acknowledge their perceived susceptibility to HIV, severity of HIV infection, benefits of VCT and subsequent cues to action.

However, in as much as there was accurate identification of how HIV may be transmitted, some students were still uncertain. For example, one participant mentioned that HIV can be transmitted by “mixing bodily fluids such as saliva” (P6). In another instance, a student (P70) highlighted the danger of coming in contact with the vomit of an HIV-positive person but failed to acknowledge the primary risk of coming in contact with the blood of an HIV-infected person. In contrast, another student correctly mentioned that HIV can be transmitted through “unprotected sex, sharing needles and other bodily fluids except saliva, sweat and urine... mostly other bodily fluids like semen” (P116). This emphasises that the quality of education about HIV and AIDS varies among youth, again possibly because of the type of schooling system they were exposed to.

On another level, a fair proportion of respondents placed emphasis on car accidents as a cause for HIV rather than explaining that it is the contact with open wounds and infected blood during car accidents that may exacerbate one’s chances of getting HIV if they do not use gloves while assisting those injured. Therefore, there is great complexity in analysing the responses to questions about HIV transmission as many explanations were not detailed. However, what became clear is that risk perceptions

were sometimes incorrectly defined and acknowledged while at other times risk behaviours were correctly identified which may both add to the dynamic in understanding the possible factors that could shape attitudes towards VCT.

*Prevention*

Taken as a whole, much emphasis among respondents was placed on sexual abstinence or if one is already sexually active then consistent and correct use of condoms as a means of preventing HIV is necessary. This may link in to the factor of religion and sexual abstinence. This again may therefore imply that religion may be used as a protective agent only when it comes to sexual abstinence and not as a barrier to engagements with other activities. In general, there was an excellent level of awareness of HIV prevention and the students seemed well clued on how HIV is transmitted and how it can be prevented.

However, against the literature, it is not certain if what youth say and what they do is necessarily the same as there may have been instances of social desirability bias in their responses (Mckay, 2004). Nonetheless, as Mckay (2004) points out, even though the anonymous reporting of sexual behaviour may not always be methodologically perfect it is a reliable way to obtain an accurate gage of the sexual behaviours of youth. This finding is consistent with the interview with the VCT counsellor who mentioned that youth at WITS are terrified of getting AIDS and most of those who visit CHWC are virgins.

Apart from sexual abstinence and condom use, other methods of prevention included getting tested for HIV regularly if one is sexually active, being cautious and wearing latex gloves when in contact with blood and bodily fluids of another person. Also, people must not share needles and razors and if one is a health professional they must ensure safe medical practices such as sterilising medical equipment. In addition, may students emphasised remaining faithful to one partner and avoidance of multiple sexual partners. Most notably, many students focused on the ABC method of prevention which links into the discussion on health promotion and health education brought forth in the literature review of this report. This means that messages of preventative behaviour is spreading but just because one is familiar with the messages of health behaviour does not necessarily mean that they engage

in preventative behaviour. This report did not aim to examine the sexual behaviours of youth at University and finds no relevance in exploring this in greater depth; however, from a social standpoint it is useful in order to gain a nuanced understanding of their health behaviours.

Moving on to another method of HIV prevention, many students highlighted that an HIV-positive woman should make use of MTCT prevention methods when she is pregnant. This is in order to avoid the possibility of her child being born with HIV and also to ensure that she must not breastfeed after the baby is born as it may be risky. Even though the prevention methods were accurate, another concern has to do with the fact that a great majority of students mentioned that contraception must be used to prevent HIV, without mentioning that condoms are most effective in HIV prevention. The issue of contraception use is important because it refers to the prevention of pregnancy rather than prevention of HIV and other STIs which is worrying because the woman may still get HIV if, for example, she only makes use of the contraceptive pill. This is important as it highlights what has been mentioned in the interview with the peer counsellor whereby there is greater concern about prevention of pregnancy than there is on prevention of HIV.

However, youth place much focus on the social and societal implications of HIV infection and expressed that knowing ones status and preventing HIV is a social responsibility. For example, one student remarked that ‘social consciousness’ is a prevention strategy (P51). Thus, the emphasis is on health education and health promotion in spreading informed messages about HIV and AIDS so as to make society aware of its implications and thereby adopt the necessary measures to live a healthy life and prevent infection. The notion of ‘social consciousness’ is interesting in understanding attitudes towards HIV-positive people and individual perceptions of being treated differently if one was found to be HIV-positive.

Against the constructs of the HBM, these responses are useful to explore youth’s health behaviour because the fact that they are concerned about the social and societal implications of going for VCT or possibly finding out that they are HIV-positive implies that their fear of what society will think or how they will be treated propels ‘good’ health behaviours. Furthermore, their relationship with an HIV-positive person or knowing someone who has passed away due to AIDS assists in gaining a

better insight into how they perceive HIV/AIDS and the benefits of VCT. As such, these insights may provide further understanding of youth's individual barriers and/or motivations to VCT uptake which relates to the impacts of structure and agency. Taking into consideration all that has been discussed thus far, this report now focuses the lens on the exploration of students' perceptions about HIV/AIDS and how it thereby shapes their health behaviours like VCT.

**Students' perceptions about HIV/AIDS**

*Perceptions of being treated differently if found to be HIV-positive*

The study revealed that there is still a great amount of fear that exists among youth in terms of being treated differently by family and friends if they were found to be HIV-positive. This fear may be the result of negative stereotypes that still exist within some communities about HIV/AIDS and the fact that some people are still not fully educated on the subject. In as much as the respondents did not show that they themselves discriminate against those infected, they fear that others will if they themselves were to be HIV-positive. Perhaps the root cause of this fear is based on cultural attitudes and simultaneous association with immoral sexual behaviours and therefore youth feel more confident discussing sexual matters with their friends rather than their family members, which is a cause for concern.

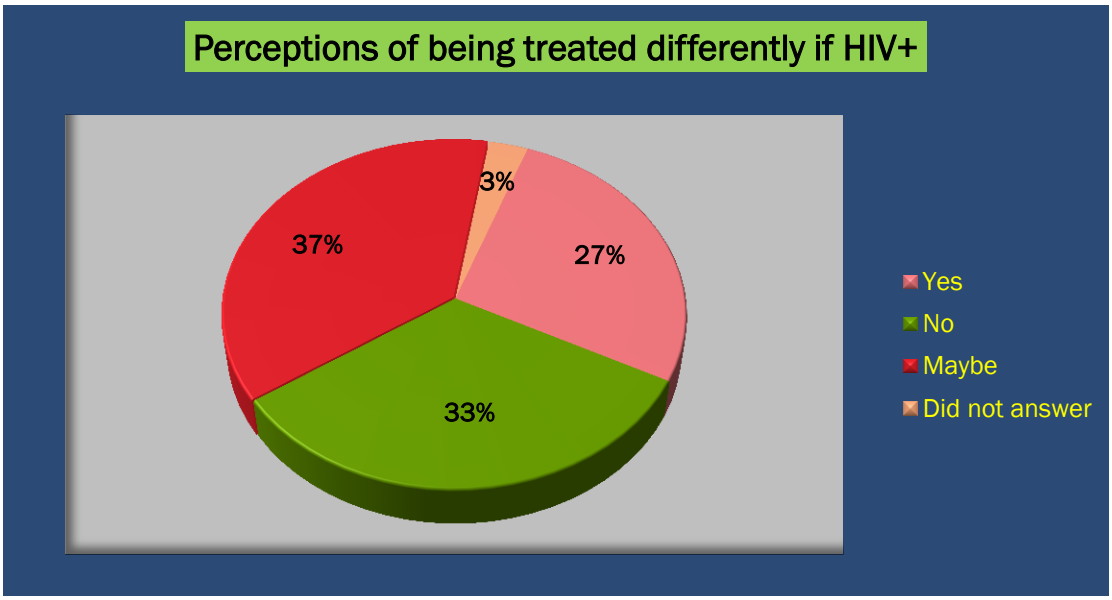



Figure .1.7. Students perception of being treated differently if HIV-positive

When asked if they thought they would be treated differently if they were found to be HIV-positive, a fair proportion (37%) of respondents admitted that they 'may be' treated differently, whereas 33% claimed that 'no' they will not be treated differently and 27% believed that 'yes' they will in fact be treated differently by their family in particular. The remaining 3% chose not to answer the question. The fear of being treated differently may simultaneously explain reasons why some students are more willing to go for VCT than others as others fear that their results will lead to isolation by their family members. This shows that fear is still a major factor in shaping attitudes towards HIV/AIDS in general and towards VCT in particular. Therefore, a nuanced understanding of VCT in a University context is important in order to understand the general familiarity with VCT-related issues and the subsequent motivations and barriers to VCT uptake.

**Understanding VCT in a University context**

*General familiarity with VCT-related issues*

Only 47% mentioned that they know VCT well, 40% admitted that they 'somewhat' had an idea of what VCT is, 8% said that they were not sure and 5% claimed that they did not know VCT at all. These percentages may be due to incorrect individual knowledge perception. However, students did correctly identify what facilities offer VCT; clinics, hospitals, university health care centres, doctors rooms, pharmacies and laboratories. This implies that even if they perceive themselves to be unaware of VCT as a concept, they do know the practical implications of VCT which is hopeful with regard to the shift to them adopting good health behaviours and encouraging others in their social environment as well.

When asked which facility offers VCT at WITS, 93% correctly mentioned that CHWC offers VCT, whereas 7% mentioned CCDU. Hence, there is a level of uncertainty among these first year students in terms of distinguishing between CHWC and CCDU. Nonetheless, this demonstrates that the students do have a level of awareness regarding the partnership between CHWC and CCDU in HIV/AIDS prevention campaigns even though they do not perceive themselves to be familiar with VCT. The data thereby revealed a discrepancy in what students perceive and what they actually know. This is positive because students know much more than

they think they do, which is useful in stemming the tide against HIV/AIDS among the population of youth (Shisana et al., 2009).

*Attitudes towards VCT*

As many as 52% knew someone who has been for VCT, 46% did not know anyone who has been for VCT and 2% chose not to answer. Of those who knew someone who has been for VCT, majority of the respondents mentioned that it was a either a friend or family member. This is important to note because the quality of relationship of the person to the student may have either positively or negatively shaped attitudes towards VCT depending on one's experiences (Boswell and Baggaley, 2002; MacPhail et al., 2009). Thus, the perceptions of whether people share their VCT experience with others is also an important factor as it may encourage VCT uptake or discourage it. When asked about whether or not they think people share their experience with family or friends, 78% said 'yes' and 22% said 'no'.

Taken as a whole, there was a general acceptance of VCT in terms of willingness to test. The responses to willingness to test were varied based on; free HIV-testing, counselling and support, quick procedure, efficient, accessible and convenient. For those who have been for testing, the responses encapsulated reasons such as; "I have already, it's part of medical aid tests, life insurance" (P46), "I prefer to go for medical aid reasons and to know that I am safe" (P72), "yes, I always do after 3 months" (P19), "I've been tested already" (P42), "I have been tested when my boyfriend and I were ready to have sex" (P40). These responses show that there are positive attitudes surrounding VCT and that youth are familiar with the advantages of knowing their HIV status, as will be discussed later.

In addition to the importance placed on knowing ones status, many students were familiar with the benefits of VCT. A great proportion (85%) mentioned that they believed there were benefits to VCT and only 2% did not believe that VCT was useful while the remaining 13% chose not to answer. The benefits of VCT will be explored shortly in order to highlight the complex understandings of VCT and why attitudes towards it are multilayered. But, in the mean while, the focus shifts to the experience of VCT.

*Experience of VCT*

In general, the study revealed that positive experiences of VCT shape youth's motivations for testing themselves and thereby encourages others to get tested too. Many respondents perceived that those who have been for testing may have shared their VCT experience with their friends and in some instances with their family in order to encourage them to find out their status. For example, one student expressed that VCT is not something to be embarrassed about and "it is important for people to know their status so I encouraged my friends and family to get tested too" (P3). This is important as it demonstrates the effectiveness in social mobilisation to encourage testing which may have a ripple effect on society (Campbell et al., 2005).

In turn, positive attitudes towards VCT also changes ones willingness to test which is thereby a by product of one's motivation/s for VCT uptake. This was commonly found in the study, for example, the key findings show the importance of one's social environment, support structure or social capital and individual and social responsibility work together to shape youth's willingness to test.

**Motivations: why students are willing to go for VCT and/or share their experiences**

The decisions to go for VCT and/or share one's experience of VCT were due to many factors working together to impact decisions to test. On the whole, the social context was focused on a lot by the participants and this is useful from a sociological standpoint as it links into the social models discussed in the review of literature. Importantly, it highlights the complexity embedded in youth's attitudes towards HIV and AIDS in general and VCT in particular, in ways that will now be discussed.

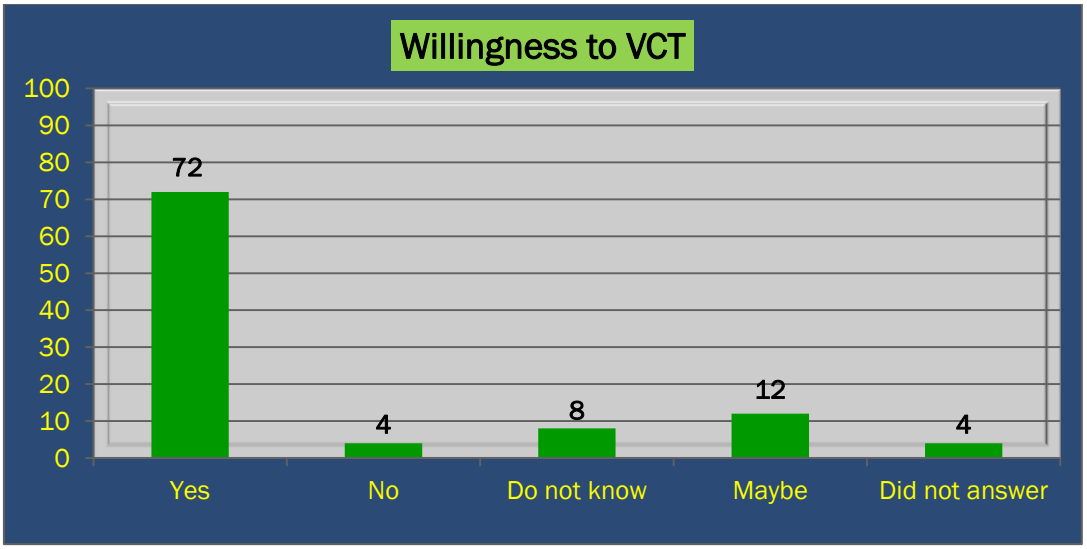



Figure .1.8. Students' willingness to test

By and large, it seems that a great majority of students are willing to go for VCT and a small minority are uncertain. Nonetheless, the results of the study reveal that overall; there is a tremendous acceptance of VCT. As revealed by the study, motivations to test are multilayered and are primarily based on ones' social and societal settings and the acknowledgment of the benefits of VCT.

The common finding in this study was the importance to know one's status which implies that the benefits of VCT were well accepted among youth. Furthermore, there was tremendous attention on the VCT results being kept confidential by the health care providers. In sum, the benefits of VCT were the primary motivation for willingness to VCT among youth and will now be explored.

*Know your status*

The results of this research showed that a great majority of youth acknowledge the importance of knowing their status. This finding is consistent with the study conducted by Njagi and Maharaj (2006) in a tertiary institution in KwaZulu-Natal which stated that the "desire to know one's status was a major factor promoting VCT uptake" (p. 113. In: *South African Review of Sociology*, 2006). The main findings of this study regarding the reasons why students place value on knowing their HIV status will now be discussed.

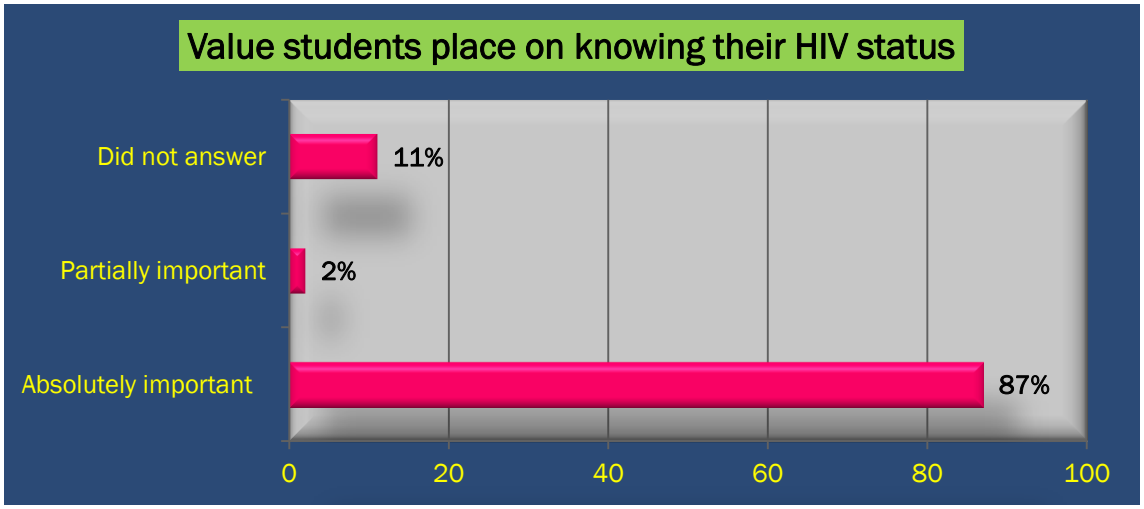



Figure .1.9. The value students place on knowing their status

As much as 87% of students mentioned that it is 'absolutely important' to know their status. When probed further, it was found that some of the key reasons were; to prevent spreading the virus, to take sexual responsibility to protect oneself and their sexual partner/s enables a positive change in health behaviours in terms of lifestyle change and it also facilitates help-seeking behaviours to ensure early treatment, care and support. Students mentioned that VCT is only important if one is sexually active and have engaged in, or considering engaging in, risky behaviours. For example, one respondent said that knowing ones status "can only be important if you are engaged in risky behaviour" (P66). Also, much emphasis was placed on an explanation that it is a disgrace to be ignorant, for example, "infecting people unknowingly is disgraceful and unforgivable" (P152) and therefore it is important to know your status.

Some of the primary reasons noted for finding out one's status was that it may decrease the spread of HIV. For example, respondents said that "it is good because it will decrease the rate of HIV spread in our country" (P8) and "students are at an age where they are sexually active and it is important to prevent the spread of HIV" (P68). In addition, "it's important for them to know their status so that they do not infect other individuals" (P34). Also, there was a tremendous focus on health behaviour and lifestyle whereby respondents asserted that it is important "to take preventative measures and promote healthy lifestyles" (P16) because "if they don't

know [their status] they can't get treatment and treatment is important to live a normal and healthy life... if they don't know they could infect others" (P61).

Most importantly, there was a big emphasis on making better decisions that relate to health in general and sexual behaviours in particular. For example, one respondent succinctly explained that "knowing one's status helps one to make better informed/premeditated decisions such as whether or not to drink, smoke and exercise. Also, it makes one even more aware of the dangers of unprotected sex" (P126). Above all, many respondents placed emphasis on the belief that "when you know better, you can act better" (P179). This emphasises the multilayered complexity embedded in reasons to test or not to test.

*Perceived confidentiality*

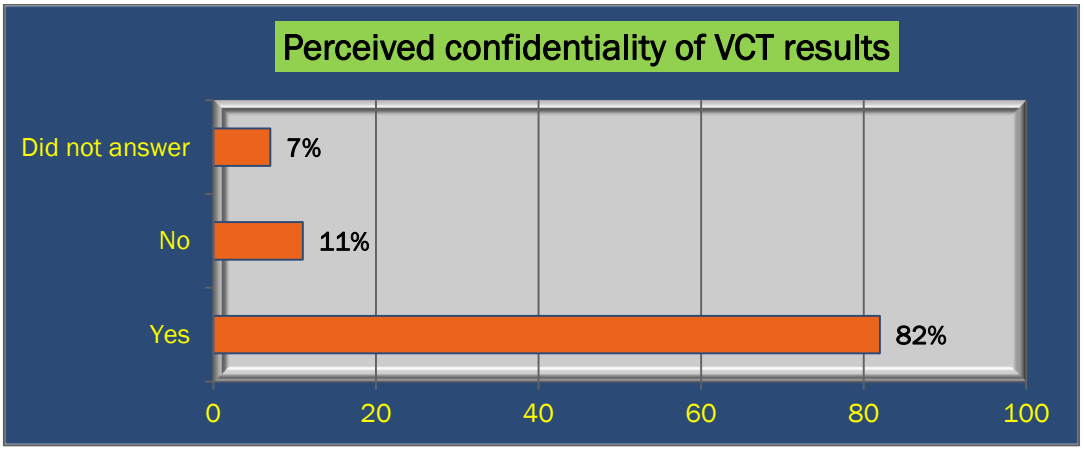



Figure .1.10. Students perceived confidentiality of VCT results

Drawing on the results of the closed-ended question, when asked "do you think the results of VCT are kept confidential?" there was a hopeful acknowledgment that the results of VCT are kept confidential and this facilitated willingness to test. The fact that majority (82%) of students perceived that their VCT results will be kept confidential highlights that there are positive attitudes towards the acceptance of VCT uptake and that confidentiality is a factor to consider. As such, this factor will be used as a basis to understanding other positive factors that shape good health behaviour among students which assist in VCT uptake.

When probed further in the open-ended questions, most reasons for VCT uptake was based on the Constitutional right to privacy. To sum up the responses from

those who remarked about the importance of confidentiality in terms of what is stated in the Constitution, one respondent emphasised that “according to the Constitution of the Republic of South Africa, everyone has the right to privacy” (P66). Much emphasis was also placed on the responsibility of health care professionals to uphold the Hippocratic Oath in terms of upholding ethics and avoiding any breach of confidentiality and always respecting the patient. For example, with regards to medical procedures such as VCT, one respondent said that it is “illegal to disclose such information” (P113) “without the individuals consent... it is the clients right (P99).

Adding onto this, one participant mentioned that, as the term suggests, it is “Voluntary. No one has the right to divulge what took place during testing... It is actually against the law” (P83). From these propositions, it becomes understandable that those who value and believe in the confidentiality of VCT results will be willing and motivated to go for VCT more often and thereby also encourage others to go for testing as well. This again highlights youth’s strong sense of agency in terms of their self-efficacy, or confidence in their ability to take the necessary cues to action.

Some other benefits of VCT mentioned by students are discussed below. The following results were derived primarily from the responses to the open-ended questions of the survey which were then coded and thematically analysed in order to compare responses.

*Early treatment, care and support*

Another benefit of VCT acknowledged by majority of the respondents in this study was the importance of, again, knowing one’s status and thereby receiving early treatment, care and support. This finding is also consistent with the previously mentioned study by Njagi and Maharaj’s (2006). For example, one student highlighted that “to know your status is important and if you are positive, you can start medical treatment as soon as possible and receive care and support” (P60). In addition, their responses leaned towards subsequent health behaviours and precautions so as to protect others from being infected. Also, the need for social mobilisation into encouraging others to know their status and to educate and spread

informed messages about the epidemic and the benefits of testing were also focused on.

For example, many respondents noted that VCT “educates people about the virus, it provides support” (P38) and ensures that informed messages are spread within a clinical setting in order to “educate patients about their health situation” (P58). Most of all, it “helps make you more knowledgeable about the disease and helps you make informed decisions” (P63) about your health which is vital in educating more people about it. Such knowledge and education thereby shapes good health behaviours and help-seeking behaviours as “early detection means early treatment and one can prevent it from turning into AIDS” (P189).

*Knowledge and education*

The need to make others aware of what VCT is to those who were uncertain came through strongly in the study. As such, informed knowledge and education were regarded as key to shaping attitudes towards sharing VCT which in turn contribute to VCT uptake. For example, people share their VCT experiences “because they were more knowledgeable and wanted others to also be and to encourage others to go for VCT” (P63) and “they shared so as to raise awareness” (P158). These were common responses found in the study and imply that education is a key factor that plays a vital role in decisions to go for VCT. In addition, it was evident that those who claimed that they knew better were certain that they are taking the necessary precautions to prevent HIV and maintain a healthy life. This is important as it ties in with the importance of health promotion and health education messages (Naidoo and Will, 1994; Clarke, 2010) that are conveyed among youth in order to stem the tide against HIV.

In general, there was a good level of familiarity with issues related to VCT. To draw on what has been mentioned before, this may be because some respondents admitted to knowing someone who has either been for VCT, who is HIV-positive or who has passed away due to AIDS. Many of the participants, both sexually and not, showed a profound interest in knowing their status and are willing to go for VCT because of the positive feed-back of the experiences of VCT received from the people whom they knew well. Most participants knew a friend or family

member who had been for VCT and this shows that social capital is an important factor that positively shapes attitudes towards, not only to those with HIV/AIDS, but towards VCT as well.

The study found that VCT is beneficial in assisting in knowledge and education about the disease and not regarding HIV and AIDS as a death sentence. For example, one participant mentioned that VCT “helps make you more knowledgeable about the disease and help you make informed decisions” (P62), while another expressed similar views about VCT in that “people become more aware of their health and can educate others as well” (P21). In line with this, another respondent acknowledged that “checking and getting counselling/ testing is a good way to prevent anything from happening. It also makes you aware of things you didn't know” (P39). These responses again tie into education and awareness as a factor in shaping attitudes towards VCT among youth. It does however simultaneously challenge the findings of, as discussed earlier, ‘imagined death’ found in this study. Reason being, in as much as there is much education and awareness about HIV and AIDS among youth, it is still unaccepted and this poses a barrier to ‘normalising’ the epidemic as well as VCT.

Adding onto this, one student said that “when one person knows about something they are able to share and teach the people around them” (P36) which is a good way to socially mobilise people into knowing the benefits of VCT. In linking education and health behaviours, another student emphasised that VCT helps “to educate people more about HIV/AIDS and to know treatments available and how to lead a healthy lifestyle and to learn what the measures are to not infect others” (P61). Building on this, it became evident that VCT was commonly referred to in relation to positive change in lifestyle choices as well as sharing experiences of VCT with others in order to motivate others to get tested and take the necessary precautions to reduce the spread of HIV in SA. Some respondents remarked that “if you are positive you can start taking medication to help you live longer and healthier” (P50) and you will “know what to do in case you are HIV positive and if negative you get to know how to stay negative” (P42). Importantly, the students mentioned that “by being aware of your condition you can prevent spreading the virus and can take better care of yourself” (P42).

*Lifestyle and behaviour change*

In relation to health behaviours, there was much emphasis placed on lifestyle change after going for VCT. For example, “you get to know your status and the available options if found HIV positive. Counselling can help you engage in a healthy lifestyle” (P115) and “you can protect yourself and others as well as changing your lifestyle” (P144). Many participants emphasised the need for one to know their status in order to remain negative and what measures they need to take if they were found to be positive. As one student succinctly explains, “a person gets to know their status voluntarily without being forced. VCT provides people with the opportunity of having a choice about their life” (P164). These all emphasise health behaviours of youth and the need to stay negative and what to do if one is found to be HIV-positive.

Most importantly, many respondents mentioned that VCT is a means of enforcing agency over one’s life in that it is a social responsibility to know your status. To emphasise this, one student asserted that “if you tested negative then you'll be encouraged to remain that way, if positive you will maintain your health and besides.... [testing for HIV] is a social responsibility” (P170). This links in to the models of health behaviours brought forward in the review of literature because in order to access treatment, for example, one needs to first perceive themselves at risk before taking the necessary actions to improve health and well-being. This was a common finding as youth do perceive themselves to be at risk as well as take cognisance of the perceived severity of HIV/AIDS. These constructs of the HBM in relation to the social models discussed in the literature review was important to gain a nuanced understanding of youth’s health behaviour.

As such, decisions to go for VCT were frequently explained in terms of the importance placed on youth to know their HIV status so as to protect themselves and their sexual partners. Most students explained the significance of remaining HIV-negative and taking the necessary precautions if found to be HIV-positive. Overall, the benefits of VCT expressed by the youth themselves are that it helps “to educate people more about HIV/AIDS and to know treatments available and how to lead a healthy lifestyle and to learn what the measures are to not infect others” (P64). In addition, it also enables you “to be aware of your health, protecting your sexual partner and your family and friends from HIV/AIDS, knowing more about

HIV/AIDS, being able to talk to someone in a support environment" (P130) which is useful in order to lead a healthy and happy life. This implies that they need to have self-efficacy, a construct of the HBM, to take action and cope with the outcome of the HIV test result.

*Coping strategy, quick and free*

One other benefit of VCT was that it is a coping strategy to enable one to know how to make informed decisions about their health. For example, "it helps one accept their position and helps them know that it is not a death sentence, most importantly, it teaches them how to live healthy and what to avoid" (P131). In addition, it "helps a person to deal with their results if they are positive and if they are negative they are told what to do to keep their status negative" (P92). These responses link in with health behaviours and how counselling during the VCT process is advantageous for knowledge about the disease and how to best handle the situation as it "prepares people so that they can cope better with an undesired result" (P54).

A great majority of participants noted that one may share their experience of VCT in order to gain support from their family, friends and community members. For example, a strong support structure helps one to cope with the results of their HIV test and this "creates a sense of comfort within social settings" (P84) in order to equip an individual with the necessary skills needed to manage their condition. Also, a friendly and accepting support structure is a driving force to VCT acceptance and these then trickles down to spreading informed messages about HIV and AIDS to others in society and may enable the 'normalisation' of the disease (Ndinga-Muvumba and Pharoah, 2008; Mathews, 2010).

With regards to accessing VCT on campus itself, it became clear that another motivating factor for willingness to test may be due to the lack of monetary costs involved. There are no incentives for testing at CHWC, however, one of the motivations why a student will want to test on campus could be because, for students, "*accessing VCT it is completely free of charge, counselling is always free of charge, testing is always free of charge, follow-ups are always free of charge*" (02; 26/08/11). Using the construct of 'perceived barriers' of the HBM, this is important as there was no evidence in the study to show that monetary costs were a barrier to

VCT uptake. In fact, youth mentioned that the lack of monetary costs were a motivation for their willingness to test as well as easy accessibility of VCT services at WITS and that VCT is a quick process and very convenient.

Thus, another important factor to the acceptance of VCT was that “it's quick, efficient and convenient” (P102), “knowing your status is a life time benefit” (P129) and plus, VCT entails “free counselling, testing and knowing of your status” (P52). In contrast to the HBM construct of perceived barriers, the study found that monetary costs were not a barrier to VCT uptake but rather the lack of costs was a motivation for students’ willingness to test. As such, the positive impact of peers in their social environment was made reference to with regards to one’s motivations for willingness to VCT.

To emphasise the students concern about their health and well-being, the VCT counsellor asserted that there is a major positive transition in patterns of VCT uptake whereby, for example, “*two weeks after the Orientation programme, [there is] massive uptake of VCT [and a] massive uptake of the morning after pill*” (02; 26/08/11). In addition, there is a “*huge uptake before students go home and then huge uptakes when students come back from home, especially* [the] *migrant population*” (02; 26/08/11) of students at WITS. These aspects are necessary to explore using the constructs of the HBM as it shows that there is a strong sense of perceived susceptibility of HIV infection, perceived severity of HIV/AIDS, perceived benefits of VCT and contraceptive use and a sense of self-efficacy in terms of adopting the necessary cues to action.

This also means that students are more health conscious and do take cognisance of, not just their health behaviours, but their help-seeking behaviours and this could be the result of the interplay of all of the aforementioned factors which work together to shape attitudes towards VCT uptake.

*Social mobilisation and individual and social relief*

Many students believed that if their friend shares their experiences of VCT with others it will encourage more people to get tested for HIV which will in turn positively impact on ‘normalising’ the disease by changing negative attitudes that surround it. For example, one student highlighted that the people they know have “shared their

experience to encourage others to get tested" so as to reduce the spread of HIV infection to others (P33). Importantly, a great number of participants acknowledged that sharing ones experience of VCT with others may 'de-stigmatise' the disease if more people are able to talk about the disease more freely and therefore it is important to motivate others to know their status.

Whilst many respondents also emphasised ambivalence to VCT, a large amount placed emphasis on the relief that comes with knowing one's status which thereby motivates one to share their experiences with others because of the 'good news' of being tested HIV-negative. For example, one student stated that the person they knew who went for VCT was happy "because they were negative therefore the good news was seen as something to share" (P34). This therefore links in to the importance of social mobilisation in spreading informed messages about the disease so that one is aware of the risks involved in unsafe sexual practices. In addition, it allows one to acquaint themselves with the severity of the disease and to take the necessary precautions in future. This again links into the importance of one's social capital and how it impacts on an individual's moral responsibility and decisions on who they share their test result with or who they discussed sexual matters with.

*Social capital, moral responsibility and selective sharing*

Knowing about ones' status and sharing the experience of VCT was regarded as the right thing to do among students because everyone has a social and moral responsibility for their health and that of others. For example, one student pointed out that "it was a responsible thing to do and more people should be aware of it" (P94). This links in strongly with the need for education and awareness in terms of health promotion and education as messages need to be well informed in order to enable one to feel comfortable to go for VCT and also to discuss their VCT experience with others. In addition, this is important from a social mobilisation point of view as it has the potential to positively transform one's social structure into a friendlier and accepting one. However, it is unclear whether correct and informed messages have the potential to change traditional norms and attitudes among elders in society and this will be useful to explore in future studies.

In general, the respondents were selective in terms of who they shared their VCT experience with. On the whole, students felt more comfortable in discussing sexual matters with their peers and a health care professional than with their parents and/or siblings. For example, one student confirmed that discussion on HIV/AIDS and sex occurs among friends because “they will not react harshly like some of the family members who are quick to stigmatise” (P111). In line with this, another student mentioned that “it was better talking to a stranger about [their] sex life because they wouldn't be judgemental” (P178). Drawing this response to that of the anonymity guaranteed in the surveys and subsequently upheld, it is believed that the participants may have shared their VCT experience and sexual behaviours in the open-ended questions as I was a complete stranger to them and they trusted that they would remain anonymous.

Overall, there were varied reasons provided by youth with regards to why people may share their experiences of VCT which in turn has the potential to motivate others to go for VCT as well. To sum these briefly, two respondents’ answers are useful. “It is necessary in society that knowledge is shared so that ignorance can cease and social ills can be cured” (P51) and “sharing the experience helps reduce the stress you may go through because of the outcome of your visit, a problem shared is a problem half-solved” (P185). These are useful in highlighting all that has been explored thus far in relation to positive attitudes towards VCT among youth. Some of the reasons why the respondents believe that people may want to go for VCT or to share their experience with others are due to the emphasis placed on societal support, love and care in one’s social context. As one respondent succinctly explains, it “enables people to share how they feel before the results and to encourage people to practice safe sex” (P195).

Adding onto this, another said that “when one shares a problem with others it will help reduce pressure or stress” (P99). These responses are valuable as it highlights how VCT is thought off in a positive light which, as discussed earlier, is a useful tool for social mobilisation to testing if one’s experiences of VCT were pleasant. In addition, the acknowledgment of the benefits of VCT is another factor that plays a key role in motivating one to get tested. However, what poses a barrier to VCT and came through strongly in the study is that youth are more comfortable talking about

VCT with their friends but feel ambivalent in discussing sexual matters with their family, which will be discussed shortly. It is unclear if the social environment youth find themselves is a 'protection' against sexual misconduct as one's peers may also have a negative influence over decisions youth make in health behaviours.

Another factor embedded in this is that VCT may be used as a disguise for discussing or expressing ideas about sex and sexuality among peers whereby actual discussions on sex in the household realm, for example, may be a taboo subject. Whatever the reason, it is worth noting as there appears to be a mismatch in communication about specific issues relating to HIV and AIDS. This may also be attributed to the language barrier that was discussed earlier. Clearly, there are many barriers to willingness to test and this is explored below.

**Barriers: why students are unwilling to go for VCT and/or share their experiences**

The study revealed that some of the main barriers to VCT uptake and sharing ones experiences had to do with feelings of shame, embarrassment, fear, rejection and denial, as well as uncertainty about societal responses. Other barriers were the nature of clinics and the perceived lack of confidentiality, difficulty in discussions sexual matters with family, cultural taboos and communication barriers, sex and secrecy, sexual abstinence and the perceived unpreparedness and lack of knowledge about VCT. All these are explored in greater depth below.

*Nature of Clinics and perceived lack of confidentiality*

The main barrier that came through strongly was the nature of clinics and in some instances, the perceived lack of confidentiality. For example, one student mentioned that if people find out that "they are HIV-positive... and if the counsellor was not a friendly and welcoming person" then they may fear going for VCT and it thereby discourages others (P195). In general, there was a sense of uniformity in responses in terms of reasons provided for unwillingness to go for VCT. Nevertheless, there were also differences with regards to the uncertainty that surrounds VCT and its perceived benefits such as confidentiality. This ties in with the HBM as the construct of perceived barriers help explore youth's evaluation of how difficult it is to trust a

health care professional. Also, these explanations highlighted that the results of their HIV test may not be kept confidential because the health care professionals are also community members who may share the result of their HIV test with others.

Furthermore, the gendered nature of clinics outside campus whereby, to pick up from the earlier discussion, young males have difficulty discussing sexuality with older females which then poses a barrier to VCT uptake among youth. This is an important barrier to explore because as mentioned earlier, youth experience difficulty in discussing sexual matters with family members which further complicates decisions not to test.

*Difficulty in discussing sexual matters with family*

Another barrier is the perception of how difficult it is to discuss sexual matters with family members because of the fear of being discriminated against. Those who were against VCT or who were unsure about what they would do; to test or not to test, emphasised that VCT is "a private matter that may or may not affect [one's] family standing, so they keep quiet about it" (P15). Based on this and in relation to other responses, the focus was primarily on what one's family would think and how they will treat them if they were found to be HIV-positive upon going for VCT.

The study revealed that; on the one hand, only 51% of participants are willing to discuss sexual matters, 32% mentioned the value of discussing sexual matters with someone who understands them and someone who will not judge them or treat them differently. On the other hand, 11% mentioned that they were 'somewhat' comfortable with discussing sexual matters with others and 6% pointed out that they were 'not' comfortable. When probed further in the question "if you do discuss sexual matters with others, with whom do you talk with?", the study found that a great majority of students discuss sexual matters with their friends rather than their siblings and/or parents.

This means that communication about sex and sexuality is still regarded as a taboo subject in some households which implies that one's religion, language and living space could be working together to shape attitudes towards HIV and AIDS as well as VCT. This is based on the evidence that sexual communication among youth at

University entails discussions with their peers which means that the social environment the students are exposed to provides an arena to their comfort and openness about sexual matters. However, cultural taboos and communication barriers within the household realm may hinder health promotion messages and health behaviours.

*Cultural taboos and communication barriers*

To touch on the taboos that surround HIV/AIDS and VCT, one participant's response is useful to highlight as she remarked that because "teenagers in [her] culture are not allowed to talk about sex with elders. It is considered taboo so they rather talk to friends" (P28). In addition to this, "black families are not open to such discussions, especially the elders" (P148). This brings to light the lack of communication or the mismatch in open discussions about sexual matters among family and friends.

Adding to this, when asked if they would be embarrassed to speak about VCT with a health care professional, 68% of respondents said 'not at all' and 26% expressed that they 'maybe' embarrassed and only 6% said 'definitely'. This means that there may not be a barrier or discomfort in discussing sexual matters or VCT as such, especially with those who are within the professional realm or circle of friends but there is a barrier within youth's familial surroundings that impact on decisions to openly discuss sexual matters. This again calls for further exploration in future studies.

Furthermore, language may or may not be a confounding barrier to VCT uptake but it is clear that means of communication differ depending on one's' social environment. This means that language and other socio-demographic factors such as those that were discussed earlier in this chapter work together to shape attitudes towards VCT. Thus, understanding each factor in isolation is both beyond the focus and scope of this study but is useful to analyse in future research. For now, what became clear was that youth fear that they would be thought of and treated differently if they went for VCT or were found to be HIV-positive.

*Fear of discrimination and stigma*

Fear of discrimination and stigma were mentioned a lot in the responses, for instance “because people may assume the worse or others may discriminate against them” (P46). This also links into the importance of supportive social structures and positive social mobilisation in order to possibly normalise the disease in order to shape positive responses to VCT. The fear that exists is a personal fear based on the concern of what others will think of them. For example, participant 51 said that it “is a personal fear, they are incredibly judgemental and sympathetic-sympathy is destructive but so is judgement”. “Some people still lack the right knowledge about HIV/AIDS...so they tend to be judgemental” (P185)**.** Also, their “family members are still stereotypical and are still not sure about HIV” (P98)**.**

With regards to stigma, one respondent made it clear that “some people don't trust sharing their status with other people if it’s positive because of the stigma around AIDS” (P120). On the upside, the fear of becoming infected with HIV may have a protective effect in preventing risky sexual behaviours and it has the potential to promote better health behaviours. For example, the person may be afraid of what others may think and how they would react if they knew that the person went for VCT as it would let out their ‘secret’ of sexual activity. Also, the person may not share their experience of VCT because they are “afraid of judgement and discrimination and what the society might think of them” (P131).

To add onto the reasons against VCT uptake, one participant’s response is important to note in relation to the negative feelings attached to VCT. In their explanation, the participant asserted that if someone goes for VCT and was found to be HIV-positive they would feel “embarrassed, fearful, neglected, discriminated against, judged... and some people exclude or treat people with HIV/AIDS differently” (P64) which adds to their feelings of isolation.

As such, they may want to keep it a secret as “they don't want their parents to know” (P75) because “most of them are still young and they don't want their families finding out that they are sexually active” (P122). These responses highlight the level of secrecy that surrounds sexual practices and this is a major barrier to VCT uptake.

*Sex and secrecy*

The level of communication about sexual matters which occur among peer networks only is a major cause for concern as it highlights the silence that still surrounds sex. The factors discussed tie in with the issue of communication, or lack thereof, within a family realm and it therefore occurs in social settings with a stranger or among friends. However, some respondents mentioned that one must guard against who they share personal information with as they may be judged. For example, “a positive result is difficult to share with family and friends” (P50) and it is a “personal burden and many people don't tell others they are HIV positive” (P55). In addition, if they have tested positive then “they are afraid to be judged” (P52). These negative responses demonstrate that there are fragmented social structures that need to be dealt with effectively in order to possibly normalise the disease and VCT.

*Sexual abstinence*

Most notable were youth’s individual level barriers to testing and this included; uncertainty, incorrect risk perceptions and lack thereof, stress, time constraints in some instances, unpreparedness and unwillingness because of sexual abstinence. For example, many of the participants mentioned out right; “I know that I am HIV negative, I am still a virgin” (P67), “I'm a virgin” (P32), “if I ever made the decision to be sexually active, I'd want to know where I stand” (P83), “I choose to abstain... so I know I am not positive and would like to keep it that way” (P29), “I am not HIV positive and I am a virgin. I will only go for it once I become sexually active which will be after marriage” (P114). These responses link in to the earlier discussion on religion and how Christianity may play a role in attitudes towards sexual abstinence as a primary HIV prevention method. It is however problematic because participants are aware of the benefits of sexual abstinence as a method of HIV prevention and therefore think that this is what must be mentioned in their responses.

*Perceived unpreparedness and lack of knowledge about VCT*

Aside from the above reasons for unwillingness to go for VCT, many participants admitted that they were just not ready to know their status. Also, many did not have

the time to go for testing and many highlighted their lack of knowledge of what VCT is so they did not take interest in it as they did not see the relevance. For instance, some reasons against VCT were, “I am not ready yet” (P38), “I already focus my attention on a lot of things, I might not be able to make time for it” (P51), “it is stressing” (P100). This links into individual barriers to testing. On another level, there were clear lack of, or incorrect individual risk perceptions as many mentioned that; “personally I do not think it’s necessary considering the precautions I take” (P96), “I haven't been so much active in sexual practices it's only a couple of times and protection was the case for sure” (P162). These responses imply that some students do not consider the fact that they may have put themselves at risk for HIV.

Many were ambivalent to testing and highlighted that; “it’s something I have not thought about as yet, when I think about it I will have a better judgement towards it” (P45), “I know it’s good to but I do not think I am ready to face another dilemma where my studies are an obstacle too” (P128), “I don't know what that is” (P117), “I don't have much knowledge about it” (P81), “I never heard of it before” (P194). These responses also relate to education and awareness as a factor that may or may not be a barrier to attitudes towards VCT. From a social and societal level, to sum up one respondents answer; “I am one of those people who do not want to be rejected by my family more especially because we are religious and believe in the Bible ("no sex before marriage")” (P173) and “depending on whether I am comfortable I might go because sometimes I just do not want to talk about my problems especially with a stranger” (P131).

These responses show the complexity embedded in reasons for and against VCT uptake because there are multiple factors that have to be dealt with simultaneously in order to gain a nuanced understanding of these attitudes. The barriers to willingness to test are on social, societal and individual levels. In addition and as discussed earlier, there were socio-demographic barriers based on religion, culture, age, gender and its relation to ones social network. Above all, there were many gendered perceptions to VCT uptake that were found in the study. To pick up on the earlier discussion, gender is important to explore in relation to the health behaviours of youth and will be focused on now.

**Gendered perceptions: VCT uptake and/or sharing experiences**

The results of the study show that 84% of respondents expressed that females test more, 10% did not answer and 6% said that males favoured testing more. Some of the main reasons provided for why females test more than males are stated below:

*Females*

In general, emphasis was placed on the fact that females are the primary caregivers in society and are regarded as being more responsible in comparison to their male counterparts. In addition, they were also considered more emotionally stable and willing to share their experiences of VCT with others for the benefit of themselves and their partners. The main reasons were based on; social responsibility and emotional stability and agency which includes discussions on; health consciousness, greater biological susceptibility, risk awareness and pregnancy.

Social responsibility

Most of the participants focused on the social responsibility of women to know their status for the betterment of society at large because they are the ones who bring life into the world. For example, one student mentioned that women “give birth to the next generation, so they are concerned about the future of their children, society and of the state” (P45). Other participants highlighted that; “women are more responsible” (P6), “women feel the need to take responsibility” (P49), “women are the ones who are responsible and are the nurturers of the nation” (P83) and are also “more open to helping others and protecting themselves and others” (P137). Such responses emphasise the social role and responsibility attached to women in society through the process of socialisation. This has a level of hierarchy of power relations (Rassjo et al., 2007; Taylor, 2007) in that, from a social responsibility standpoint, women are regarded as more powerful than men in terms of taking care of themselves and others and are generally more responsible.

On another level, women were considered more in tune with their health status because of their awareness of their biological susceptibility to HIV and are thereby generally more concerned about the consequences thereof. To emphasise this,

many of the respondents explained that women are “more open to getting advice and help” (P7), “more concerned with their health” (P16), “more conscious about their health and well-being” (P57) and “they are more concerned about their status and they are also more at risk” (P34). These responses highlight the level of risk awareness among youth in that women’s biological susceptibility is well acknowledged.

For example, the most common responses in relation to this was that “females are more careful... they stand a greater risk of contracting the disease” (P38), “they more at risk of contracting HIV” (P16), “it is easier for women to contract HIV through sexual activity than males and there is the whole rape factor to be considered” (P69). Adding onto this, participant 85 noted that “females may be more aware and willing as they may infect a child and are at higher risk due to rape and violence in our society”. This is again demonstrates the broadmindedness and non-judgmental attitudes of youth as they thought of HIV/AIDS and VCT in a more holistic and liberal way rather than judging someone who either goes for VCT or has become infected with HIV.

Building on this, participants also considered the fact that women test more because of their ability to bring life into the world and thereby have the responsibility to know their status in order to protect their unborn child. To highlight this, many of the respondents pointed out that; “it becomes a must when they are pregnant... for the baby's safety” (P62) and “women are more willing [to test] because of the consequences such as breastfeeding” (P46). Therefore, “during pregnancy more women want to know their status for the sake of the baby” (P91). Another point that came through strongly in the study were ideas about emotional stability and the power dynamics embedded in reasons for and against willingness to test.

Emotional stability and agency

Emphasis was placed on women’s strong emotional stability to handle various issues in life. In general, women were considered more prepared and mature to deal with the outcomes of their status and may therefore be more willing, not only to go for testing, but also to share their status with others. For example, some of the responses to this were that women are; “more willing to share their emotions” (P2),

“they are more likely to share experiences” (P21), “females tend to worry more and share their emotions more” (P90), “females are emotionally stronger than males and therefore understand that they need to accept and move on” (P182). These responses challenge the review of literature on gender in terms of the agency young women have over their sexual and reproductive health.

The literature points out that young women lack control over when to have sex and how to negotiate condom use. However, the study revealed that the females in the study are well informed about the dangers of not knowing their status. Also, many of them are abstaining from sexual relations and are empowered to make the correct decisions about their sexual and reproductive health. This implies that the female participants do have agency over their health and well-being and that they are taking the necessary precautions in terms of adopting the necessary health behaviours. In addition, many females admitted to having gone for VCT which means that their help-seeking behaviours are different in comparison to the general literature on young females in SSA.

However, there were instances of lack of agency inherent in the responses; for example many respondents mentioned that; “most women are the victims of the disease” (P18) and are more affected by HIV than males. This is true in terms of biological susceptibility and is a valid point to note as it is simultaneously laden with relations of power (Ingham and Aggleton, 2006; HEAIDS, 2010; Rassjo et al., 2007). For example, one respondent expressed that “because of subordination, especially in African families. At times men send their wives for check up and once they are found negative they also assume that they are negative” (P10). This response links into what has been mentioned in the literature and the cultural beliefs, rather than race, as a factor that may shape attitudes towards willingness to test.

In addition, it also adds to the discussion that men use women as indicators of their test results which imply that again, there are power dynamics inherent in reasons for and against VCT. For instance, to sum up, one respondent noted that women “always seem like the most vulnerable... and societal stereotypes focus on females to empower themselves more” (P114).

*Males*

The study found that young men were not willing to test because of societal and individual barriers. Most participants mentioned that it is a fact that men test far less than women and it is uncertain why. This implies that willingness of VCT is not just laden with social and individual perceptions but the level of perceptions that exist is complex to understand. May responses highlighted issues of masculinity such as pride, fear, denial, embarrassment and ignorance. These are discussed below.

Pride

Against the literature and in relation to the study, it is evidenced that men have a level of pride that shapes their reasons against testing and, as discussed earlier, will much rather have their partners go for VCT than accessing it themselves. To sum up the responses to the issue of pride, many respondents noted that; “males are too proud... being male gets to them and they think they don't need it [VCT]” (P20); “males are proud and many do not even want to think about the existence of HIV or AIDS for that matter” (P40), “most men have pride and won't want to get help” (P61) and “males feel they are supposed to be strong and lead all the time, so they will not talk about their problems” (P131). These were generally the common finding in the study which revealed that men are, in comparison to women, unconcerned with health and sexual matters. They are also afraid of the outcome of their results and how it may impact on their life. Therefore, men have a certain level of fear about finding out their status which ultimately shapes negative attitudes towards VCT.

Fear

Many responses to male willingness to test were provided in relation to the overall fear of finding out ones HIV status and how it may negatively impact on their life. For example, many respondents expressed that “men hate feeling vulnerable” (P65), men “do not want to be seen as vulnerable... are scared of getting stigmatised and have a 'status' to uphold” (P44). In addition, men fear the stigma that surrounds HIV/AIDS and the subsequent stereotypes that may arise. In sum, the responses highlighted that “there is a stigma attached with men” (P103), “males are

stereotyped” (P81) and therefore “they have trouble trusting the process” [of VCT] (P23).

Based on all that has been mentioned thus far, men intentionally choose not to know their status because of the issue of denial.

Denial, embarrassment and shame

Above all, young men seemed to be in denial and were regarded by the females as being secretive because of their promiscuous behaviours. For example, “men tend to be more promiscuous than women and are more hesitant and ashamed. They may see it as stripping them of their masculinity” (P116) and therefore “most males are afraid of knowing their status” (P97) because “most males have multiple sex partners and therefore are more scared to test than women” (P121). In general, the responses explained that “men tend to be in denial about being affected by AIDS” (P25) and “would rather keep it a secret” (P68). This was considered as being a result of patriarchy whereby for example, as mentioned earlier in relation to culture, within the households of Black families “patriarchy promotes less disclosure of a man about his personal life” (P35) which further adds to the embarrassment and shame that surrounds HIV/AIDS and thereby poses a barrier to VCT. In general, the responses strongly claimed that “men would be embarrassed or ashamed” (P15) to know their status and they are therefore ignorant to VCT.

Ignorance

On the whole, responses about fear, pride, denial, embarrassment and shame were brought forward by the participants and were laden with beliefs about the general ignorance among men. For example, many respondents described that “males are ignorant when it comes to HIV/AIDS" (P52), “males tend to be more ignorant” (P78), “males don't really take into account health issues” (P5) and “men would rather not test because it will limit their sexual activity and change their lifestyles” (P46). Against the literature, all these responses confirm some of the reasons why men may be less willing to test. However, the complexity embedded in reasons for and against testing among men in particular is beyond the aim or scope of this study but is worth considering for future research.

Nonetheless, by and large and in as much as gender is a vital factor in shaping attitudes towards HIV/AIDS and VCT, the study found that there was a tremendous emphasis placed on students to know their status. This means that regardless of gender as a motivation and barrier to testing, the positive attitudes towards knowing one's status overall came through most strongly in the study.

In the final analysis, the findings illustrate that attitudes towards HIV, AIDS and VCT are shaped under complex social and societal circumstances that also go beyond individual factors. The factors that surfaced in this study all work together to influence the health behaviours of youth and impact on their decisions to either accept or reject VCT uptake. These decisions unfold in multilayered and complex ways and shapes how society functions which thereby give character to one's social environment. Thus, the study gained a nuanced understanding of the health behaviours of youth as it was situated within the framework of the social model. Furthermore, the constructs of the HBM as a point of reference to health behaviours was useful for a macro-sociological view of how multiple factors shape attitudes towards HIV/AIDS in general and VCT in particular among youth at University. As such, an in-depth examination of these factors is both beyond the aim and scope of this report but is a solid base that is important to explore in future research. For now though, to further assist in understanding the health behaviour among youth at University, a review of the WITS HIV/AIDS Policy is brought forward.

## UNIVERSITY OF THE WITWATERSRAND HIV/AIDS POLICY 2000/ 573A

### Background

As part of the study on VCT among first year students at WITS, there is a need to examine the institutional policy in relation to the findings brought forward in the previous chapter. This is important as a backdrop to highlighting the positive change in attitudes among youth through health promotion initiatives on campus.

### The primary aims and objectives of the policy and its relation to the study findings on youth's attitudes towards VCT

WITS recognises that the HIV/AIDS epidemic has devastating consequences that go beyond a health issue but is an issue that concerns the entire University community and society in multiple respects. This demonstrates that HIV/AIDS is a social issue and therefore WITS is committed to engaging society in playing an active role to alleviate the impacts of HIV/AIDS. This is strived for both, within the University's "internal constituency of staff and students, and on society as a whole" (p.1.). As such, WITS aims to make tremendous success by "integrating HIV/AIDS into its core functions of teaching, research and service" (p.1.). This is important to note as the study findings point out that these have been greatly achieved and progress has been made by integrating Schools and Faculties to promote HIV/AIDS awareness about the consequences of engaging in risky behaviours such as alcohol drinking and unsafe sexual practices and to thereby promote lifestyle changes, healthy nutrition and HIV prevention.

In addition, the strong clinical partnerships that take place with CHWC have created a youth friendly environment which encourages social mobilisation among peers to promote VCT uptake. Also, as the study reveals, the strong relationship with CHWC and CCDU assists students in taking initiatives to know their status which is important in stemming the tide among youth. As such, the study found that youth at WITS are very well informed and are aware of the dangers of risky behaviours. Also, because of the successful collaboration between CHWC and CCDU, many first years seem to be actively seeking out the necessary health behaviours in terms of willingness to know their status and adopt the necessary practices to maintain a

negative status and take the necessary treatment if they were found to be HIV-positive. As the findings show, HIV/AIDS awareness campaigns have been adequately promoted which further add to successful integration within the teaching, research and service environment among students and staff.

As a result, the University community actively branches out through social mobilisation in order to spread informed messages about the benefits of knowing ones HIV status. In linking this to the review of literature brought forward thus far, social networks among youth are an important factor in shaping attitudes towards HIV/AIDS and finding out ones status. Based on the findings and in relation to the WITS HIV/AIDS Policy, the study found that a caring community exists among the first year students who were found to be very caring and accepting of both HIV-negative and HIV-positive people.

**Values underlying the policy**

The HIV/AIDS Policy consists of important values that underlines and guide the policy. The key values entail:

1. Non-discrimination towards People Living with HIV/AIDS (PLWHA) in terms of accessing education and/or employment at the University.

   This implies that there is a focus on equality and equity in the University community to positively change attitudes towards the disease which may thereby facilitate VCT uptake among youth. A key finding highlighted in the study was the perceived non-discrimination among youth at University and within some familial settings due to education about HIV/AIDS. Therefore, some respondents mentioned that they did not perceive their family or friends to treat them differently. However, what came to light was the uncertainty embedded in social relations and therefore many students were uncertain as to how they would actually be treated within their social networks if they were found to be HIV-positive.

2. PLWHA have the right to dignity, respect, autonomy and privacy concerning their HIV status whereby stigma and prejudice will be opposed.

   This was a major finding in the study which revealed that youth have positive attitudes of acceptance towards HIV-positive people as they have either known someone who is infected or know someone who has passed away due to AIDS. Therefore, their personal experiences are an important factor in promoting the rights of those infected with HIV. In addition, there did not seem to be any stigma or prejudice attached to an HIV-positive person at University but what was feared most is the treatment from others in society; like ones family and community members in particular.

3. Acknowledgement that HIV/AIDS affects everyone and therefore the policy should "recognise specific vulnerabilities and risk factors arising from physiology or social power relations" (p.1.).

   This was also one of the key findings of the study in that both the interview respondents and the survey participants mentioned that HIV/AIDS is "everybody's disease" and therefore there should be equal treatment in society. Also, in relation to the literature discussed thus far, there was much evidence in the study to show that there is a hierarchy of power that exists in various social contexts, for example, among males and females in terms of reasons for and against VCT uptake.

4. HIV/AIDS is an issue that concerns everyone and therefore a suitable response to HIV/AIDS from various stakeholders and groups in society is needed.

   In relation to the HIV/AIDS Policy, literature and findings, it is recognised that this may only be achieved if HIV/AIDS is considered as part of everyday activity in the University and therefore there needs to be active involvement from various stakeholders in defining and implementing the responses to HIV/AIDS at WITS. This came through strongly in the study which found that HIV/AIDS is a serious matter that needs collaboration from everyone in society in order to 'normalise' the disease so as to possibly 'de-stigmatise' and encourage others to talk openly about it.

5. HIV/AIDS must be understood and addressed in its social context which includes "power relations between men and women and sexual violence against women, changing values and meanings around sexuality, and the multiple legacies of apartheid" (p.1.).

   The study showed that HIV/AIDS is a social disease that is laden with multiple complexities in terms of attitudes towards the diseases which is further complicated by the dynamics of power within society which poses a barrier to VCT uptake in particular. Also, it found that there is a positive transition in attitudes among youth which emphasise the change in values and meanings around sexuality with a huge focus on abstinence and the avoidance of risky behaviours. In addition, HIV/AIDS is no longer seen as a 'black disease', as it once was considered based on the legacies of apartheid, but it is now seen as everyone's disease which highlights this positive shift. Also, this study finds interest in examining HIV/AIDS as a social disease and therefore emphasises a move beyond a purely biomedical approach.

6. Appropriate advancements for caring for and treating PLWHA are important.

   In general, the study revealed that HIV-positive people are thought of as 'normal' and there was a huge focus on accepting and caring for PLWHA and the need for them to have access to proper care, treatment and support.

**Components of the policy**

1. Rights and responsibilities of staff and students affected and infected by HIV/AIDS.

   In relation to the findings, much emphasis was placed on the Constitutional Rights of people in general with a specific focus on youth in terms of their privacy and confidentiality within medical and social settings. Also, many participants confirmed the responsibility people have to know their status so as to protect themselves and others. The policy states that no staff or student may be discriminated against or refused any benefits such as refusal of University residences, financial aid and scholarships (p.3.). This was not found in the study because it did not ask a student to reveal their HIV-status or any related form of treatment within University. However, what was evident is that free counselling and testing offered by CHWC was one of

the benefits for VCT uptake. The policy is useful to examine in relation to the findings because it states that “HIV related illness will be treated no differently to other comparable chronic or life threatening conditions” (p.2.) which may thereby assist in ‘normalising’ the disease in society in general and University in particular. This came through strongly in the study and it was evident that attitudes towards HIV/AIDS are positively changing.

As such, the policy states that staff and students both need to take “responsibility to become informed about HIV/AIDS and to develop a lifestyle in which they will not put themselves or others at risk of infection” (p.4). This was a common focus among youth who mentioned that knowing one’s status is the right thing to do in order to protect oneself and not put others at risk of infection. In relation to this, behaviour and lifestyle choices were expressed throughout the study whereby the necessary health behaviours and help-seeking behaviours were considered vital to living a healthy and happy life. The policy states that “[s]tudents are also encouraged develop and implement their own student-led responses to HIV/AIDS” and “[t]he University will support these initiatives. This was focused on in the expert interviews as the student representative council (SRC), although it was not mentioned in the survey responses and was therefore not analysed in the findings and analysis chapter, the SRC was considered by the experts as key role players in positively shaping attitudes towards HIV/AIDS and VCT as well.

2. Integration of HIV/AIDS into teaching, research and service activities of all Faculties.

This is adhered to as, for example, there are courses in public health and humanities that merge social and biomedical perspectives to HIV/AIDS in a holistic manner. The policy states that HIV/AIDS education at University is important for students to help them understand “how HIV/AIDS will impact on their future professional lives” and they should also “know the legal implications of HIV/AIDS” (p.4.). With regards to this study for instance, Health Sociology is a subject that focuses on teaching and research that enables a broader understanding of society and HIV/AIDS in the workplace which further adds to exploring the inside constituencies of the University community.

With regards to research, “mechanisms will be established to support HIV/AIDS research activities that are innovative, address strategic priorities, and are inter-disciplinary” (p.5.). In relation to this, the study goes beyond a biomedical explanation of HIV/AIDS to holistically explore the factors that shape attitudes towards HIV/AIDS and VCT from a social perspective. As such, the potential implications of this study serve as a basis for future research among youth at University and to understand how and why each factor works together to impact on decisions to seek or not to seek VCT. As been discussed earlier, the joint services offered by CHWC and CCDU by engaging all Schools and Faculties is important in integrating HIV/AIDS awareness into, not only teaching and research, but also through service provision and health promotion strategies.

3. Provision of prevention, care and support services on campus.

The study revealed that most participants acknowledged the importance of prevention, treatment, care and support. For example, CHWC and CCDU play a major role in this regard within the University context and their strong partnerships have promoted knowledge and awareness among youth. It is therefore important that research on the attitudes among youth is important in stemming the tide against HIV/AIDS. Thus, “[a]ll students and staff will be offered education that examines the relevance of HIV/AIDS to their own lives, in the context of broader challenges facing them as young adults” (p.5.). This research thereby placed importance in understanding the factors that shape attitudes towards VCT in particular by relating it to the social models discussed in the review of literature that shape health behaviour.

As a result, the study found a positive acceptance of HIV-positive people which shows the shift in social attitudes among youth. Also, these positive social attitudes help develop a “caring and non-discriminatory approach to HIV/AIDS as well as a tolerance for, and understanding of, different social groups” (p.5.). The study found a commonality in responses in this regard whereby the students who either knew someone who had been for VCT, who is HIV-positive or has passed away due to AIDS were more accepting of others. However, their own fear of rejection was cause for concern. In terms of prevention, the policy states that “[c]ondoms will be freely available and widely distributed through multiple channels, on campus and in

residences" (p.5.). These strategies are available and have been successfully implemented but the use of condoms is questioned.

In addition, "[t]he use of free STD care provided through the Campus Health and Wellness Centre will be promoted" (p.5.). This was well recognised among youth who placed emphasis on free VCT services, for example, as a motivation for their VCT uptake at CHWC. In addition, the policy highlights that "[i]nformation on services in and around campus will be made available to all staff and students" (p.6.). This links into the health promotion initiatives on campus and was an effective measure that was revealed in the study.

4. Implementation: structures, processes, monitoring and evaluation.

   The policy states that "[a]ll Heads of schools, departments and units will be briefed on the policy, its content and its implementation" (p.7.) which has been done successfully. Also, "[i]n the implementation of the HIV/AIDS Policy, the University will seek to collaborate with other tertiary educational institutions. This includes the Tertiary Education HIV/AIDS Initiative" (p.7.). This was evident in, for example, WITS acceptance of the Department of Health's First Things First campaign which proved to be a huge success for testing among youth.

5. Policy review

   The Policy acknowledges that "HIV/AIDS is not static and policies addressing aspects of the pandemic as they affect the institution must be revised from time to time" (p.7.). However, the Policy still stands in effect from the year 2000 and there is a dire need for revisions and additions so as to address the changing nature and patterns of HIV/AIDS as well as their multiple and dynamic effects within a University context and society at large. A new WITS HIV/AIDS Policy will need to evaluate the current policy in terms of effectiveness, new initiatives around HIV/AIDS that took place over the past eleven years and consider some much needed amendments to the policy with regards to all that has been discussed thus far.

## GENERAL DISCUSSION

While it is clear that there are numerous reasons for and against willingness to VCT uptake, it became evident that respondents viewed VCT as a useful process. This is important to mention as there is a level of complexity embedded in the reasons to test or not to test for HIV. For example, on the one hand, in as much as 82% of respondents mentioned that they thought the results of VCT were kept confidential; a number of students did not believe that it remained confidential. On the other hand, only 72% of respondents were willing to go for VCT. It is assumed that if such a big focus (82%) was placed on confidentiality then the willingness to test would have been greater, but this was not the case. This highlights the fact that understanding willingness to test is complex and goes beyond the perceived benefits such as confidentiality. These responses depict the multilayered reasons for and against VCT based on array of factors that work together to shape the health behaviours of youth at WITS.

Students mentioned that people will think of them differently, treat them differently by feeling sorry for them and misjudging them if they were found to be HIV-positive or known to have gone for VCT. Also, they said that they will be considered irresponsible because of ideas of promiscuity or sexual decadence. These were some of the main barriers to VCT uptake and many asserted that their family and friends will be disappointed in them while others feared being stigmatised against. In addition, religion played a strong role in shaping the ways in which ideas about HIV/AIDS and VCT are perceived.

Most notably, familial rejection and ignorance were evidenced in student responses which show that HIV and AIDS is still a taboo subject in many social settings. Therefore attitudes towards these health-related issues need to positively change in order for the disease to be normalised over time. However, it is argued that in as much as HIV/AIDS is still somewhat thought of in a negative light among youth, the evidence that VCT is accepted and that many students are willing to test implies that attitudes are positively changing among this population group; albeit slowly. It is hoped that just because the youth know better they will do better in future.

A large number of students revealed that their family and friends already know someone who is HIV-positive and the infected person was not treated differently or rejected in any way. Others mentioned that they have a very supportive environment whereby the people in their lives are well-educated about the AIDS epidemic and they will therefore accept their status if they were found to be HIV-positive. In addition, feelings of love, care, understanding and support came through strongly in explanations why they will not be thought of or treated differently if they went for VCT and/or were found to be HIV-positive.

However, even though the study revealed that many students perceive themselves to be accepted upon going for VCT and finding out their status, many still believed that people change their thoughts and behaviours. Hence, it is uncertain that what members of society say and what they do will be the same. There is an underlying complexity in understanding attitudes towards VCT specifically and HIV/AIDS among youth that is much deeper and extends beyond the scope of this research. However, the main factors that were found in this study provide a solid base for in-depth exploration in future research. For the most part, even though there was much complexity embedded in understanding youth's motivations and barriers to VCT, the importance youth placed on knowing their status was a worthwhile exploration.

The findings of this study relate to the conceptual framework as it found evidence to support the simultaneous operation of individual, social and societal factors that not only shape attitudes towards HIV and VCT but also influences reasons for and against VCT uptake among youth.

The constructs of the HBM in relation to the health behaviours and help-seeking behaviours of youth were also evidenced in this study which helped gain a nuanced understanding of student's motivations and barriers to VCT uptake. Some of the motivations for VCT uptake included; knowing someone who has been for VCT, someone who is HIV-positive or someone who passed away due to AIDS, positive peer influence and social mobilisation as well as the awareness of VCT benefits. Some of the barriers against VCT uptake included; incorrect and/or no risk perception, fear of stigma and discrimination, gendered stereotypes, secrecy surrounding sex and sexuality.

Hence, this study has proven to be unique in that it focused on HIV/AIDS and VCT within a broader macro-sociological South African context. It examined multiple factors that affect health behaviour among students in University based on individual, social, societal and familial barriers to VCT. While current research investigates HIV/AIDS in isolation and primarily focuses on a Western biomedical paradigm, this research contextualised the epidemic in a social paradigm. Although, some of the issues that emerge are beyond the aim and scope of this study, it is valuable for future research because it has the potential of adding to the nuanced understanding of health behaviours and attitudes of youth beyond a University context.

## CONCLUSION

The study set out to explore the reasons why first year University students choose to 'test' or not to 'test' for HIV. Within the context of health behaviour, this study also explored the barriers to VCT uptake that poses challenges to the efficacy of HIV/AIDS campaigns in the awareness and alleviation of the epidemic in SA. Therefore, studying HIV/AIDS in relation to VCT uptake among youth at University provided nuanced insights into their health behaviours in addition to the perceived symptoms and decisions to seek, or not to seek, medical help.

This research argued that understanding whether or not youth recognise prevention benefits can only be done by a holistic understanding of the attitudes and barriers towards HIV/AIDS and VCT which helps explore reasons why youth engage in certain health behaviours. With these notions in mind, this research found a need to identify the factors that affect youth's perceptions of VCT in University. In so doing, it examined aspects that shape human behaviour, the institutional settings these factors unfold within, how it contributes to the way in which youth consider HIV-positive people and how it shapes their engagement in health-related matters thereafter. Hence, the exploration into the factors and social processes has helped understand the structure and agency of youth by providing a more nuanced understanding of their health behaviours.

From the findings it is concluded that many students know that VCT is a necessary and highly beneficial process, not only to the individual but society as a whole. As such, the overall acceptance of VCT among the students and their willingness to test is influenced by multiple factors that simultaneously work together to shape attitudes towards VCT among youth at WITS.

The use of VCT services is concurrent with students' social networks and quality of relationships and the societal attitudes and behaviours towards HIV-positive people whom they knew. The responses showed that VCT is an important process and plays a key role in HIV prevention, early detection of HIV infection as well as early treatment, care and support. In this study, VCT had further implications for 'good' health behaviours such as risk reduction among certain groups of students. This is important because with young adults at the centre of the epidemic it is useful to

understand their attitudes towards HIV/AIDS in general and VCT more specifically. This proves beneficial to understanding their reasons for and against VCT uptake and the factors that are associated with it. Furthermore, these understandings thereby shape future health promotion strategies to target youth by including them in HIV/AIDS prevention campaigns and other initiatives.

With all this in mind, VCT is an optimal characteristic of health behaviour and found to be the most important approach towards the control of HIV/AIDS as it is the entry point to the management of AIDS and its prevention. Thus, knowing ones status was a common reason for testing and also to educate and make others aware of what VCT entails. The study found that even though youth place emphasis on knowing their status there was also perceived barriers to VCT uptake as well that negatively impacts on attitudes towards VCT.

In sum, the study concludes that there are multiple factors that work together in multilayered and complex ways to shape attitudes towards VCT among youth at WITS. Though an in-depth exploration of each factor in isolation was beyond the scope of this report, it was useful to analyse against the social models of health behaviour as it proved useful to address the macro-sociological issues in a nuanced way. The results of this report therefore paves the way for future research as the factors identified is a solid base for individual examination henceforth.

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## APPENDIX

Copy of participant sheet and questionnaire for first year students

| Participant Number: |
| --- |
| Date: |

Dear: First Year WITS Sociology Student

Re: request for your participation in my Masters research

Good day, my name is Priya and I am a Masters of Arts (MA) in Health Sociology student at Wits. My study is trying to understand what factors shape attitudes towards Voluntary Counselling and HIV Testing (VCT) among first year Wits University students. For this reason I kindly seek your participation in my research.

Please note that your contribution to this study is completely voluntary and there are no rewards or penalties involved. All you are required to do is to complete the attached questionnaire. You are not obliged to answer any questions of which you are uncomfortable with and you therefore have the option to refuse to respond to any question asked. You also have the option of not completing the questionnaire at any stage you choose. As such, completing the questionnaire means that you are giving me permission to use the data for my study. All data collected will remain anonymous as you will not be asked for your personal details unless you are willing to be interviewed by me at a later stage.

**If you are willing for me to interview you as my research progresses, please fill in your e-mail address and/or contact number in the space provided at the end of this questionnaire.**

If you require any additional information, please contact me to discuss these further.

Kind regards,

Priya

Cell phone: _____

E-mail: _____

INSTRUCTIONS:

- **Do not** write your name on the questionnaire.
- **Do not** detach any pages.
- **Mark (x)** your response in the column provided- there may be more than one response.
- Please make sure you **submit the questionnaire** even if you do not complete it.

QUESTIONS:

1. What is your age? _____

2. What is your gender?

| | | | |
|---|---|---|---|
| 01= Male | | 02= Female | |

3. What is your race group?

| | | | |
|---|---|---|---|
| 01= Black | | 02= White | |
| 03= Indian | | 04= Asian | |
| 05= Coloured | | 06= Other (please specify) | |

4. What is your marital status?

| | | | |
|---|---|---|---|
| 01= Single | | 02= In a relationship and living together | |
| 03= In a relationship but not living together | | 04= Married | |
| 05= Widowed | | 06= Separated but not divorced | |
| 07= Divorced | | 08= Other (please specify) | |

5. What is your primary home language?

| | | | |
|---|---|---|---|
| 01= English | | 02= Afrikaans | |
| 03= Ndebele | | 04= Sepedi | |
| 05= Sesotho | | 06= Swati | |
| 07= Tsonga | | 08= Tswana | |
| 09= Venda | | 010= Xhosa | |
| 011= isiZulu | | 012= Other (please specify) | |

6. What is your religion?

| | | | |
|---|---|---|---|
| 01= Christian | | 02= Hindu | |
| 03= Muslim | | 04= Jewish | |
| 05= Atheist | | 06= Agnostic | |
| 07= Other (please specify) | | | |

7. Who do you share your living space with?

| | | | |
|---|---|---|---|
| 01= Both parents | | 02= Mother | |
| 03= Father | | 04= Friend/s | |
| 05= Sibling/s | | 06= Spouse/ partner | |
| 07= I live alone | | 08= Other (please specify) | |

8. Which of the following activities do you participate in:

| | | | |
|---|---|---|---|
| 01= Exercise/ Sports | | 02= Prayer | |
| 03= Internet Social Networking | | 04= Meditation | |
| 05= Smoking | | 06= Alcohol drinking | |
| 07= Study groups | | 08= Clubbing | |

9. Are you comfortable discussing sexual matters with others?

| | | | |
|---|---|---|---|
| 01= Yes | | 02= No | |
| 03= Somewhat | | 04= Not sure- it depends who | |

10. If you do discuss sexual matters with others, with whom do you talk with?

| | | | |
|---|---|---|---|
| 01= Friends | | 02= Co-workers | |
| 03= Sibling/s | | 04= Parent/s | |
| 05= Other (Please specify) | | | |

11. Do you think you are familiar with issues regarding health?

| | | | |
|---|---|---|---|
| 01= Yes | | 02= No | |
| 03= Somewhat | | 04= Not sure | |

12. What does the acronym “HIV” and “AIDS” mean?

Please write the words in full for:

HIV: _____

AIDS: _____

13. Do you know what *Voluntary Counselling and HIV Testing (VCT)* is?

| | | | |
|---|---|---|---|
| 01= Yes- I know it well | | 02= No- Not at all | |
| 03= Somewhat – I think I know | | 04= Not sure- I have an idea but I am not sure | |

14. Where do you think a person can get tested for HIV?

| | | | |
|---|---|---|---|
| 01= Hospitals | | 02= University health care centres | |
| 03= Clinics | | 04= Pharmacies | |
| 05= Doctors rooms | | 06= Traditional Healers | |
| 07= Laboratories | | 08= At home | |
| 09= Other (please specify) | | | |

15. Do you know anyone who is HIV-positive?

| | | | |
|---|---|---|---|
| 01= Yes | | 02= No | |

16. If you answered yes to question 15, what relation is this person to you?

| | | | |
|---|---|---|---|
| 01= No relation | | 02= Family member | |
| 03= Friend | | 04= Co-worker | |
| 05= Other (please specify) | | | |

17. If you answered question 16, do you know the person well?

| | | | |
|---|---|---|---|
| 01= Yes | | 02= No | |

18. Do you know anyone who has passed away due to HIV/AIDS?

| | | | |
|---|---|---|---|
| 01= Yes | | 02= No | |

19. If you answered yes to question 18, what relation was this person to you?

| | | | |
|---|---|---|---|
| 01= No relation | | 02= Family member | |
| 03= Friend | | 04= Co-worker | |
| 05= Other (please specify) | | | |

20. What images come to mind when you hear the words "HIV-positive"?

| | | | |
|---|---|---|---|
| 01= Physical appearance | | 02= Hospitals | |
| 03= Blood | | 04= Medication | |
| 05= Gender | | 06= Religion | |
| 07= Traditional healers | | 08= Bedridden | |
| 09= Death | | 010= Other (please specify) | |

21. How do you feel about HIV-positive people?

_____

_____

_____

_____

22. Briefly name how a person can get HIV?

_____

_____

_____

_____

23. How can HIV be <u>prevented</u>?

_____

_____

_____

_____

24. Do you think HIV causes AIDS?

| | | | |
|---|---|---|---|
| 01= Yes | | 02= No | |

25. Do you know of anyone who has been for VCT?

| | | | |
|---|---|---|---|
| 01= Yes | | 02= No | |

26. If you answered yes to question 25, what relation is this person to you?

| | | | |
|---|---|---|---|
| 01= No relation | | 02= Family member | |
| 03= Friend | | 04= Co-worker | |
| 05= Other (please specify) | | | |

27. Do you think they shared their experience of VCT with their family or friends?

| | | | |
|---|---|---|---|
| 01= Yes | | 02= No | |

28. Why do you think they may/may not have shared their experience of VCT?

_____

_____

_____

_____

29. Do you think there are any benefits of VCT?

| | | | |
|---|---|---|---|
| 01= Yes | | 02= No | |

30. If you answered <u>yes</u> to question 29, what do you think are the benefit/s?

_____

_____

_____

_____

31. Do you think the results of VCT are kept confidential?

| | | | |
|---|---|---|---|
| 01= Yes | | 02= No | |

32. If you answered <u>no</u> to question 31, please explain why:

_____

_____

_____

33. Would you be willing to go for VCT?

| | | | |
|---|---|---|---|
| 01= Yes | | 02= No | |
| 03= Do not know | | 04= Maybe | |

34. Please explain your answer to question 33:

_____

_____

_____

_____

35. Who do you think are more willing to go for VCT?

| | | | |
|---|---|---|---|
| 01= Males | | 02= Females | |

36. Please explain your answer to question 35:

_____

_____

_____

_____

37. Do you think your family or friends will think differently of you if you go for VCT?

| | | | |
|---|---|---|---|
| 01= Yes | | 02= No | |
| 03= Maybe | | | |

38. Do you think your family or friends will treat you differently if you were found to be HIV-positive?

| | | | |
|---|---|---|---|
| 01= Yes | | 02= No | |
| 03= Maybe | | | |

39. Please explain your answer to question 38:

_____

_____

_____

40. Do you think you will be embarrassed to speak about VCT to a health care professional?

| | | | |
|---|---|---|---|
| 01= Definitely | | 02= Maybe | |
| 03= Not at all | | | |

41. Do you know where students can go for VCT at WITS?

| | | | |
|---|---|---|---|
| 01= Yes | | 02= No | |

42. If you answered yes to question 41, please specify which facility offers VCT at WITS:

_____

_____

43. If you answered no to question 41, have you ever tried to find out?

| | | | |
|---|---|---|---|
| 01= Yes | | 02= No | |

44. Why have you not tried to find out?

_____

_____

45. How important is it for students to know their HIV status?

| | | | |
|---|---|---|---|
| 01= Absolutely important | | 02= Partially important | |
| 03= Not important at all | | | |

46. Please explain your answer to question 45:

_____

_____

_____

_____

**If you would like to be contacted by me for an interview, please fill in the following:**

Your e-mail address: _____

Your contact number: _____

Thank you very much for your time and cooperation,

Have a lovely day!! ☺