



**A STUDY OF CONDOM USE AS PART OF THE SEXUAL CULTURE OF TERTIARY
STUDENTS IN SOUTH AFRICA**

By

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DECLARATION

I *Ayanda Precious Ndlovu* declare that the research report entitled: *A study of condom use as part of the sexual culture of tertiary students in South Africa* is my own work and has not been submitted for any other degree at any other university. All sources used in this this report have been acknowledged by complete references.

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
HEAIDS	Higher Education AIDS Programme
HIV	Human Immunodeficiency Virus
UKZN	University of KwaZulu-Natal
WHO	World Health Organisation
USAID	United States Agency for International Development
UNDP	United Nation Development Program
HSRC	Human Science Research Council
UNICEF	United National International Children's Emergency Fund
HBM	Health Belief Model
ART	Anti-retroviral Treatment
STI	Sexually Transmitted Infection

ABSTRACT

In South Africa, the province of KwaZulu-Natal remains the most affected province. Additionally, South Africa faces a challenge of unintended pregnancies among young people. The issue remains a public health concern and suggests that young people are engaging in unprotected sexual intercourse. Condoms, if used correctly, are argued to be the most effective preventative strategy from both STIs such as HIV and pregnancy.

The main aim of the study was to find out the rate of condom use among college students and the motivating factors behind the rates and to uncover barriers of condom consistency.

This study employs both the quantitative and qualitative research techniques. A sample was drawn using convenience sampling for quantitative data collection. Data was collected using self-administered questionnaires with 202 students and semi-structured interviews with 6 students.

Almost 66% of the participants in this study reported having used a condom during their last sexual encounter. The dual protection the condom offers, the students' hunger for a bright future as well as fear of responsibility came up as motivating factors of condom use. No significant relationship between race, age and marital status against condom use was observed. A significant relationship was detected between gender and condom use. Condom use consistency remains a problem among students.

Condoms still remain the most effective preventive method to prevent both pregnancy and HIV infection. The increase in the level of condom use among students gives hope. More attention needs to be paid to methods and strategies aimed at increasing the levels of condom use consistency.

Chapter One

Introduction

1.1 Background to the Study

At the end of 2014 more than 40 million people were estimated to be living with HIV and AIDS in the world, with about 2 million new infections estimated to have occurred in the year (UNAIDS, 2015). Statistics show a decline in the number of new infections that occurred annually between 2000 and 2014. Globally new infections have decreased by 35% since 2000. According to UNAIDS (2015), 2 million people were newly infected in 2014, a decrease from 2.6 million in 2011 (amFAR, 2012) and 3.1 million in 2000 (UNAIDS, 2001). It is also evident that there has been a decrease in AIDS-related deaths. AIDS-related deaths have decreased by 42% globally since the peak of the epidemic which occurred in 2000 (UNAIDS, 2015). In 2000 the number of AIDS-related deaths were estimated at 2 million (UNAIDS, 2001), down to 1.2 million in 2014 (UNAIDS, 2015).

In the sub-Saharan Africa region more than two thirds of all people living with HIV/AIDS which is estimated at 25.8 million over the global infection of 36.9 million (UNAIDS, 2015). Approximately 1.4 million people in the region became newly infected in 2014 (UNAIDS, 2015). In 2014 the number of AIDS-related deaths was estimated at 990 000 (UNAIDS, 2015). This is a decline of 48% between 2004 and 2014.

South Africa has one of the highest HIV/AIDS epidemics. An estimated 6.19 million people in South Africa were living with HIV in 2015 (Statistics South Africa, 2015). In the same year 162 445 people were estimated to have died of AIDS related diseases, a decrease from 270 190 in 2011 (UNAIDS, 2012). Even though this number shows a large number of people who have lost their lives in the country due to AIDS, the number has decreased by more than 100 000 deaths since 2002 (275 444 deaths). This decrease suggests that many lives have been saved in the twelve years (2002-2014). The decrease may be a result of a number of factors such as access to basic healthcare, awareness interventions and the huge roll out of antiretroviral treatment.

The epidemic has been argued to have had an impact on the overall mortality rate in South Africa. Statistics South Africa (2009) states that the overall annual number of deaths increased rapidly between 1998 and 2006, where 316 559 and 607 184 died respectively. In South Africa the HIV prevalence is 17.3% amongst the general population, but varies a lot by regions (HSRC, 2014). KwaZulu-Natal, which is where the research is based, has been found to be the region with the highest rates of HIV prevalence. It is evident from local research that those who are shouldering the AIDS burden are mostly young adults. Approximately 32% of adults aged 15-49 years were living with HIV (HSRC, 2014). Most HIV transmissions that occur in South Africa are transmitted through heterosexual sexual activities (Kaida et al., 2010).

According to UNFPA (1999), heterosexual intercourse is the most common route of transmission of HIV in developing countries. UNAIDS (2008) state that, at least 80% of infections that occur in Africa are acquired heterosexually, while mother to child transmission accounts for less than 2% of infections and transfusion of contaminated blood accounts for about 5%. In sub-Saharan Africa injecting drug use is not very common as it is in other parts of the world, and HIV is mostly transmitted through unprotected heterosexual intercourse, with women and young people more susceptible to contracting the virus (Muula, 2008). According to the reports compiled by the WHO (2013), at the end of 2012, women accounted for nearly 54% of all people living with HIV globally.

Young people in the 15-24 age group are argued to be at a high risk of HIV infection. They account for nearly half of the world's population; almost 3 billion people are estimated to be under the age of 25 (UNAIDS, 2012). The prevalence of HIV infection among young people is worrying. According to the GNP Report (2012) of the 34 million estimated to be living with HIV in the world, 5.4 million of them are young people between the ages of 15-24. Further, the report reveals that 40% of new infections are amongst the 15-24 age group.

A number of studies reveal that more than 50% of South African young people are sexually active. According to Shisana et al. (2004), the proportion of 15-24 years olds who reported to have ever had sex ranges from 55-67%. It is evident from research that this varies across gender and age groups. Pettifor et al. (2004) found that of the total number of young people aged 15-19 years,

reporting having ever had sex was 48% compared to 89% of young people aged 20-24 years. Shisana et al. (2005) found that more women (62.3%) reporting having ever had sex than men (53.9%). In South Africa, the prevalence of HIV infection among young people is said to be amongst the highest in the world (HSRC, 2014)

The National Antenatal Sentinel HIV and Syphilis prevalence survey conducted by the Department of Health (2012) reported that 21% of youth aged 15-24 were infected with HIV in South Africa. KwaZulu-Natal has made remarkable progress in expanding access to antiretroviral treatment as well as condom distribution, which has contributed to the reduction in new HIV infections. Despite the good progress in the province, it remains the country's most affected region, with more than 1.6 million people living with HIV (Nel et al., 2012). The HIV prevalence among people aged 2 years and above (49 years) in the KwaZulu-Natal increased from 6.6% in 2002 to 8.9% in 2011. The percentage of all adults aged 15-49 living with HIV in KwaZulu-Natal was 28% in 2012 (van der Linde, 2013). According to Statistic South Africa, (2013), 24% of the total 15-24 years population living in KwaZulu-Natal was infected.

Young people in South Africa face high levels of unplanned pregnancies (Maharaj, 2006). Unwanted pregnancy among young people in South Africa has been highlighted as a major challenge facing the country (Department of Welfare and Population Development, 1998). The Department of Basic Education (2014) reported that more than 99 000 school girls out of 2 650 385 fell pregnant in 2013. This rate is a dramatic increase from that of the previous year from 81 000 school girls who fell pregnant and 68 000 in 2011. These alarming rates of pregnancy among young people may indicate that young people of South Africa engage in unsafe sexual activities. Insel and Roth (2000) argue that many health professionals consider unwanted pregnancies and STDs to be the major concerns for college students. Young women often want to avoid these unwanted pregnancies at such early ages. Safer sexual behaviours such as use of condoms may reduce the risk of occurrence of unwanted pregnancies and STD transmission (Murray et al., 2000). Apart from complete abstinence the only form of birth control that is effective in preventing both pregnancy and HIV as well other STDs transmission is condom use (Murray et al., 2000).

1.2 Preventing Strategies

“Prevention is better than cure” is a famous tag line that is normally used in HIV/AIDS adverts and campaigns in South Africa. It basically calls upon the nation to work more towards reducing the rates of new infections. HIV transmission can be prevented using different strategies. These include, improved STI treatment, sexual health provision and life skills education programmes for young people, national HIV awareness programmes, and targeted interventions for those who are argued to be more at risk, such as commercial sex workers or migrant workers (Jewkes et al., 2002). It is evident from South African research that the common mode of transmission in South Africa is unprotected heterosexual sexual intercourse. Thus condoms (male and female) become the most effective protection method for preventing the spread of HIV transmission among young people in South Africa (Jewkes et al., 2002). Condoms have a special place in prevention among young people as few are in stable partnerships, and young women in particular because of their biological make up and social factors, are more at risk of contracting STIs including HIV (UNAIDS, 2004).

Condoms are being promoted as the overall strategy to promote safer sexual behaviour, in an attempt to reduce HIV transmission (WHO, 2005). According to the Department of Health (2000), condom use was a priority area of prevention outlined in the South African HIV/AIDS Strategic Plan. The plan proposed to expand distribution of condoms through non-traditional outlets; to improve access to condoms in high transmission risk areas (e.g. truck stops, borders, mines and brothels). The strategy further aims to increase condom use as a form of contraception among young people where condoms were distributed in schools and Higher Education Institutions. In South Africa distribution of condoms lies with the Department of Health’s public sector condom programme. Condom distribution has increased noticeably from 267 million in 2001 to 845 million in 2011 (Health24, 2012). Male condoms are the most commonly available to the South African population while female condoms are not as popular as the male condoms and they are not as easily accessible (Frezelle, Jwili & Nene, 2013). Condoms have a number of benefits when compared to other strategies. Condoms prevent exposure to HIV from occurring altogether, unlike other strategies such as - ‘being faithful to your partner’ and “getting your partner to test” - that only reduce the risk of an exposure leading to infection (Crosby & Bounse, 2012). Condoms also prevent infections despite the health status of sexual partners. Moreover,

condoms are a preferred preventive strategy (Maharaj & Cleland; 2011) because it effectively prevents both pregnancy and HIV infection. This may be highly beneficial in a context where young people need help to curb the high rates of HIV and unintended pregnancies.

1.3 Overview of Condom Use in South Africa

Shisana et al.(2005) argue that condoms distributed for free (‘choice’) by the Health Department have been found to be used mostly by the population who live in the rural areas rather than urban areas, and in informal rather than formal areas. Some authors argue that this is because the ‘choice’ condoms are viewed as inferior in quality than the other branded condoms (Mulwo, Tomaselli, Dalrymple, 2009; HEAIDS, 2010).

Low perceptions of personal HIV risk and effectiveness of condoms affects use. Levels of awareness of the HIV effectiveness of condoms seem to have increased amongst young people in South Africa. A large number (60.3%) of young women aged 18- 39 who participated in a survey conducted by van Loggerenberg, (2012) reported having used a condom at least once in their sexual lives. In the same study fewer young people reported having used a condom in their last sexual encounter; with 29 % reporting to have used a condom during their last sexual encounter.

Even though the government has made condoms widely available there are still challenges in the uptake of condom use and in getting young people to use them effectively and consistently. Nyembezi et al. (2014) state that whilst the rate of condom use has been observed to be increasing condom use consistency still remains a challenge in South Africa. Condom use consistency means using a condom for all sexual encounters, this includes other sexual activities such as oral and anal sex (Cederbaun et al., 2014). The reported condom consistency among young people aged 15-24 in South Africa is argued to be even lower than the reported condom use at last sexual encounter (Nyembezi et al., 2014).

HIV infection rates serve as evidence that young people, more especially young women, have a great unmet need for protection. A study conducted by Happy et al. (2012) on youth sexual practices showed a gender difference in condom use, with figures for young men using condoms greater than those of young women; consistent with the higher levels of HIV among women.

Although two-thirds of young people reported having used condoms, males were significantly more likely to report condom use than their female counterparts (Njau et al., 2013). This is consistent with the National Youth Survey which was conducted by Pettifor et al. (2004) which showed similar gender differences in condom use, with males reporting more condom use behaviour than women (57 % and 44 % respectively). Similarly, a study conducted by the HSRC (2014) reports significant age differences in condom use with a higher percentage of males (38.6%) reporting having used a condom during last sex encounter than females (33.6%).

In addition to demographic factors, condom efficacy has been argued to be a determining factor of condom use. It is evident from research that people who are confident in their ability to use a condom are more likely to employ this preventive strategy than someone who is not confident.

Further, a study conducted by Maharaj and Cleland (2011) in KwaZulu-Natal among young college students suggests that there are differences in how people of different races, gender and age use condoms. Their bivariate analysis suggests that that race, experience of a sexually transmitted infection and sexual anticipation were important predictors of condom use for both sexes, while number of lifetime partners was significant solely for women (Maharaj and Cleland, 2011). However, it was revealed in the same study that age, partner type and use of alcohol/drugs were not associated with condom use. The results show that race was the dominant predictor of condom use, with Africans reporting much higher use and Whites reporting the lowest use. The probability of reporting condom use was much higher among men and women who reported not ever having a sexually transmitted infection. The adjusted results for women show that condom use was significantly lower among those with five or more life partners.

1.4 Justification of the Study

South African population is largely made up of young people. Nationally, youth aged 15-24 constitute about 24% of the total South African population (UNFPA, 2013). Of the total youth population, women account for about 55%, while males account for approximately 45% (Statistics South Africa, 2013).

Research that has been conducted on HIV among young people in KwaZulu-Natal shows that the distribution of HIV among young people differs by age and gender. Young people aged 20-24 continue to have the highest levels of HIV infection, and women are said to be infected at their prime age of 20-24 whereas their male counterparts get infected later, at about age 24-29 years (Department of Health, 2011).

In 2010 statistics from the Higher Education in Context Report indicate that of all young people in the 18-24 age group, approximately 20% of them were enrolled in a higher education institution (Department of Higher Education and Training, 2010). The number of males aged 18 who are attending an educational institute exceeds that of young females in the same age who are attending an educational institute (Statistics South Africa, 2013).

It is argued that the constraints of the societies in which young people grow up exposes them to high risky behaviour and attitudes (Population Bureau, 2006). Studies also suggest that university students lead lifestyles that place them at an increased risk of contracting HIV (Anarfi, 2000; Tagoe & Aggar, 2009). This is because universities provides a sense of independence, self-determination and experimentation; coupled with other factors such as peer pressure to obtain luxury items may motivate young girls to engage in transactional sex (Bazargan et al., 2000; Njagi & Maharaj, 2006; Ankomah, 1998). Levine and Ross (2000) in their survey estimate the rate of HIV infection in South African universities at 30%. In 2005 this rate increased to approximately 33%, calling for highly effective interventions (Cornelissen, 2005). An HIV survey conducted by HEAIDS (2009) at the University of KwaZulu-Natal revealed that 675 students out of the 1317 that were surveyed were infected. These results are shocking and highlight the need for major intervention.

Studies on condom use demonstrate that condoms are an effective preventative strategy if used correctly and consistently. Studies measuring condom use consistency report lower rates. Thomson et al. (1996) states that there has been a lack of regular or consistent condom use among college going students which is observed through descriptive studies that look at sexual activity and condom use among college students. The study conducted by Thomson et al. (1996) indicates that about 38% of students reported using condoms during every sexual encounter.

Moreover, data from a nationally representative sample of 15 to 25 year old South Africans revealed that about 39% of young men and 29% of young women reported always using a condom with most recent partner (Pettifor et al., 2005).

This highlights the urgent need for a study of this nature that looks at the facilitators of condom use as well as barriers of condom use consistency among students. Factors which inhibit condom use have received considerable universal research attention, while little research exists on factors which may act as facilitators of condom use among young people. This research seeks to explore and examine factors which may encourage young people to use condoms. A number of studies (Manlove et al., 2003; Maharaj and Cleland, 2011; Maharaj, 2006) show that there are other driving factors to the increase in condom use among young people apart from just protecting themselves from HIV infection. People may have different definitions of condom use as they may have used condom for other purposes, such as making a ball with them or blowing them up as balloons; a strategy used to normalize condoms and remove the stigma attached to them. It should be made clear therefore that condom use in this regard means using condoms during sexual activities as protection from HIV transmission as well as unwanted and unplanned pregnancy. This research study will follow on a similar study which was conducted by Maharaj and Cleland (2006) among college going students in Durban.

1.5 Overall Aim of Study

The overall aim of the study is to examine condom use among students in Durban, South Africa.

The specific objectives of the study are to:

- Determine levels of condom use at last sexual intercourse among students.
- Investigate the socio-economic and demographic determinants of condom use.
- Examine facilitating factors of condom use among South African college youth.
- Examine factors that hinder consistent use of condoms.

1.6 Theoretical Framework

The theoretical framework of the study draws heavily on the health belief model. The health belief model (HBM) is a psychological model that was originally developed by Rosenstock (1966). It has been widely used to explore the relationship between health beliefs and behaviour in various contexts. The model attempts to explain and predict health behaviours by exploring reasons why individuals become encouraged or discouraged to participate in prevention programmes. This is done by focusing on the individual's personal perceptions which is influenced by a whole range of intrapersonal and interpersonal factors affecting health behaviour e.g. attitudes, beliefs, knowledge, motivation, skills and developmental history. There are four main perceptions which can be used to explain behaviour according to this model namely; perceived seriousness, perceived susceptibility, perceived benefits and perceived barriers. All these variables or perceptions may be influenced by demographic variables such as race, age structure, gender, age, ethnicity, socioeconomic status, educational level, experience, motivation and skill.

This model posits that people become concerned and thus respond to preventive programmes if they perceive that they might be susceptible to a certain condition (e.g. HIV or pregnancy), that there will be serious consequences if they do not respond, if they believe that there may be reduced susceptibility if they participate in preventive programmes (perceived benefits) individuals might be more responsive to the preventive programmes (e.g. condom use). Even though there might be perceived barriers and individuals might think responding may not make a difference in their condition there are other external factors which may come to play to change this perception, factors such as the media, motivation from others and self-efficacy.

The HBM applied to the current study would predict that condom use would be linked to the high levels of perceived threat to contracting HIV and fewer perceived barriers than benefits of condoms. Condom use will in turn be positively linked with the level of importance of being a healthy individual. It highlights the important factors that may come to play, leading to an increase in the numbers of students who use condoms. Students may come to a decision of using a condom as an HIV preventive strategy if they believe that there is a chance of them contracting HIV should they decide otherwise. Further, understanding that being infected with HIV or even

getting pregnant may come with serious consequences which may also greatly encourage students to condomise. Moreover, knowing that using a condom is beneficial t may greatly decrease the chances of one getting infected with HIV and other STIs as well as getting pregnant may make students want to use condoms more.

Previous studies have argued that susceptibility is not the major contributing factor for safe sexual behaviour (Bandura, 1992; Conner & Norman 1996 and Sheeran & Abraham 1996). The authors continue to argue that it is reasonably the perceived benefit of engaging in safer sexual behaviour that is the main contributor and determinant.

The HBM, like any other theory, has shortcomings. Brown et al. (1991) state that this model may be insufficient to study condom use among youth because it overlooks certain factors that may play a role in influencing youth behaviour. The factors include emotional reaction, peer group influences and influence of development and development constructs. This notion is supported by research conducted by Abraham et al. (1992) which established that variables outside those specified by the HBM predicted HIV prevention intentions. A conclusion they reached was that, although the variables specified in the model are useful predictors, there are other essential predictors not accounted for in the model.

An additional shortcoming that is frequently referenced is that, the HBM has not really evolved over the years. According to Sheeran and Abraham (1996), it has not undergone any real conceptual reformulation, considering the advances in research globally - except for the addition of self-efficacy in 1988 (Rosenstock, Strecher & Becker, 1988). Regardless of the limitations of the model, the HBM has a number of strengths that are very useful to employ in health prevention, particularly, in condom use. One of which is that it was developed by researchers working directly with health behaviour (Conner & Norman, 1996). Further, the model provides researchers with a useful theoretical framework that consists of core variables that are essential predictors of health behaviour – which have also been incorporated successfully into other cognate theories of behaviour, such as the theory of reasoned action (Ajzen, 1988).

1.7 Outline of the Dissertation

This dissertation is made up of five chapters. The first chapter gives an introduction, background and the aims of the study. Further, it looks at the theoretical framework employed. The second chapter covers a review of literature. In the third chapter the study method is outlined. Chapter four outlines the results and findings of the research study. The discussion, conclusion and recommendations are captured in chapter five.

Chapter two

Literature Review

2.1. Introduction

Youth in the contemporary South Africa are said to be facing escalated rates of HIV/AIDS and the South African Department of Health (2003) states that these high HIV infections are a result of risky heterosexual behaviour of young people. This is supported by the General Household Survey conducted in the year 2012 which reported high rates of adolescence pregnancies - 11.6% and 12.1% of girls aged 17 and 18 respectively, were pregnant during the 12 months prior to the survey (Statistics South Africa, 2013). The survey also suggests that the average pregnancy prevalence for adolescents aged 13 to 19 in 2011 was estimated at 4.9%. This may mean that a lot of young people in South Africa do not use condoms even though condoms are a widely available contraceptive which gives dual protection (Harrison & Xaba, 2001); protects against both unwanted pregnancies and sexually transmitted diseases like HIV.

Prevention programmes have been designed and implemented with an aim to prevent uninfected people from becoming infected as well as preventing those who are already infected with HIV from being re-infected. The ABC (Abstain, Be faithful and Condomise) prevention programme is one that has been highly praised in some parts of the world (Gacoin, 2010). When the ABC campaign was in its early stages of implementation more emphasis was put on the first two strategies but not so much on condoms. Gacoin (2010) states that condoms were presented as the last resort for people who fail to abstain or stay faithful to their partners. This somehow introduced a stigma associated with condoms and people who carry them. However, recently more emphasis is being put on condom use as an effective strategy for preventing the sexual transmission of HIV infection in the absence of a cure. Although condom use has, over the years been one of the main HIV-prevention strategies used successfully in the country, especially among young people, in 2012 condom use at last sexual encounter by both males and females across all age groups appeared to have decreased to 36.2% (HSRC, 2014). These levels are

similar to those that were recorded in 2005 (35.4%) by UNAIDS (2011), a peak having been observed in 2008 (45.1%).

This chapter will explore the different types of condoms and their effectiveness, perceptions of condoms as well as barriers and facilitators of condom use.

2.2 Types of Condoms

Male condoms are also referred to as rubbers or love gloves. They are made of latex, a rubber which comes from the tapping rubber trees in Brazil, South East Asia and West Africa (Goodyear, 1958). Other ingredients such as potassium laurate (a stabilizer) are added to make the latex stronger and hard to break. Before condoms are distributed they undergo a process of being checked and rechecked for strength. The latex condoms are declared 99% safe if they are used correctly (Hearst & Chen, 2004). They protect against pregnancy and sexual transmitted diseases such as HIV/AIDS. Polyurethane (a strong thin plastic) condoms are recently available. These can be an alternative for people who are allergic to latex; they are reported to be effective in protecting against pregnancy and STIs but they also break easy (Billy, 2009). Another type of condoms is made of lamb skin and is normally referred to as the “natural condoms”. These are more expensive and less effective in preventing the spread of STIs because that they have large microscopic openings which may allow for infection to occur (Billy, 2009).

The female condom is 17cm long with two flexible rings situated at each end of the condom. One ring is inserted into the vagina to keep the condom in place while the other stands outside allowing part of the condom to cover the outer part of the vagina, thus protecting it from other STIs. It comes lubricated, but water-based lubrication can be used if extra lubrication is preferred. The original version of the female condom was made of polyurethane. This type of plastic was expensive, so the inventors of the female condom produced the second version of the female condom using synthetic nitrile (cheaper material). The material change was announced in 2005 and the full transition of the product line to FC2 was done by October 2009 (Leeper, 2011). Female condoms made of latex are recently found and are said to be shorter than the other female condoms; they are 9cm long (Ruminjo et al., 1996).

The female condom was introduced more than 18 years ago as an alternative to the male condom (Hoffman et al., 2004). According to Dawn (2009) the female condom was introduced to enable women to have greater control over their own protection from disease. The polyurethane material of the condom is highly effective in preventing both pregnancy and transmission of STIs. Laboratory studies have established that the female condom can be as safe as the male condom if it is used correctly (Dawn, 2009). There has been some evidence which suggests that the polyurethane female condom can be washed, disinfected and reused. Reusing the polyurethane female condom is not considered as safe as using a new one, however McIntyre et al. (1998) state that new unused female condoms were subject to seven cycles of disinfection (using bleach), washing, drying and re-lubrication.

2.3 Effectiveness of Condoms

For condoms to work against HIV/AIDS they must be effective, meaning sexually active people should use them (Hearst & Chen, 2004). Effectiveness of condoms refers to how well the method works (Darrow, 1989) and is measured by consistency and correct use of condoms. Consistency means using a condom for every sexual encounter. The consistent use of condoms is argued to be effective for reducing HIV sexual transmission. Davis and Weller (1999) states that mathematical models of HIV suggest that a small number of people who use condoms consistently can have a greater impact in reducing HIV transmission than a large number of people who use them inconsistently. Condom research has revealed that condom consistency is a major problem more especially in long-term relationships (Beksinska et al., 2013). A couple may use a condom in the early stages of a relationship and as they get used to each other trust for each may build up and condoms may discontinue being part of the relationship. Consistency also relies on the distribution system that provides condoms for individuals (Morwane, 2010) and if the system is not reliable then this may distract consistency. For instance if an individual gets condoms from a public health facility, the facility should not run out of supply.

Promotion of condom use had played a major role in successful AIDS control programmes, especially in regions where exclusive or 100% condom programmes are adopted. Ford and Koetsawang (1999) state that in Thailand there was an increase in HIV transmission and the

spread of HIV was attributed to the country's large sex industry, when this was realized the health officials responded with a 100% condom programme that instructed brothel owners to enforce condom use for every paid sexual act. According to UNAIDS (2000) this response is responsible for the decrease in STI transmissions and HIV prevalence rates in Thailand. Condom use has increased in many parts of the world including South Africa which is said to be having one of the highest HIV prevalence rates. Data from the HSRC (2014) suggest that the epidemic seems to be leveling off. According to Shishana et al. (2014), HIV-incidence rate among individuals aged 15–49 years was 2.2 % in the period 2002–2005. HIV incidence in this age group remained at a slightly lower level of 1.9% in the subsequent periods 2005–2008 and 2008–2012. HIV incidence among youth aged 15–24 years, however, declined steadily over the three inter-survey periods, from 2.8% in 2002–2005 to 2.3% in 2005–2008 to 1.5% in 2008–2012. The proportion of the population reported to be using condoms at their most recent sexual encounter was found to have increased.

2.4 Barriers to Condom Use

Condoms are an important part of HIV/AIDS prevention because as discussed above; correct use of them reduces the risk of contracting HIV by almost 99% (WHO, 1995). The World Health Organization (1995), states that this is the reason why condom promotion has received so much attention in the fight against AIDS. This is particularly important in sub-Saharan Africa where it has been reported that the common mode of HIV transmission is sexual contact (Muula, 2008; Jung et al., 2013; Kaida et al., 2010). However widespread condom use has been said to be the most difficult issue to address in designing programmes aimed at reducing sexual transmission in Africa (Eshetu et al., 1997). People either use or don't use condoms. This decision doesn't just lie with the individual; other factors may influence the decision to use condoms. Gender inequalities and gender roles are culturally defined and may act as barriers to condom use. Most cultures especially African cultures are patriarchal and women are expected to be desexualized, passive and submissive (Delius & Glaser, 2010). Their main role is to please the man and let the man take control over the sexual relationships. If women are not in the position to initiate sex they certainly are in no position to negotiate or even suggest using a condom. Thus the decision lies entirely with their male partner. There are issues of pleasure as well; according to Gacoin

(2010), sexual behaviour is a result of seeking pleasure. Condoms are known to reduce pleasure (Randolph, 2007) and therefore people may feel they undermine the purpose of engaging in sex. The perceived pleasure deficit associated with using a condom may demotivate people from using condoms. The results of the study provide evidence that many people believe that condoms reduce sexual pleasure and that men, in particular, who believe that condoms decrease pleasure are less likely to use them. This is an indication that some individuals still view condoms as a barrier to experiencing real pleasure. Socio-economic status of women may make them less powerful in negotiating condom use in relationships when they depend on their partners for financial support. Condom use may also be determined by the nature of a relationship. Recent surveys conducted in African countries suggested that condom use has increased faster in less committed relationships than in more committed relationships (Kamya et al., 1997). This is consistent with a finding from a study conducted by Matser et al. (2014) that suggests that couples in committed relationships use condoms only 14% of the time, as opposed to casual couples who reported using condoms 33% of the time. This means that there is less condom use among married and/or cohabitating couples. Cohen and Trustsell (1996), state that there is a widespread resistance to condom use among people who are in committed relationships. These inhibiting factors are discussed in detail below.

2.4.1 Discriminatory Policies

According to Shisana and Simbayi (2002) the HIV/AIDS epidemic emerged in South Africa around 1982. The country at that time was in the midst of horrible apartheid policies. The issue of HIV/AIDS was therefore ignored (Burgard, 2004), as there were more pressing matters. Furthermore the policies that were in place during apartheid denied black African people to access quality health care (Burgard, 2004) and since 79% of the total population in South Africa was black Africans (Burgard, 2004) the outcome was bound to be a rapid increase in the spread of HIV, particularly among this sector of the population. Burgard and Kunosoki (2009) argue that young black South Africans health beliefs, relationship characteristics and condom use have been shaped by the country's history of institutionalized racially discriminatory policies. During apartheid all life chances and access to resources was determined by the racial group you belonged to. The majority of the black population was offered the fewest educational and employment opportunities, while the minority white population practically controlled most of the

country's resources and political power (Treiman et al., 1996). Furthermore, black South Africans were constrained residentially as they were allocated into segregated under resourced areas. This meant that in order for black people to make ends meet they had to move to find jobs. This social and political history played a major role in shaping sexual relationships among black South African youth. In a lot of families, males, especially fathers would migrate to areas where they would find jobs and make money to support their families. The male role of being a sole breadwinner in the house automatically made males more important figures in the households and therefore their hard work had to be rewarded. Since a man's job was to support the family it was a woman's duty to please a man at all times. This gender role socialization was then passed on from generation to generation and today it shapes how males and females relate to each other and in turn shapes the dynamics of romantic and sexual relationships. This created gender power imbalances between a man and a woman in a relationship. These hidden power relations are of significance to sexual relationships. They play a highly important role during decision making about whether or not the condom is used during a sexual encounter. It is usually the male who has the deciding rights (Ulin, 2001).

2.4.2 Gender Dynamics

A study conducted in the United States by Abma et al. (1998) on young women's degree of control over first intercourse suggests that the majority of young women never really wanted to have sex when they started having sex. In their research they used a nationally representative sample of 20142 women aged between 15 to 24 years. The study looked at different variables such as first intercourse, family history and risks factors. The study highlighted research on the issue of involuntary sexual experiences due to pressure from partner. The study revealed that young black women were more likely to rate their first sexual experience as least wanted. Black women experienced higher rates of involuntary sex than White women (11% to 18%). A significant inverse relationship between age of male partner to girl and girls rating the experience as less wanted was also found (Abma et al., 1998). This means that the older the male the less likely the girl wanted the sexual experience. This highlights that males have major influence on the decision made in sexual relationships (Abma et al., 1998). It also shows that women especially black women possess less power and opinion in the relationships they are engaged in. This can be linked to the decision to use condoms during the sexual encounter in a relationship.

Since males have more say and are usually the ones to initiate sex, they are the ones who have final say over the use of condoms. In a study by Treiman (1999), girls who rated first experience as least wanted were less likely to use any form of contraception. Because men have more power in relationships some women may be coerced into sexual activities and according to Jewkes et al., (2002) there is a link between forced sex and sexual ill health due to condom use resistance. This link is confirmed by a study which sought to show an association between forced sexual initiation and the risk of pregnancy (Jewkes et al., 2001). Jewkes et al. (2001) in their study investigated factors associated with pregnancy among young women. They found that 30% of pregnant young women reported having experienced forced sexual initiation and that 97% of all pregnancies were unwanted. This means that young girls lacked control over their relationships and in turn lacked power of negotiating condom use to avoid the unwanted pregnancies (Vundule et al., 2001). A cross-sectional stratified household survey was conducted by Pettifor et al. (2004) to investigate the effect of sexual power on the woman's likelihood to use condoms consistently and risk for HIV infection. The study used a sample of 4066 sexually active females between the ages of 15 to 24. The study revealed that having low relationship control and being forced to have sex were strongly associated with inconsistent condom use among young women (Pettifor et al., 2004). These results are also aligned with those found by Pulerwits et al. (2002) which suggest that low levels of relationship power inhibit American women's ability to negotiate condom use with their partners successfully. Male threat or forced sex was highlighted and identified as the main predictor of inconsistent condom use (Hoffman et al., 2006). Another study conducted in Uganda to determine gender dynamics in intimate relationships of rural youth that contribute to risk for HIV infection among 50 young males and females also supported the notion that forced sex inhibits condom use (Hoffman et al., 2006). Young women who had been coerced to have sex reported less condom use than those who had not been coerced (13% and 33% respectively) and less likely to report constant condom use (Hoffman et al., 2006).

2.4.3 Type of relationship

With the false impression of fidelity among supposedly HIV-negative couples, health providers see marriage as a risk factor for HIV infection (Smith & Watkins, 2003). Married monogamous women are highly vulnerable to HIV infection due to their lack of power in marriages,

difficulties negotiating safer sex, extended partner absence and domestic violence (Sinding, 2005). According to Newman et al. (2000), the majority of newly infected women in sub-Saharan Africa have been infected within marriage by their husbands. This trend of HIV infection is reflected globally. In Cambodia 50% of all married women who contracted HIV in 2002 were infected by their husbands (Nakamura et al., 2002). Hall (2009) and Dunkle (2008) state that in the sub-Saharan Africa marriage is perceived as increasing the individual's chances of HIV infection especially among women. These women understand the "BE FAITHFUL" part of the ABC prevention strategy. However, they fail to understand that being faithful only prevents HIV infection if both partners in a relationship are faithful and are HIV-negative.

Although condoms are highly effective at preventing unwanted pregnancies and infections, research shows that it has not yet gained popularity among married couples. Data from the DHS shows that condoms are used by less than 6 percent of married couples in the sub-Saharan Africa. This may be due to the fact that condoms have been associated with negative images, especially when used within stable unions such as marriage (Muhwamva, 2007). A study conducted by Reid (1996) in South Africa revealed that individuals view condoms as something which should be considered only when having sexual intercourse with extra-marital sexual partners referred to as "back-pockets partners" and not for spouses. A Demographic and Health Survey (1999) conducted in Zimbabwe showed that only 1% of women who were currently married at that time reported having extra-marital affairs in the last 12 months prior to the survey, compared to 16% of married men who reported extra-marital sexual activity in the last twelve months. This suggests that a lot of women may think that their husbands are being loyal as they are and may then have little motivation to take protective measures such as negotiating for safer sex. On the contrary, some married women may be aware of their husband's extra-marital relationships but may fear to act on or question their husband's behaviour. A study conducted in Zimbabwe among 72 HIV positive women concluded that women do not question their husband's extra-marital affairs and that STIs and HIV are accepted as the risk of marriage life (Muersing & Sibindi, 1995). In contrary, the findings from a study conducted by Shishana et al.(2014) suggest that HIV prevalence was found to be higher in the unmarried, co-habiting population than in the married population. This may suggest that the dynamics of condom use among married couples in South Africa has changed. In Kenya condom use rates are low and

condoms are mainly used with casual partners. 1.5% of women and 16% of men reported to be currently using condoms by 1998 (KDHS, 1998). A study conducted in Kenya by Bouni and Jarabi (2000) on a randomly selected sample of 1422 sexually active male and female respondents between the ages of 18 and 49 to explore condom use among married couples, gives evidence that men refrain from using condoms in marriage but are willing and actually use condoms in casual sexual relationships they engage in outside of marriage. A male respondent was quoted saying “you mean with my own wife? There is no need of using condoms. People use condoms with prostitutes” (Bouni & Jarabi, 2000). The main reason for resistance to condom use, highlighted from focus group discussions was the negative associations of condom with promiscuity. The majority (68%) of respondents who were not using condoms agreed with the notion that condoms encourage promiscuous behaviour and 58% agreed with the notion that the only reason to use a condom is that you don’t trust your partner (Bouni & Jarabi, 2000).

The results of this study are aligned to the findings of Knodel and Pramualratana (1996) which looked at prospects for increased condom use within marriage in Thailand. One major barrier to condom use that was identified was that the suggestion of condom aroused suspicion among partners. Since condoms are normally seen as a means to prevent the spread of disease, the suggestion by either spouse to start using condoms during marital sex is likely to raise suspicion of infidelity and may imply that there is a risk of infection with STDs (Knodel and Pramualratana, 1996). This would therefore raise questions about the origin of this risk. Furthermore, a study by Maharaj and Cleland (2004) on condom use within marital and cohabitating partnerships revealed the very same results about the inappropriateness of using condoms with a spouse. According to Maharaj and Cleland (2004) respondents felt that condom use was more acceptable in non-marital than in marital unions, with more men agreeing to this perception than women. 43% of men and 60% of women found it acceptable to request that their husbands use a condom (Maharaj and Cleland, 2004).

This mentality and perception is shared by young people, even those who are not married but are involved in long- term committed relationships. According to a study conducted by Hendriksen et al. (2007) on predictors of condom use among the youth in South Africa, trust and commitment are associated with decreased condom use in South Africa. In their study,

participants who were married or had been involved in a relationship for six months and longer were less likely to have used a condom during their most recent sexual intercourse (Hendriksen et al., 2007). Studies by Runganga (1992) and Matshalaga (1999) found that condom use is almost non-existent among married couples or people in steady relationships, because it is viewed as an indication of lack of trust or that the partner requesting a condom is already infected.

2.4.4 Socio-economic Status

Poverty is directly linked to HIV (Wojcicki, 2005); socio-economic circumstances can influence the use of condoms in sexual relationships. According to the International Center for Research on Women (2014) women make up two thirds of the world's illiterate people. This means that most of the women are employed outside of the formal sector, in jobs characterized by income insecurity and poor working condition (Rees, 1998). Varga (1997) argues that since economic opportunities tend to be greater for men than they are for women, women may get involved with sexual partners for the economic support their partners can provide for them. A qualitative study conducted by MacPhail and Campbell (2001) reported that men engage in sexual relationships primarily to fulfill their sexual desires while women cited economic support as the main reason for their sexual relationships. A lot of women in the black community face severe economic difficulties, which may make women relinquish condom use to maintain financial support and continued aid for their partners (Burgard et al., 2008).

Women's economic vulnerability and dependence on men increases their vulnerability to HIV infection by constraining their ability to negotiate the use of a condom, discuss fidelity with their partners or leave risky relationships (Campbell, 1995; Eaton et al., 2003). Underdevelopment, lack of economic opportunities in the distribution of power, resources and responsibilities between men and women create a risk environment that supports high level of HIV infection (Kreuger et al., 1990). A good example of this perception is a study of low income women in long term relationships in Mumbai, India. The women who were respondents in this study reported that the economic consequences of leaving a relationship that they perceived to be risky were far worse than the health risks of staying in a relationship (UNIFEM, 2000). According to Eaton and Flisher (2000) power imbalance in heterosexual interactions leads to a

culture of silence that surrounds women's sexuality and this may restrict women's access to information about their bodies and about sex. This lack of knowledge may in turn make women unable to protect themselves from contracting HIV. These findings are in line with the study by Shishana et al. (2014) that rural women from South Africa reported not liking condoms because they feared that if the condom fell off inside their vagina it could get lost and perhaps travel to the throat or other parts of the body.

Studies conducted by Wilkins et al. (1991) and Gregson et al. (2001) suggest that men with access to resources, including those who are employed have more chances of getting a greater number of female partners, because they have a disposable income and as a result, are at increased risk of HIV infection. Furthermore, Colvin et al. (2000) state that some women often feel the need to take on more than one partner to defy economical constraints, which increases their chances of HIV infection.

A study conducted by Chimbidi et al. (2010) on socio-demographic determinants of condom use among 3914 sexually active young people between the ages of 15-24 in rural KwaZulu-Natal, found that belonging to a family with middle or high socio-economic status to be a positive determinant of condom use. In the same study a relationship between education status and socio-economic status was tested and it was revealed that there is a positive significant association between educational levels and socio-economic levels. The results suggest that belonging to higher socio-economic status household can afford one the ability to comprehend HIV prevention messages i.e. condom use (Chimbidi et al., 2010). One other finding was that those who are better off socio-economically are in a stronger position to negotiate for safer sex practices which include condom use than those with lower socio-economic status and are also more likely to be older than their partners (Chimbidi, et al., 2010).

Having an older partner is associated with lower odds of condom use and less consistent use among young women (Burgard & Kunosoki, 2009). Power inequalities in relationships may mean that older partners are more likely to make decisions in relationships than younger partners, and are also less likely to use condoms (Dorrington, 2004). Although this notion of having older partners for financial security is highly associated with women, there are males in low socio-economic societies who are with older women for financial support they offer (Jenkins

& Thomas, 2000). There is a fast growing trend among young males to date older women; In South Africa these young males are named after a famous cartoon character called Ben10 (ENCA, 2016). Despite condom use being male driven, young men may find condom use with older partners reduced because of socio-economic gain that usually follows from such age differentials in relationships (Hallman, 2005).

2.4.5 Lack of Accessibility

The ability to access condoms remains a hurdle to their use, despite the fact that they are freely distributed in South Africa. According to Abdool Karim and Abdool Karim (2010), one of the most fundamental barriers in South Africa is the poor availability. A study that used young men and women to assess accessibility of condom use in KwaZulu-Natal found that in the 10 of the 12 clinics there were condoms available, but actually accessing condoms proved difficult. The female respondents complained about the lack of privacy, thus they felt intimidated by the clinic staff who disapproved of sexually active young women (Little et al. 2002).

2.5 Facilitating Factors for Condom Use

A lot of research has focused on factors which hinder condom use among young people. However, there is evidence which shows that there is an increase in the rates of condom use among young people (Hendriksen et al., 2007). A person's attitude towards condoms and their opinions about the use of condoms are significantly correlated with actual condom use among college students (Peltzer, 2000). It is therefore mandatory that determinants of condom use among young people be explored. Thato et al. (2003) states that identifying the determinants of young people's condom use is important for designing effective HIV preventive interventions, because as Joseph et al. (1991) argue that consistent condom use during sexual intercourse is the most effective HIV preventive measure among sexually active youth. In an effort to understand condom use behaviour, researchers have attempted to identify factors that may influence a person's decision to use a condom. There are studies which have identified some factors which act as facilitators of condom use among college going young people. These include condom use self-efficacy (Kwok et al., 2010; Asante & Doku, 2010; Baele et al., 2001), belief by young people that condoms effectively prevent HIV transmission (Maharaj & Cleland, 2006; Manlove

et al., 2003; Meekers & Klein 2002) and the dual protection that condoms offer (Maharaj & Cleland, 2006; Manlove et al., 2003; Meekers & Klein 2002; Williams et al; 1999). College students are not immune to social pressure (Schuster, 1998), so it is not a surprise that perceived social norms has been found to be a significant predictor of frequent condom use (Hoque and Ghuman, 2012) and risky sexual behaviour among college going students (Zembe et al., 2012). These facilitating factors will be discussed in detail below.

2.5.1 Self-Efficacy of Condom Use

Self-efficacy is said to be the most important prerequisite for behaviour change in Bandura's theory (Bandura, 1986). Self-efficacy refers to one's confidence to carry out a specific behaviour (Bandura, 1986) and is associated with a number of health behaviours including behaviour to prevent HIV transmission (Asante & Doku, 2010). Condom self-efficacy is defined by Kwok et al. (2010) as a person's confidence in their ability to use a condom correctly under a variety of circumstances. Condom use self-efficacy has been argued to be a significant predictor of condom use among college going students (Brien et al., 1994; Mahoney et al., 1995; Wulfert & Wan, 1993). Even though self-efficacy can be clearly defined in general terms there have been difficulties in coming up with a universal explanation and measurement of self-efficacy (Gist & Mitchell, 1992). Most research studies have identified variables such as technical skills, purchasing and carrying of condoms as well as proposing and convincing a partner to use condoms as the most important and relevant variables of measuring condom self-efficacy (Kwok et al., 2010; Asante & Doku, 2010; Baele et al., 2001). The studies highlight that males are better at technical and purchasing skills, while females score higher on communication skills (Kasen et al., 1992; Joffe & Radius, 1993; Shishana et al., 2014). However, the main argument is that the higher the condom use self-efficacy score the more likely it is that condom will be used (Kwok et al., 2010; Asante & Doku, 2010; Baele et al., 2001).

A study conducted by Buele et al. (2001) on condom use self-efficacy among 428 young people between the ages of 17 and 22 confirmed the above discussed argument. In the study self-efficacy of condom use was measured using a global condom use self-efficacy scale which consisted of three general statements about the perceived ability to use condoms in the future with a new partner: "I think I would succeed in using a condom when I have sex with a new

partner” and “I am not sure I could use a condom when I have sex with a new partner” as well as “I would find it difficult to use a condom when having sex with a new partner” (Buele et al., 2001). Specific condom use was measured using 37 items about skills necessary for condom use, such as buying and carrying condoms and communication skills (Buele et al., 2001). Findings from this study suggested that the higher the Global Condom Use Self-efficacy score the greater the chances of condom use. Those who reported condom use consistency scored high on the Specific Condom Use Self Efficacy Scale.

The results yielded by a study by Buele et al. (2001) study are in line with the findings of DiIorio’s et al. (2000) study among 1380 sexually active college going students between the ages of 18 to 25 on condoms and self-efficacy. The results of the study suggested a direct relationship between self-efficacy and condom use behaviour. The findings of this study confirms that college students who express confidence in using condoms were more likely to use condoms than the less self-efficacious participants (DiIorio’s et al., 2000). Another study in Ghana among college students yielded the same results on self-efficacy and condoms (Kwako & Doku, 2010).

Furthermore, a cross-sectional survey conducted by Peltzer (2000) among South African University students on factors affecting condom use found that condom use self-efficacy was associated with decreasing age, past condom use and condom use intentions. High condom use self-efficacy was found within the four items: easily convince a partner to use condoms, suggest using a condom, discusses condom use and successful use of condoms (Peltzer, 2000). Condom use self-efficacy was also associated with decreasing age; younger ages reported more confident to put on a condom, carry a condom and suggest using it (Beksinska et al., 2012). Those with high condom use self-efficacy also reported intentions of using condoms in the future.

2.5.2 Dual Protection

There has been research that has indicated an increase in condoms among college going students because of the dual protection they offer (Murray et al., 2000; Maharaj, 2006; Maharaj & Cleland, 2006); preventing both pregnancy and HIV infection.

A study conducted by Campbell et al. (1992) indicated that 75% of college students reported having used a condom during their last sexual encounter because they believed that condoms are

effective in protecting them from STDs and pregnancy. Another study conducted by Maharaj (2006) confirms the argument that young people actually use condoms because of the dual protection condoms offers. According to Maharaj (2006) 64% of condom users overall used this method for dual protection against both pregnancy and STIs, including HIV; the proportion was similar among men and women (63% and 66% respectively). Maharaj and Cleland (2006) conducted a similar study among college going youth, which highlighted that condoms were well known and a highly popular method in the majority of participants with more than 75% stating that they were aware of the dual protective benefit of condoms. Furthermore, their findings suggest that the condom was primarily being used as a method of preventing pregnancy (Maharaj & Cleland, 2006). These findings are consistent with findings of Murray et al. (2000) on birth control and condom usage among college students. The results of the study reveal that 88% of the students used condoms to prevent unwanted pregnancy as opposed to preventing HIV infection (Murray et al., 2000). The results of this study show that college students are more worried about getting pregnant hence they use condoms primarily for preventing unwanted pregnancies.

2.5.3 Belief in Condom Effectiveness

A person's attitude towards condoms can be a great deal maker. How young people perceive condoms can determine whether they will use condoms or not. According to Meeker & Klein (2002) perceiving condoms as an effective method to protect one from contracting HIV can be strongly associated with a high prevalence of condom use. A South African Demographic and Health Survey (SADH) conducted by the Department of Health (2007) revealed that beliefs and attitudes held by youth about condoms are predictors whether or not one intends to use this method of contraception, with 75% reporting strong beliefs in condom effectiveness also reported using condoms with their partners.

2.5.4 Condom Convenience

The popularity of condoms as a birth control method among young people is due to its convenience of use (Cederbaum et al., 2014). The advantages pointed out by adolescents that participated in the study included affordability, accessibility and lack of side effects. Further, some male participants eluded that condoms assisted in the prevention of premature ejaculation.

2.6 Summary

HIV prevalence remains a major health crisis among young people in South Africa. In the absence of a cure, prevention remains the best strategy to halt the HIV rates. To reduce the incidence of HIV transmission among young people, youth oriented reproductive health programmes have been implemented. However, a lot of focus has been on barriers of condom use. It is therefore about time more attention is paid to facilitating factors of condom use and further, more emphasis be put on those areas during prevention programmes development and implementation. Since condoms are effective for preventing both unplanned pregnancies and HIV/AIDS, condom distribution and promotion can play an important role in decreasing the occurrence of unplanned pregnancies and HIV rates. The literature review points to the need for HIV prevention efforts to fully take into consideration the issue of contraception. Moreover, the most important lesson offered by the reviewed literature is that it is no longer possible to deal with the risk of unplanned pregnancy and HIV among young people separately because of the dual protection condoms offer. It is therefore important for programme managers and policy makers to understand factors which facilitate condom use among young people in order for them to implement relevant and effective programmes.

Chapter Three

Methodology

3.1 Introduction

The study draws on both qualitative and quantitative data collection methods. It is an exploratory study that uses primary data its main source of data. This chapter covers the research design used in the research study. It discusses the sampling and data collection procedures that were employed when the research study was conducted. Moreover, it goes on to discuss the data analysis procedures, ethical considerations as well limitations of the study at hand.

3.2 Study Context

The University of KwaZulu-Natal (UKZN) is an institution of higher learning that is globally recognised. The institution is a merge of five campuses, one of which is the Howard College Campus - where the study was conducted. Howard College Campus is situated in Durban, Manor Gardens. Durban is part of the eThekweni Municipality located on the East of South Africa in the Province of KwaZulu-Natal (eThekweni Municipality IDP, 2014/2015). According to the eThekweni Demographic Survey (2011), the population size of Durban alone was estimated at 3.01 million. Census 2011 highlights that Durban is a young population, with 66% of its population below the age of 35.

Firstly, a cross sectional survey was carried out which measured the frequency of condom use among students. A survey was carried out in the form of self-administered questionnaires. A survey is defined by Cozby (2004) as a detailed inspection or investigation which employs questionnaires and interviews. A survey research is useful because it provides the researcher with a method of getting people to tell him/her about themselves (biographical questions). It enables the researcher to gather facts and not just unreliable data (Cozby, 2004). It is assumed that questionnaires are a way of gathering truthful and accurate answers from people because it ensures anonymity and confidence.

The study also used qualitative data to capture subjective experiences, feelings and thoughts of students regarding condom use. This was done to find the reasons why students choose to use or not use condoms. This filled the gap and missing information gathered from the quantitative part of the study. Maxwell (1998) defines a qualitative study as that which serves three purposes: to understand the meaning of life experiences, to understand a particular context within which people act and to understand the process by which events or actions take place. Mauthner & Doucet (1998) also argue that qualitative research gathers information on people's experiences that are often omitted by quantitative research. As much as the topic at hand is not an easy topic to discuss, participants were relaxed and comfortable with the researcher because they somewhat fell in the same age category.

3.4 Sample Strategy

A cross-sectional survey was conducted among 202 Psychology undergraduate students at the University of KwaZulu-Natal. On consultation with other research papers of a similar nature - in the same study site with the same target population (Mvududu, 2014 and Mthembu, 2013), a minimum sample of 200 seemed a reasonable size to produce sufficient data for the study of this magnitude. The additional 2 students were sampled with the purpose to eliminate the element of error by replacing spoiled questionnaires, had it happened.

Six students were further selected to participate in interviews. The six students comprised of three males and three females; they were from mixed races. The sample was selected using convenience sampling. Cochran (1977) defines convenience sampling as a type of non-

probability sampling which involves the sample being drawn from that part of a population which is close at hand. The sample population selected was selected because it was readily available and convenient. This type of sampling is useful because it allows the researcher to obtain basic data and trends regarding his study without the complications of using a randomized sample (Hedt & Pagano, 2011). However, the most obvious criticism for selecting only students from the psychology discipline is that it is biased and not a true representation of the whole population. This bias was eliminated by comparing the results of the study to the other similar studies previously conducted.

3.5 Data Collection Instruments

For quantitative data a questionnaire was administered. Secondly, a questionnaire measuring frequency of condom use was completed.

3.5.1 The Self-administered Questionnaire

The self-administered questionnaire used in the study was made up of items relevant to the demographic characteristics of students (i.e. their age, gender, race classification), their sexual experiences as well as condom use. Self-administered means that respondents complete the questionnaire themselves with limited interaction with the researcher, giving the participants some independence in answering the questions (Njagi & Maharaj, 2005). This means that the responses attained from the survey have little to zero influence of the researcher. HIV/AIDS being a sensitive topic to engage with, self-administered survey was used to allow participants the freedom to respond freely without fear of being judged due to the responses they were giving. This freedom and independence of participants increases accuracy and truthfulness in the responses given by the study participants. However, one of the disadvantages is that some participants did not respond to all questions, some of the questionnaires were incomplete.

The content of the questionnaire was derived from a questionnaire used by Maharaj and Cleland (2006) in their study of condom use among college going students. Moreover, the conceptualization of the questionnaire was largely influenced by the literature reviewed.

3.5.2 The Interviews

Qualitative data was collected using semi-structured interviews. A semi-structured interview is said to be a tool which allows some flexibility, where a researcher can ask open needed questions and be able to pose additional probes (Brink et al., 2006). This allows for a more relaxed environment and allows for rapport to be established between the researcher and interviewee. Because this technique creates a conversation kind of situation, it opens up an opportunity for high validity. The meaning behind behavioral patterns may be revealed because the interviewee is able to speak freely with little direction from the interviewer. In addition, the interviewer has room to probe areas suggested by the responses provided, allowing the researcher to uncover relevant information that had either not occurred to the researcher or of which she had no knowledge of. The method however, doesn't fall short of flaws. One disadvantage of the semi-structured interview is that, it is time consuming and may lack direction if the interviewer is inexperienced. Further, the lack of formality and concrete structure may lead to non-standardized interviews-where participants are asked different questions-making it difficult to generalize research findings.

The interviews were held in a quiet office on campus where participants were comfortable. The interviews took about 30 to 40 minutes during times that were suitable for the participants to ensure that their day activities were not disturbed. The interviews were conducted using an interview schedule which was made up of open ended questions which followed themes developed from a review of the literature. During interviews the schedule was respected but, more probing questions were asked by the researcher when more clarity and/or information were needed. The interviews were recorded using a tape recorder to ensure data accuracy and notes were also taken during the interviews. Notes included hand gestures, facial expressions and body language which came with the responses.

3.6 Data Collection Procedure

3.6.1. Interviews

Upon getting permission to carry out the research study the participants who were going to participate in the interviews were contacted to schedule an appointment. During the interviews participants were informed about the nature as well as the purpose of the research study. They were told what was expected of them and what participating in the study would involve. Issues of confidentiality and anonymity were discussed as well as the ability to withdraw from the study at any given point of data collection without facing negative consequences. The interviewees were then asked to sign a form of informed consent before the interviews commenced.

3.6.2 The Survey

The quantitative instrument was administered in lecture rooms during a psychology lecture. The researcher received a lot of help from a research assistant who was part of the class. Psychology students were used as a sample for this research because this is a big discipline with many students, therefore administering questionnaires occurred in one instance. Participation in this study was voluntary. Thus, the students who declined the invitation were excused from the lecture hall. Participants volunteered to participate in the study received standardised instructions on how to complete the instruments. They were also given a brief description of the study. The issues of anonymity, confidentiality voluntary participation and the right to withdraw from the study were discussed with the participants and since no names or identification were required on the instruments, confidentiality and anonymity was not questioned. Participants were informed of their right to withdraw from participation without harm or being judged. They were also asked to give written consent to participate in the research.

3.7 Ethical Considerations

Ethical clearance for the study was obtained from the Ethics Committee of the University of KwaZulu-Natal and consideration was given to ethical principles i.e. informed consent, voluntary participation and withdrawal from the study. The research participants received a letter which was attached to the questionnaire that gave participants information concerning the study and the details of the supervisor guiding this research. The letter included issues of anonymity

and confidentiality, voluntary participation and the right to withdraw from the study. However, these issues were discussed verbally with the participants for emphasis purposes. The questionnaire did not require any identification, but the declaration form required it. This is the reason why declaration forms were completed separately and put away before the questionnaires were distributed to participants. This way no questionnaire could be traced back to the respondents.

Permission was also sought from the participants who took part in qualitative data collection before the interviews began. Furthermore, the aims of the study were verbally explained, in detail, to the interviewees and they were asked to sign an informed consent form before participating in the interviews. Permission to use the tape-recorder was sought from each participant taking part in the interview before using the tape-recorder. No risks to the research participants were anticipated. Confidentiality and anonymity was achieved by asking participants not to reveal their names during the interviews. Audiotapes of the interviews are stored safely in a lockable safe so that no one except the researcher has access to them.

3.8 Data analysis

Quantitative data that was collected was coded and captured into statistical programme called Statistical Package for Social Science (SPSS, version 21). Frequencies were calculated for all the items of each scale and descriptive statistics were calculated to explore the central tendency of the data. In some instances, recoding was done to improve the response categories for analysis. The race item had to be recoded to improve response categories, because the frequency table showed that a large proportion of the responses were African. Initially there were five categories (African, Coloured, Asian, White and other). This variable was recoded to have two categories (African and other); scale items were re-coded in the same direction. The variable age was also categorised into 4 main groups: 19 years or younger, 20 years, 21 years and 22 years or older. Marital status was also re-coded into two: single and other. Recoding of the items was done to ensure that all the responses are in the same direction.

The questions on confidence and communication of condom use were also recoded, so that a high value of that scale would reflect a high confidence and communication about condom use with sexual partner. The original coding was 1= Not at all difficult, 2 = A little bit difficult, 3 = quite difficult, 4 = very difficult and 5 = Extremely difficult. These were all recoded as 5 = Not at all difficult, 4 = A little bit difficult, 3 = quite difficult, 2 = very difficult and 1= Extremely difficult.

Under the Attitudes and Beliefs about Condom, I created five subscales. These include *Condom use effectiveness* (4 questions: 2, 3, 8, 9), *Condom use self-efficacy* (3 questions: 5, 13, 14), *Access to condom* (2 questions: 6, 7), *Peer/social influence* (4 questions: 1, 10, 11, 12) and *Condom use* (2 questions: 4, 15). To examine the relationship between these subscales and condom use and communication, a Pearson correlation coefficient was used.

The qualitative data collected was transcribed verbatim. Data obtained from the interviews was analysed using thematic analysis. Thematic analysis is described by Braun and Clarke (2006) as a method for identifying, analysing and reporting patterns or themes within the data. Thematic analysis summarizes the key features of a pool of data; it helps researchers cope with large bodies of data and may also offer a thick description of data (Braun and Clarke, 2006). It works to highlight the similarities and differences across the whole data set. It also helps the researchers arrange data into patterns, themes and codes. It requires the researcher to be familiar with the data set at hand because all the codes and themes are grounded and should be supported by the data. Braun and Clarke (2006), state that a lot can go wrong if the thematic analysis process is not guided by a set of guidelines therefore they propose a 6-phase guideline which researchers may follow when using this form of qualitative analytic technique. These are the phases proposed by Braun and Clarke: 1) familiarizing yourself with data, 2) generating initial codes, 3) searching for themes, 4) reviewing themes, 5) defining and naming themes and 6) producing the report. Some researchers choose to skip some phases and only go through a few, this decision lies entirely on the researcher. Some of these phases are not unique to this analytic method but are similar to those of other qualitative research analysis method like grounded theory.

In the process of reviewing the data, a search for themes that can be grouped together was conducted. Coding these themes was then followed by a process of elaborating on each theme, then interpretation and verification by looking at the overall themes and patterns common to each transcript. According to Ulin et al. (2002) this method is useful in exploring context and meaning. Thematic analysis was chosen because it is a flexible and useful research tool which has a potential of providing a rich and detailed account of data. It manages to do this through the theoretical freedom this form of analysis offers. The core reason behind the decision of employing thematic analysis is that it is an easy method to learn and use. It is accessible to researchers with little or no experience of qualitative research. Being an inexperienced qualitative researcher myself this form of analysis becomes a handy tool to use for analyzing the data.

Chapter Four

Results

4.1 Introduction

This chapter presents the overall findings from both the survey and interviews. The chapter starts by providing a socio-demographic profile of the sample. It then looks at condom use and factors associated with it.

4.2 Socio-demographic Characteristics

Table 4.1 shows the characteristics of the sample in the study. Of the 202 participants, the mean age was 20.42 years ($SD = 2.59$, range = 17–31). The majority of the sample was females ($n=114$, 56.4%). A large number of the sample was not married. Approximately 94% reported that they have never been married. The majority of the participants (62.4%) were Africans. Approximately 43% were Zulu speaking, while 33% designated English as their home language. The rest of the African participants were Sotho (3%), Swati (0.5%), Xhosa (1%), Ndebele (0.5%), Tsonga (1.5%) and Venda (1.5%) speakers. 4.5% were Afrikaans speaking, while the remainder (2%) did not speak any of the South African languages that were listed on the questionnaire; falling in the “other” category.

Table 4.1: Socio-demographic information of the participants

Characteristics	N	%
<i>Gender</i>		
Male	88	43.6
Female	114	56.4
<i>Age (Mean =20.42, SD =2.59) Range: 17 – 31</i>		
<20 years	79	39.1
20 years	47	23.3
21 years	31	15.3
22+ years	45	22.3
<i>Marital Status</i>		
Single (not married)	189	93.6
Others	13	6.4
<i>Race</i>		
African	126	62.4
Others	76	37.6
<i>Language</i>		
Tswana	3	1.5
Sotho	6	3.0
Zulu	86	42.6
Xhosa	20	9.9
Siswati	2	1.0
Ndebele	1	.5
Tsonga	1	.5
Venda	3	1.5
English	67	33.2
Afrikaans	9	4.5
Other	4	2.0

4.3 Sexual Behaviour

Figure 4.1 as well as Tables 4.2 and 4.3 report on the sexual behaviour of participants in the study. The results of the study reveal that the majority of the participants have had penetrative sexual encounter. Over 83% indicated having had sexual intercourse prior to the study.

Approximately 7 out of 10 (71.5%) report having had sex with a regular partner, with 15% with a casual partner and 7.3% with a “one-night stand”. Over half of the participants (54.9%) reported that their last sex act was planned, and over three-fourths of the participants (77.8%) said that they had discussed condom use prior to having sex.

The results in Table 4.4 also indicates that 20.3% have had a sexually transmitted infection, over 76% had taken an HIV test and only a small number (15.8%) have fallen pregnant or impregnated someone. The majority of the participants in the study reported that they know a friend or family relative who have died from an HIV related disease (64.4%) and had attended a funeral of someone who have died of AIDS.

Table 4.2: Participant’s sexual partners at last sex prior to the study

Type of Sexual Partners at Last Sexual Encounter	
Type of partner	%
Wife/Husband	5.7
Regular partner	71.5
Casual partner	15.5%
One-night stand	7.3%
N = 202	

Table 4.3: Participant’s intentions to have sex with a sexual partner & discussion of condom use during participant’s last sex

	Sexual Behaviour		
	Yes (%)	No (%)	Unsure
Participants intentions to have sex	54.9	19.2	25.9
Discussion of condom use	77.8	22.2	0
N = 202			

4.4 Condoms and Demographic Characteristics

Condom use according to gender shows that more female students (73.8%) used condom in their last sex than males (55.8%). This is illustrated in Figure 4.1 below. Further analysis shows that this difference was very significant [χ^2 (1, N=202) = 6.88, $p > 0.01$]. Condom use at last sex among students varies according to the various ages. Students between the ages of 17-19 years used condoms (67%) more than those who are 20 years old (65.2%) and 22 years old (58.1%). It is only those age 21 years (74.2%) who indicated the highest use of condoms during their last sexual encounter. The results therefore showed that there was no significant relationship between condom use and age among the sample in this study [χ^2 (3, N=202) = 2.16, $p > 0.541$]. The results of the study also showed that there was no significant relationship between condom use and race and marital status. The results therefore suggest that condom use by the study participants is greatly influenced by gender.

Figure 4.1: Condom use at last sex by gender

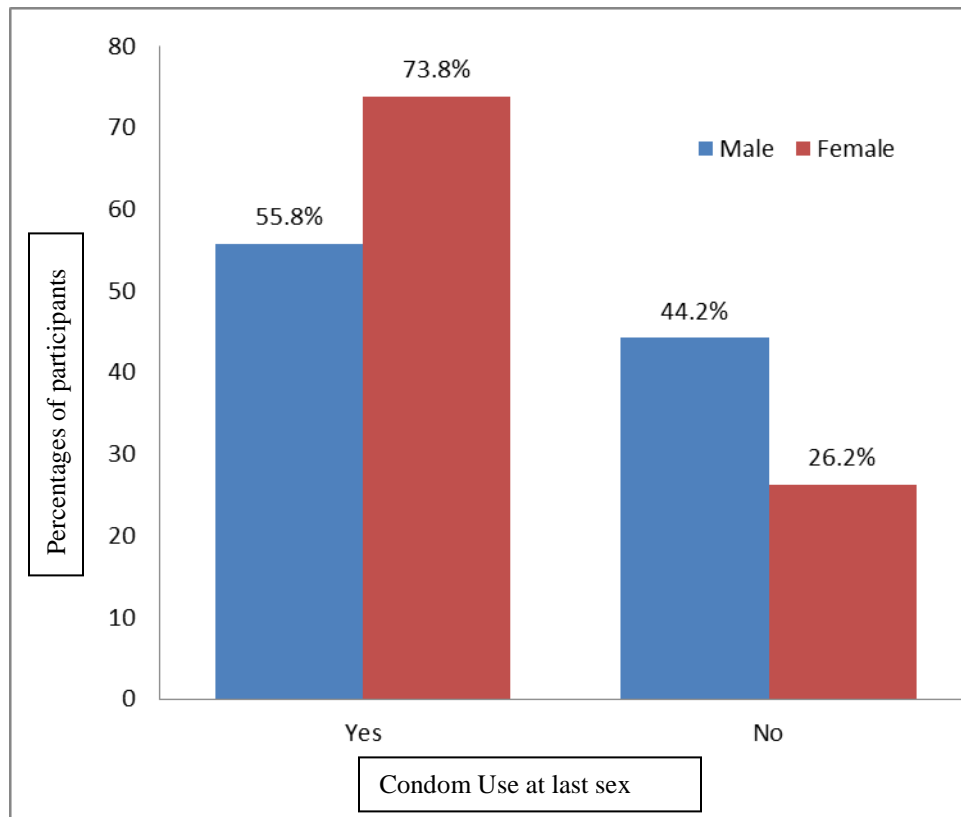


Table 4.4 amongst other factors illustrates a relation between life experiences of the participants and condom use. Over all, the results of the study show a relatively high rate of condom use amongst the study participants. 65.8% of the participants in this study reported having used a condom during their last sexual encounter. In addition, a relationship was also observed between ever having a sexual transmitted infection and condom use [χ^2 (1, N=193) = 8.67, $p > 0.01$]. Only 46.3% of those who have had an STI had used a condom, as compared to 53.7% who did not use a condom. This therefore suggests that those who had an STI were less likely to have used a condom in their last sex. The results from Table 4.4 further suggest that having been pregnant or impregnating someone was related to condom use at last sex [χ^2 (1, N=193) = 6.02, $p > 0.05$]. More than half (53.1%) of the students who had fallen pregnant/impregnated someone reported to have not used a condom at last sexual encounter. On the other hand, 69.6% of those who have never been pregnant or impregnated someone reported to have used condoms at last sex. These results indicate a link between engaging in unprotected sexual activity and the risk of contracting an STI and/or pregnancy.

Additionally, other interesting finding that came out of the study was the low rate of condom use amongst students who have never tested for HIV. Of all the students who have never tested for HIV, 66.7% reported to have not used a condom during last sexual intercourse.

Table 4.4: Condom use at last sexual intercourse by selected characteristics

Characteristics	Condom Use at last sexual Intercourse				Chi –Square (χ^2)
	Yes		No		
	Number	%	Number	%	
<i>Gender</i>					6.88**
Male	48	55.8	38	44.2	
Female	79	73.8	28	26.2	
<i>Age Groups</i>					2.16
<20 years	49	67.1	24	32.9	
20 years	30	65.2	16	34.8	
21 years	23	74.2	8	25.8	
22+	25	58.1	18	41.9	
<i>Marital Status</i>					0.18
Single (not married)	80	66.9	40	33.1	
Others	46	63.9	26	36.1	
<i>Race</i>	120	66.3	61	33.7	0.32
African	7	58.3	5	41.7	
Others					
<i>Ever had a STI</i>					8.76**
No	108	28.9	44	71.1	
Yes	19	46.3	22	53.7	
<i>Ever tested for HIV</i>					0.26
No	28	66.7	14	33.3	
Yes	98	65.3	52	34.7	
<i>A friend/family died of AIDS</i>					0.52
No	78	63.9	44	36.1	
Yes	49	69.0	22	31.0	
<i>Attended a funeral of someone dying from AIDS</i>					0.78
No	115	66.9	57	33.1	
Yes	12	57.1	9	42.9	

Characteristics	Condom Use at last sexual Intercourse				Chi –Square (χ^2)
	Yes		No		
	Number	%	Number	%	
<i>Ever been pregnant/ impregnated someone</i>					6.02*
No	112	69.6	49	30.4	
Yes	15	46.9	17	53.1	

Note: * p value < 0.05; ** p value < 0.01

4.5 Condom use vs Beliefs and Attitudes

The results presented in Table 4.5 show the relationship between condom use, communication and confidence of condom use.

Participants were asked questions on whether they feel comfortable asking their partners about their past sexual relations and further suggesting condom use with partners. Questions around whether condoms often broke or slipped off during sex were asked to assess condom effectiveness. Further, to measure condom use efficacy, the participants were asked if they feel confident that they know how to use a condom effectively. Peer/social influence was measured using questions like; “Most of my friends who are having sex, use condoms” and “my friends would give me respect if I have sex without a condom”.

The findings show that confidence and communication of condom use was positively and significantly related to frequency of sex ($r = .167$, $p < 0.05$) and negatively related to access to condom ($r = -0.306$, $p < 0.01$). This therefore suggests that students who frequently had sex with their partners were more likely to have high levels of confidence as well as a greater chance of communicating about condom use. However, at the same time the results suggest that participants find it difficult to access to condoms when they need them.

The results further show that frequency of sex was positively related to condom effectiveness ($r = .141$, $p < 0.05$) and peer influence ($r = .170$, $p < 0.05$) but strongly negatively related to access to condoms ($r = -0.249$, $p < 0.01$). This therefore implies that students who frequently had sex

with their partners do so as a result of peer influence but also believe that that condom is effective in preventing both pregnancy and STIs. However, participants who had sex frequently also find access to condom as problematic, as it is difficult to get them when needed.

Table 4.5: Condom use vs Beliefs and Attitudes

Variables	1	2	3	4	5	6	7
1 Confidence and Communication		.123	.167*	-.077	-.306**	-.029	-.019
2 Frequency of sex			.141*	.086	-.249**	.170*	.017
3 Condom effectiveness				.137	-.049	.453**	.134
4 Condom Use Efficacy					.268**	.216**	.180*
5 Access to Condoms						.083	.184**
6 Peer/Social influence							.101
7 Condom use							

*Correlation is significant at the 0.05 level (2-tailed).

**Correlation is significant at the 0.01 level (2-tailed).

Condom use efficacy was shown in this study to be positively and significantly related to access to condom ($r = 0.268$, $p < 0.01$), peer influence ($r = 0.216$, $p < 0.01$) and condom use negotiations ($r = 0.180$, $p < 0.05$). These results suggest that as student's self-efficacy for condom use increases, so does the ability to access condoms when needed. Students are also likely to experience more peer influence and may lead to increased levels of condom use negotiation with sexual partners. The results further reveal a positive relationship between condom effectiveness and peer influence ($r = 0.453$, $p < 0.01$). Also, access to condom was significantly related to condom use negotiations. These findings suggest that students who have access to condoms when needed are also likely to negotiate for its use with sexual partners. Additionally, more peer influence leads to a corresponding increase in knowledge that condoms are effective in preventing STIs including HIV.

4.6 Factors Influencing Condom Use

4.6.1 A brighter future

The interviews highlighted the fact that most students go to institutions of higher education with the aim to prepare themselves for a brighter future. The study participants strongly believe that going to university is a step towards a better future and building one's career. The importance of getting an education was highlighted with emphasis. Therefore, they stated that every student has a strong desire to isolate themselves from situations that may hinder them from getting what they came for and reaching their goals. Further, it came out that getting infected with STIs including HIV and/or getting pregnant may hinder one from achieving the specific targets that students have set for themselves.

“Basically most college students are here because they want to get educated and this means a lot to them. Therefore, they don't need anything that's going to hinder them from finishing on record time or that might be a disturbance to their education. No matter how stupid or wild they can be, they are cautious about why they are here and what they are here to do. So basically a student would not want to be pregnant because that is the biggest obstacle that can prevent one from completing on record time or probably affect their studies. So eventually a college student

would worry about condomising especially because they don't want situations like that to happen.” (P5)

This illustrated that students are not blindly using condoms because they can. They are using condoms because they understand the consequences of engaging in sexual intercourse without a condom. It further shows they perceive using condoms not just as a short or mid-term outcome but as an act that has a long term impact. One participant explains:

“When I think of condom use, I think of the reason why I am using the condom. I mean that's the main thing for me. I think of the fact that I have to avoid pregnancy. I am avoiding impregnating someone. I am avoiding STIs. Anything that will harm my progress in life...I think of my future. This is the defining moment that either makes me or breaks me.”(P1)

It may also be argued that students do not just view condom use as an act one needs to engage in for health reasons but for social and psychological reasons as well. One participant refers to condoms as the key to a more prosperous future.

“It's the prospects of a bright future. I don't want to constantly live with the knowledge that I have a disease that I got through unprotected sex that could have been prevented. The fact is medication or not, you do not lead a normal life after that. Yes, people deal with it but they do not live the types of lives they lived before they found out that they were infected. So for me it is more about securing my future as a young person.” (P6)

It is evident that the ideology that condoms are effective in preventing pregnancy and STI transmission is shared by both male and female students. The males feel they have the responsibility of carrying and negotiating condom use as a means of protecting their female partners from getting pregnant. This indicates that men are taking some responsibility in the sexual relationship. They are worried about the consequences for women. It may also suggest that females need them to control the sexual relationship including female reproduction. This is alluded to by two participants P2 and P6 who stated:

“I think of myself, I think of the person that I am having sex with... In my mind it is a situation of, if she falls pregnant it will slow down her life.”(P2)

“As a man in the relationship I need to take care of the outcomes of the sexual relationship”
(P6)

Females also feel it is their responsibility to negotiate condom use since they have the physiological ability to carry a child. They stated that carrying a condom and suggesting use during sexual intercourse should be something that every female feels comfortable to do, despite the fact that women who carry condoms are at times labeled as promiscuous. The participants also point out that condoms have become such a huge part of their lives that they even regard them as an item that every girl needs in their cosmetic bag. This indicates that some female students have overlooked the stigma attached to females carrying condoms and have chosen to put their safety and health first. One woman felt really strongly about this as she stated that:

“I think girls are the ones to be afraid because we are the ones who fall pregnant. Men get you pregnant and they run away. So the first thing, if I am going to have sex I ask for a condom. I make sure that I always have condoms in my bag which is good because I do not want to get pregnant. I do not want to lie about it. If a man chooses to think that I am always ready to have sex, then it is their problem”(P1)

Another concurred with the sentiment when she said that:

“A condom for me is like a pocket mirror for some girls, I never leave the house without it. Like, lip-gloss it is part of my cosmetics. I am the one to take it out during sex. I don’t even wait for the man. If he thinks I am too forward or he is going to start spreading rumors about me being a whore carrying condoms all the time and expecting to have sex all the time I do not care. What matters is that I am safe.” (P4)

However, one female student said:

“If a man brings a condom, I feel that that he is a responsible guy but if he doesn’t then he is a joke. We might as well just stop there. They are usually the ones who want and initiate sex. They should therefore take it upon themselves to prepare for the whole occasion.”(P3)

This highlights that as much as some female students feel it is their responsibility to make decisions about their health and reproduction others still feels the opposite. One participant’s

statement reveals that some females still leave the decision of whether or not they have sex or use a condom entirely up to their male counterparts.

In addition, a male respondent stated that:

“Like I have never been told by a girl to put on a condom during sex, I am always the one who actually decides. That is me taking on my role of being a man. Not that I am calling the shots. But I am in control of the situation because men are presumed to be dominant. That is why it makes me feel more of a man.” (P2)

The two extracts indicate that there is still a strong belief that males are the ones who should carry a condom at all times to show that they are responsible. This may suggest that there is still the fear of carrying condoms amongst females. The fear may be that of being labeled promiscuous. Moreover, it may suggest that it is the male that is responsible to initiate sex at all times.

4.6.2 “Great Sex, No Consequences”

The interviews revealed that the students’ decision to use condoms lies in the belief that one act of responsibility saves you from a lifetime of premature responsibilities. Meaning that acting responsibly by using a condom may save one from the ill-timed responsibilities of being a parent. Students perceive condom use as an opportunity to have sex with no price to pay thereafter.

“...I am only 20 and I do not see myself buying nappies for a baby or having to remember to take pills every day. I am a responsible person, I know that I can be very responsible, but I am just not ready for that level of responsibility. So that is why condom use is important. It protects me from both these unfortunate situations.” (P2)

“...when people say condoms, it’s a good word now because it means you can have sex and you can have safe sex, in terms of, you are not at risk. So when someone says Condomise, I’m thinking great sex no consequences” (P3)

“I feel like I am too young to get infected with HIV or any other STIs, and moreover to be a father to someone.” (P5)

It is evident from all the statements above that both males and females fear being parents immaturely despite them engaging in an activity that is viewed to be solely meant for reproduction by some. Hence, they look at condoms as a tool that allows them to engage in a fun activity without fear of getting pregnant or impregnating someone. Whilst the fear of pregnancy and STIs could slow your down their progress in life, the condom is perceived as a precocious measure to mitigate these risks.

4.6.3 Condoms are convenient

One other factor that facilitates condom use among students is the condoms’ convenience. The study participants reported that one of the other reasons why they use condoms is because of the dual protection the condom has to offers. This for them is like hitting two birds with one stone; preventing them from HIV infection and pregnancy. The participants stated that the fact that the pill only protects against pregnancy makes it less favorable because they do not want to get STIs as much as they don’t want to be associated with pregnancy. Two participants highlighted that the one thing that sets the condom apart from all the other contraceptive methods is the fact that it eliminates the most worrisome risks. One of the most important factors that were pointed out by them is the issue of sexual networks within the universities.

“...contraceptives are only there to prevent pregnancy. So a condom can prevent all the other things that can harm me like HIV and other STIs. So condom use is important for me. It’s more important than any other method because it protects from both.” (P6)

“A pill is just going to help me not to get pregnant but I don’t want to get pregnant just as much as I don’t want to get infected with some disease that I cannot cure. So as much as the pill is good idea because the health department is trying so much to prevent this whole teenage pregnancy thing, it’s a good idea. But at the end of the day I mean I don’t want to be HIV positive. I don’t want to be sick. A pill, it works for some people but I just don’t think it’s the way to go because you will get sick especially if you’re a college student where there are causal

relationships everywhere and probably everybody is having sex with everybody without even knowing.” (P4)

Female participants also stated that condoms are a bonus for them because they do not have to take contraceptives. They reported that as much as contraceptives are good, they require too much administration and at times have side effects. The side effects include nausea and weight gain. Being “fat” is one of the things that females in general fear. According to the female participants, the oral contraceptive makes you eat more than usual which results in weight gain for some. Gaining weight for females may impose other health and psychosocial threats such as anxiety and other disorders (i.e. anorexia nervosa). Thus condom use may eliminate this trail of threats.

In addition, condoms are argued to be the best because it is only required during sexual intercourse. While on the other hand, one needs to be consistent with contraceptives all the time. This means that contraceptives become a burden because they require to be taken every day even when one is planning on having sexual intercourse. Students argue that a condom is convenient because it is used when needed. It is not something you constantly need to keep up with every day even when there is no need.

“I prefer using a condom because it is convenient; you use it when you need it. With contraceptives you have to constantly take them. I mean this is the main reason why a lot of us do not want to get infected with HIV. We do not want to take pills every day. So taking a contraceptive is as bad. They also make you fat on top of the other side effects they come with. Who wants to be fat? I don’t like the idea of manipulating my body into thinking that I am pregnant because that’s what the pill does right.” (P3)

“I have been using a patch, I stick it on my thigh or tummy or my butt. I change it every week. It works the same way as the pill but gives you less side effects. It works but it is not as good as a condom though. Having to remember to take it off every week and every month I have to go back to my gynecologist for more patches. It can be a huge inconvenience. Also there is a free week and anything can happen during that free week. With a condom I know that should anything happen I can quickly go to my bag and take out one and get done.” (P4)

One participant associates the use of contraceptives to the administration of antiretrovirals. According to the participant, one of the inconveniences of being infected with HIV is having to take medication every day. She further states that one goes through the same thing when taking oral contraceptives. Likewise, another participant also alluded to the contraceptive patch as also requiring constant administration, where one needs to remember to change it every week. Additional to that, with the patch, there is a free week where one is not protected. That on its own is risky because one cannot guarantee that they will not be engaging in any sexual activities that might lead to pregnancy.

Further, it came out during the interviews that a condom may also make sexual intercourse less painful and more fun for females. There are times where a female feels dry; a few days after they have had their menstrual cycle or when taking certain medication that causes dryness of the vagina. The lube from a condom plays a very important role in making intercourse pleasurable to the female. One participant asserted that:

“I enjoy using a condom because I don’t have to go through the whole dryness issue. You know when you have intercourse, sometimes a girl does not get wet enough so when a dry penis penetrates the vagina it hurts. Whereas a condom is more lubricated so it is easier for it to penetrate inside you.” (P4)

4.6.4 Being a Responsible Young Adult

The interviews suggest that coming to university teaches a person a lot of things; it is important to take responsibility for your own life. It teaches students that they need to be responsible for their own academic progress, social progress as well as well as their health status. What transpired in the interviews is that students may decide to use condoms because of the fear of contracting STIs, as this would have a negative impact on their health. Therefore, when they use condoms they feel like they are responsible young adults. They perceive themselves as having the agency to take charge and control what happens in their lives health-wise.

“I won’t lie it makes me feel responsible as a young person because right now that’s the issue. It’s a matter of being responsible or being irresponsible. Each man is responsible for their own life. The decisions I make either break or make me... so whenever I do have sex and I actually

use a condom I feel responsible. It doesn't make me feel less of a man. It makes me feel more of a man. A responsible man”

4.7 Factors Hindering Condom Use

There are two major factors that emerged from the interviews which have been identified to be role players in hindering consistent condom use among students. The two factors are discussed below.

4.7.1 Access to Condoms

Participants reported that as much as condoms are widely available and presumed to be easily accessible, widespread availability is still a problem. They stated that they find it difficult to obtain condoms from the clinics or over the counter for those who prefer using condoms that they purchase. It is evident that there is still a lot of stigma that is attached to condoms especially when young people attempt to access them. Evidence gathered through interviews reveal that there is a great deal of judgment in society which is also in denial of the fact that young people do indeed engage in sexual behaviour. Participants y complained about being judged by the health professionals or other staff working at the counter; especially older, people, when they try to obtain or buy condoms. Participants y stated that:

“I went to the campus clinic this one time to get a box of condoms for a workshop that was going to take place at residence and the way I was received by the sister was shocking. She told me to get lost and refused to give me condoms. It was a Friday and she thought I was planning on having sex the whole weekend. In fact, those were her words. I did not understand the logic behind her statement and reaction. What if I really wanted to have sex and she refused to give me condoms? I would have had unprotected sex.” (P1)

“I really feel embarrassed every time I have to go and pay for condoms. The looks that those elderly tellers give you when you are buying condoms makes a person feel so shy. Sometimes I end up not buying them if there is no teller who is my age at the shop.” (P2)

“... That look that says ‘you are such a dirty child’ puts me off from buying condoms really. I mean, why do they have to do that? Others even ask you what you are going to do with condoms because you are so young you should be focusing on your studies.” (P4)

These comments are highly disturbing considering the high rates of new infections that occur on a daily basis in South Africa. This highlights that the health professional staff play a role in limiting access to condoms. Students may resort to having unprotected sex because they are avoiding being humiliated by the health professionals and some adults that have the authority to sell or distribute condoms.

4.7.2 Fear of pregnancy versus fear of HIV

Besides the problem of access, one other factor that hinders condom use consistency among students is the fear of pregnancy over that of contracting HIV. It is evident that students would rather prevent pregnancy than HIV if they were given an option to prevent just one of the two. This is said to be due to the fact that pregnancy shows quickly as opposed to HIV and other STIs. Pregnancy is also perceived as more expensive and associated with more responsibilities.

“For me I fear more getting someone pregnant because it would slow down both our lives and I wouldn’t want that to happen. At least with HIV it takes a bit of time to show and if you find out early you don’t even have to be seen by people that you are sick. You can easily get your treatment and no one would know that you are suffering from the virus and you can carry on with your studies.” (P2)

“I don’t want to be pregnant because I want to finish this degree in record time and I don’t want a baby to hinder because we have a lot of success in our minds. HIV and STIs can be hidden with ease, and you get treatment for free. A baby on the other hand ... R300 a month is not enough to sustain a baby. Especially if you are always on campus and cannot breastfeed.” (P4)

The comment by this participant clearly shows that an unintended pregnancy may be an emotionally draining experience for an unmarried young woman who may not be prepared financially and psychologically to raise a child. Caring for a child and studying could prove to be

a challenge that could lead to poor academic performance by the young mother. Thus, it could potentially result in a delay in finishing a qualification within the stipulated timeframe.

4.8 Summary

The findings of this study indicate that there is a relatively high rate of condom use among university students. These results are interesting considering the number of students who reported to have been once infected with sexually transmitted diseases. This suggests that there is lack of condom use consistency among students. Participants indicated that there were advantages and benefits that came with using condoms. The condom's ability to prevent both pregnancy and sexually transmitted diseases was the main benefit that was identified in almost all interviews. One other benefit was the convenience the condom offers. Accessibility – even though challenged- was also flagged as a benefit. Additionally, the participants indicated that condoms may provide extra lubrication, when needed, making intercourse more pleasurable. Additionally, a correlation that was conducted showed a significant relationship between condom self-efficacy and the ability to negotiate for condom use. These results concur with the previous studies that argue that the greater the condom use self-efficacy, the higher the chances of condom use. The study also confirmed some of the research findings that emerged from similar studies that have been conducted among students. The study also uncovered some of the barriers to consistent condom use by college going students. There were two specific barriers that stood out during data collection and analysis. The difficulty in obtaining condoms by young people was one that was common throughout the interviews. In addition, the fear of pregnancy by students outweighed the fear of HIV infection. Since there are other methods to prevent pregnancy, students may not use condoms consistently.

Chapter 5

Discussion and Conclusion

5.1 Discussion

This chapter is a discussion of the research results, focusing on the aims and objectives of the study. The aim of this current chapter is to give a presentation of the possible explanations of the research findings. This will be achieved by referring to the literature that is already available on the subject. The main objectives of the study were to find out the rate of condom use among college going students and the motivating factors behind the rates. In addition, the study explored the relationship between socio-demographic factors and condom use as well as trying to uncover barriers to condom consistency.

Young people are the future of South Africa. The growing rates of HIV infection and early pregnancy among the youth thus become a concern. Condoms still remain the most effective preventive method against both pregnancy and HIV infection. The research study was mainly aimed at investigating the level of condom use among university students. Further, it looked at the factors associated with condom use. Moreover, it sought factors that may come into play to encourage condom use.

The age of the 202 participants that were sampled ranged from 17 to 31 with the mean age being 20. The majority of university students come straight from high school. The common age of starting university is therefore around the age of 19. The fact that second year students were sampled for this study may be an explanation of the mean age of this study. Psychology is a profession that has been widely labeled as a profession for females (Caswell & Baker, 2008), despite the fact that the great theorists and contributors of the discipline are mainly male. This justifies the findings on the number of females that were participants of this study. 56.4% of the participants were 114 females (n=114), mainly because only psychology students were sampled. A large number of the sample was not married. Approximately 94% reported having never been married. Marriage is not the norm in South Africa. According to a number of studies, the mean age at marriage in South Africa is 29 years (Statistics South Africa 2012; Budlender,

Chobokoane & Simelane 2004). The province of KwaZulu-Natal is dominated by IsiZulu speaking people (STATSSA, 2012). Hence 62.4% of the participants consisted of Africans. Further, approximately 43% were Zulu speaking, with 33% indicating English as their home language.

The results from the study show a significantly high rate of condom use among university students. Almost two thirds of the participants reported to have used condom in their last sexual encounter. This finding is in line with the findings that were found by Maharaj and Cleland (2011) on HIV preventive strategies among college students in Durban, South Africa. Their study found that approximately 67% of the participants reported having used condoms during their last sexual encounter. The general assumption is that a high rate of condom use results in low rates of HIV prevalence. The results of this study on condom use rate are thus interesting because they are in contrast with the general assumption. According to Africa Check (2015) a significant increase in HIV prevalence among college going students has been observed. The research shows that the infection rate has increased from 3.4% to 11.2% between 2009 and 2015. This contrast may be attributed to condom use inconsistency, which will be looked at later in this chapter.

Reid (1996) and Newman et al. (2000) argue that marriage can be a major barrier to condom use. The authors state that condom use in marriage raises questions of trust and infidelity. This may be the reason why high condom use among the participants was reported. The majority of the participants of this study have never been married. This may make it a lot easier for them to negotiate condom use in their relationship.

Further, the acknowledgement of the risk one is exposed to may be the other factor that encourages condom use (Rosenstock, Stretcher & Becker, 1988). During interviews students revealed that knowing that they are at risk or susceptible to contracting HIV and/or getting pregnant are a major motivation for them to use condoms. This decision is made in order to avoid getting themselves in the above mentioned unfortunate situations.

There may be a number of reasons why people decide to go to college or university. According to Kyn (2014), the main reason why people go to institutions of higher level of education is because of the hunger to better their lives. This finding aligns with the interview findings of this

study. Five out of six students that were interviewed stated that coming to university, their main objective is to get an education which will get them good jobs and therefore secure a better future. This finding was common across all races. This mindset shared by students may be another condom use motivating factor. It is common knowledge that having an unplanned pregnancy or getting infected with HIV may change a person's life drastically. It therefore makes sense that students would decide to use a condom to avoid the drama that would hinder their academic progress and development.

There is a law in Physics that says, for every action there is a reaction (Newton, 1687). This law is normally translated by the lay society to mean; everything that one does has a consequence. HIV infection and pregnancy not only slows down academic progress; it also comes with additional responsibilities. The study participants are fairly young (mean age = 20.4) and feel they aren't ready for major responsibilities such as taking care of a baby that came before time and having to constantly watch out for their health and behaviour just because they are infected with HIV. So to try and prevent the premature responsibilities they may see condom use as a reliable solution. Further, condom use is also seen as an act of great responsibility among university students. The word responsibility came up more than 20 times during interviews, meaning there is a strong feeling about responsibility.

In their study, Maharaj and Cleland (2006) reported that condoms take first preference because they are convenient. These findings align with the findings of the current study. Participants reported that condoms do not require too much work and are easy to use. In addition, both the male and female participants indicated that the fact that condoms prevent both pregnancy and HIV infection make them much more favourable. .

There was a significant difference between males and females regarding condom use with females (73.8%) reporting higher levels of condom use than males (55.8%). This indicates that gender may influence condom use among university students. The result may be an indication that females have a heightened concern because they are the ones who actually suffer the physical consequences of pregnancy; slowing down their lives. These results differ from the results obtained by Burgard and Kusunoki (2009) in the study they conducted on gender and

condom use. The study revealed that 34% of men compared to 47% of women in the sample reported not using a condom at last sex, a statistically significant difference.

The results of the study show no significant relationship between age and condom use [χ^2 (3, N=202) = 2.16, $p > 0.541$]. Age is therefore not a predictor of condom use among university students. This insignificant relationship is similar to the findings of Jama (2010) regarding gender and age differences in condom use patterns among youth.

Race and marital status were found not to be related to condom use. The results from the study show no significant relationship between condom use and race and marital status. This may be due to the imbalance in the number of married people and single participants within the sample. Black Africans were also a dominant race among the sampled participants; which may have had an influence on the results yielded by the data of the study. Results from previous studies associate marriage with low rates of condom use (Demographic and Health Survey, 1999 & De Jongc et al., 2010)

Students in the study reported that having the ability to communicate with your partner about condom use and having confidence about using a condom leads to higher levels of condom use. These findings indicate that condom self-efficacy may be a predictor of condom use among university students. According to Bandura and Edwin (2003), self-efficacy beliefs influence the choices they make at important decisional points. This means that students are more likely to use condoms if they believe that they are capable of using condoms properly. Consistent findings were produced by a study that was conducted by Kwok et al. (2010) on the relationship between condom use self-efficacy and condom use using the Condom Use Self-Efficacy Scale (CUSES). The study participants who scored higher on the CUSES reported higher levels on condom use during last sexual encounter (Kwok et al., 2010).

Although the findings indicate a high level of condom use among university students, the percentage of students who have had STIs suggests that condom use among students is not consistent. These findings are consistent with the findings of the study conducted by Weisman et al. (2010) regarding condom use consistency among adolescents. The lack of condom use consistency could be a result of a number of factors coming into play. According to Sinding

(2005) the type of relationship a person is in may influence the decision one makes on condom. It is argued that people in more stable relationship find it hard to negotiate condom use because a condom is perceived as a sign of disloyalty (Chimbiri, 2007). Approximately 7 out of 10 (71.5%) participants in the current study reported having had sex with a regular partner. In a study conducted by Maharaj and Cleland (2011) students reported that condom use is more common during the early stages of a relationship and less common as the relationship progresses and the involved parties 'trust' each other. These findings by Maharaj and Cleland (2011) may be an explanation why there is condom use inconsistency among the university students.

Access to condoms may also play a role in condom use inconsistency. Students reported having problems with accessing condoms despite the fact that condoms are widely available and at everyone's disposal. The problem of access is said to be brought by the treatment students get from either the health professionals in clinics or the till attendants when they try to get or buy condoms. A similar problem was indicated in a study conducted by Ayman-Nolley and Taira (2010) and Wood & Jewkes (2006) where young people complained about being called names by the health professionals when they go to the clinic to get condoms. The current study shows a negative relationship between access to condoms and frequency of sex. Those who have sex frequently reported having faced difficulties in accessing condoms. This means that university students who are also the youth of South Africa at times have sex without a condom. This may be supported by the levels of adolescent pregnancy and HIV infections in South Africa (van der Linde, 2013), particularly in KwaZulu-Natal (Statistics South Africa, 2013).

Maharaj and Cleland (2006) state that pregnancy avoidance is a top priority for the students, particularly for women, for whom pregnancy spells disaster for progress through college. An additional interesting factor that stood out from the results is the students' fear of pregnancy being greater than the fear of contracting HIV. The students reported that pregnancy would be more of a challenge than HIV because in South Africa HIV treatment is accessible free of charge. Pregnancy on the other hand requires a person to be financially fit to be able to cope with the consequences and responsibilities that come with it. Pregnancy can be avoided by other methods of contraceptives; such as oral contraceptives. This implies thus that students who use other methods of contraceptives may refrain from using condoms.

5.2 Conclusion

Students reported fairly high levels of condom use. This highlights that students have adopted condom use and have made it part of their sexual culture. A number of condom use motivating factors came up during interviews. Students reported that the dual protection the condom offers is one of the reasons why condoms are preferred. The students hunger for success also came out as a strong motivating factor behind the condom use decision. In addition, students indicated that condoms are convenient and require less administration because one only uses it when there is a need for it. This distinguishes condom use from other preventive methods that require constant administration.

There was a significant difference between males and females regarding condom use that was observed. The females reported higher levels of condom use than males. However, the results showed no significant relationship between race, marital status and condom use. In addition, condom use was similar among all ages.

Good communication and condom use self-efficacy was reported to be significantly related to condom use. Participants who reported confidence in their ability to use a condom as well as communicate safer sex with their partners reported higher levels of condom use.

Even though there were high levels of condom use that were detected, condom use inconsistency was also observed. The students revealed that pregnancy is more of a concern for them than HIV infection. Pregnancy can be prevented using other preventive strategies; making students use condoms inconsistently. Difficulty in accessing condoms may also be a role player in the lack of condom use consistency.

5.3 Strengths of the dissertation

The study has paved the way for further research to be conducted on the subject matter, looking at other variables that were not planned for that came out during research, that require further exploration. It will make considerable contributions in sexual health research as well as when sexual health strategies are being designed and implemented in countries like South Africa. In society there has been a great deal of emphasis on research that hinders condom use, to such an extent that there is insufficient in-depth research on facilitators of condom use among young

people. The research findings are also anticipated to give a better understanding of the lack of condom consistency among students. Consequently, assisting policy makers and sexual health strategists to come up with strategies that will increase condom use consistency and in turn decrease the rate of HIV infection among students as well high levels of pregnancy.

An additional strength lies in the research's employment of a mixed approach. The mixed methods approach is known to increase validity because it employs both quantitative and qualitative techniques. Creswell et al (2003) state, that both these techniques have unique strengths. Thus a combination of both allows the researcher to bring together a comprehensive account of the area of enquiry. Using both quantitative and qualitative techniques in this research assisted in answering questions that could not be fully answered by just one approach. The qualitative research assisted in explaining the reasons behind the high rates of condom use among students. It further uncovered reasons behind the lack of condom consistency that was indicated by the quantitative research approach.

5.4 Limitations

Like any other study, this study also had limitations. Firstly, the results that were generated by the data collected were from a small sample. Further, the sample was drawn from one institution and therefore results could not be generalized for all students in South Africa. When studying a phenomenon such as condom use among college going students, students from different universities, faculties and courses should be sampled because the degree of condom use is expected to vary as a product of various factors coming into play.

One other limitation is that convenient sampling was used and the disadvantage of using convenience sampling is that the sample can be highly researcher biased and since it's a non-probability technique the results acquired from the study cannot be generalizable since the sample is not representative of the population.

Another shortcoming of the research is that it did not explore the relationship between condom use and the nature of relationships that the study participants were in. According to De Jongc et al. (2010) the strong association between the Sexual Relationship Power Scale and consistent

condom use supports the hypothesis that relationship power plays a key role in safer sex decision making.

Moreover, the lack of experience and skills needed to conduct a semi-structured interview and record the important and relevant information is another limitation.

5.5 Recommendations

Future research on this subject may be conducted using a bigger sample than the sample size used for this research. Students from different institutions, with different backgrounds should be sampled because an environment can be highly influential on the decisions that people make. Additionally, a different sampling technique can be used to avoid a sample that is researcher biased.

Knowledge is a major factor that may influence ones' decisions. It is therefore important that other researchers who will explore the subject of condom use among college going students consider investigating a relationship between the amount of condom knowledge students have and the level condom use.

Pertaining to the interviews, students voiced that a major barrier to access to condoms is the attitude they get from the people dispensing or selling condoms. Workshops and training sessions should be put in place to train people who are in a position to dispense condoms to young people. Lack of training of the above mentioned people make it difficult for some students to access condoms, putting them more at risk of getting infected with HIV (Frizelle et al., 2013).

De Jongc et al. (2010) argue that a few empirical studies have tested the hypothesis that sexual relationship power constitutes a key factor in condom use negotiation. Therefore, it may also be important for studies similar to this one to explore the hypothesis further.

According to Nyazi (2011), prevention strategies and sexual health education aimed at the South African youth has been more focused on the danger metaphor. This approach has not been as successful as envisaged, mainly because the focus on danger and disease makes the material uninteresting and hard to engage with. It is therefore, recommended that policy makers and

strategists consider using an approach that is flexible and easy to engage with. In order for this to happen, strategists will need to look at and borrow from the factors that facilitate condom use. Focusing on facilitators rather than barriers will result in a positive rights based approach that promotes positive sexual health messages.

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APPENDIX 1

LETTER TO PARTICIPANT

I am Ayanda Ndlovu, a Masters student in Population Studies at the University of KwaZulu Natal-Howard College Campus. I wish to conduct a survey study using a questionnaire. The questionnaire will help me understand the reasons behind condom use among students. The aim of the study is to understand the levels of condom use among South African students. I would highly appreciate your participation in this study.

As a participant in this study, your participation is voluntary, which means that you have a right to choose not to participate in this research study if you do not wish to do so. You will not be penalised if you do not wish to participate. However your participation will be highly appreciated. You may withdraw from the research study at any point in time without fear of any negative consequences following your withdrawal. I also want to assure you that your status of anonymity and confidentiality will be guaranteed and protected. The questionnaire does not require any identification. After data collection the research results will be kept in a safe and private place. After a period of five years having kept the data, it will then be destroyed.

Should you have any questions or concerns related to this research, please feel free to contact Prof P. Maharaj on 031-260 2243 or email her at maharajp7@ukzn.ac.za.

If you have any queries about your rights as a research respondent please contact Ms. Phumelele Ximba in the Humanities and Social Science Research Ethics Office.

APPENDIX 2

INFORMED CONSENT FORM

I..... agree to be a participant in the study on condom use among tertiary going students, carried out by a Population Studies Masters student researcher attending the University of KwaZulu Natal –Howard College Campus.

I acknowledge my voluntary participation in this study and that if I wish to withdraw during the process; I am free to do so. I am aware that my anonymity and confidentiality will be protected. If I have any concerns or questions related to the study I will contact Prof P. Maharaj and Ms Phumelele Ximba.

.....

Signature of Participant

.....

Date

.....

Signature of Researcher

.....

Date

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APPENDIX 3

Questionnaire:

Section 1: BIOGRAPHICAL QUESTIONS

Please mark with an **X** the number that corresponds with the correct answer; answer **all** questions.

1. Sex

Male	1
Female	2

2. How old are you? (Mark the age category you fall into)

16-20	1
21-25	2
26-30	3
31-35	4

3. How would you describe yourself?

African	1	White	4
Coloured	2	Other (Please specify)	5
Asian/Indian	3	_____	

4. What is your home language?

Tswana	1	Pedi	7
Sotho	2	Tsonga	8
Zulu	3	Venda	9
Xhosa	4	English	10
Siswati	5	Afrikaans	11
Ndebele	6	Other (Please specify)_____	12

5. What is your marital status?

Single	1
Married	2
Widowed	3
Divorced	4
Separated	5

6. What year of study are you in?

First Year	1
Second Year	2
Third Year	3
Forth Year	4
Post Graduate	5

Section2: Risk and worries regarding STDs/HIV and Pregnancy

All questions in this section should be answered by **everybody**, regardless of whether you have had sex before or not. Remember, all your answers are strictly confidential, so please read the questions carefully and answer as honestly as possible.

1) Below, on the scale from 1-5, 1 represents the activity with **no risk** of getting a **sexually transmitted disease (STD)** (including HIV/AIDS), and 5 represents the activity **with the highest risk** if a protective measures are not taken (eg condom not used). Mark with an **X** a number from 1-5 for each of the activities listed below according to how risky you think each one is.

No.	Activity	No risk	Low risk	Medium risk	High risk	Very high risk
a.	Kissing (with tongues)	1	2	3	4	5
b.	Vaginal intercourse	1	2	3	4	5
c.	Touching each other's genitals	1	2	3	4	5
d.	Sharing a toilet	1	2	3	4	5
e.	Oral sex	1	2	3	4	5
f.	Anal sex	1	2	3	4	5

No.	Questions	Not at all worried	A little worried	Quite worried	Very worried	Extremely worried
2)	How worried are you about becoming infected with HIV?	1	2	3	4	5
3)	How worried are you about becoming infected with an STD other than HIV?	1	2	3	4	5
4)	How worried are you about unintentionally falling pregnant / making someone pregnant?	1	2	3	4	5

No.	Questions	Not at all likely	A little likely	Quite likely	Very likely	Extremely likely
5)	How likely do you think it is that your sexual activities nowadays will result in you being infected with HIV?	1	2	3	4	5
6)	How likely do you think it is that your sexual activities nowadays will result in you being infected with an STD other than HIV?	1	2	3	4	5
7)	How likely do you think it is that your sexual activities nowadays will result in you unintentionally falling pregnant / making someone pregnant?	1	2	3	4	5

Section 3: Attitudes and Beliefs

For these questions say whether you strongly agree, agree neither agree nor disagree, disagree or strongly disagree with the statements listed. If you strongly agree with the statement, then please circle in column 1. If you strongly disagree, then please mark with an **X** in column 5 and so on.

No.	Statement	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1)	Most of my friends who are having sex, use condoms	1	2	3	4	5
2)	Using condoms is an effective way of preventing AIDS	1	2	3	4	5
3)	Condoms are not necessary unless you suspect the other person has an STD or HIV/AIDS	1	2	3	4	5
4)	It is up to me whether or not I use a condom every time I have vaginal intercourse	1	2	3	4	5
5)	I feel confident that I know how to use a condom effectively	1	2	3	4	5
6)	It is easy to get a condom any time I want to	1	2	3	4	5
7)	Condoms are part of sex these days	1	2	3	4	5
8)	The only reason to use a condom is because you don't trust your partner	1	2	3	4	5
9)	Condoms are only necessary if you're not using any other form of contraception	1	2	3	4	5
10)	Carrying condoms is difficult because it makes it look as if one has planned to have sex	1	2	3	4	5
11)	My friends would give me respect if I have sex without a condom	1	2	3	4	5
12)	It's cool to carry a condom in your wallet/pocket	1	2	3	4	5
13)	Condoms often slip off	1	2	3	4	5
14)	Condoms often break	1	2	3	4	5
15)	The man has greater influence than the woman over whether or not a condom is used	1	2	3	4	5

Section 5: Confidence and Communication

All questions in this section should be answered by **everybody**, regardless of whether you have had sex before or not. Remember, all your answers are strictly confidential, so please read the questions carefully and answer as honestly as possible. Please mark with an **X** the most appropriate response.

For these questions say

1)	How difficult do you think it is/would be for you to....:	Not at all difficult	A little difficult	Moderately difficult	Very difficult	Extremely difficult
a.	Ask a new partner about their past sexual behaviour?	1	2	3	4	5
b.	Suggest condom use with a new sexual partner?	1	2	3	4	5
c.	Use a condom every time you have first sexual intercourse with someone you don't know very well?	1	2	3	4	5
d.	Suggest condom use with a stable long term partner (someone you have been in a stable relationship with for a long time)?	1	2	3	4	5
e.	Always use a condom when you are having sex under the influence of alcohol and/or drugs?	1	2	3	4	5
f.	Use a condom every time you have sexual intercourse with a regular partner?	1	2	3	4	5

Section 6: Sexual Experience

Please answer all of the following questions by marking with an **X** the appropriate number. Remember that the information is completely confidential.

1) Have you ever had a sexually transmitted disease?

No	1
Yes	2

2) Have you ever been tested for HIV/AIDS?

No	1
Yes	2

3) Has a member of your family or a friend ever suffered or died from AIDS?

No	1
Yes	2

4) In the last 12 months, have you attended the funeral of someone who has died from AIDS?

No	1
Yes	2

5) Have you ever unintentionally become pregnant / made someone pregnant?

No	1
Yes	2

6) Which of the following best describes your sexual orientation?

Heterosexual (straight)	1
Bisexual	2
Homosexual (gay/lesbian)	3
Not sure	4

7) Which of the following best describes your current sexual situation? Please read all the options before making your selection. **(Select one answer only)**

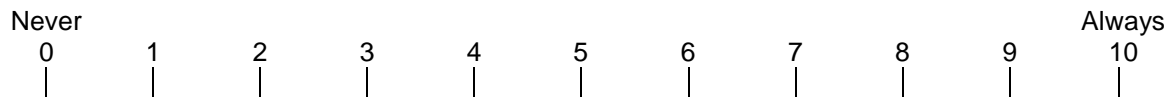
I'm not currently in any kind of sexual relationship	1
I'm not in a regular sexual relationship but I sometimes have sex with casual partners	2
I'm in a faithful, regular sexual relationship with one person	3
I'm in a regular sexual relationship with one person but I also sometimes have sex with casual partners	4
Other (Please explain):	

This question is only for people who gave a response of 2, 3, 4 and other for question 7.

8) How long have you been in the situation you describe above? (For example, 1 week, 3 months, etc.)

Number.	Unit
	weeks
	months
	years

9) Thinking of all the times you have ever had sexual intercourse (vaginal sex), on a scale from never to always (1-10), how often have you used condoms? **(Please circle the appropriate number)**



Remember all your answers are strictly confidential, so please answer honestly.

10) How long has it been since you **last** had sexual intercourse (vaginal sex)? **(For example, 1 day, 3 week, 3 months, etc.)**

Number.	Unit
	Days
	weeks
	months
	years

11) Have you had sexual intercourse with this person before?

No	1
Yes	2

12) How would you describe your relationship with this person?

Wife/Husband	1
Regular Partner	2
Casual Partner	3
One night stand	4

13) On that occasion, did you expect to have sexual intercourse?

No	1
Yes	2
Unsure	3

14) With this partner, did you ever discuss condom use?

No	1
Yes	2

15) How often do you and this sexual partner use a condom? Always, occasionally or never?

Always	1
Occasionally	2
Never	3

16) The last time you had sexual intercourse, did you use a condom?

No	1
Yes	2

17) Which of the following best describes when the condom was put on? Please read all the options before making your selection.

Before penetration	1
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18a) If the condom was put on before penetration (option 1 in Q17), did any genital to genital contact occur before the condom was used?

No	1
Yes	2

After penetration	2
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18b) If the condom was put on after penetration (option 2. in Q17), was it being used for ejaculation purposes only?

No	1
Yes	2

19) The last time you had sexual intercourse did a condom you were using break? Please read all the options before making your selection. **(Choose one answer)**

Yes, whilst the packet was being opened	1
Yes, whilst the condom was being put on	2
Yes, during intercourse	3
Yes, as the condom was being removed	4
No	5

20) During the last time you had sexual intercourse, did a condom you were using slip? Please read all the options before making your selection. **(Choose one answer)**

Yes, the condom slipped down the penis but didn't slip right off	1
Yes, the condom slipped right off the penis	2
No	3

THANK YOU!!!

APPENDIX 4

Interview Schedule

Participants socio-demographic Information

Age

Gender

Race

Marital Status

Level of Study

Questions

1. What do you know about condom use? When you hear the word Condomise what comes to mind?
2. How do you feel about using a condom during sex?
3. Do you think it is important for people who live together or married or in a stable relationship to use condoms? Or should it be used by casual partners? Why?
4. Do you think condoms are useful if a woman is on the pill? How? Why?
5. Who is responsible for condom negotiation in a sexual relationship and why?
6. What kinds of ideas are created about girls who carry condoms?
7. When you use a condom or if you were to use a condom why would you use it? What would be the reasons behind the decision?

More probes will be added during the interviews.

APPENDIX 5



**UNIVERSITY OF
KWAZULU-NATAL**
INYUVESI
YAKWAZULU-NATALI

13 December 2012

Miss Ayanda Precious Ndlovu 207503856
School of Built Environment and Development Studies
Howard College Campus

Dear Miss Ndlovu

Protocol reference number: HSS/1303/012M
Project title: A Study of Condom Use as Part of the Sexual Culture of Tertiary Students in South Africa

EXPEDITED APPROVAL

I wish to inform you that your application has been granted Full Approval through an expedited review process.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. Please note: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Professor Steven Collings (Chair)

/pm

cc Supervisor: Professor Pranitha Maharaj
cc Academic Leader: Professor Franco Frescura
cc School Admin.: Mrs Meera Dalthaman

Professor S Collings (Chair)
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