

**TO USE OR NOT TO USE: MEDIATORS OF CONDOM USE
AMONGST STUDENTS IN HETEROSEXUAL SEXUAL
RELATIONSHIPS**

Lois Jessica Deacon

November 2010

**TO USE OR NOT TO USE: MEDIATORS OF CONDOM USE
AMONGST STUDENTS IN HETEROSEXUAL SEXUAL
RELATIONSHIPS**

Lois Jessica Deacon

Submitted in partial fulfillment of the requirements for the degree of:

Master of Social Science (Clinical Psychology)

At the School of Psychology, University of KwaZulu-Natal, Pietermaritzburg

November 2010

Declaration

I declare that, unless specifically indicated to the contrary, this dissertation is the result of my own work. It is being submitted in partial fulfilment of the requirements for the Degree of Masters of Social Sciences (Clinical Psychology) in the School of Psychology, University of KwaZulu-Natal, Pietermaritzburg. It has not been submitted before for any degree or examination in this or any other university.

Lois Jessica Deacon

206505955

November 2010

Mary van der Riet

Supervisor

Acknowledgements

I would like to thank the following people for all the help and support they gave me while completing this research.

Mary van der Riet, without her support and supervision this thesis would never have been completed. My family and close support network for all the ~~alone time~~ that they afforded me. Last but not least, thank you to all those who participated in making my study as colourful as it is.

Abstract

Any form of sexual interaction contains risk, for example the risk of pregnancy and/or STI transmission. There are a range of measures that can be used to prevent the above mentioned risks, namely contraceptive practices. However, condom use is the best method to prevent all risks related to sex. Although South Africa has the highest number of people living with HIV (Shisana et al., 2009), it has been found that the HIV prevalence is low amongst students in comparison to nationwide statistics (HEAIDS, 2010). Additionally condom use amongst students at last sex is reportedly high (HEAIDS, 2010). However there are many reasons why students in particular do not engage in protective sexual practices such as condom use. The question that guided this research study was what motivates students to engage or not engage in condom use? The study explored dynamics of condom use amongst heterosexual students at the University of KwaZulu-Natal, Pietermaritzburg. This qualitative study used Hollway (1984) and Willigø (1995) discourses to examine the ways in which men and women relate to each other in engaging in sex, relationships and protective sexual practices. Information was gathered using two focus groups (one female and one male group) and five individual interviews. Students saw the risks related to pregnancy and HIV differently which impacted on their preferred method of contraceptive use and the ways in which they viewed condom use. Students seem to draw on Hollwayø (1984) òmale sexual drive discourseö and òhave/hold discourseö, and Willigø (1995) òmarital discourseö, to position themselves with regards to each other and their sexual activities. This suggests a need to redirect health promotion strategies.

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION	1
CHAPTER 2: LITERATURE REVIEW	3
2.1. Introduction	3
2.2. HIV and South Africa: The broader picture	3
Table 1: South African HIV prevalence by age from 2002 to 2008	3
2.3. Knowledge about condom use and the nature of sex	4
2.4. Intentions of condom use, pressure to engage in sex and perceptions of HIV	5
2.5. Gender relations	5
2.6. Gendered responsibility and contraceptive practices	6
2.7. Communication and negotiation at a partner level	7
2.8. Relationship type	7
2.9. Mediators of condom use in South Africa and in universities	8
2.9.1. Previous South African studies regarding contraceptive beliefs	10
2.10. The current state of health and condom promotion campaigns	11
2.11. The social constructionist viewpoint	12
2.11.1 Discourses about sexual relationships	13
2.12. Focus of this study	16
CHAPTER 3: AIMS AND RATIONALE	18
3.1. Aim and rationale	18
3.2. Research questions	18
CHAPTER 4: METHODOLOGY	20
4.1. Research design	20
4.2. Sample	21
4.2.1. Participants	21
4.2.2. Recruitment	22
4.2.3. The sample	23
4.3. Data collection techniques	23
4.3.1. Focus groups	24
4.3.2. Individual interviews	24
4.5. Instruments and equipment	25
4.5. Procedure	25
4.5.1. Ethical considerations	25
4.6. Data analysis	28

CHAPTER 5: RESULTS.....	30
5.1. Introduction	30
5.2. Review of questions posed.....	30
5.3. Explanation of extracts.....	31
5.4. -Whatø was found	31
5.4.1. Risks and motivation for condom use	32
5.4.2. Condom use	33
5.4.3. A focus on HIV or pregnancy	39
5.4.5. Being a student and freedom	45
5.5. Summary of findingsí í í í í í í í í í í í í í í í í í í í í í í í ..	46
CHAPTER 6: DISCUSSION.....	47
6.1. Introduction	47
6.2. -Whyø are condoms not being used	47
6.3. Condoms as a gendered issue	47
6.3.1. Men: Sex, relationships and condoms	48
6.3.2. Women: Sex, relationships and condoms	52
6.3.3. Men, women and trust.....	57
6.4. Summary of findingsí í í í í í í í í í í í í í í í í í í í í í í í ..	60
CHAPTER 7: RECOMMENDATIONS AND CONCLUSIONS	62
7.1. Limitations of the research.....	62
7.2. Conclusions	63
7.3. Recommendations based on the findings	65
REFERENCES.....	66
APPENDIX 1: POSTER.....	72
APPENDIX 2: FLYERS.....	73
APPENDIX 3: POSTERS FOR MALE VOLUNTEERS	74
APPENDIX 4: FOCUS GROUP QUESTIONS	75
APPENDIX 5: INDIVIDUAL INTERVIEW QUESTIONS.....	76
APPENDIX 6: TRANSCRIPTION CONVENTIONS.....	77
APPENDIX 7: FOCUS GROUP PARTICIPANTS INFORMATION SHEET	78
APPENDIX 8: INDIVIDUAL INTERVIEWS PARTICIPANTS INFORMATION SHEET	80
APPENDIX 9: INFORMED CONSENT	82
APPENDIX 10: AUDIO CONSENT	83

CHAPTER 1: INTRODUCTION

Any form of sexual activity contains risk. In the South African context the risk of contracting a Sexually Transmitted Infections (STI) such as HIV, is quite high. In a previous study, Deacon (2009) found that the predominant method students used to combat risks associated with sex was hormonal contraceptives because their worst perceived risk in sex was pregnancy. Condoms are however, the best method to combat both the risk of STI transmission and pregnancy, particularly with the high HIV prevalence in South Africa. The question that directed this research study was, why are condoms being used or not used?

South Africa has the largest number of people living with HIV in the world, and KwaZulu-Natal has the highest prevalence of HIV in the country (Shisana et al., 2009). HIV is predominantly transmitted through unprotected sexual intercourse (Parker, Colvin & Birdsall, 2006). With regards to students, condoms are readily and freely available on campus. Students also have a higher level of education and access to resources regarding reproductive health, and thus should have a higher awareness of condoms and the importance of using them. HEAIDS (2010), a study on HIV and tertiary institutions, found that condom use amongst students is high and HIV prevalence amongst students is low in comparison to nationwide statistics. However this is not to say that students do not engage in risky, condomless sex, which could potentially lead to STI (and HIV) transmission. Thus another pertinent research question that guided this research study was what factors make students not use condoms in sexual relationships?

This study thus aimed to explore the reasons why students engage or do not engage in condom use, and the ways in which men and women position themselves on matters regarding sex, relationships and protective sexual practices. This was best done by implementing a qualitative study that paid particular attention to students' talk on the matter. Thus a social constructionist approach was used to look at the way in which the students positioned themselves with regards to the abovementioned issues. Hollway's (1984) discourses were used to gain a deeper understanding of the information that was gained. Thematic analysis was employed to answer some of the pertinent questions regarding the use and non-use of condoms. The results of this process are presented in Chapter 5, the results chapter. Discourse analysis was used in order to understand the students' underlying motives for the use and non-use of condoms. These discourses are explored in more depth in Chapter

6, the discussion chapter. A small, purposive, convenience sample was used to gain the required information. Participants had to be students on campus, over the age of 18, and were sexually active. The students recruited took part in either a focus group or individual interview discussion, and were asked questions related to the use and non-use of condoms. These questions included; what are the risks that students perceive when engaging in sex and what is their motivation for their condom use or non-use? In total eight female and five male participants had taken part in this study.

CHAPTER 2: LITERATURE REVIEW

2.1. Introduction

The review of the literature discusses the issue of non-condom use within a South African context. Non-condom use in South Africa is highly problematic as the HIV prevalence rate (although decreasing) is still relatively high. More specifically it also looks at the ways in which South African students negotiate condom use and the reasons why they do not engage in protective sexual practices (i.e. sex with a condom). A new way of looking at condom use or non-use may highlight some of the possible reasons why students in particular do not engage in condom use. More specifically the discourses or talk about sex between men and women will be a beneficial means to understand students' reasoning for condom use or non-use.

2.2. HIV and South Africa: The broader picture

South Africans live in a context of high HIV and AIDS prevalence. In 2008 there were an estimated 5,2 million people living with HIV and AIDS, higher than any other country in the world (Shisana et al., 2009). The KwaZulu-Natal province has the highest prevalence in the country (15,8 %) (Shisana et al., 2009). The national prevalence of HIV/AIDS is approximately 11%, with particular age groups being more affected by the pandemic (Statistics South Africa, 2008). Approximately one in three women in the age range 25-29 and one in four men in the age range 30-34, are living with HIV (Statistics South Africa, 2008). The changes in the estimated prevalence among South Africans by age from 2002 to 2008 can be seen in the table below (Shisana et al., 2009).

Table 1: South African HIV prevalence by age from 2002 to 2008

Age	2002(%)	2005(%)	2008(%)
Children (2-14 years)	5,6	3,3	2,5
Youth (15-24 years)	9,3	10,3	8,7
Adults (25 and older)	15,5	15,6	16,8
15-49 years	15,6	16,92	16,9

In 2008, prevalence of HIV had decreased significantly in the age ranges of children and youth. Additionally the prevalence of HIV amongst 15-49 year olds stabilized over the

period spanning 2002-2008. Although this decline is important and suggests that some prevention interventions have been successful, the prevalence is still high and the country still has one of the highest prevalence rates of HIV in the world (Shisana et al., 2009). A closer look at the reasons for this high prevalence is needed. If one addresses these statistics at face value, then anyone who engages in risky sex in any high prevalence age group within KwaZulu-Natal is at higher risk. In terms of the South African student population, HEAIDS (2010) found that within the major universities across the country there was an HIV prevalence of 3%. Additionally prevalence rates were three times higher in students over the age of 25, with female students having a higher prevalence rate than that of their male counterparts (HEAIDS, 2010).

Sexual activity contains risk, especially the risk of STI or more importantly HIV transmission. When condoms are used consistently they provide an 80% protection rate for HIV and STI (Parker, Makhubele, Ntlabati & Conolly, 2007). Since HIV is mainly transmitted through sexual intercourse, condom use is the predominant means promoted in preventing HIV transmission (Parker et al., 2006). Yet condoms are also useful in preventing pregnancy (Peltzer & Pengpid, 2008). Rationally condoms are thus the best method for preventing both the risk of HIV and pregnancy which are two of the predominant risks associated with risky sexual practices. However condom use for most individuals is problematic.

The next few paragraphs discuss the issues that hamper and promote the use of condoms within a South African context. Additionally issues that are related to South African students and condom use are addressed. The final portions of this review of the literature look at the ways in which gender dynamics are one of the reasons for heterosexual couples not engaging in condom use. Finally a way in which to look at the talk of men and women about sex and protective sexual practices will be discussed.

2.3. Knowledge about condom use and the nature of sex

Having correct knowledge about condoms facilitates their correct use and informs one's choices with regards to safe sex practices (Ahlberg, Jylkas & Krantz, 2001; Amazigo, Silva, Kaufman & Obikze, 1997; Bodibe 2009; Delva, et al., 2007). The nature of the sexual encounter may also pose a risk in terms of non-condom use. For example, some individuals

want to keep their sexual activity a secret as they do not want their parents or other significant individuals to find out about their sexual practices or promiscuity (Amazigo et al., 1997). Many individuals may also feel embarrassed to purchase condoms or even make inquiries about their use as others will then know about their sexual engagement (Taylor et al., 2002). Additionally the spontaneous nature of sex may lead to the lack of condom use because individuals are unprepared and do not have condoms with them at the time of sexual interaction (Amy & Loeber, 2007). Maharaj (2001) argues that although condoms use is seen as a reliable method of preventing pregnancy and STI transmission, it is still an unpopular method. In her study, many men expressed concerns about condoms which included problems of utilization interruption of sex, discomfort, and that they ruined the excitement of sex (Maharaj, 2001). Engaging in condom use is also viewed as an 'annoyance' as many individuals feel that going out and purchasing them 'ruined the mood' (Amy & Loeber, 2007) Aesthetic reasons including a decrease in sensation during sex, also prohibited condom use (Maharaj, 2001).

2.4. Intentions of condom use, pressure to engage in sex and perceptions of HIV

Hendriksen, Pettifor, Lee, Coates and Reesø (2007) South African study found that the highest correlate of condom use was whether an individual had engaged in condom use at first sex. In other words individuals who had engaged in condom use the first time they engaged in sex, generally continued condom use in later sexual relationships (Hendriksen et al., 2007)

Van Empelen and Kok (2006) found that 'intention' is an important predictor of condom use. Specifically preparatory behaviours such as buying condoms, carrying them and communication were paramount in their use (Van Empelen & Kok, 2006; Harvey et al., 2006). Van Empelen and Kok's (2006) study highlights that in relationships, when condom use is routine then this become a direct influence in protective behaviours later in the relationship. For example when a sexually active couple agrees to use condoms, they may use them without needing to discuss it and ensuring condom use becomes almost second nature.

Hartelø (2005) South African research indicates that student populations do not engage in protective practices such as condom use because most students believed that HIV and AIDS

would not affect them or the population group/community they belonged to. Additionally, pressure to engage in early unprotected sexual intercourse, pressure to have children, inaccessibility of user friendly reproductive services, negative perceptions about condoms, low perceptions of personal risk of contracting STI's or HIV, and low perceived self-efficacy in protective behaviour, were also associated with a lack of condom use (Hartel, 2005)

2.5. Gender relations

Notions of masculinity and femininity may also compromise sexual and reproductive health. Unequal decision-making between partners, poor communication skills about sex and sexual issues between partners, and a lack of preparation for sex were found in relation to engaging in risky non-condom use sexual behaviour (Varga, 2003). Additionally, women tend to be given responsibility for making certain decisions about sexual health. Van der Spy (2009) found that women are either expected to be able to reproduce to prove their man's virility or to ensure contraceptive use (including condoms) to protect them from becoming pregnant.

The gendered nature of contraceptive use may also affect the use or non-use of condoms. More specifically, gender norms and ideals instruct what may be seen as appropriate behaviour in terms of positions held by, and the relationships between, men and women. These gender differences and norms may be an important moderator of sexual and reproductive practices (Varga, 2003). More specifically the ways in which men and women relate to each other and position themselves with regards to each other, may determine whether condoms are used. For instance men may be positioned in such a way as to gain sexual pleasure or gratification, and women may be positioned to ensure that this happens. Thus if condoms cause a lack of sensation or displeasure they will not be used, purely based on the ways that men and women position themselves regarding sex and relationships.

2.6. Gendered responsibility and contraceptive practices

Kaufman, Shefer, Crawford, Simbayi and Kalichman (2008) found that in South Africa there were negative attitudes towards condom use. These attitudes were linked to feelings of masculinity and male pleasure, condoms were related to prostitution, and that they defied the purpose of sex (i.e. reproduction and fertility). Moreover condom use tended to conflict with values of womanhood, family and stable relationships, as it conflicted with the goals of pregnancy and childbearing. Whilst men found sexual pleasure in engaging in condomless

sex, women found pleasure in the affirmation of trust and fidelity through condomless sex. Men who engaged in condom use only did so until trust had been established in a relationship (Kaufman et al., 2008)

2.7. Communication and negotiation at a partner level

Condom use requires communication and negotiation between both partners. In other words open discussion about condoms generally facilitated condom use in relationships (Hendriksen et al., 2007). Ahlberg et al. (2001) found that poor communication at a partner level leads to the lack of condom use. Blanc and Wolff (2001) argue that 'protective negotiation' or communication could be due to the prevailing norms of sexual roles regarding men and women. These include norms about initiating sex and being able to say 'no', and a norm that tends to permit and/or encourage men to have a greater sexual need than that of women (Blanc & Wolff, 2001).

Harvey et al.'s (2006) study highlights this 'gendered norm' by suggesting that there is one unique factor of condoms that may affect the negotiation and use of condoms. Hormonal contraceptives are marketed for, and taken by, women and it is thus up to their discretion to use them, and there is little to no need for communication with their male partner. However men wear condoms and women need to get their partners to wear or use them. Condom use thus involves skill of being able to talk about and negotiate their use (Harvey et al., 2006). This power differential between men and women with regards to condom use is problematic, as it may lead to their non-use. Men and women may regard certain contraceptives as only the responsibility of the individual it was marketed for, rather than both men and women taking responsibility regardless of the fact.

2.8. Relationship type

Relationship type is also seen to influence condom use. Men and women tend to view condoms negatively within marital and cohabiting relationships (Maharaj & Cleland, 2004). Condom use in these types of relationships was viewed as a suggestion of infidelity (Maharaj & Cleland, 2004). The assumption in these types of relationships is that one's partner can be 'trusted' to not have engaged in sex with anyone else, and therefore the protective practice of condom use is not needed. In this context of 'trust' instigating condom use may jeopardize the relationship. Thus condoms are viewed as a preventative measure that is associated with

less meaningful or risky sex, and engaging in condom use has been coupled with a lack of trust or commitment to a relationship (Foss, Watts, Vickerman & Heise, 2004). Condoms are seen to be useful primarily in relationships that are seen as high risk, for example casual sex with non-regular partners and/or sex workers or "one night stands" (Hearst & Chen, 2004). Condom use has thus become linked to illicit sex and promiscuity (Maharaj, 2001). Condom use is thus more common in non-marital relationships, than in marital or "long-term" stable relationships (Hendriksen et al., 2007; Maharaj & Cleland, 2004). Individuals who were married or had been involved in a sexual relationship for six months or more were less likely to engage in condom use (Hendriksen et al., 2007)

Boulle et al. (2008) found that 37% of men felt that they did not use a condom because they believed that their partners were faithful (compared to 23% of women), and 27% of women reported not using condoms because their partners refused (compared to 3% of men). Foss et al. (2004) report that even when individuals have access to condoms they are selective as to the partnerships in which condoms are used. More specifically the condom is most often not used in primary long-term sexual relationships. The condom seems to be "commonly conceptualized as something that is used in less meaningful or more risky sex" and is associated with a lack of trust and commitment (Foss et al., 2004, p. 186). Similarly in Boulle et al.'s (2008) study the lowest condom use was amongst couples who lived together (i.e. long-term, committed relationships) and the highest use was amongst those participants in short-term relationships.

In a similar South African study, it was found that 41,1% of learners explained that a condom was vital if one did not trust one's sexual partner (Taylor et al., 2002). Maharaj and Cleland (2004) found that in countries with generalisable HIV epidemics, only 8% of married participants used condoms. This suggests that once a certain level of trust is gained and maintained within a relationship, condom use ceases.

2.9. Mediators of condom use in South Africa and in universities

In South Africa condoms are free in many public and private institutions, including universities. Tertiary students, given their level of education and their access to certain resources (e.g. the Campus Clinic and access to free condoms), should have a higher awareness of condoms and the importance of using them. They serve as a protective factor in

the prevention of STI transmission and HIV. At the University of KwaZulu-Natal condoms are freely available in toilets and at the Campus Clinic.

In Pettifor, Rees and Steffenson (2004) South African survey, 87% of their student sample reported that it would be easy to obtain condoms if the need arose, but actually consistent use was low. In a study specifically looking at condom use and South African students (HEAIDS, 2010), 60% of students reported using a condom at last sex. This means that 40% of students are still not using condoms. This research indicated that many people do not engage in condom use for a variety of social reasons. One of the predominant reasons that students do not engage in protective sex is their reported lack of experience in making good decisions regarding sexual partners. In other words most students reported that their new found freedom at university increased the likelihood that they would engage in condomless sex (HEAIDS, 2010). For example, high alcohol intake was suggested as one of the primary reasons that students did not engage in condom use.

Given the high HIV prevalence in South Africa, engaging in condom use only in certain kinds of relationships is potentially risky. If one in every three women and one in every four men, are living with HIV (Shisana et al., 2009), then unless a recent HIV test has proven a negative status there is a chance that your partner could be HIV positive. HIV testing is believed to be one of the best means for prevention of HIV as it provides information dissemination and personal affirmation about one's status (HEAIDS, 2010; Peltzer & Pengpid, 2007; Shisana et al., 2009). HIV testing is important as knowledge of one's status could lead to behaviours that protect individuals and their partners from infection. Peltzer and Pengpid's (2008) study found that only a quarter of adults had taken an HIV test and only 7% had taken a test in the previous 12 months. According to HEAIDS (2010), many students do not use the Voluntary Counselling and Testing (VCT) centres within the university setting. Reasons included that the students' perception of these centres were poor and that the counsellors at these sites did not understand the students and were often seen as uncaring (HEAIDS, 2010). In addition to this the practice of multiple concurrent partners is fairly common in South Africa (Parker et al., 2007). This means that individuals engage in sex with an overlap in sexual partners. This increased number of partners means that VCT would be a better form of prevention as many individuals may engage in sex with multiple partners without being tested each time risky sex takes place (Parker et al., 2007).

Condom use in South Africa is on the increase, suggesting that messaging about condom use has been successful. In 1998 only 8% of females in South Africa, in the age range between 15 and 49, used a condom at last sex (Parker et al., 2006). However condom usage has increased from 57% in 2002 to 87% in 2008 (Shisana et al., 2009). Additionally awareness of condom use has increased significantly. This added awareness around condom use may explain the change in HIV prevalence statistics mentioned above. However the HIV prevalence in this country, especially in KwaZulu-Natal is still exceptionally high and thus potentially problematic for many young sexually active people.

Knowledge about how to prevent STI transmission is also quite high, which could account for the lowering rates of HIV transmission. When asked how to prevent STI transmission (more specifically HIV), 94,3% of male participants and 93,3% of female participants in Parker et al. (2007) study suggested the condom or barrier method. Half of the participants mentioned abstaining from sex. However, reducing the number of sexual partners was mentioned by less than 5% of the participants and only a quarter (20,2% of males and 24,5% of females) mentioned faithfulness to one's partner. Although this knowledge is useful, it does not account for the high rates of HIV in this country.

2.9.1. Previous South African studies regarding contraceptive beliefs

A previous study conducted on a student population in KwaZulu-Natal (Deacon, 2009) found that pregnancy was a greater concern as a risk in sexual activity, than STI's or HIV. Students thus focused their protective practices on contraceptive use, particularly hormonal contraceptives in the form of the pill, or the injection (Deacon, 2009). Thus, although students seem to have a fair understanding of the risks related to unprotected sex, and they were aware of how condom use prevented the transmission of STI's and HIV in particular, their primary concern was the prevention of pregnancy (Deacon, 2009). Although hormonal contraceptive use was high, condom use amongst the group of students sampled was low and thus worrying. Interestingly HEAIDS (2010, p. 84) reports that although condom use amongst students is high at last sex, condoms were still regarded as only a preventative means for 'casual, once off, and new sexual relationships'.

MacPhail, Pettifor, Pascoe and Rees (2007) broader South African study indicated that the majority of women chose to use hormonal methods of contraception rather than barrier

methods. This was due to the fact that condom use declines as the duration of a relationship increases (MacPhail et al., 2007). It was found that the issue of trust became a significant factor in sexual decision making in long-term relationships. Furthermore it was found that women in a long-term stable sexual relationship used contraceptive methods that offered little or no protection from STI's and HIV infection, and this was attributed to the concept of trust (MacPhail et al., 2007).

Given the prevalence of HIV in the province (15,8% in 2008) and the prevalence of HIV amongst South African youth in the same age groups as these students (8,7% in 2008) (Shisana et al., 2009), this lack of condom use is of concern. The lack of condom use in the students sampled in the earlier study (Deacon, 2009) is also in contrast to the national statistics which indicate an increase in condom use. This study thus explored the protective practices of students involved in sexual activity, their perception of risks and why they may be prioritizing the risk of pregnancy as opposed to STI transmission.

2.10. The current state of health and condom promotion campaigns

The many health promotion campaigns in South Africa (i.e. *Khomanani*, *Soul City*, *Soul Buddyz*, and *LoveLife*) have raised awareness of condom use as a protective factor (Shisana et al., 2009). Recent research conducted by the Human Sciences Research Council (HSRC) suggests that despite many health promotion campaigns, accurate knowledge concerning HIV and AIDS is still relatively poor. The HSRC study revealed that across all age groups and both sexes, less than half of South Africans knew about the preventative effect of condoms and that having fewer sexual partners could reduce the risk of contracting HIV (Shisana et al., 2009).

Many of these health promotion campaigns assume that distributing information about safe sex practices will increase awareness of risky behaviour and thus decrease the behaviour (Kafaar, Kagee, Lesch & Swartz, 2005). For instance, Hendriksen et al. (2007) found that factors that mediated condom use were self-efficacy in condom use, optimism about one's future and reported behaviour change. In other words, understanding one's current risky behaviour was seen to be a positive step in changing one's behaviour and adopting protective practices, such as condom use (Hendriksen et al., 2007). Within the HIV and AIDS field, the focus on information provision as the key determinant of behaviour change has been

criticized (Shisana et al., 2009). Having information about the risks related to sex, and knowing that condom use is a preventative measure is not sufficient to prevent people from engaging in risky practices. The focus on understanding risky sexual behaviour has shifted to understanding the factors which influence behaviour as well as the contexts, in which behaviour occurs (Campbell, 2003).

2.11. The social constructionist viewpoint

If one examines this problem of lack of behaviour change from a social constructionist viewpoint (Terre Blanche, Kelly & Durrheim, 2006), one might value the way in which individuals position themselves within discussions about sex, preventative practices and relationships and the way they construct their reality accordingly. From this perspective individuals are authors and actors in the realities they construct (Maticka-Tyndale, 1992). In this construction of reality individuals rely on the constructions that are developed through language, shared meanings and understandings (Maticka-Tyndale, 1992). Adopting a discursive analysis of heterosexual students' talk about relationships, sex and protective practices assumes that individuals draw on discourses in order to make sense of their reality. Adopting this approach to this study might make sense of the ways in which they do, or do not, engage in protective sexual practices. Gavey, McPhillips and Doherty (2001) suggest that these discursive influences are important in understanding the ways in which heterosexual couples are constrained or enabled to employ condoms for protective purposes.

Gavey et al. (2001) use Hollway's (1984) discursive framework in order to explore the understandings of condomless sex. Gavey et al. (2001) suggest that the 'male sexual drive' discourse directly affects women's experience of sex. In other words, a woman's ability to 'please a man' is more important than engaging in protective sex, as this is a fundamental component of their identity. Meeting a man's sexual needs, which might mean not engaging in condom use, is important for a woman's construction of her identity. This assumption constructs male sexuality and desire as supreme in heterosexual sex. Even in situations where there is no force or coercion of sex, women produce ways in which they may be seen as particular kinds of subjects (e.g. good sexual partners), which is more important than engaging in protective practices such as condom use (Gavey et al., 2001).

2.11.1. Discourses about sexual relationships

Henriques, Hollway, Urwin, Venn, and Walkerdine (1984, p. 203) suggests that "particular forms of rationality are produced through and depend on particular technologies and practices". They argue that discursive practices provide the subject with positions through which they make sense of their daily lives and actions. The way in which subjects position themselves within a certain discourse helps the subject to organise and understand a set of beliefs. Gender differences and gender subjectivity are founded on these discourses by the positions that a subject assumes on a matter (Henriques et al., 1984). In particular Hollway (1984) and Willig (1995) discursive frameworks on heterosexual relationships may illustrate the dynamics at play when engaging in protective practices in sexual relationships.

2.11.1.1. The "male sexual drive discourse" and the "have/hold discourse"

Hollway (1984) chapter suggests that a person's practices position them in relation to others. She believes that gender differences, power and status are based on the gender of the individual in relation to what they objectify. For example men position themselves in a certain way because they wish to objectify women. Thus it is heterosexual couples that produce the key position for gender differences (Hollway, 1984). Similarly, Foucault (1986, in Wilbraham, 1999) argues that power relations with regards to heterosexual relationships are defined in terms of "monopolization" or control over sexual pleasure. More specifically, within the discourse that is patriarchal in nature, one may see instances in which power is divided unequally between men and women in terms of this sexual monopoly (Wilbraham, 1999). Hollway (1984) argues that men and women use a set of discourses in order for them to make sense of their distinct sexuality. Hollway (1984) two discourses "the male sexual drive discourse" and "the have/hold discourse" will be used.

The first discourse, "the male sexual drive discourse", is characterized by the inherent belief that men are biologically programmed to want sex. In other words the main tenet of male sexuality is an inherent biological drive. This drive is the product of a need to ensure reproduction of the species or to prove virility (Hollway, 1984). Wilbraham (1999, p. 161) describes this discourse as the way in which men are programmed to "seek sexual variety", with women being the object of their desire. Moreover men seem to gain status through the number of women they are able to have sexually (Hollway, 1984).

The second discourse, 'the have/hold discourse', is associated with the Christian values of monogamy and family life (Hollway, 1984). This discourse contains the inherent belief that a woman's sexuality is 'rabid and dangerous and must be controlled' (Hollway, 1984, p. 233). In accordance with this have/hold discourse, a woman's sexuality is defined in terms of satisfying a need for the maternal instinct and family life. More specifically one can see this discourse in the divided or polarized terms of 'wife and mistress, virgin and whore, Mary and Eve' (Hollway, 1984, p. 232). Women can be seen as both 'pure' and 'virtuous' or as a 'mistress'. However, women find this 'juggling act' between categories difficult.

Hollway (1984, p. 233) argues that women are not the mere victims of the male sexual drive, but rather that one of the goals of a woman's sexuality is to 'attract and keep a man'. There is a power and status awarded to women who are able to attract and keep men. Women have this ability to be able to entrap a man and ensure that they will stay in a relationship (Hollway, 1984). Wilbraham (1999) describes how each discourse complements the other. Women are positioned to have a need to 'keep' a man which is in contrast to the male sexual drive discourse, where a man's need is sex and from which he attains his status. Both discourses work alongside one another as women need men to gain power and status, and men need women for the same reasons, however the actual ways and means to attain power and status are different. For women there is also a need to maintain or sustain a monogamous sexual relationship with emotional attachments. Within these various discourses, Wilbraham (1999, p. 165) argues that women position themselves as taking responsibility for all emotional dilemmas/crossroads in a relationship, what she labels as the 'emotional housekeeper' role. More specifically women assume this role of responsibility by taking care of all reproductive issues, in order to maintain and keep a relationship (ibid).

2.11.1.2. The "marital discourse" and the issue of trust

Willig (1995, p. 75) suggests that 'discursive constructions of what it means to use a condom in a relationship may constrain or facilitate particular behaviours within particular contexts'. The 'marital discourse' constructs marriage and long-term relationships as being unsuited or mismatched with condom use (Willig, 1995). She argues that the concept of trust is a crucial component within the discursive framework. Thus people who engage in sex and who are in long-term relationships, position themselves in a way that they are unable to request safe sex from their significant others. Most literature about the concept of trust associates condom use with promiscuity or casual sex. This belief about condoms conflicts with the 'ideal of

heterosexual monogamous love manifested most obviously in the institution of marriage (Willig, 1995, p. 76). Condoms are usually disregarded in these relationships, as terminating condom use signifies a level of trust in a relationship. This assumption of safety within a relationship is problematic for STI (particularly HIV) transmission. In conjunction with Willig's (1995) work; Holland, Ramazanoglu, Scott, Sharpe and Thomson (1991) suggest that condoms have some symbolic meaning within sexual relationships. The way women conceptualize sex as meaning 'love and romance' and the way they give permission to men to direct choices surrounding sex (e.g. penetrative sex and non-condom use), allows for unsafe sexual practices (Holland et al., 1991). Women allow men to make decisions and influence choices related to their (and both partners') reproductive health, as this intensifies their belief that this is done to prove meanings of love, or even further to instil a sense of trust.

Use of the 'marital discourse' can thus provide a way of understanding how condom use is constructed. If condom use signifies promiscuity and casual sex, then it is understandable why sexually active couples in a relationship do not use condoms. Moreover, if the concept of trust is used as a benchmark of a committed sexual relationship then it is understandable why sexual partners in a relationship terminate condom use. Willig (1995) argues that the 'marital discourse' constructs relationships as indicators of trust and safety. A relationship apparently based on trust does not necessarily protect sexual partners from transmitted diseases, but may act as a barrier to condom use (ibid).

Willig (1995) outlines three themes or 'sub-discourses' around the issue of trust and the 'marital discourse' that may help explain the ways in which men and women engage in sexual practices (i.e. 'assumption of safety', 'assumption of marital failure', and 'assumption of trust'). The 'assumption of safety' is associated with the belief that when an individual is involved in a long-term, stable, or married relationship, then this affirms a certainty that one is safe from contracting an STI (Willig, 1995). The 'assumption of possible marital failure' indicated that although individuals may acknowledge that a relationship may end or change, being in a relationship demands trusting one's partner (Willig, 1995). More specifically in a South African context, even though there is a possibility that one's life may be endangered (i.e. contracting HIV), and even though there is no complete certainty or guarantee of safety, a partner must implicitly assume trust, for fear of losing the relationship. The final theme, 'assumption of trust' is associated with the belief

that in a relationship one is expected to trust one's partner (Willig, 1995), even in matters such as STI contraction or transmission. Thus if one is to suggest condom use then you are inadvertently undermining the trust of the relationship and thus could potentially damage the relationship (Willig, 1995). This may fit into Hollway's (1984) 'have/hold discourse' as women may feel that they cannot negotiate condom use for fear of damaging the relationship. Willig's (1995) marital discourse is helpful in identifying the ways individuals position themselves within relationships and how they use the concept of trust in relationships when engaging in risky sexual behaviours.

2.12. Focus of this study

For this study, the way in which people motivate their beliefs about their sexuality is dependent on the discourse in which they position themselves. Importantly, the practice of using or not using condoms may be understood in terms of how men and women position themselves discursively. According to this discursive framework, women may be seen to have a larger burden to bear in terms of sexual health. In terms of the 'have/hold discourse' women may have the inherent need to keep and maintain a relationship. Following the same principle it may be argued that due to a man's desire and need for sex, safe sexual practices may be seen as unimportant compared to unsafe sex. Additionally if men place a larger responsibility on women for protective practices, and women assume this position, then a man's need for unsafe sex may become more important than protective sexual practices. Hollway's (1984) discursive framework may identify ways in which men and women position themselves in certain discourses and engage in sexual practices and contraceptive use. This may help explain the reasons behind risky or unsafe sexual practices.

Using these discourses may be useful in understanding how students position themselves in relation to relationships and sex, and the way this mediates protective sexual practices such as condom use. More specifically the ways in which men and women discuss or 'talk' about issues related to relationships, sex and condoms, may show that there are more than just general issues that hamper condom use (i.e. pleasure and disruption of sex). Additionally these discourses may be helpful in understanding how men and women work within these discourses and how this impacts on issues pertaining to sex. For example it takes both a man and woman to negotiate condom use during sex, but there may be reasons why women feel that men are the ones who should initiate and purchase condoms. In a similar vein it may

shed light on the issue of trust and how men and women position themselves within a relationship and use this notion of trust to mitigate condom use.

CHAPTER 3: AIMS AND RATIONALE

3.1. Aim and rationale

The aim of this study was to explore the dynamics around condom use or non-use amongst heterosexual university students. The study aimed to explore whether students' primary concern was condom use related to the risk of pregnancy or STI transmission. In a previous study of a similar nature (Deacon, 2009), the dominant risk was pregnancy and hormonal contraception was the primary solution. If this is the case then the risk of HIV and STI transmission is high as condom use is the best method to prevent all types of risks in sexual behaviour, including pregnancy. This study aimed to further explore the protective practices of students involved in sexual activity, their perception of risks and why they may be prioritizing the risk of pregnancy as opposed to STI transmission.

Additionally this study aimed to investigate reasons for non-condom use specifically in a student population. Current literature on the reproductive health of students (HEAIDS, 2010) has suggested that although HIV prevalence is low amongst this population and condom use has increased, a study that explores the reasons why students do not engage in condom use is appropriate. Students are educated and hence have a generous amount of knowledge about safe sexual practices and many available resources on campus, including free access to condoms and other contraceptives. An investigation that explored the reasons why students do not engage in protective sexual practices despite their knowledge and access to resources, was thus seen as relevant.

This study further investigated if there were any gender differences or dynamics regarding the use of condoms. More specifically the focus was on, what were the perceived risks which motivated students' condom use, and how did the risks of STI and pregnancy relate to their use? This study will potentially contribute to health promotion strategies, with a focus on HIV and/or unplanned pregnancies.

3.2. Research questions

This study focussed on the following research questions:

What possible reasons are there for non-condom use?

What risks in sexual activity are dominant for students, and how do these risks mediate condom use?

Are there any issues in obtaining or accessing condoms?

Does the type of relationship one has, affect condom use?

Are there any particular gender dynamics when engaging in sex and condom use that may hamper or hinder the use of protective sexual practices?

What discourses do students position themselves in, and how does this positioning effect protective sexual practices?

CHAPTER 4: METHODOLOGY

4.1. Research design

This study used a qualitative research design to explore the dynamics of condom use amongst university students. Quantitative studies tend to describe the general trends in condom use but do not elucidate the dynamics around the choice and use of condoms. Qualitative research provides access to more detailed and richer accounts of the phenomena under investigation (Babbie & Mouton, 2005). Moreover, qualitative studies try to make sense of feelings, experiences, social situations or phenomena as they occur in the real world (Kelly, 2006) and make use of describing and understanding actions of the participants with regards to their beliefs, history, and context (Babbie & Mouton, 2005). Naidoo (2008) argues that although surveys are useful in determining the extent of a situation, the quality and meaningfulness of the data may be lost. Thus a qualitative research design was best suited to creating a locally relevant study that illustrated the dynamic processes of condom use practices within a university context.

A social constructionist approach was used for this study to understand the participants' thoughts, feelings and experiences as products of the social systems that are created (Terre Blanche et al., 2006). Social constructionists argue that identity stems from the interactions individuals have with other people and is based on their language or 'talk' (Burr, 1995). This fitted with the focus of inquiry being directed on the social practices engaged in by the sample and their interactions with each other (Burr, 1995). Moreover, this approach is useful as it focuses on how accounts and experiences are constructed by individuals and how these are constructed by the rhetoric tools that they utilise (Burr, 1995). This approach holds that people make understandings (or sense) about their world in relation to the language that they use and that their 'talk' helps to construct their reality or the positions (Burr, 1995). Hollway (1987) and Willig's (1999) discursive frameworks were used in order to make sense and meaning of the data. A social constructionist/discursive analysis approach made use of Hollway (1987) and Willig's (1999) discursive framework to understand how the participants construct their own reality through the ways in which they position themselves and each other in terms of sexual relationships, and how this affected use or non-use of condoms.

4.2. Sample

The aim of the study was to explore the dynamics of condom use. This was best done through a small, purposive, convenience sample. Purposive sampling involves not only the willingness to participate in a study but also cases that are typical of the population (Durrheim & Painter, 2006). Additionally the participants are selected due to similar characteristics that they possess (Patton, 1990), for example being a student and being sexually active. Convenience sampling involves selecting participants who are easily accessible (Henry, 1998) and from a population that is close at hand (Patton, 1990). Sexual activity and condom use is a private activity. Accessing and using a purposive convenience sample moderated the difficulties of accessing participants, as participants actively chose to take part in the study and were fully aware from the start about the scope of the study.

4.2.1. Participants

Students were selected for the purpose of this study. This was done as students have access to many resources on campus with regards to contraceptive use and information about STI transmission (i.e. the Campus Clinic, free condom access, HIV testing facilities). This was similar to Pettifor et al. (2004) research which found that students reported an ease in finding and obtaining condoms. Additionally it has been reported that amongst students condom use has increased by 60% (HEAIDS, 2010). Thus students may be perceived as well informed with regards to condom use and STI transmission.

In order to participate the participants had to be students on campus, as the study wished to focus on young adults who have the resources offered by the university and who engage in sexual activities. Moreover a portion of the heightened HIV prevalence rates are between the ages of 15 and 24 (Shisana et al., 2009), which is the general age of many students on campus. In the study students had to be over the age of 18 and sexually active or have previously been sexually active. This age range of students was chosen for ethical purposes and because older students are more likely to be sexually active and more open to discussion on the matter. This was also chosen as this is the legal age range for participating in a study. Race of the participants was not a criterion for this study as racial differences were not under investigation. However, male and female participants were recruited because the study wished to identify any gender dynamics with regards to condom use.

4.2.2. Recruitment

Notices about the study (see Appendix 1) were displayed around campus asking for volunteers. Participants were recruited in this way because the sensitive nature of the study meant that participation needed to be voluntary. Students were given the researcher's email addresses and cell phone numbers, and asked to send an email with their contact details if they chose to participate. The participants were contacted by cell phone and asked the following questions:

- 1) Are you sexually active?
- 2) What is your relationship status? (i.e. "Single" or "In a Relationship")
- 3) What is your year of study?
- 4) What is your gender?
- 5) What is your age?
- 6) Which faculty do you belong to?
- 7) Would you prefer having a focus group session or an individual interview?

Participation was voluntary and the only criteria that were needed were for the individual to be sexually active and over the age of 18. If participants said that they were not sexually active, they were thanked for wanting to take part in the study but told that only sexually active participants were needed. Their contact details and information were subsequently destroyed.

After approximately four weeks of recruitment and after replacing posters that had been taken down, only 12 people had responded, of which only 8 could participate in the study based on the above mentioned criteria. Another strategy for recruitment was then deployed by making flyers (see Appendix 2) and distributing them outside a well-used second year psychology exam venue. Problems that could be encountered by using such a recruiting procedure are that some of the students found in this area may not be completely representative of the population of students at UKZN (Pietermaritzburg). For example second year psychology students may have different opinions of sex and condom use compared to other students on campus.

After the university vacation, additional posters were posted around campus that were aimed more specifically at male participants (see Appendix 3). This was done as by this stage of the

recruitment, enough female participants had joined the study but only 2 male participants wanted to take part. This was perhaps because men do not feel as comfortable discussing sex within a focus group setting and/or that they did not feel comfortable discussing issues related to condom use and sex with a female researcher. To attract more male participants to the study, it was advertised that the participants would receive a R20-00 food voucher for the university canteen. It was decided that this would not be a form of coercion as former participants that had taken part in the study also received the voucher, but were just unaware of it at the point of recruitment. However some of these participants could have been motivated to participate because of the voucher, whereas other participants had not.

4.2.3. The sample

In total eight female and five male volunteers were suitable for the study. The average age of the female participants was 21, and the average age for the male participants was 21. There was only one female participant that was not in a relationship. The average year of study for the participants was third year and degrees being achieved by the participants varied from a BSocSci, BA, and BCom. The majors of the participants ranged from Psychology, to Marketing, Law and English.

To maintain confidentiality, the participants were not asked to check their names against a roster. For this reason the demographic details given are only an approximation of their age, year of study and whether they were in a relationship. When participants were approached for the individual interviews their details were recorded and therefore the reason the exact age of the interview participants are known.

4.3. Data collection techniques

Interviews and focus groups were used to collect data. Focus groups were used as they allowed for a general overview of what is being studied. Moreover focus groups were used because they are good for quickly identifying qualitative similarities (Stewart & Shamdasani, 1998). Individual interviews were chosen because they allow for a more in-depth data collection procedure due to the one-on-one interaction. Taylor and Bogdan (1984) argue that individual interviews allow the researcher to enter the participants' experiences vicariously. In addition to this, individual interviews allow for the participants to engage in the discussion from their own viewpoint without there being any coercion in the conversation.

4.3.1. Focus groups

Two focus groups were used. One consisted of four female participants, while the other consisted of four male participants. Focus group participants and individual interviews were exclusive to each session. In other words, focus group participants only took part in the focus group discussion. The focus group sessions lasted for approximately two hours each. The sessions were held in a room at the School of Psychology where privacy was maintained. The discussion was largely in the form of a semi-structured interview. A set of questions (see Appendix 4) was used to encourage and guide the discussion. The questions were generated by the review of the literature. More specifically factors in these studies identified as hampering the use of condoms were used to produce the questions, for example what types of relationships are there and do these types of relationships hamper condom use, what issues do/do not hamper condom use amongst students, and are there any particular gender dynamics with regards to condom use and university students.

A participatory technique was used during the focus group in order to encourage discussion and ease the participants into a discussion of the topic of sex and condom use. Moreover this type of data collection technique is useful in the way it can successfully research sensitive areas needed for health promotion programmes (Johnson & Mayoux, 1998). A technique used by Cornwall (1992, in Johnson & Mayoux, 1998) which accessed women's knowledge about reproduction and contraception by asking them to draw the reproductive system and the ways in which contraception affect this cycle, was replicated for this study. In the study this technique was also used in order to discover if there were any gender differences between the focus groups with regards to knowledge about contraceptive use.

4.3.2. Individual interviews

There were five individual interviews: with four female participants and with one male participant. The individual interview sessions lasted for approximately half an hour to an hour each. The sessions were held in a room at the School of Psychology where privacy was maintained. Similar questions and topics (see Appendix 5) to the focus groups were used during the individual interviews with the exception that they were directed at the participant's personal experience. Topics of discussion included: why the participant uses condoms, what

risks does the participant fear when engaging in sex, what are their experiences of obtaining condoms, and who in their relationship initiates sex and condom use.

4.5. Instruments and equipment

Two audio recording devices were used to record information from the focus groups and individual interviews. This was done in order to ensure the best quality of recording information. Field notes were taken during the focus groups and the individual interviews. This was done to ensure that no other extra information was lost during the process. An audio programme was used to convert the audio recordings to text. Transcribing was done by the researcher. Transcription conventions by Du Bois (n.d.) were used to aid the process of analysis and to ensure that the best possible way of presenting the text (See Appendix 6).

4.5. Procedure

4.5.1. Ethical considerations

There are four widely accepted philosophical ethical principles that are applied to determine whether research is ethical, namely: autonomy and respect for the dignity of persons; nonmaleficence; beneficence; and justice (Wassenaar, 2006). The above mentioned principles were put into practice through the building of collaborative partnerships, addressing questions that hold social value, having a fair selection of participants, having a favourable risk/benefit ratio, an independent ethical review, informed consent, and ongoing respect for participants and study communities (Wassenaar, 2006). The sections which follow outline how the abovementioned were considered for this study.

4.5.1.1. Informed consent and confidentiality

The aims and objectives of the study were extensively explained to the participants when they were initially approached (i.e. posters and flyers) and when they were contacted via cell phone. This information was given verbally and in written form for the participants to keep, in case they needed any necessary contact details. The research process was discussed with the participants, and issues such as confidentiality and how the research data will be used were considered. The participants were given a participant's information sheet before the focus groups and individual interviews began (see Appendix 7 and Appendix 8 respectively). This sheet contained contact details for the research supervisor and the researcher. Additionally the contact details for the Student Counselling Centre, Campus Clinic and

School of Psychology Higher Degrees Ethics Committee were given. This information sheet also included information about the storage and dissemination of the data.

The participants had to sign the informed consent sheet (see Appendix 9) in order to take part in the study. This form included information about how confidentiality would be maintained and the right to withdraw from the study. The informed consent sheet also had a waiver that needed to be signed for audio recording of the sessions to be permitted (see Appendix 10).

When the participants were initially contacted, their names and the focus group they were attending (i.e. male or female) were written down. However during both the focus groups and individual interviews, they were not asked to check their names against a roster for obvious confidentiality purposes. For this reason the demographic details given are only an approximation of their age, year of study and whether they were in a relationship. When participants were approached for the individual interviews their details were recorded and therefore the reason the exact age of the interview participants are known.

4.5.1.2. Maleficence

There was a potential risk that the sensitivity of the topic could cause some embarrassment or harm to the participants. Goodram and Keyesø (2003) guidelines in addressing a sensitive topic were used to help moderate or manage the participants' safety. These guidelines stipulate that when researching a sensitive topic there should be a defined and detailed informed consent process, heightened awareness of confidentiality, and careful data management (i.e. storage and dissemination).

This was managed accordingly as this study used purposive convenience sampling; the participants volunteered and knew beforehand what the topic of discussion was about, as the study was clearly defined on the posters. Additionally the participants were allowed to contact the researcher discreetly via email if they wanted to take part in the study. The participants were then well informed about the study via the telephone, and were allowed to decline once they had the specific information. More specifically the participants were told what the study was about studying how men and women perceive sex, safe sex, and condom use. The focus group discussions were differentiated by gender, thus the possibility of discussing a potentially embarrassing topic in front of the opposite sex was reduced. The participants were allowed to leave the study at any point in time. Thirdly, confidentiality of

the research process was explained. Confidentiality was maintained by allocating a code to each participant (e.g. P1;F2 would indicate participant number 1 in focus group 2). The codes of the participants, rather than their names, were written down in the field notes.

The two types of data collection also helped to minimise risk. The focus group and individual interviews were managed very carefully. Both were conducted in a private area and a notice was placed on the door to notify others that there was a private session taking place. This was done in order to give the participants a sense of privacy and respect. In terms of the individual interviews, the one-on-one interaction between the researcher and the participant reduced the risk of social disclosure. Confidentiality was maintained for both the focus groups and the individual interviews. However focus group confidentiality did pose a small problem, as there is no sure way of ensuring that all of the participants in the study would guarantee confidentiality outside of the focus group setting. In order to combat this, a confidentiality agreement/pledge (see Appendix 11) was signed by the participants in the focus group. This pledge requested that the participants would individually respect each participant's right to privacy. This was done to explain to the participants what might happen if confidentiality was not maintained. Additionally it was felt that if the participants were given a sense of ownership over the process then they would not discuss the study outside of the focus groups.

4.5.1.3. Cost/benefits

In order to repay the cost of time for the focus group participants (i.e. took approximately 2 hours) and individual interview participants (i.e. approximately 1 hour), a R20-00 voucher was given to the participants. This was not advertised on the initial notices placed around campus as I did not want students to participate for monetary gain only. However this was later advertised in order to recruit additional participants.

This study may benefit the participants indirectly, as the results of the study may help in the design of future health campaigns about issues of STI transmission, pregnancy and contraceptive choices (especially condom use).

4.5.1.4. Storage and dissemination

To maintain confidentiality, all documentation was stored in a locked cabinet either at the School of Psychology or at my place of residence. Moreover all documentation at the end of

the study was destroyed and any published reports will only contain the code of the participants and no identifying information.

The findings of the study were presented at a Post Graduate Research Conference at UKZN, and the thesis will be stored in the university library.

4.6. Data analysis

The study used two forms of analysis. Initially interpretive thematic analysis was used, which is based on techniques described by Terre Blanche et al. (2006) and Boyatzis (1998). Finally discourse analysis was used, which was related to Antaki, Billig, Edwards, and Potterø (n.d.) methods.

Thematic analysis was utilised because it is a useful method for assisting in the organisation and interpretation of qualitative information (Boyatzis, 1998). This process involved encoding information that required an 'explicit code', which includes a list of themes. These themes were used as information patterns that describe and organise observations and interpret aspects of the phenomenon under observation (Boyatzis, 1998).

The five steps that Terre Blanche et al. (2006) identified were also used in order to analyse the data. These steps included familiarisation, inducing themes, coding, elaboration and interpretation and checking. During the first stage of data collection the reading and re-reading of the data was done in order to see what was supported by the data (Terre Blanche et al., 2006). Throughout this stage I related the responses of the participants to the issues discussed in the literature review. During the second stage of data analysis I used the language of the participants to label the themes and the codes (Terre Blanche et al., 2006). For example the theme of 'HIV' was used to locate and find discussions that centred on this risk. This blended into step three, where I coded the relevant data in terms of the theme (Terre Blanche et al., 2006). This worked in conjunction with the fourth stage as the raw information became less of a text and more of a way of grouping related issues, themes and codes (Terre Blanche et al., 2006). During the final stage, the overall themes and codes were checked for any contradictions and to ensure that the information was coded in such a way as to make sense to the reader (Terre Blanche et al., 2006).

It may be argued that thematising the data was used as a way of summarising the text into similar themes and codes (Terre Blanche et al., 2006). Thus discourse analysis was used in conjunction with Hollway (1987) and Willigø (1995) discursive frameworks in order to make sense of the way the participants positioned themselves in relation to issues that surround contraceptive use. This approach is defined as a way of ðshowing how certain discourses are deployed to achieve particular effects in specific contextsö (Terre Blanche et al., 2006, p. 328). Discourses are thus viewed as ways in which individuals verbalise issues in order to make sense of their world or social reality (Terre Blanche et al., 2006). In terms of this study the transcripts from the data collection process were analysed for Hollway (1987) and Willigø (1995) discourses. These were then used as a framework to understand the positions that the participants assumed in their ðtalkø about sex and about condom use.

In addition to the above, Antaki et alø. (n.d.) guidelines were taken into consideration. This was done by compiling quotations into a profile, in order to investigate whether the participants ðtalkø was a commonly used discursive resource. Moreover this is useful to determine whether participants used shared patterns of understanding or interpreting the questions posed. Thus the speech may have shared meaning or a shared pattern of speech which was common. The quotes used thus become a justification for asserting the discourses employed. This then implies that the participants made use of that particular ðtalkø because they share these discourses, repertoires, and/or ideologies (Antaki et al., n.d.). A profile was made from the participantø ðtalkø on sex, relationships, and condom use. Shared patterns of speech that were common (Antaki et al., n.d.), and fitted into these discourses were ðflaggedø for discussion.

CHAPTER 5: RESULTS

5.1. Introduction

In this section I present the results of the analysis of the data. I will discuss these in relation to the frame and findings of other studies presented in the literature review. The results section will deal more with *what* was found, whereas the discussion section will deal more with the *why* or *how* and look at the students' *talk* on the matter.

5.2. Review of questions posed

This study aimed to explore the possible reasons for students' use or non-use of condoms. Students are afforded many opportunities to combat the risks associated with sex. Additionally students are an educated population, and in essence understand the risks associated with unprotected sexual practices. As condoms are the most effective preventative measure, students' dynamics of condom use needed to be explored.

Firstly, what risks motivate condom choices? In a previous study looking at a student population, it was found that pregnancy was deemed a higher risk than that of STI transmission (Deacon, 2009). Thus hormonal contraceptive use, such as the pill and the injection, was primary and condom use a measure rarely considered for numerous reasons. If this is the case then students may be engaging in risky sex as their *hierarchy of risks* are primarily pregnancy and then STI transmission. In this instance then individuals are at a risk for contracting STIs such as HIV. Given that the HIV prevalence is so high in South Africa, students' reasoning is very worrying.

Secondly, what are the issues in using and obtaining condoms for this specific population? Students are given access to free condoms, thus the reasons why they are not used needs to be explored.

Thirdly, does relationship type affect condom use? Condom use may be affected by the length of time one is with, and the trust one has in, a sexual partner, or the number of partners one has had. For example if an individual trusts his/her sexual partner (i.e. that they are not *cheating* or having condomless sex with others) then condom use is discontinued. However

this is problematic as in South Africa having multiple concurrent partners is normative (Parker et al., 2007). It is important to explore what factors may mitigate condom use.

Finally, are there any particular gender issues in condom use? It may be logical to assume that anything to do with safe sex is negotiable, as it takes two people to engage in sexual activity. Thus one can presume that engaging in condom use is similar. For instance if one individual is uninterested in engaging in condom use, students may engage in unprotected sexual practices. There may be a particular gender dynamic or pattern that may explain why students engage in condomless sex.

5.3. Explanation of extracts

In the presentation and discussion of the findings, extracts from the data will be used. Extracts from the interviews and focus groups will be in italics. The race and gender of the participant will follow the extract. Although racial differences were not under investigation, the race of the participant was used in order to distinguish individuals from each other. Individually interviewed participants will also be identified by age. For example; 'White male, 22' is an interview participant. Additionally for those who participated in the focus groups a code will be given to indicate the number of the participant and which focus group they took part in. For example, Black female (P2), would indicate that the participant was coded as P2 in the transcripts and was from the female focus group. Whereas Black male (P4) would indicate that the participant was coded P4 in the transcripts and from the male focus group.

In the extracts non-italicised brackets shown within the excerpt will be my own interpretation of the words that are missing to make the sentence more understandable to the reader. If (<>) is found in the excerpt some of the text has been deleted as it was too long in relation to the point being made. A (...) indicates a pause in speech made by the participant. The use of (≠) indicates that the participants are using speech as a form of expression or reported speech. Underlining of words used by participants indicates emphasis placed by them on the words or words. For a list of transcription conventions see Appendix 6.

5.4. 'What' was found

The transcripts were analysed using two methods of analysis (i.e. interpretive thematic analysis and discourse analysis). The data was analysed using interpretive thematic analysis.

In other words, after the transcripts were produced, certain themes were common among the students' talk. These themes were then used to answer the research questions posed. The following themes were found throughout the study: the sexual risks and the participants' motivation for condom use; the reasons that were given for the use and non-use of condoms, which included the spontaneous and secretive nature of sex, aesthetic reasons, accessing condoms, knowledge about condoms, condoms being related to certain kinds of sex, and issues related to trust and condoms; a focus of HIV and pregnancy as hindering or promoting the use of condoms, and the reasons why HIV and pregnancy are seen as high risk; and being a student as a factor that may mitigate the use of condoms.

5.4.1. Risks and motivation for condom use

From here on all excerpts from transcripts have been indented

In asking students about the risks related to sex, they mentioned; pregnancy, HIV and other STIs.

The usuals, HIV, STI and pregnancy...even when you are using the protection, they are not one hundred percent ó Black Male, P2

Pleasure today, HIV positive and pregnant tomorrow ó Black Female, P4

Interestingly there seemed to be a mixed response as to which risk was perceived to be the worst, with pregnancy and HIV being the predominantly mentioned risks. Nearly all of the female participants were on some form of hormonal contraceptive, but admitted to not using condoms in several previous sexual encounters. This may suggest that students are ambivalent about what they feel they need to be protected against (i.e. pregnancy and/or STIs such as HIV), and thus their method of contraception (i.e. hormonal or barrier) may be related to their greater perceived risk.

I mean that's why I use a condom because I am scared, I don't want to become pregnant or become sick ó Black Female, 20

It's scary because (HIV is) irreversible, (< >) I mean you going to die (laughter)...and that sucks...you know a baby you can deal with. I mean with a baby it's easier to manage, and it is reversible, you could get an abortion ó White Female,

22

5.4.2. Condom use

Most of the participants said that they had used condoms at some point during previous or present sexual relationships. But condom use was never consistent, as some of the participants admitted that at some point in their sexual histories they had not used condoms. One participant in particular had never actively engaged in condom use, and admitted to be reluctant to use one. The participants understood the risks of such behaviors but they did not feel that using a barrier/condom method was necessary, even when they viewed pregnancy and HIV as their main concerns in unprotected sex. This discovery is in stark contrast to the HEAIDS (2010) research that suggests that condom use at last sex for students is quite high.

Some of their reasons for non-condom use were:

(Students) believe that both condoms and pill are negative...I mean people are so frigging paranoid, they like if I take a pill, it's going to make me fat, and then they'd rather not use a condom because of the feeling, and I'm like 'Come one guys, you (are) putting your life at stake here' ó Black Female, P4

To be honest with you, I also don't like condoms, it's not even more than five times that I've used a condom, I prefer like going in for a (HIV) test with the person, and then we can at least try without the condom ó Black Male, P1

Most of the participants said that access to condoms was relatively simple. Interestingly all of the participants understood and acknowledged that condoms were the best method for preventing pregnancy and STI transmission. As one participant stipulated:

I don't find sex to be risky for me, because I've always used a condom...and she's always been on the pill as well, so it's like double protection - White Male, 22

However despite awareness of the risks, many of the participants felt that condom use was at some point in their relationships unnecessary. The issue of trust became a predominant theme throughout their discussion which will be discussed later. Additionally many participants said that condom use was linked predominantly to risky sex or HIV prevention, which was not their predominant concern and thus one of the core reasons for their nonuse.

5.4.2.1. Using and not using condoms

Some participants felt that condoms were the best method of preventing all the risks that were mentioned. However, the participants had many reasons why they did not engage in condom use. Some of the reasons included: condoms ruined the mood or excitement of sex; they were aesthetically unpleasing; some participants had issues with access to condoms; knowledge of using condoms; condoms were related to risky and promiscuous sex and trusting in one's sexual partner.

5.4.2.1.1. The nature of sex

From the literature review it may be seen that access to contraceptives may be hindered by the secretive and spontaneous nature of sex (Amazigo et al., 1997; Hansen & Skjeldstad, 2007; Amy & Loeber, 2007). These studies also suggest that in spontaneous moments condoms may not be available and therefore not used. Similar findings emerged in this study as many of the participants felt that condoms either disrupted the spontaneous pleasure of sex, or that in some cases sex may just happen and they were unprepared with a condom. As one participant said:

I mean, sometimes you just want to do it and then you got to leave and go find a condom...I mean if you at home and you don't have a condom on you...you not going miss out on the opportunity (to have sex to get a condom) ó Black Male, P3

Moreover it was found that being secretive about sex meant that participants were embarrassed to purchase or even ask about contraceptives, due to some of the negative reactions that they had received. For instance:

They (store clerks and nurses) look at you like, 'Ha-ha he's going to go home and have sex', instead of being, 'Good he's trying to be safe and responsible'í - Black Male, P1

Again there is a sense that participants need to be secretive around issues of a sexual nature, as they do not want there to be proof of their sexual activity.

5.4.2.1.2. Ruining the mood: Aesthetic reasons

According to Amy and Loeber (2007) and Maharajó (2001) studies, condoms were not used as they ruined the mood and that it decreases sensation during sex. The participants in

this study mentioned that condoms were not used because of aesthetic reasons such as sensation, their smell and that they ruined the mood:

It just felt like we were masturbating and that's it, and then we take it off and it feels real again ó Black Male, P1

And even to take a condom out, take off the plastic, aim it on...I mean it takes a lot of time and by then the girl is snoring, and for girls it takes a long time to get turned on and a short time to get turned off and by the time you've got the thing on, then it's over and you're like, 'well all I wanted was sex and now she's not interested'...You might have saved yourself from AIDS being safe and responsible but now you've missed out...and also you just not thinking straight, your blood is rushing, adrenalin going and now you have to think of putting a condom on... - Black Male, P4

I mean we heard other people talking about not using condoms, and we were like... 'What's the fuss?' ...and then we tried it (not using condoms) and I was like, 'Oh now I get it' ...it just feels so much better, like the real deal ó White Male, 22

It seems that for many of the participants (including the female participants) condoms were aesthetically unpleasing and one of the reasons for non-condom use. But this was not the case for all participants. Some argued that although condoms did not feel pleasurable, it was the safety of them and the certainty after sex of being protected that made them more pleasurable. As one female participant argued her point:

I mean what I like about the condom is...like after you've finished, you just know that it's done and that you were responsible and safe and that you can't like get pregnant or get someone's nasties ó Black Female, P2

5.4.2.1.3. Access, availability and affordability

According to Pettifor, Rees and Steffenson (2004) South African survey 87% of their student sample reported an ease in acquiring condoms. Additionally HEAIDS (2010) found that 60% of students used condoms at last sex. Many of the participants in this study felt that there should be no issue in gaining access to at least one type of contraceptive (i.e. either condoms or a hormonal contraceptive), especially since students within the university are given resources such as the Campus Clinic and access to free condoms in the bathrooms.

Many participants in the study felt that condoms were easily accessible and they did not understand why other students did not use them:

Condoms and the pill, I mean you get those for free ó White Female, 22

A possible hindrance to the use of condoms may be that accessing condoms is viewed quite negatively, the lack of knowledge about how to use condoms, and the quality of free government issued condoms. As one male participant said:

Some say 'I don't want to walk the distance to get a Choice condom' (laughter) and it's just a walk to the bathroom, and some say 'I don't want to waste my money on the ones at the store', where you also get judged ó Black Male, P2

Some of the male participants also said that there was some difficulty in accessing condoms due to the price of some of the brands, but these were preferred for various reasons, such as quality and better sensation. Some of the participants explained:

They never give you the instruction to use it safely, instead they stand there and judge you, and the free condoms are crap anyway...so it's a lose-lose situation ó Black Male, P2

Since when is sex not supposed to be fun? ...I mean you could use the free ones but they just feel like shit, but then the other ones are so expensive...what do we do? ó Black Male, P3

Interestingly accessibility of condoms for men was an issue, but for women, actually carrying condoms on them was an issue. Some of the participants felt that if a woman carried condoms around then that would mean that she was engaging in a lot of sex.

5.4.2.1.4. Knowing, understanding and actually using condoms

Having correct knowledge about condoms facilitates their correct use and informs one's choices with regards to safe sex practices (Ahlberg et al., 2001; Amazigo et al., 1997; Bodibe, 2009; Delva, et al., 2007). Many of the participants had the knowledge about how condoms protected them against STI transmission. However, many of the participants felt that some students did not know how to actually use them or put them on. As two participants explained:

The funny thing is, is that you think that we (students) have all this knowledge, but then I've been in a situation before where a guy doesn't even know how to put one (a condom) on ó Black Female, P3

Some dudes are too embarrassed to admit that they don't even know how to put it (a condom) on...I mean guys should know how to use their tool (penis) ó Black Male, P2

Interestingly many of the female participants commented that knowing how to actually use a condom was the man's job or that it was a man's responsibility to ensure that they carried condoms and that they knew how to wear them and use them. This fits into Harvey et al's. (2006) study where condoms are designed for men's bodies and for men to understand how to use them, but that it is the woman's task or duty to ensure that they wear them. If men do not know how to actually use a condom then it becomes problematic, as women are the ones expected to know this. It is also problematic when there is a negative attitude to women carrying condoms, because of being seen as promiscuous, but then men are expected to carry them and know how to use them.

5.4.2.1.5. Condoms related to risky sex

Similar to Foss et al's. (2004), Hearst and Chen (2004), and Maharaj's (2001) research, individuals do not engage in condom use as it is linked to illicit sex and promiscuity, and more common in non-marital or short term relationships. Clear links were made by the participants that condoms use implied risky sex. As one participant suggested:

The main reason for people and why they use condoms, is because they don't want to get sexually transmitted diseases (< >) because condoms are better at protecting that sort of stuff... - White Male, 22

Other statements made by participants suggested that condoms were a method only used in sex that could potentially lead to disease. In other words using a condom meant that you felt that you could either transmit a disease, or that you felt that the other person was a risk.

I mean if you go to a girl's house and she has a lot of condoms then that means she's having lots of sex...which makes me kind of worried that she might have something ó Black Male, P1

Non-condom use on the other hand, meant that you had faith in your and your partner's own reproductive health. This links to having some form of trust with your sexual partner. Another participant mentioned:

We both know we don't have anything (STI's) and I'm on the pill so...we trust each other ó White Female, 22

Condoms are thus affiliated with risky sex and thus only necessary in instances where you think you could contract a STI or HIV. This links to the notion of trusting one's sexual partner, or at least knowing some of the individual's previous sexual history or HIV status.

5.4.2.1.6. Trust, condoms, HIV and relationships

In response to the risks of STI's and HIV, the issue of trust in one's partner was brought up frequently. The issue of trust has been seen to be one of the major reasons for individuals to stop using condoms in a relationship (Flood, 2003). Believing in, or trusting your partner mitigates the risk of infection and thus condoms are discarded. In situations where condoms were not used, participants often referred to trusting their partners in the relationship depending on the length of time they knew a person and whether they had had an HIV test with that person to confirm a negative status. They often spoke about "knowing" their partners and therefore trusting them with their reproductive health. As some of the participants explained:

But if it's with a random girl that you don't know and then don't trust then you have to do it...unless it's a person that you've dated for like 4 or 5 years, the girl could have built up so much trust in you to put her life in your hands... - Black Male, P4

If I am going to a party and I am meeting you for the first time, I cannot take that chance and sleep with you, I have to get to know you first, so that we can get to know each other first and I can get to trust you ó Black Male, P1

Kaufman et al. (2008) reported that whilst men found sexual gratification in engaging in condom-less sex, women found pleasure in the affirmation of trust and fidelity through condom-less sex. Thus as soon as trust had been established in a relationship, then condoms were not used in the relationship.

I think that you get to a stage in a relationship where it's ok to do the whole unprotected sex thing, where both you and your partner know that you're not

transmitting anything to each other... I mean you learn to trust each other but trust is only built up when you've been together for quite a while, so at the beginning of a relationship, I would highly recommend that you use a condom. ó White Male, 22

This can also be linked to the beliefs that condoms are affiliated with risky sex, prostitution, HIV, disease, illicit sex and promiscuity (Hearst & Chen, 2004; Maharaj, 2001; Maharaj & Cleland, 2004). Thus students reasons for engaging in "condom-less" sex is because they feel that if they engage in condom use they feel that they may be portrayed as having engaged in multiple sexual relationships, or that they have taken part in something sordid, untasteful or unattractive.

"Condomed" sex is associated with promiscuity and casual sex (Willig, 1995). Many of the participants have associated condoms with risky sex, and more specifically, sex related to HIV and AIDS. As some participants said:

I insisted that we used a condom because I knew that he had slept with girls in that period where we hadn't been with each other ó White Female, 23

Some people would use it as a measure, you know, like if he uses a condom then it means that he doesn't trust me that much, or if he doesn't then that means he does ó Black Female, 20

Because if I don't trust a person, it means I'm putting my life on the line for him, and if I don't trust him, I'm not going to risk my life for him ó Black Female, P1

Just condomise and know the person you are with if you are not going to use a condom ó Black Male, P3

5.4.3. A focus on HIV or pregnancy

Pregnancy and HIV were seen as the predominant risks of sexual intercourse. Although HIV was mentioned as a high risk, pregnancy dominated the discussion. It seems that pregnancy is related to loss of future achievements, whilst HIV is related to a loss of life. The following issues were dominant in the discussion of why pregnancy and HIV were the predominant risks of sexual intercourse: The visibility of being pregnant; HIV as something outside of

their situation; unrelated roles of being a parent and a student; and the financial responsibility that comes with having a child.

5.4.3.1. Hidden sex: Pregnancy and HIV

Pregnancy was perceived as being worse than acquiring an STI because it is noticeable, whilst having an STI such as HIV is not publically visible, and can be hidden. As female participants commented:

So a pregnancy would be the thing to give us away (that we are sexually active) -
White Female, 23

Because when you're pregnant, everybody sees this, and when you've got the virus you can die on your own ó Black Female, P3

People will then know that you've (had sex) but with HIV you can get it many ways firstly, and because you don't get like a tattoo on your head saying 'I've had sex' ó
Black Female, P4

Pregnancy is thus seen as a risk because it is 'proof' of sexual activity. Pregnancy proves to others that a person is sexually active and no longer a virgin, which may threaten their identity as a woman. Women are thus constructed as virtuous beings that are impure when they engage in sexual activity. Thus for women sex is seen as something that is conflictual to their being or sense of self. However this is not to say that women do not engage in sexual activities. The conflict however is that pregnancy affirms this impurity to others as it is visible. This was similar to Deacon's (2009) research in which women felt that proof of sexual activity would invariably hamper their identity to significant others, including parents, peers and future partners. Through history it has been noted that the topic of sex and women is a taboo subject, in which women are positioned in such a way as to suggest that sex is only a mere reproductive right and pleasurable sex for women is somewhat unjust (Wilbraham, 1999). Thus sex outside the reason of reproduction is seen as something taboo for women. Pregnancy is visible proof that a woman has had sex. Pregnancy is thus seen as a high risk of engaging in sex, as it means that a woman could be positioned in such a way that suggests that she is promiscuous, a notion that may harm her 'reputation' with others, such as prospective male partners and other significant relationships.

On the other hand, some participants perceived HIV to be a higher risk as it meant a lifelong disease that needed to be continuously cared for, and which could potentially mean death. However, HIV was only perceived as a threat if one did not trust one's sexual partner (the issue of trust will be discussed in detail later). Moreover an HIV status could be easily identified through an HIV test, which put many of the participants' minds at ease. This can be seen in accordance with Parker et al's. (2007) study which identified that having an HIV test could reduce the chance of contracting STIs such as HIV if condom use is not consistent. For instance, one participant suggested:

We knew that it (HIV) wasn't a problem because we both went for a test together
Black Female, P3

However many of the participants only used one HIV test to determine whether their partners were HIV negative. They felt that one test was fine as a standard, because they could then trust their partners not to engage in other sexual endeavours. This is problematic as they could still be at risk for contracting other STIs and HIV if their partners are not 'faithful'

Interestingly many of the participants did not want to have an HIV test because of the connotations that surrounded it. In other words some participants felt that to have an HIV test was an admission that they had engaged in risky sexual interactions and thus had made the wrong decisions. This again demonstrates a concern with proof of sexual activity. Although an HIV status can remain a privately known issue, the students still felt that this would be admission of engaging in risky sex.

5.4.3.2. The right choice of protective practice

What risk in sex is perceived as worse by students seemed to determine what type of contraceptive practices were engaged in by the students. Most of the students perceived pregnancy as the biggest risk when engaging in sex, and thus used hormonal contraceptives to combat this. As one participant suggested:

Well most girls don't like using a condom, even the ones that are promiscuous, they prefer using the morning after pills or contraceptives that won't let them fall pregnant
Black Male, P4

This is problematic as condoms are the best method for preventing all risks related with sex. Other methods to ensure that STI and HIV transmission were excluded from sexual activity included the use of HIV tests.

I went to test with my partner, so we scratched the HIV part, falling pregnant...I think I had that covered...but really we never know what the other person does ó Black Female, 20

Some participants did argue that HIV was a large risk, but argued that being tested for STIs, such as HIV, was a better method of prevention than condom use. According to Parker et al. (2007) VCT is one of the best preventative measures if individuals are going to take part in risky condom-less sex. Some participants suggested this:

In my last relationship it was more about falling pregnant because we sort of knew that, um, neither of us had AIDS because we went for a test ó White Female, 22

Because people are meant to use condoms all the time, unless they know each other's status... - Black Male, P1

Although these statements about trust and testing were made, many participants understood that this still did not ensure that their sexual partner was being faithful. However in some cases they did not feel the need to have an HIV test because they still trusted their partners:

There's never been a need to get any of the STI testing's...and because I trust her... But I think that if I dated someone who had quite a lot of sexual partners previously, then I would probably suggest some sort of HIV testing ó White Male, 22

5.4.3.3. Denial of risk: HIV

Hartelø (2005) study found that one of the reasons why student populations do not engage in condom use, is their belief that HIV and AIDS would not affect them. This could be seen by many of the participants talk on the matter:

Like they (students) are just so sure that (they) are not going to get AIDS, and people like block out the information (< >). Like if you've engaged in sex like SO many times without a condom and nothing has happened, so you would actually think that you've got control over the situation ó Black Female, 20

A lot of people have that 'it won't happen to you' thing ó Black Female, P2

Interestingly this belief that HIV would not affect them seemed to also be present in the ways that students viewed pregnancy as a risk:

I mean every day we are told about STI's and HIV and getting pregnant, but you never think it's going to happen to you until you get pregnant - Black Female, 21

When discussing HIV as an issue specifically, students would link opinions about HIV to people who were considered promiscuous or "unsafe" (i.e. people who did not engage in condom use).

I mean I'll only use a condom when I think the chick is like dirty and stuff...you wouldn't know if she has like HIV or stuff ó Black Male, P1

However the participants' own behaviors were never taken into account when considering this risk. This goes back to the students' belief that condom use is linked to risky, promiscuous and unsafe sex, while non-condom use is linked to being able to enjoy sex because you are healthy and do not have HIV.

5.4.3.4. Tension between parent and student roles

Being a student and being a parent were also seen to be conflicting roles, especially for women as they felt that they were the ones who are directly affected. Participants commented:

You're at varsity and it's a privilege and you don't want to screw it up having a baby ó White Female, 22

Well for guys it's the in thing for them to sleep around, I mean you're the man if you have so many girls at the same time, and if you make a girl pregnant, its fine because you continue with your life, in a sense that there's drama, but you don't have to miss years of schooling...but I'm the one that if I get pregnant, I've got all these complications, I have to take care of the baby, and sometimes you're not even there to support the child, I'm not saying a baby is a burden, but an unplanned baby is a burden... - Black Female, P3

Because I pay a lot of money to enroll in university and if I get pregnant then that all goes away - Black Female, 20

5.4.3.5. *Financial responsibility*

The monetary cost of having a child was also a significant disadvantage of pregnancy. This can also be seen in the male-based research conducted by Flood (2003) and Maharaj (2001). Men rationalised the fear of pregnancy over STI transmission in terms of taking responsibility for a child and their partner, and in terms of being able to support a child financially. In this study a male participant commented:

It's a lot of pressure on you, you might end up leaving varsity and then looking for a job, and your financial status does not allow you to be a good parent, and you're young, you can't take care of a kid and yourselves ó Black Male, P4

One, I don't have any money, two, I think I'm way too fucking young, three, in her family her parents would freakí - White Male, 22

Although the male participants showed a need to help monetarily and show some form of responsibility for a pregnant partner, many of the female participants felt that they were the ones who would have to face the full responsibility, as pregnancy directly influences women. Participants commented:

A man can just run away from their responsibilities but a woman doesn't have that option... - White Male, 22

For a women or for a mother it's like they have to miss varsity, you know, you're the one changing, it's your hormones, it's your mental health, um and at the end of the day it's your baby ó White Female, 22

This is similar to Vargaø (2003) argument that women bear most of the burden in terms of reproductive costs. In other words they suffer the consequence of both falling pregnant and contracting an STI. Interestingly, in this study both men and women were concerned about pregnancy but for different reasons. Thus the risk is not a gendered issue but rather the issue of contraceptive use and responsibility is. More specifically men view pregnancy as a cost in terms of time and in money, whilst women view pregnancy in terms of a cost of time in raising a child and possibly being left alone to raise a child.

5.4.5. Being a student and freedom

Most students felt once they had started university their beliefs and values about relationships and sex had changed. In line with the research conducted by HEAIDS (2010) some of the participants believed that they engaged in sex and unprotected sex due the freedom they experienced in university. As one participant said:

Its more freedom than Mandela fought for (laughter), and no one is telling you what to do, you don't attend lectures, nobody's asking, and they just give you everything at the beginning of the year, so it's up to you to write anything or nothing, so people have more time to think about these things, and having no parents telling you, do this, don't do that, you decide on your own (< >) but many of the people here (at university) are like waking spirits, they are very easily influenced here, and this sex idea is really dominated into them ó Black Male, P1

Additionally many of the students experienced acts of unprotected sex due to high alcohol intake. For instance:

(When you are) sober right, and you're just making out and he says, 'ok let's have sex', you can still think like 'we don't have a condom so it's not a good idea'. But when you're drunk, it's a completely different story, it's like 'I don't give a rats ass right now, let's just have sex'. ó Black Female, P2

In terms of the HIV context of these students using a condom seems essential. However, women do not use condoms because of sensation and because their partners did not want to use one. Some of the female participants felt that they did not need to use a condom if they were in a long-term and stable relationship. If their partners insisted on having sex without condoms, and they trusted them, then it was alright to do so. The male participants did not want to use condoms as they caused a lack of sensation and reduced the pleasure of sex. In some instances, purchasing condoms was problematic. Both men and women related to the notion that condoms are seen as something related to promiscuity or disease. Women felt (and the men's talk confirmed) that if they purchased and carried condoms with them, then they would be seen as promiscuous. This is problematic as prior research indicates that carrying condoms is a good predictor of condom use (Harvey et al., 2006; Van Empelen & Kok, 2006). This is problematic as the students related non-condom use as a standard of trust and condom use as related to risky sex.

5.5. Summary of findings

In terms of risk, although most participants felt that HIV and pregnancy were the highest risks when engaging in unprotected sex, many of the participants focussed on pregnancy as the major concern. Hormonal contraceptives were thus used over condoms, as they prevent pregnancy as a risk.

Female participants felt that it was their responsibility to take hormonal contraceptives as they needed to ensure that they did not fall pregnant, as they were directly affected. It is also the only risk that they can prevent by taking charge of hormonal contraceptive use. This is similar to Harvey et al. (2006) research which indicated that hormonal contraceptives are marketed for and used by women, and thus it is up to their discretion to use them, and their responsibility to take them. However, men wear condoms and women are the ones who need to get their men to use them (Harvey et al., 2006). Condom use is problematic as women need to rely not only on themselves for protective practices, but be able to negotiate condom use. Men then put pressure on their female partners to prevent pregnancy by relying on them to use hormonal contraceptives, as condoms are not the most favourable preventative measure. This can be seen to relate to Van der Spuy (2009) report in which women are either expected to be able to prove their man's virility by producing children, or to ensure protective sexual practices (contraceptives) to protect themselves from falling pregnant.

Given this focus on pregnancy, HIV and other STIs then become a lesser risk for students. The participants provided many reasons for not using condoms (i.e. discomfort, desensitisation, kills the mood etc.), but HIV and STI transmission also seems to be linked directly to trust, and condoms are related to promiscuity.

CHAPTER 6: DISCUSSION

6.1. Introduction

Hollway (1984) and Willigø (1995) discursive frameworks may help to conceptualise some of the difficulties that students face in using condoms. More specifically these discourses may help one to understand the ways in which men and women position themselves and how this may potentially construct condom use practices. The discussion section of this study is related to the ñwhyø condoms are not being used.

6.2. 'Why' are condoms not being used?

The participants in the study felt that there was no difficulty in accessing condoms especially given the resources that students have. The issue is that the participants know about the ñsafetyø of condoms and are able to access them, but they still do not use them.

The issues raised in the results section help to descriptively explain the non-use of condoms amongst students. However this section and the following subsections are dedicated at looking at the ways in which male and female participants discuss the issues of sex, relationships and protective practices. The ways in which the participants positioned themselves on these matters and how these positions may explain why condoms are not being used need to be taken into consideration. Hollway (1984) and Willigø (1995) discourses were used to look at the ways in which particular gender dynamics may in fact lead to the non-use of condoms.

6.3. Condoms as a gendered issue

According to Wilbraham (1999) power dynamics between men and women are dependent on the ñmonopolizationö of sexual pleasure. More specifically she suggests that men and women use sex as a means for power, and use this power in different ways. For instance for men, status is obtained through having a long list of sexual encounters or conquests, in which women and their bodies are their object (Hollway, 1984; Wilbraham, 1999). Women on the other hand gain status by means of attracting and keeping a man and maintaining a relationship (i.e. their object) (Hollway, 1984; Wilbraham, 1999). The two positions work in conjunction with each other, as men are inclined to succumb to ña needø for sex. Women accept this position, as they will lose their status if they cannot keep a man and ñmonopolizeø

his sexual pleasure. More specifically if a woman cannot contain or look after her man's sexual needs then she has failed in the relationship, and might lose the relationship and the accompanying status. It is thus a woman's responsibility to take care of all reproductive health issues within a relationship. Women do not complacently take on this responsibility, but rather do so in order to keep and maintain the relationship and ensure that their men stay with them. This job of taking on the responsibility is something that Wilbraham (1999) coined 'the emotional housekeeper'.

The importance of sex, for both men and women, was evident in this study. All of the participants in this study felt that sex in some way was important in a relationship (*If we are in a relationship and we cannot have sex then the relationship doesn't work properly...* - Black Male P3) and understood that all sexual interactions are risky in some way. Interestingly condoms, although accessible to both men and women, are not always used.

The next sections will look at the ways in which men and women position themselves with regards to sex, relationships, and protective practices such as condom use.

6.3.1. Men: Sex, relationships and condoms

Hollway's (1984) male sexual drive discourse (hereafter MSD) positions men as beings that are 'biologically driven to seek sexual variety' (Wilbraham, 1999, p. 161). Moreover a man's sexuality functions only to ensure reproduction (Hollway, 1984). Men are positioned as mere victims of their sexual desires and urges, as if they are unable to control these instinctual drives (Wilbraham, 1999).

Many men in the study felt that engaging in multiple sexual encounters gave them a sense of status and power, which fitted within the MSD. For example some of the participants commented:

The belief is that in order to be a real man, you don't have to have one chick, you've got to have lots of them ó Black Male P2

I think that guys like to have (sex with) lots of women, because if they don't then they doubt their sexual potential, because if you don't then other guys are going to think that you are a failure ó Black Male P4

Women in the study also felt that men had sex in order to gain status. This shows that the male sexual drive discourse and the have/hold discourse (hereafter HHD) (Hollway, 1984) coexist together.

For a guy it's a status thing, 'like look how many women I have' - Black Female 21

When a women has multi(ple) partners, then they say she's a hoe, but when a guy creates a polygamous thing, then he's a player and he's the man ó Black Female, P1

For men, if they were not engaging in sex then this seemed to injure their sense of self, and how others perceived them as men. The following comments from the focus group discussion illustrate this:

I also think it's like a peer pressure kind of thing, like if you haven't had sex in a like a year (Black Male, P4)...People will start laughing at you and think that you're gay (laughter)... - Black Male, P2

In other words, if men were not engaging in sex then they had power and other men see them as powerless. Sex is thus linked to a man's identity. One male participant said:

If you're not having sex then you're like an outcast (< >). And these days you're a 'moffie' or stupid if you (are) not having sex, there's this idea that there is something wrong with you when you are not doing sex ó Black Male, P1

Interestingly for men, it was not only about how other men perceived them as being able to have sex (which resulted in status), but also that in order to keep a women they needed to be good at sex as well. This could be seen in the following statements made by male participants:

Girls don't want inexperienced men, so it's good for us (to have had multiple sexual relationships)...because if you are inexperienced then they wouldn't want to be with you ó Black Male P4

It is very embarrassing for a man to have a girlfriend and not (have had sex), because you know if you have sex with that girl, you know that she won't dump you because you're bad at it, well she won't dump you easily like that because she knows how good you are ó Black Male P3

Men thus felt that in order to prove themselves and entrench their status to others they had to be good at sex. This is understandable as in the MSD a man's identity is determined by his sexual prowess. In other words men felt that they would lose some of their status if they could not keep a woman satisfied sexually.

Many men also made statements not only about having sexual relationships with many women but about having the ability to 'conquer' or to have as many virgins as possible.

If you are a girl and you're a virgin, the guys will go after you, that's why girls want to keep that safe because then they know that those guys will be interested in you ó Black Male P4

Interestingly the MSD stipulates that a man's status is obtained through having many sexual relationships. In addition to this an ability to prove their virility or be able to prove that they can ensure the reproduction of the species, is essential to a man's identity. However in this study many of the male participants' greatest perceived risk was pregnancy. This tension between proving their virility and ensuring that their partner does not fall pregnant, could be seen in the following statements:

If you (are) taking the pill, it's like you're killing, it's like for guys it's like 'I'm just going to waste my sperm on you, you killing my sperm'...for guys, they all say that they want a child, they say it because it's here in front of me, like 'Look what my sperm can do', but it's all at the back of their minds, they don't want a child right now, but they would like a child - Black Female P1

That's why you make mistakes...because in order to redeem yourself properly you forget or don't use a condom, and then because you've done it properly (had unprotected sex), you make her fall pregnant ó Black Male P4

These statements show how a man's virility is implicitly important to their identity. In other words if sex had been 'done' properly, without a condom, then participant P4 would be able to prove his virility and make a girl pregnant. This means a man cannot show or prove his virility by practicing protective sex (i.e. using condoms). However, engaging in unprotected sex brings consequences.

Many of the men argued that one of the reasons why they did not engage in condom use was due their uncontrollable urge for sex. In other words in the 'heat of the moment' they become irrational with desire. As one male participant argues:

Once I got my hands on you I go blind, I don't think, and only after I've done it I'm like, shit there were no condoms ó Black Male P1

This uncontrolled urge for sex is primary to that of safe sexual practices. However, women take on the role of ensuring responsibility for all relationship needs, including reproductive health issues. As one participant argues:

It's better for them if it's (the condom) off, and they are like sexual beings, so...and it's my job to take the pill, so that I can't get pregnant... - White Female, 22

Women do not complacently take this position, but rather do so in order to keep and maintain a relationship, the main goal of the 'have/hold discourse' (Within Hollway (1984) 'have/hold discourse' women assume the role of being the 'emotional housekeepers' for all dilemmas including ones related to sex. As one female participant said:

If I don't do it (buy hormonal contraceptives), then there's no way that we will be protected...I mean I take the responsibility for everything...I buy the pill and the condoms ó White Female, 22

Thus it is up to most women to take responsibility for preventing the worst perceived risk in that relationship, which is pregnancy. Men then use their position of having an uncontrollable urge for sex to negate responsibility for ensuring condom use. Women take on the position to ensure that they can at least protect themselves against one of the risks of unsafe sex. Many women in the study felt that men in some way did not think about condoms, because having sex for men was seen as more important than initiating safe sex.

We both want sex but it's me that has to make sure that we use a condom...he just gets too, um, like excited (to think about using a condom) ó Black Female, P3

Reasons and justifications for men not initiating condom use were that men were not as responsible as women in thinking about the consequences of unsafe sex, because of their uncontrolled need for sex. For instance, a female participant argued that:

A man thinks with his little head (penis) and not with his brain...soon as the blood rushes to the wrong brain then its game over ó Black Female, P1

In this context of men's uncontrollable need for sex, sex becomes more important than protective practices. Additionally men allow women to take on the responsibility in order to relieve themselves from making decisions regarding condom use.

However, many of the female participants did not use condoms because of their male partner's resistance to use them. Reasons such as comfort and pleasure for their men were used by the female participants to explain why they stopped using condoms. It seems that women do not use condoms for their men, whilst men did not use condoms for themselves. This leads the discussion onto the ways in which women position themselves with regards to condom use.

6.3.2. Women: Sex, relationships and condoms

Hollway (1984, p. 232) has/holds discourse positions women in such a way as to support the 'Christian ideals associated with monogamy'. Furthermore this discourse positions women as needing to keep a man, and maintain a relationship (Wilbraham, 1999). Many of the female participants expressed a need to have a relationship, as a means to gain status.

I think as women we always want to belong, and when we (are) having casual sex, then really, you don't to belong to somebody - Black Female, 20

You're not something without one (a relationship) - Black Female, 22

Women take responsibility for ensuring that the strict rules of monogamy are ensured with their relationships and their men (Wilbraham, 1999). However, women forgive men for cheating for two reasons. One, they believe that men cannot override their inherent need and desire for sex, and two, because women obtain status by attracting a man, and keeping and maintaining a relationship. A woman's need for a relationship may come in the form of a need for security, status and/or sex (Wilbraham, 1999). In short, a woman's goal is to attract and keep a man (their object), as they gain status and power from the fact that they are attractive to men (Hollway, 1984).

In accordance with the HHD (Hollway, 1984), a woman's goal is to attract a man, keep him and maintain a relationship. Additionally it is the woman's responsibility to attract a man and

monopolize his sexual pleasure, as this ensures that she is able to keep him. This was expressed by a female participant:

Like (if a guy doesn't want sex) the girl might feel that she's not like sexy enough or she's not good enough or whatever...and you almost think like why aren't we doing it? 6 White Female, 22

Hollway (1984, p. 232) HHD holds that women are positioned to have to coexist in constructing men's sexual practices, in which they portray two different and contradictory standards for men (i.e. virgin versus whore). As one participant said:

There was this guy that used to live with us, and at one point in time, we had slept with the same number of people, but for some reason it was more shocking for my housemates to have heard this from me, and for him I'm sure he was only including the people that he could remember their names (laughter), but for some reason it was more acceptable for him, or for a boy to be a bit of a player... - White Female, 23

A woman is thus expected to be seen as virginal in order to attract a man, and then she is expected to be sexual in the relationship in order to keep her man and maintain the relationship.

Women are then caught in a double-bind, in order to protect and uphold the family honor, a woman needs to maintain this outsider's perspective of being a virgin, but also needs to be subservient to her man sexually (Hollway, 1984). Women are thus seen as the object of men's natural and uncontrollable sexual urges (what men gain status from), which is important as a woman's main goal is to attract and keep a man and the relationship that goes with it (Hollway, 1984).

Within the HHD women are compelled or obligated to resist the sexual advances of men (Wilbraham, 1999), as they wish to be seen by outsiders as virtuous or clean. Due to this great need to attract and keep a man, women consider single women to be hypersexualised whores, who can sexually entice already taken men who have no control over these sexual urges (Wilbraham, 1999, p. 166). Thus single women become the demonic metonym for men's permissiveness (Wilbraham, 1999, p. 166). Thus if a woman cannot attract or keep a man then they are seen as violating a woman's responsibility or impinging on their status.

In essence if a woman is unable to attract a man with her sexual prowess, then she has failed to do what is so important to a woman's identity, namely finding and keeping a man. Thus, in a sense, if a woman is unable to provide a man with what he wants then she has failed the relationship and, in essence, failed to achieve some status.

Interestingly many of the female and male participants said that using a woman's 'virginity' in some way, was related to being able to attract a man. This was expressed by one of the participants:

Like a lot of guys on this campus say that they would never marry a girl that isn't a virgin, but then they go around... they take away all of these girls virginitities, but then if you're not a virgin then they not going to marry you...which in a way is so not fair...we have sexual needs too but then you deal with the repercussions... - Black Female, P1

Thus the ideal of a woman being seen as virginal at the beginning of a relationship is important to initially attract a man. The dilemma occurs after the fact when women then need to switch and become sexually active (or 'vixens') in the relationship in order to keep their men. This works in accordance with the MSD as having sex is important to the male identity. Many of the participants commented on this dilemma of sexual double standards.

If you (are) a girl and you lose your virginity, or like you have sex before marriage, you are considered a very bad person, like 'how could you, you're a slut, you're a hoe', but then if you're a guy and you have sex before marriage, 'it's like ooh he's the man', you're a man now because you've had sex... - Black Female, P1

Because if girls had to work off the same principles as guys, eish, their image would go down... I mean there's a lot of pressure put on a girl to maintain this thing of being a virgin (for men to want them)... - Black Male, P4

Like chicks have to stay virgins until they're married, and it's ok for men to sleep with women in brothels...it's just always going to be ok and nothing is going to change that, even though it isn't necessarily acceptable ó Black Female, 20

Women then have to work through the sexual double standards of being seen as something pure or virginal to outsiders, but then also as sexual beings to men once they are in a

relationship. If women are not viewed as virginal to outsiders then their prospects of being able to find a relationship are hindered. However, if they do not engage in sex then they cannot keep the relationship.

Men also position women within the polarized terms of virgin and whore. Men are attracted to women who are seen as virgins. One male participant expressed that they would not want a woman that is -damaged due to having too much sex, and commented on how attractive a virgin is to a man. This highlights the intense prejudice related to women acting out on their sexuality. As one participant stated:

Especially for those (women) when sex becomes addictive, they go through bodily changes and they get a name for themselves...but it also affects their performance as well, because us dudes want to look for the fresh one (a virgin) all the time, because the more sex the more damaged she is... - Black Male, P2

The conflict comes into play when men decide that women need to maintain this -virgin position in order to be valuable to men. But after that relationship has been established the focus shifts to sex, where women then need to become sexual in order to keep and maintain the relationship.

The female participants also saw this dilemma, as they viewed pregnancy as a risk due to the fact that it is visible. In other words, women viewed pregnancy as a threat as it was proof of sex. Thus if men are attracted to women because they appear -virtuous or -virgin-like then, having a child makes it difficult for them to attract men and keep them.

Additionally within this discourse women assume the role of the -emotional housekeepers for all dilemmas including sexual and safe sexual practices (Wilbraham, 1999). Women do not complacently assume this responsibility, they do it actively to maintain the relationship at all costs, including sexual health issues. Thus women are generally the ones who take responsibility for their reproductive health, in order to ensure that no decisions made during sex will potentially threaten the relationship. This participant expressed this when discussing having to take the pill and be the one who initiated condom use:

But when it's my responsibility (to buy condoms and the pill) it's a bit horrid, but it's ok being the responsible one...especially if you want sex ó White Female, 23

Women, even though they find this to be a burden, take on the responsibility. In essence women preferred to be the responsible ones as they felt that men could not or did not want this position. In addition if women felt that a consequence of risky sex would endanger the relationship then they would assume this role to diminish the threat. As one female participant expressed:

My preferred (method) is the morning after pill, I think that is the only way you can control the situation or take care of the situation is the morning afterí - Black Female, 20

Women positioned in the HHD will assume this responsibility in order to ensure that they can protect the relationship. The female participants expressed a marked concern that pregnancy would cause a man to leave a relationship. This could be seen in the following statement:

Because the guys can always up and leave...the girls are the ones left with the baby ó White Female, 23

Many participants felt that men were the ones who bought and stored condoms, due to the negative connotations associated with women doing such things. For instance:

Because if girls are buying condoms then guys might be thinking, like 'wow she must be getting a lot' ó Black Female, 20

More men in the study bought, kept and stored condoms. This was justified by the fact that women who did such things were seen negatively. However, women assumed the dominant responsibility for safe sex. As this participant suggested:

I feel that if I had to keep on initiating it, then I would be like 'oh he doesn't want to' or like I'm forcing him to, and because let's say it's less pleasurable for them with it on - White Female, 22

Women want to keep and maintain a relationship, and in so doing will not use condoms in order to ensure their man's happiness. This is similar to Gavey et al's. (2001) study in which a woman's ability to please a man is more important than engaging in protective practices such as condom use.

This could be the reason why women engage in hormonal contraceptive practices over condom use. Taking a hormonal contraceptive allows them to assume responsibility and take

care of matters that could potentially threaten the relationship, such as pregnancy. If men refuse to use condoms women will comply rather than risk losing the relationship. In this instance women view keeping a relationship as more important than ensuring condom use.

Many of the female participants felt that they did not need to protect themselves with the use of condoms, because they either trusted their partner or because their partner did not want to use a condom.

6.3.3. Men, women and trust

According to Willig (1995) condoms are usually disregarded in long-term relationships, as not using a condom signifies a level of trust in a relationship. In conjunction with Willig's (1995) work, Holland et al. (1991) suggest that condoms have some symbolic meaning within sexual relationships. The way women conceptualize sex as meaning 'love and romance' and the way they give permission to men to direct choices surrounding sex (e.g. penetrative sex and non-condom use), allows for unsafe sexual practices (Holland et al., 1991). Women allow men to make decisions and influence choices related to their (and both partners) reproductive health, as this affirms their belief that this is done to prove a sense of love, or even further to instil a sense of trust.

Many of the participants argued that people engage in risky sexual practices because they inherently trusted the person and the sexual relationship that they were in. In other words most of the female participants felt that they could engage in risky sexual practices because they were in a relationship. Believing in, or trusting, your partner was linked to particular contraceptive practices. 'Trust' negated the need to be concerned about STIs such as HIV.

The issue of trust was used frequently in the participants' talk in instances where condoms were not used. This fits into Willig's (1995, p. 76) marital discourse, which suggests that individuals will not engage in protective sexual practices, such as condom use, as they do not fit into the 'ideal of heterosexual monogamous love manifested most obviously in the institution of marriage'. Condom use is considered to be related to promiscuous or unsafe sex, which contrasts with the ideals of a safe and trusting relationship. Interestingly many of the participants felt that there was no way to ensure that partners with whom they had had sex were safe, or in essence 'trustworthy'. As many of the female participants said:

I trust him, and I know that we (are) both negative...so...it's ok...(< >) but then again I don't know what he's doing behind my back...I mean he could be sleeping with a million other girls – White Female, 22

I don't use a condom because I trust him...but then again...what he says and what he does are two different things ó Black Female, P2

This falls under the way women view men and how they draw on the MSD, in which men have an uninhibited urge to have sex. Thus men cannot be trusted to be able to resist the urge to want and need sex, and that other women may entice or allure them.

Many of the male participants felt that women who carry condoms around were promiscuous, unsafe. As some male participants suggested:

If a girl is carry(ing) condoms then it means that she's having loads of sex...safe sex...but then she might have something as well ó Black Male, P2

I mean I wouldn't sleep with you if I just met you, I mean I don't know you, I don't know if you've been with a lot of other people...it's like I don't trust the fact that I don't know you ó Black Male, P3

According to the HHD, women need to maintain the fine balance between being seen as virgin or as being sexually active in order to attract a man. Carrying condoms elicits an image that a woman is engaging in promiscuous and potentially risky behaviour. This is problematic for women as the need to be able to attract a man is seen as more important than engaging in protective sexual practices.

According to Willig (1995) 'marital discourse', a sexually monogamous relationship is dependent on the individuals trusting each other in terms of all things sexual. The three sub-discourses that Willig (1995) discusses were seen in the participants' talk when discussing condom use. The sub-discourse 'the assumption of safety' was evident in the participants' talk. As some participants suggested:

She's a good girl...she only has sex with me so I know that we're ok (will not contract an STI) ó White Male, 22

It's just me and him (in the relationship), so we are safe ó Black Female, 22

These statements suggest that when individuals can define or label themselves as being in a monogamous relationship then this negates the risk of STI transmission. Although both male and female participants felt that there was no sure way of ensuring that their partners were faithful or trusting, the sense of having a relationship was strong enough to ensure their safety from STI transmission. Interestingly all the participants agreed that students engage in multiple sexual relationships.

She has a minister of finance, a minister of health, and a minister of transport...all girls need is to show off their legs and have sex with guys, so that they can have what they need and want ó Black Male, P2

It sounds silly when you say it out loud...but it's not like he's married to me, and I know that he could just walk out on me if there was a problem...but there just is a point in a relationship where you love the person and just...ja...trust them to not give you anything – Black Female, P2

This fits into Willigø (1995) ðassumption of marital failureö whereby one feels that although it is logical to assume any relationship can end, you still need to trust your partner in order for the relationship to work. According to the HHD, women need to ensure that they can keep and maintain a relationship, which according to this statement also suggests that in order to do so, one needs to trust ones sexual partner implicitly. However, initiating condom use means that there is something wrong with the relationship or with one of the sexual partners. For instance as one male participant commented:

If my girlfriend suddenly wanted to whip on a condom...and like we've never used one before, I'd be thinking, 'what the hell? She's been having sex behind my back or she doesn't trust me' ó Black Male, P2

Although these statements are in stark contrast to the ones based on condom use and trust, the participants still felt that it was safe to engage in risky sex in a relationship, as a relationship was believed to negate any risks involved in sex. This is potentially problematic as there is no way to ensure that a partner is being completely faithful or is immune to acquiring and transmitting an STI (such as HIV).

The above discussion illustrates how men and women hold positions in the above mentioned discourses with regards to matters on sex, relationships and condom use. There are many factors that contribute to lack of condom use, but there seems to be an underlying trend in the participants' talk about issues related to protective practices.

6.4. Summary of findings

Condom use is not implemented due to the ways that men and women position themselves in relation to each other. Both men and women felt that sex was important and necessary in a relationship. Men are then positioned to need and want sex above the need for safe sex practices, such as condom use. Men assume that women will take on the responsibility for all reproductive health matters. Women, on the other hand, are positioned to believe that having a relationship is more important than engaging in safer sex practices, as they acquire status from this. Additionally women take responsibility for reproductive matters, as this ensures that she can keep a man and maintain the relationship.

Trust is in essence deemed to be the building block for a relationship. Condom use was seen to be linked to promiscuous or casual/risky sex, which does not fit into the meaning of a long-term stable relationship. Condoms are thus seen as a protective method that negates the very nature of a committed relationship. Condoms were not used in relationships that were seen as long-term, stable and committed, as using them would mean that one of the partners did not trust the other, or that one person had betrayed the other.

Protective practices and not engaging in condom use may not be as straightforward as many health promotion campaigns make out. Although there are many issues that prevent condom use practices such as aesthetics and communication barriers, there are also discursive practices at play which underpin lack of condom use. Relationship dynamics and the ways that men and women position themselves to understand and make sense of issues related to sex will inevitably contribute to (or hamper) protective practices. Condoms are not being used as they are seen as a violation to the make-up of a loving and caring relationship. Additionally if the relationship is a means for creating power and status then both men and women will prevent the use of anything that may hamper the attainment of such status.

One needs to take a step back from the descriptive reasons that may explain non-condom use, and look at the underlying, possibly, hidden agendas that men and women have in their non-use. Looking at men and women's talk on matters related to these topics, and looking at the discursive practices that these individuals employ, highlights other issues that underpin protective practices.

CHAPTER 7: RECOMMENDATIONS AND CONCLUSIONS

7.1. Limitations of the research

Some of the limitations of the study are related to the sample that was used for data collection. There were an odd number of male and female participants in the individual interviews. This could be problematic as opinions or voices of men may be not as clear as those of women. Additionally the cultural and racial differences were not very representative. Although during sampling race was not a criteria for joining the study, these variations should be taken into consideration, as the talk of African participants may be different to that of White or Asian participants.

Moreover, the sampling technique was not consistent throughout the study. The study initially used a convenience and purposive sampling method. It then resorted to handing out leaflets and posting additional posters aimed at men. This could mean that the talk of the participants is not very generalisable, as the individuals who took part in the study could have similar ideologies and ways of looking at matters of relationships and sex because of the context from which they were sampled. However due to time constraints I could not wait for more participants to join the study after the initial posters had been put up. This may affect the results as there may have not been enough variety (backgrounds and experiences) among the participants that volunteered. However one of the benefits of qualitative studies is that the views of a few participants can provide enough rich data to illustrate a point.

The reason for having two types of data collection techniques (i.e. focus group and individual interviews) was motivated. However individuals that took part in the focus group discussions might not have revealed personal information pertaining to the questions due to the group setting. It may be argued however, that group discussions help facilitate a discussion as there are many voices and opinions (Stewart & Shamdasani, 1998). Additionally focus group participants may have taken a certain stance regarding the questions due to the group setting. A limitation for the individual interviews may be that the participant may have felt nervous or awkward to discuss an issue related to sex in front of one interviewer. However due to the fact that confidentiality was ensured and reiterated to the individual interview participants, this may have combated this issue. Additionally similar themes and issues were brought up in both individual interviews and focus groups. No overt differences in responding to

questions were found between the two. However the focus groups provided more detailed information, as the participants were able to discuss topics, contend issues that individual participants brought up, and expand on some important topics. Individual interview participants responded in a clear and directive way. More specifically the participant answered the questions in a goal directed manner, as there were no other participants to make them defend or justify their answers.

In terms of the credibility, dependability and transferability of the study there may be some limitations to this project. Van der Riet and Durrheim (2006) argue that credible research findings are convincing and believable. Babbie and Mouton (2005) stipulate several ways in which to ensure credibility. Some of these were achieved for this project, such as referential adequacy, persistent observation, and peer debriefing (Babbie & Mouton, 2005). Referential adequacy was achieved by ensuring that audio tapes, transcripts and field notes that were used during the focus groups and individual interviews were available as documents during the research process and outcomes (Babbie & Mouton, 2005). Persistent observation was achieved by creating questions for the participants using current literature surrounding sex, condom use, and relationships surrounding sex and condom use in South Africa (Babbie & Mouton, 2005). Peer debriefing was achieved as analyses and interpretations were shared with an acculturated colleague (i.e. the supervisor) (Babbie & Mouton, 2005). Other points such as prolonged engagement and member checks could not be done due to the time constraints of the study and thus could limit the study's credibility.

In terms of dependability of the project, it should be noted that some of the questions that were set up for the interviews and focus groups were a bit confusing to the participants. In order to explain what was meant I may have unintentionally re-phased a question in a leading way.

In terms of transferability, the project did have a small sample, and more women than men overall. This could have been due to the fact that men may have felt uncomfortable discussing a topic such as sex in front of a female researcher. However the sample that participated in the study did generate a lot of rich and detailed data. According to Lincoln (1984, in Babbie & Mouton, 2005) obtaining thick descriptions and using purposive sampling enables transferability. This was accomplished in this study to ensure transferability.

7.2. Conclusions

Engaging in risky sexual behaviours was prevalent amongst the participants in the study. The risks considered most serious when engaging in sex were pregnancy and HIV. The students were ambivalent about which of these two risks were worse for them. However it could be seen that the two risks were perceived differently, which then influenced the protective sexual practices in which they engaged. In circumstances where students perceived a high level of trust and safety they did not use condoms, as their highest perceived risk was not HIV transmission, but pregnancy. This was then combated by ensuring that hormonal contraceptives were used. Thus condoms were only used in sexual interactions that were considered risky or unsafe.

In answering the research questions in this study the following was found. Students do not engage in condom use for many reasons. This includes aesthetic reasons, that they disrupt the excitement of sex, students are embarrassed to purchase them and that in some instances some students did not know how to use a condom. Additionally it was found that students relate STI risks to condom use, and thus in instances where they felt that sex was safe and that they knew or trusted the individual then it was reasonable to not engage in condom use. Students feel that there are no obstacles in obtaining condoms, and thus no reason for not using them. However, the students did feel that access to non-government condoms was difficult. The type of sexual relationship one has also affected condom use. Being with a person for a long enough time period and gaining a sense of trust and knowledge of that individual would lead to unprotected sexual endeavours. However, if one felt that they did not know or trust an individual then condom use became a necessity in those sexual encounters. Students felt that condoms were related to risky sexual practices or used when you engaged in promiscuous sex.

However protective sexual engagement may not be so straightforward or uncomplicated as just implementing condom use for protective strategies. Men and women may engage in sexual activities for other inherent needs and purposes when looking at Hollway (1987) and Willig (1995) discursive frameworks. Participants position themselves by using these discursive frameworks (i.e. the 'have/hold discourse', the 'male sexual drive discourse' and the 'marital discourse') in order to make sense of sexual relationships, which in turn influences contraceptive practices. It was found that the participants position themselves

within this discursive framework and then draw on complex and sometimes contradictory discourses.

Men and women look at protective sexual practices differently. This different way of looking at risk is based on a hierarchy of needs and threats. For men, the 'male sexual drive discourse' positions men in such a way as to view unprotected sex as more important than that of safe sexual encounters. For women, the 'have/hold discourse' positions them in such a way that attracting a man, and keeping and maintaining a relationship is deemed more important than ensuring protective sexual practices. The way that men and women position themselves in relationships ('the marital discourse') does not allow for condom use, as this is seen as a disregard for the foundations of a relationship (i.e. trust). For instance men do not engage in condom use, as they are relieved from having any responsibility in ensuring safe sexual practices, as their need and drive for sex overrides the need to be responsible. When men do not want to engage in condom use, women also will not. This is due to their need to keep and maintain a relationship, which is threatened when introducing or suggesting condom use.

7.3. Recommendations based on the findings

The data produced from the study suggests that health promotion strategies need to take a different approach towards safer-sex campaigns. This may be done by looking at the ways in which men and women interact in decision making about sex and condom use. Sexual health campaigns perhaps need to be redirected to look at ways in which men and women position themselves in sex and relationships. It was evident in this study that the ways in which men and women position themselves with regards to the discourses implicates condom use. However, changing discourses that individuals draw on is easier said than done.

REFERENCES

- Ahlberg, B. M., Jylkäs, E., & Krantz, I. (2001). Gender construction of sexual risks: Implications for safer sex among young people in Kenya and Sweden. *Reproductive Health Matters*, 9(17), 26-36.
- Amazigo, U., Silva, N., Kaufman, J., & Obikze, D.S. (1997). Sex activity and contraceptive use among in-school adolescents in Nigeria. *International Family Planning Perspectives*, 23(1), 28-33.
- Amy, J. & Loeber, O. (2007). Editorial. Pregnancy during adolescence: A major social problem. *The European Journal of Contraception and Reproductive Health Care*, 12(4), 299-302.
- Antaki, C., Billig, M., Edwards, D., & Potter, J. (2003). Discourse analysis means doing analysis: A critique of six analytic shortcomings. *Discourse Analysis Online*, 1(1). Retrieved June 09, 2009, from <http://extra.shu.ac.uk/daol/articles/v1/n1/a1/antaki2002002-t.html>.
- Babbie, E., & Mouton, J. (Eds) (2005). Qualitative Studies. In E. Babbie & J. Mouton (Eds), *The practice of social research* (pp. 269-311). Cape Town: Oxford University Press.
- Blanc, A. K. & Wolff, B. (2001). Gender and decision-making over condom use in two districts in Uganda. *African Journal of Reproductive Health*, 5(3), 15-28.
- Bodibe, K. (2009). *Knowledge gap about risk of multiple sexual relationships*. Retrieved July 27, 2009, from <http://www.health-e.org.za/news/article.php?uid=20032364>
- Boulle, A., Hilderbrand, K., Mentan, J., Coetzee, D., Ford, N., Matthys, F., Buelaert, M., & Van der Styft, P. (2008). Exploring HIV risk perception and behavior in the context of antiretroviral treatment: Results from a township household survey. *Aids Care*, 20(7), 771-781
- Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage
- Burr, V. (1995). *An introduction to social constructionism*. London: Routledge.
- Campbell, C. (2003). *Letting them die: How HIV/Aids prevention programmes often fail*. Indiana: Double Storey.
- Deacon, L. J. (2009). *Choosing and using: The dynamics of contraceptive use amongst university students*. Unpublished Honours Project. UKZN, Pietermaritzburg.

- Delva, W., Guillaume, F., Vansteelandt, S., Claeys, P., Verstraeten, H., & Temmerman, M. (2007). Sexual behaviour and contraceptive use among youth in the Balkans. *The European Journal of Contraception and Reproductive Health Care*, 12(4), 309-315.
- Du Bois (n.d.) *Comparison of transcription symbols*. Retrieved September 01, 2009, from <http://www.linguistics.ucsb.edu/projects/transcription/A04comparison.pdf>
- Durrheim, K. & Painter, D. (2006). Collecting quantitative data: Sampling and measuring. In M. Terre Blanche, K. Durrheim & D. Painter (Eds), *Research in practice: Applied methods for the social sciences* (2nd ed.) (pp. 90-94). Cape Town: UCT Press.
- Flood, M. (2003). Lust, trust and latex: Why young men do not use condoms. *Culture, Health and Sexuality*, 5(4), 353-369.
- Foss, A. M., Watts, C. H., Vickerman, P., Heise, C. (2004). Condoms and prevention of HIV: Are essential and effective but additional methods are also needed. *Biomedical Journal*, (329)7459, 185-186.
- Gavey, M., McPhillips, K., & Doherty, M. (2001). 'If it's not on, it's not on, or is it': Discursive constraints on women's condom use. *Gender and Society*, 15(6), 917-937.
- Goodram, S. & Keyes, J. L. (2003). *In-depth interviews on emotionally sensitive topics: Guidelines and considerations*. Retrieved March 11, 2009, from http://www.allacademic.com/meta/p_mla_apa_research_citation/1/0/7/5/8/pages107587/p107587-1.php
- Hansen, T. & Skjeldestad, F. E. (2007). Adolescents: Is there an association between knowledge of oral contraceptives and profession of provider? *The European Journal of Contraception and Reproductive Health Care*, 12(4), 303-308.
- Hartel, C. G. (2005). HIV/AIDS in South Africa: A review of sexual behaviour among adolescents. *Adolescents*, 40(157), 171-181.
- Harvey, S. M., Beckman, L. J., Gerend, M. A., Bird, S. T., Posner, S., Huszti, H. C., & Galavotti, C. (2006). A conceptual model of women's condom use intentions. Integrating intrapersonal and relationship factors. *Aids Care*, 18(7), 695-709.
- HEAIDS, (2010). *HIV prevalence and related factors – Higher Education Sector Study, South Africa, 2008-2009*. Pretoria: Higher Education South Africa.
- Hearst, N. & Chen, S. (2004). Condom promotion for AIDS prevention in the developing world: Is it working? *Studies in Family Planning*, 35(12), 116-124.
- Hendriksen, E. S., Pettifor, A., Lee, S., Coates, T. J., Rees, H. V. (2007). Predictors of condom use among young adults in South Africa: The reproductive health and HIV

- Research Unit National Youth Survey. *American Journal of Public Health*, 97(7), 1241-1248.
- Henriques, J., Hollway, W., Urwin, C., Venn, C., & Walkerdine, V. (1984). Introduction to section 3: Theorising subjectivity. In J. Henriques, W. Hollway, C. Urwin, C. Venn, & V. Walkerdine, *Changing the subject: Psychology, social regulation and subjectivity* (pp. 202-226). London and New York: Methuen & Co. Ltd.
- Henry, G. (1998). Practical sampling. In L. Bickman & D. Rog (Eds), *Handbook of applied social science methods* (pp. 101-126). Thousand Oaks, CA: Sage Publications.
- Holland, J., Ramazanoglu, C., Scott, S., Sharpe, S., & Thomson, R. (1991). Pressure, resistance, empowerment: Young women and the negotiation of safer sex. In P. Aggleton, P. Davies, & G. Hart (Eds), *Aids: Rights and risk and reason*. London: Falmer Press.
- Hollway, W. (1984). Gender differences and the production of subjectivity. In J. Henriques, W. Hollway, C. Urwin, C. Venn, & V. Walkerdine, *Changing the subject: Psychology, social regulation and subjectivity* (pp. 202-226). London and New York: Methuen & Co. Ltd.
- Johnson, H. & Mayoux, L. (1998). Investigation as empowerment: Using participatory methods. In A. Thomas, J. Chataway & M. Wayts, *Finding out fast* (pp. 147-171). London: Open University Press
- Kafaar, Z., Kagee, A., Lesch, & Swartz, A. (2005). Is participation in HIV vaccine trials a health promoting behaviour? *Aids Care*, 19(10). 1307-1309.
- Kaufman, M. R., Shefer, T., Crawford, M., Simbayi, L. C., & Kalichman, S. C. (2008). Gender attitudes, sexual power, HIV risk: A model for understanding HIV risk behaviours of South African men. *Aids Care*, 20(4), 434-441.
- Kelly, K. (2006). From encounter to text: Collecting data in qualitative research. In M. Terre Blanche, K. Durrheim & D. Painter (Eds), *Research in practice: Applied methods for the social sciences* (2nd ed.) (pp. 90-94). Cape Town: UCT Press.
- MacPhail, C., Pettifor, A., Pascoe, S., & Rees, H. V. (2007). Contraceptive use and pregnancy among 15-24 year old South African women: A naturally representative cross sectional survey. *BMC Medicine*, 5(31).
- Maharaj, P. (2001). Male attitudes to family planning in the era of HIV/AIDS: Evidence from KwaZulu-Natal, South Africa. *Journal of Southern African Studies*, 27(2), 245-257.
- Maharaj, P. & Cleland, J. (2004). Condom use within marital and cohabitating partnerships, in KwaZulu-Natal, South Africa. *Studies in Family Planning*, 35(2), 116-124.

- Maticka-Tyndale, E. (1992). Social constructionism of HIV transmission and prevention among heterosexual young adults. *Social Problems*, 39(3), 238-252.
- Naidoo, K. (2008). Researching reproduction: Reflections on qualitative methodology in a transforming society. *Forum: Qualitative Social Research*, 9(1), 1-16.
- Parker, W., Colvin, M., & Birdsall, K. (2006). *HIV and Aids scenarios for South Africa: 2005-2025. An overview of factors underlying future trends*. Retrieved September 01, 2009, from <http://www.cadre.org.za/files/CADRE%20Overview%20of%20Factors%202006.pdf>
- Parker, W., Makhubele, B., Ntlabati, P., & Connolly, C. (2007). *Concurrent sexual partnerships amongst young adults in South Africa: Challenges for HIV prevention communication*. Retrieved September 01, 2009, from <http://www.comminit.com/en/node/269915/cchange picks>
- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed). Newbury Park, California: Sage Publications Incorporated.
- Peltzer, K., & Pengpid, S. (2008). Dual protection, contraceptive use and HIV risk among a sample of South African male and female students. *Gender and Behaviour*. 6(2), 1858-1869.
- Pettifor, A. E., Rees, H. V., & Steffenson, A. (2004). *HIV and Sexual Behaviour Among Young South Africans: A National Survey of 15-24 Year Olds*. Johannesburg: Reproductive Health Research Unit, University of the Witwatersrand.
- Shisana, O., Rehle, T., Simbayi, L. C., Zuma, K., Jooste, S., Pillay-van-Wyk, V., Mbelle, N., Van Zyl, J., Zungu, N. P., & Pezi, S. (2009). *South African national HIV prevalence, incidence, behaviour and communication survey 2008: A turning tide among teenagers?* Cape Town, South Africa: HRSC.
- Statistics South Africa (2008). *Mortality and causes of death in South Africa, 2006: Findings from death notifications*. Retrieved March 03, 2010, from <http://www.statsaa.gov.za>
- Stewart, D. W. & Shamdasani, P. N. (1998). Focus group research: Exploration and discovery. In L. B. Bickman & D. J. Rog (Eds), *Handbook of applied social research methods* (pp. 505-525). Thousand Oaks: Sage Publications.
- Taylor, S. J. & Bogdan, R. (1984). In-depth interviewing. In S. J. Taylor and R. Bogdan, *Introduction to qualitative research methods: The search for meaning* (2nd ed.) (pp. 76-105). New York: Wiley & Sons.

- Taylor, M., Dlamini, S., Kagoro, H., Jinabhai, C., Sathiparasdad, R., & de Vries., H. (2002). Self-Reported Risk Behaviour of Learners at Rural KwaZulu-Natal High Schools. *Agenda*, 53, 67-74.
- Taylor, M., Dlamini, S. B., Nyawo, N., Huver., R., Jinabhai, C. C., & de Vries, H. (2007). Reasons for inconsistent condom use by rural South African high school students. *Acta Paediatrica*, 96, 287-291.
- Terre Blanche, M., Durrheim, K., & Kelly, K. (2006). First steps in qualitative analysis. In M. Terre Blanche, K. Durrheim & D. Painter (Eds), *Research in practice: Applied methods for the social sciences* (2nd ed.) (pp. 320-344). Cape Town: UCT Press.
- Terre Blanche, M., Durheim, K., & Painter, D. (2006). *Research in practice: Applied methods for the social sciences* (2nd ed.). Cape Town: UCT Press.
- Terre Blanche, M., Kelly, K., & Durrheim, K. (2006). Why qualitative research? In M. Terre Blanche, K. Durrheim & D. Painter (Eds), *Research in practice: Applied methods for the social sciences* (2nd ed.) (pp. 271-284). Cape Town: UCT Press.
- Van der Riet, M. & Durrheim, K. (2006). Putting design into practice: Writing and evaluating research proposals. In M. Terre Blanche, K. Durrheim & D. Painter (Eds), *Research in practice: Applied methods for the social sciences* (2nd ed.) (pp. 80-112). Cape Town: UCT Press.
- Van der Spuy, Z. (2009). HIV and reproductive health: A South African experience. *Reproductive BioMedicine Online*, 18(2), 3-10.
- Van Empelen, P. & Kok, G. (2006). Condom use in steady and casual sexual relationships. Planning, preparation, and willingness to take risks amongst adolescents. *Psychology and Health*, 21(2), 165-181.
- Varga, C. A. (2003). How gender roles influence sexual reproductive health among South African adolescents. *Studies in Family Planning*, 34(3), 160-172.
- Wassenaar, D. R. (2006). Ethical issues in social science research. *Research in practice: Applied methods for the social sciences* (2nd ed.) (pp. 60-77). Cape Town: UCT Press.
- Wilbraham, L. (1999). What is the risk of the wife getting AIDS? Psychological regimes of body regulation in talk about HIV/AIDS and monogamy-rules in advice columns. In D. Hook, M. Terre Blanche, & K-K. Bhauani (Eds), *Body politics: Power, knowledge and the body in the social sciences* (pp. 160-171). Johannesburg: Histories of the Present Press.

Willig, C. (1995). 'I wouldn't have married the guy if I had to do that': Heterosexual adults' construction of condom use and their implications for sexual practice. *Journal of Community and Applied Social Psychology*, (5), 75-87.

APPENDIX 1: POSTER

Research Volunteers Urgently Needed!!!

Would you be interested in participating in a discussion about **sex, students and condom use?**

If you are **18 years or older**, a **student** on campus and **sexually active...**

Please contact **Lois** (School of Psychology) with your **name** and **contact number**:

Email to: loisdeacon@gmail.com

Sms or call: 083 513 9936

Lois Deacon 083 513 9936 loisdeacon@gmail.com Please leave your name and contact number
Lois Deacon 083 513 9936 loisdeacon@gmail.com Please leave your name and contact number
Lois Deacon 083 513 9936 loisdeacon@gmail.com Please leave your name and contact number
Lois Deacon 083 513 9936 loisdeacon@gmail.com Please leave your name and contact number
Lois Deacon 083 513 9936 loisdeacon@gmail.com Please leave your name and contact number
Lois Deacon 083 513 9936 loisdeacon@gmail.com Please leave your name and contact number
Lois Deacon 083 513 9936 loisdeacon@gmail.com Please leave your name and contact number
Lois Deacon 083 513 9936 loisdeacon@gmail.com Please leave your name and contact number

APPENDIX 2: FLYERS

<p>Research Volunteers Urgently Needed!!!</p> <p>Would you be interested in participating in a discussion about sex, students and condom use?</p> <p>If you are 18 years or older, a student on campus and sexually active...</p> <p>Please contact Lois (School of Psychology) with your name and contact number:</p> <p>Email to: loisdeacon@gmail.com</p> <p>Sms or call: 083 513 9936</p>	<p>Research Volunteers Urgently Needed!!!</p> <p>Would you be interested in participating in a discussion about sex, students and condom use?</p> <p>If you are 18 years or older, a student on campus and sexually active...</p> <p>Please contact Lois (School of Psychology) with your name and contact number:</p> <p>Email to: loisdeacon@gmail.com</p> <p>Sms or call: 083 513 9936</p>	<p>Research Volunteers Urgently Needed!!!</p> <p>Would you be interested in participating in a discussion about sex, students and condom use?</p> <p>If you are 18 years or older, a student on campus and sexually active...</p> <p>Please contact Lois (School of Psychology) with your name and contact number:</p> <p>Email to: loisdeacon@gmail.com</p> <p>Sms or call: 083 513 9936</p>
<p>Research Volunteers Urgently Needed!!!</p> <p>Would you be interested in participating in a discussion about sex, students and condom use?</p> <p>If you are 18 years or older, a student on campus and sexually active...</p> <p>Please contact Lois (School of Psychology) with your name and contact number:</p> <p>Email to: loisdeacon@gmail.com</p> <p>Sms or call: 083 513 9936</p>	<p>Research Volunteers Urgently Needed!!!</p> <p>Would you be interested in participating in a discussion about sex, students and condom use?</p> <p>If you are 18 years or older, a student on campus and sexually active...</p> <p>Please contact Lois (School of Psychology) with your name and contact number:</p> <p>Email to: loisdeacon@gmail.com</p> <p>Sms or call: 083 513 9936</p>	<p>Research Volunteers Urgently Needed!!!</p> <p>Would you be interested in participating in a discussion about sex, students and condom use?</p> <p>If you are 18 years or older, a student on campus and sexually active...</p> <p>Please contact Lois (School of Psychology) with your name and contact number:</p> <p>Email to: loisdeacon@gmail.com</p> <p>Sms or call: 083 513 9936</p>

APPENDIX 3: POSTERS FOR MALE VOLUNTEERS

Male Research Volunteers Urgently Needed!!!

Would you be interested in participating in a discussion about **sex, students** and **condom use**?
If you are **18 years or older**, a **student** on campus and **sexually active...**

Please contact **Lois** (School of Psychology)
with your **name** and **contact number**:

Email to: loisdeacon@gmail.com

Sms or call: 083 513 9936

Lois Deacon 083 513 9936 loisdeacon@gmail.com Please leave your name and contact number
Lois Deacon 083 513 9936 loisdeacon@gmail.com Please leave your name and contact number
Lois Deacon 083 513 9936 loisdeacon@gmail.com Please leave your name and contact number
Lois Deacon 083 513 9936 loisdeacon@gmail.com Please leave your name and contact number
Lois Deacon 083 513 9936 loisdeacon@gmail.com Please leave your name and contact number
Lois Deacon 083 513 9936 loisdeacon@gmail.com Please leave your name and contact number
Lois Deacon 083 513 9936 loisdeacon@gmail.com Please leave your name and contact number
Lois Deacon 083 513 9936 loisdeacon@gmail.com Please leave your name and contact number

APPENDIX 4: FOCUS GROUP QUESTIONS

Hi everyone. You are here today because I am really interested in finding out about how students perceive condoms, sex and relationships. Before we start I want to play a game with you to help us relax before we talk about sex. I know this can be nerve wracking but I hope this game with help us open up to each other. Just remember if you feel uncomfortable to engage in any stage of this process you can leave the study and you will not be prejudiced in any way.

1. Are any of you in relationships?
2. What does a 'having a relationship' mean to you?
3. What do you think it means to students?
4. What does having sex in a relationship mean to students?
5. Do you think that students feel that sex in a relationship is important?
6. What risks do you think students have when they engage in sex?
7. How can these risks be prevented?
8. What kinds of contraceptives are used by students?
 - a. Do you think these are used?
 - b. Do you think contraceptives help relationships or do you think they can cause a problem in relationships?
9. Do you think students use condoms?
 - a. Why or why not?
10. Why do you think students use condoms?
11. Do you think that students have sex without condoms?
 - a. Why or why not?
12. How do you think students feel when they do not use condoms?
13. If students don't use condoms, do you think there are there any other methods that help the risks you have mentioned?
14. When do you think using a condom is nessessary?
15. Who do you think initiates condom use when you or other students engage in sex?
 - a. Do you think that students are happy with that?
16. Who do you think purchases condoms?
 - a. Why is that the case?
 - b. Do you think that students are happy with that?
17. What do you think happens when students say no to using a condom?
18. If you could change anything about condoms what would you change and why?
19. Have you ever been to a VCT clinic or had a HIV test?
 - a. Why did you do this?
 - b. Do you think having an HIV test is important?
20. What role does trust play in using condoms when people are in a relationship?

APPENDIX 5: INDIVIDUAL INTERVIEW QUESTIONS

Hi. I asked you here today because I am really interested in finding out about how you perceive condoms, sex and relationships.

1. Are you in a relationship?
 - a. What's your relationship like?
2. What does 'having a relationship' mean to you?
3. Is sex in a relationship important to you?
 - a. Why is it important?
4. Do you use contraceptives?
 - a. What kind?
5. Do you use condoms?
 - a. Why or why not?
6. Have you ever engaged in sex without a condom?
 - a. Why?
 - b. How did that make you feel?
7. Do you feel protected if you use a condom?
 - a. If yes, why? If not why?
8. What risks are you worried about when you engage in sex?
9. How can these risks be prevented?
10. Who initiates condom use when you engage in sex?
 - a. Why do you think that is the case?
 - b. Are you happy with that?
11. Who purchases or keeps condoms on them when you engage in sex?
 - a. Why is that the case?
 - b. Are you happy with that?
12. What do you think would happen if you said no to using a condom?
13. When do you think using a condom is necessary?
14. If you could change anything about condoms to make them better for you, what would you change and why would they then be better?
15. If you don't use a condom are there any other methods you can think of that might help any concerns?
16. Without disclosing your status, have you ever been to a VCT clinic or had a HIV test?
 - a. Why did you do this?
 - b. Do you think that it is important to have an HIV test in a relationship?
17. Why do you think people use condoms?
18. What is the biggest threat to you when you have sex?
19. Why is one more risky than the other?
20. Do you think that trust plays a large role in the misuse or nonuse of condoms?

APPENDIX 6: TRANSCRIPTION CONVENTIONS

Transcription convention	Meaning	Example
Non-italicized words	Own interpretation	<i>Like they (students) are just so sure that (they) are not going to get AIDS</i>
(< >)	Text deleted	<i>Like they (students) are just so sure that (they) are not going to get AIDS, and people like block out the information (< >).</i>
(...)	Pause in speech	<i>But if it's with a random girl that you don't know and then don't trust then you have to do it...unless it's a person that you've dated for like 4 or 5 years</i>
(-Ø)	Expression or reported speech	<i>Some say 'I don't want to walk the distance to get a Choice condom'</i>
Underlined words	Emphasis on word	<i>Like if you've engaged in sex like <u>SO</u> many times without a condom and nothing has happened, so you would actually think that you've got control over the situation</i>

APPENDIX 7: FOCUS GROUP PARTICIPANTS INFORMATION SHEET

Firstly thank you so much for wanting to take part in this study for my Master's thesis, your help and active participation is much appreciated. But before we can start I need to inform you about what we will be doing and how we will be doing it.

I am Lois Deacon, and I am a Masters student from the University of KwaZulu-Natal Pietermaritzburg. For my thesis I am asking students to participate in research on sex and condom use among university students on campus, which I hope will inform sexual health campaigns in South Africa. This means that a few sensitive topics and questions about sex and condom use may be addressed during the process. When it comes to answering these questions, **there are no right or wrong answers.**

Two forms of data collection will be used for this thesis a focus group and individual interviews.

Focus Group

The focus group will last approximately two hours. I will be asking you a few questions that need to be answered in a group setting. When you participate in the focus group, other participants may use your name. During this discussion you may choose to be known by a pseudonym if you wish. The discussion will be an informal one, wherein personal references and stories are not mandatory. I am not looking for what you think the appropriate opinion might be, but rather your own opinions and values on the subject. **Some questions may be personal and/or sensitive and you may choose not to answer those questions.**

A group confidentiality agreement (or pledge) will be signed; however **it is up to you to maintain confidentiality.** I will be recording the discussion with the use of a tape recorder, but your identities will be protected with the use of pseudonyms when the results are published, and the tapes will subsequently be destroyed.

The information that is gained during the project will be stored in a locked cabinet in my supervisor's office (Mary van der Riet), which only my supervisor and I will be able to access. After the study has been completed any information that links your identity to the data will be destroyed.

The results of the study will be presented in a report that will be assessed by three examiners and presented at the School of Psychology Postgraduate conference. I and my supervisor may also present the results of the research at other conferences. The findings may also form the basis of

future journal articles. The project, however, will be stored in the School of Psychology's Archives. Please know that no details signaling your personal identity will be released.

If I ask you a question which makes you feel uncomfortable or embarrassed, I can stop and talk to you about it or you may come to me at a later stage to discuss the issue, or you may contact me (details at the bottom of the page). There are also people from the university who are willing and available to talk to you about issues which may emerge during the research process. The **Student Counseling Center's** (situated on Main Campus) number is **033-260 5208**. If you would like to learn more about safe sex and contraceptive use, and/or gain access to contraceptives, the **Campus Clinic's** (also situated on Main Campus) number is **033-260 5853**.

Please understand that **your participation is voluntary** and you are not being forced to take part in this study. **The choice of whether to participate or not is yours alone**. If you choose not to take part in this study, you will not be affected in any way whatsoever. If you agree to participate you may discontinue your participation at any time of the study. If you refuse to participate or withdraw at any stage, there will be **no penalties** and **you will not be prejudiced in any way**.

If you have any **questions, queries or complaints** about any aspect of this study, you may contact **Mary van der Riet** by email (vanderriet@ukzn.ac.za) or by telephone (**033-260 5853**). If you have a complaint about any aspect of this study, you may also contact the **SoP Higher Degrees Ethics Committee (033-260 5853)**.

Thank you

Lois Deacon 083 513 9936 loisdeacon@gmail.com

APPENDIX 8: INDIVIDUAL INTERVIEWS PARTICIPANTS INFORMATION SHEET

Firstly thank you so much for wanting to take part in this study for my Master's thesis, your help and active participation is much appreciated. But before we can start I need to inform you about what we will be doing and how we will be doing it.

I am Lois Deacon, and I am a Masters student from the University of KwaZulu-Natal Pietermaritzburg. For my thesis I am asking students to participate in a focus group and possibly an individual interview, for research I hope will be of benefit to your community and possibly similar communities in the future. Firstly thank you so much for wanting to take part in this study for my Master's thesis, your help and active participation is much appreciated. But before we can start I need to inform you about what we will be doing and how we will be doing it.

I am Lois Deacon, and I am a Masters student from the University of KwaZulu-Natal Pietermaritzburg. For my thesis I am asking students to participate in research on sex and condom use among university students on campus, which I hope will inform sexual health campaigns in South Africa. This means that a few sensitive topics and questions about sex and condom use may be addressed during the process. When it comes to answering these questions, **there are no right or wrong answers.**

Two forms of data collection will be used for this thesis a focus group and individual interviews.

Individual interview

The individual interview process will approximately take one hour. I will be asking you a few questions and request that you are as open and honest as possible in answering these questions. Some questions may be of a personal and/or sensitive nature. **You may choose not to answer these questions.** Confidentiality will be assured during this process as you will only be addressed by me (the researcher). In other words your participation in the process and your identity will not be known by anyone other than me. I am not looking for what you think the appropriate opinion might be, but rather **your own opinions, beliefs and values** on the subject. I will be recording the discussion with the use of a tape recorder, but your identity will be protected with the use of pseudonyms when the results are published, and the tapes with subsequently be destroyed.

The information that is gained during the project will be stored in a locked cabinet in my supervisor's office; only our supervisor and I will be able to access it. After the study has been completed any information that links your identity to the data will be destroyed.

The results of the study will be presented in a report that will be assessed by three examiners and presented at the School of Psychology Postgraduate conference. I and my supervisor may also present the results of the research at other conferences. The findings may also form the basis of future journal articles. The project, however, will be stored in the School of Psychology's Archives. Please know that no details signaling your personal identity will be released.

If I ask you a question which makes you feel uncomfortable or embarrassed, I can stop and talk to you about it or you may come to one of us at a later stage to discuss the issue, or you may contact me (details at the bottom of the page). There are also people from the university who are willing and available to talk to you about issues which may emerge during the research process. The **Student Counseling Center's** (situated on Main Campus) number is **033-260 5208**. If you would like to learn more about safe sex and contraceptive use, and/or gain access to contraceptives, the **Campus Clinic's** (also situated on Main Campus) number is **033-260 5853**.

If you have any **questions, queries or complaints** about any aspect of this study, you may contact **Mary van der Riet** by email (vanderriet@ukzn.ac.za) or by telephone (**033-260 5853**). If you have a complaint about any aspect of this study, you may also contact the **SoP Higher Degrees Ethics Committee (033-260 5853)**.

Thank you

Lois Deacon

083 513 9936

loisdeacon@gmail.com

APPENDIX 9: INFORMED CONSENT

I hereby agree to participate in the study regarding sex and condom use. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can withdraw and/or stop the interview or focus group at any point should I not want to continue. I also understand that this decision will not in any way affect me negatively.

The purpose of this study has been explained to me, and I understand what is expected of my participation.

I have received the telephone number of a person to contact should I need to speak about any issues that may arise in this interview.

I understand that this consent form will not be linked to the questionnaire, and that my answers will remain confidential.

Initial and signature of participant

Date

APPENDIX 10: AUDIO CONSENT

In addition to the above, I hereby agree to the audio recording of this interview and/or focus group for the purposes of data capture. I understand that no personally identifying information or recordings concerning me will be released in any form. I understand that these recordings will be kept securely in a locked facility and will be destroyed or erased once data capture and analysis are complete.

Initial and signature of participant

Date

APPENDIX 11: FOCUS GROUP PLEDGE

In taking part in this study, I agree not to discuss any of the issues that are divulged during the focus group process. I also hereby agree not to divulge any names or identities of focus group members to anyone outside of the study. I understand that each participant within this study has a right to privacy.

I understand that although the researcher (Lois Deacon) has no immediate control over my actions, if I do not maintain this privacy and confidentiality pledge the repercussions may affect others and further research in the field. In other words other participants may be harmed by my actions or may not wish to partake in further research.

Initials and signature of participant

Date