

**Sexual attitudes and behaviours of students at the University
of KwaZulu-Natal, Westville Campus.**

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TABLE OF CONTENTS

1.0	ABSTRACT	1
2.0	INTRODUCTION	2
3.0	CONCEPTUAL FRAMEWORK	4
3.1	Definition of Terminology	4
3.2.	The Acquisition of Attitudes	4
3.3	Types of Attitudes	6
3.3.1	Prejudice	6
3.3.2	Stereotypes	7
3.3.3	Prejudice based on gender	8
3.4	The Relationship Between Attitudes and Behaviour	8
3.5	Theoretical Framework of the Relationship Between Attitudes and Behaviour	9
3.5.1	The theory of reasoned action or theory of planned behaviour	9
3.5.2	The attitude to behaviour process model	10
3.5.3	Critique of models	10
4.0	LITERATURE REVIEW	12
4.1	<u>Sexual Behaviour</u>	<u>12</u>
4.2	Sexual Attitudes	14
4.3	The Relationship Between Sexual Attitudes and Sexual Behaviours	15
4.4	Summary	18

5.0	SPECIFIC RESEARCH QUESTIONS	19
6.0	HYPOTHESIS	20
7.0	METHOD	21
7.1	<u>Ethical Clearance</u>	<u>21</u>
7.2	Sampling Strategy	21
7.3	Instruments	21
7.3.1	The Revised Attitudes Towards Sexuality Inventory	21
7.3.2	The Sexual History Questionnaire	23
7.4	Procedures	24
7.5	Analysis	25
8.0	RESULTS	27
8.1	Predictor-Criterion Variable Relationship Between Gender and Sexual Attitudes	27
8.2	Sexual Behaviours of Entire Sample	28
8.2.1	Sexual encounter	28
8.2.2	Penetrative sex	29
8.2.3	Age of first penetrative sex	29
8.2.4	Unprotected penetrative sex	30
8.2.5	Number of sexual partners in previous month	31
8.2.6	Type of sex during last sexual encounter	32
8.2.7	Form of contraceptive used during last sexual encounter	33
8.2.8	Self assessment of HIV/AIDS risk	34

8.2.9	HIV antibody test	35
8.3	Sexual Attitudes	35
8.3.1	Attitudes towards sexual coercion and assault	36
8.3.2	Attitudes towards sexuality issues	36
8.3.3	Attitudes towards gender roles	36
8.4	Relationship Between Sexual Attitudes and Behaviours	37
8.4.1	Attitudes towards sexual coercion and assault	37
8.4.1.1	Sexual encounter	38
8.4.1.2	Penetrative sex	38
8.4.1.3	Age of first penetrative sex	38
8.4.1.4	Unprotected penetrative sex	39
8.4.1.5	Number of sexual partners in last month	39
8.4.2	Attitudes towards sexuality issues	39
8.4.2.1	Sexual encounter	40
8.4.2.2	Penetrative sex	41
8.4.2.3	Age of first penetrative sex	41
8.4.2.4	Unprotected penetrative sex	41
8.4.2.5	Number of sexual partners in last month	41
8.4.3	Attitudes towards gender roles	42
8.4.3.1	Sexual encounter	43
8.4.3.2	Penetrative sex	43
8.4.3.3	Age of first penetrative sex	43
8.4.3.4	Unprotected penetrative sex	44
8.4.3.5	Number of sexual partners in last month	44
8.4.4	Relationship between self-assessment of risk and HIV antibody test	45

8.4.5	Relationship between self-assessment of risk and condom use	48
8.4.6	Relationship between HIV antibody test and condom use	50
9.0	DISCUSSION	53
9.1	Sexual Behaviour	53
9.2	Sexual Attitudes	55
9.2.1	Attitudes towards sexual coercion and assault	55
9.2.2	Attitudes towards sexuality issues	56
9.2.3	Attitudes towards gender roles	57
9.3	The Relationship Between Sexual Attitudes and Sexual Behaviours	58
9.3.1	Attitudes towards sexual coercion and assault	58
9.3.2	Attitudes towards sexuality issues	59
9.3.3	Attitudes towards gender roles	60
9.3.4	The relationship between self-assessment of risk, having an HIV antibody test, and engaging in high risk sexual behaviour	62
10.0	SUMMARY STATEMENT OF MAJOR FINDINGS	65
11.0	LIMITATIONS OF THE STUDY	66
12.0	RECOMMENDATIONS	67
13.0	CONCLUDING COMMENTS	69
14.0	REFERENCES	70

15.0	APPENDICES	76
15.1	Appendix 1: Consent and Confidentiality Forms	76
15.2	Appendix 2: Demographic Information	77
15.3	Appendix 3: The Revised Attitudes Towards Sexuality Inventory	78
15.4	Appendix 4: Sexual History Questionnaire	82

LIST OF TABLES

Table 1:	Group Statistics – Relationship Between Gender and Sexual Attitudes	27
Table 2:	Independent Samples Test – Relationship Between Gender and Sexual Attitudes	27
Table 3:	Chi-Square Test - Selected History Questions	28
Table 4:	Chi-Square Test - Type of Sex During Last Sexual Encounter	32
Table 5:	Descriptive Statistics – Attitudes	36
Table 6:	Descriptive Statistics – Attitudes Towards Sexual Coercion and Assault * High Risk Sexual Behaviours	37
Table 7:	Independent Samples Test - Attitudes Towards Sexual Coercion and Assault * High Risk Sexual Behaviours	37
Table 8:	Oneway ANOVA - Attitudes Towards Sexual Coercion and Assault * High Risk Sexual Behaviours	38
Table 9:	Descriptive Statistics – Attitudes Towards Sexuality Issues * High Risk Sexual Behaviours	39
Table 10:	Independent Samples Test - Attitudes Towards Sexuality Issues * High Risk Sexual Behaviours	40
Table 11:	Oneway ANOVA - Attitudes Towards Sexuality Issues * High Risk Sexual Behaviours	40
Table 12:	Descriptive Statistics – Attitudes Towards Gender Roles * High Risk Sexual Behaviours	42
Table 13:	Independent Samples Test - Attitudes Towards Gender Roles * High Risk Sexual Behaviours	42

Table 14: Oneway ANOVA - Attitudes Towards Gender Roles * High Risk	
Sexual Behaviours	43
Table 15: Crosstabulation – Self Assessment of Risk * HIV Antibody Test	45
Table 16: Chi-Square Test - Self Assessment of Risk * HIV Antibody Test	45
Table 17: Crosstabulation 2 – Self Assessment of Risk * HIV Antibody Test	46
Table 18: Crosstabulation – Self Assessment of Risk * Unprotected	
Penetrative Sex	48
Table 19: Chi-Square – Self Assessment of Risk * Unprotected Penetrative	
Sex	49
Table 20: Crosstabulation – HIV Antibody Test * Unprotected Penetrative	
Sex	50
Table 21: Chi-Square – HIV Antibody Test * Unprotected Penetrative Sex	50
Table 22: Crosstabulation 2 – HIV Antibody Test * Unprotected Penetrative	
Sex	51

LIST OF FIGURES

Figure 1: Sexual Encounter	28
Figure 2: Penetrative Sex	29
Figure 3: Age of First Penetrative Sex	29
Figure 4: Unprotected Penetrative Sex	30
Figure 5: Number of Sexual Partners in Last Month	31
Figure 6: Type of Sex During last Sexual Encounter	32
Figure 7: Form of Contraceptive Used During Last Sexual Encounter	33
Figure 8: Self-Assessment of HIV/AIDS Risk	34
Figure 9: HIV Antibody Test	35
Figure 10: Relationship Between Self-Assessment of Risk and HIV Antibody Test	47
Figure 11: Relationship Between Self-Assessment of Risk and Unprotected Penetrative Sex	49
Figure 12: Relationship Between HIV Antibody Test and Unprotected Penetrative Sex	51

1.0 ABSTRACT

This study assessed the sexual attitudes and behaviours of the students at the University of KwaZulu-Natal, Westville campus. The relationships between high risk sexual behaviour and sexual attitudes were explored. The sample was obtained from the second and third year psychology classes, and 111 questionnaires were analysed using a quantitative, correlational analysis. The findings indicate that the majority of the students are engaging in high risk sexual behaviour. These high risk behaviours were found to relate to more traditional attitudes towards rape myths and sexual coercion, as well as more traditional attitudes towards sexuality issues. These findings can be used to inform future research on the campus, as well as to inform future intervention strategies.

2.0 INTRODUCTION

Kelly (2001) stated that many universities in Sub-Saharan Africa (Benin, Ghana, Kenya, Namibia, South Africa and Zambia) do not have an adequate understanding of the HIV/AIDS situation on their campuses and as a result of this lack of information, they have not made any effort to create awareness or implement intervention strategies. Based on this, she argued for an urgent and immediate implementation of intervention strategies at African universities as a result of the HIV/AIDS crisis. Kelly (2001) also argued that these interventions should be community specific, that is, based on research conducted within each university environment. As a result of Kelly's (2001) argument that it is important for research to be conducted within the specific campus' context, this study focuses on the University of KwaZulu Natal (UKZN), Westville campus.

This study aims firstly to explore students' sexual behaviour, as this will provide valuable information as to whether they are at risk for HIV/AIDS infection. Another aspect of the study is to explore the stereotypical sexual attitudes held by the students. McPhail (1998) argues that stereotypical sexual attitudes are prevalent in South African society, and that these attitudes impact on the sexual behaviour of young South Africans. It is clear that further research needs to be conducted which examines whether certain individuals resist the stereotypical norms which are prevalent in society. This study will further examine whether particular stereotypical attitudes are related to high risk sexual behaviour.

This study hopes to provide valuable information regarding students' sexual attitudes and behaviours at UKZN, Westville campus. This information can then be used to

inform intervention programmes targeting HIV/AIDS on the campus. Without this valuable information, it is not possible to establish the areas of focus for the interventions which need to be implemented on campus. This research, as well as further research which will be informed by this study, will attempt to provide this focus.

3.0 CONCEPTUAL FRAMEWORK

A conceptual understanding of attitudes and behaviour will include a definition of attitudes, a discussion of the various ways attitudes are acquired, and an exploration of the various relevant types of attitudes relevant to this study. Finally, the relationship between attitudes and behaviour will be explored.

3.1 Definition of Terminology

Baron and Byrne (2003) define attitudes as “evaluations of various aspects of the social world” (p. 119). Attitudes are often ambivalent, meaning that the evaluations of a particular aspect of the social world can be both positive and negative. Once formed, attitudes are extremely difficult to change.

Baron and Byrne (2003) argue that “attitudes strongly influence our social thought, even if they are not always reflected in our overt behaviour” (p. 119). However, attitudes often do influence our behaviour, especially when the attitudes are strong and well established. Attitudes can strongly colour our perceptions and thoughts and they allow us to express our personal beliefs.

3.2 The Acquisition of Attitudes

Attitudes can be created by a number of processes. Examples of these include classical conditioning, instrumental conditioning, and observational learning. A brief overview of these follows: Classical conditioning occurs when “one stimulus, initially neutral, acquires the capacity to evoke reactions through repeated pairing with another stimulus” (Baron & Byrne, 2003, p. 121). Instrumental conditioning occurs when

attitudes that are followed by positive outcomes are strengthened. Conversely, attitudes followed by negative outcomes are weakened. Classical and operant conditioning based on simple stimulus response associations are very basic processes (Kirsch, Lynn, Vigorito & Miller, 2004). Humans present with behavioural flexibility which therefore requires a more complex process of learning. Kirsch et al (2004) speculate that the great complexity of human beings results in automatic conditioning processes playing a smaller role. Therefore, with regards to sexual attitudes and behaviour, it may appear that learning by observation or through verbal communication may play a greater role.

Observational learning occurs when attitudes are acquired through the observation of others' attitudes. This process is reinforced by social comparison, which is "the tendency to compare ourselves with others in order to determine whether your view of social reality is or is not correct" (Baron & Byrne, 2003, p. 123). If others hold the same attitudes as us, these attitudes are reinforced. The learning is strengthened if the other person is perceived as attractive, trustworthy, similar to the individual, and competent (Brewer & Wann, 1998). Brewer & Wann's (1998) study investigated the role that social power plays in observational learning. They found that observational learning was greater in the groups taught by a model with a base of social power. This finding has significance with regard to sexual attitudes and behaviour, as young people may perceive their peers as being in a position of power and therefore they are more likely to emulate their behaviour and attitudes. The same applies to the media, which tend to portray some movie and music stars as engaging in high risk behaviour. People may thus learn from these models and engage similar high risk behaviour.

3.3 Types of Attitudes

There are three types of attitudes which are pertinent to this study as they may influence sexual behaviour: prejudice, stereotypes, and prejudice based on gender. These attitudes warrant further discussion.

3.3.1 Prejudice

Prejudice is an important type of attitude with regards to this study. Baron and Byrne (2003) define prejudice as “an attitude (usually negative) toward the members of some group, based solely on their membership in that group” (p. 209). An individual who is prejudiced against a particular group will process information about this group differently to information about other groups. Information related to and consistent with the prejudice is focused on and remembered. The prejudice is thus reinforced and strengthened over time. There are two main reasons why people hold prejudiced views. Firstly, prejudice allows individuals to feel superior. Secondly, prejudice saves individuals from mental effort. It is far easier to assume that all members of a group are the same.

While many scholars have argued that prejudice is based on social and economic competition, Legge (1996) argues that prejudice against minority groups may be the product of “early political and value socialisation” (p. 518). The identity variable in Legge’s (1996) study was particularly strong in accounting for hostile attitudes towards foreigners. This suggests that the symbolic theory of racism is more applicable when attempting to explain the relationships between races. Legge (1996) argues that these relationships can be explained “... largely as a consequence of the

negative prejudices of majority towards minority groups with self-interest not necessarily involved” (Legge, 1996, p. 517-518). Minority groups are often viewed as a racial threat, and it is therefore easy for individuals to hold prejudicial views about these ‘different’ people.

Heaven’s (1983) study examined three explanations of prejudice: the individual approach, the sociocultural learning approach and the intergroup approach. The individual approach to race relations sees prejudice as a function of a particular personality type (Heaven, 1983). However, this approach does not place any focus on group characteristics. The sociocultural learning theory of prejudice, however, focuses on the influence of society on the individual, and argues that prejudice is transmitted interpersonally and through accepted norms of society (Heaven, 1983). The intergroup approach views prejudice as the result of “... socially or culturally shared cognitive organisations of a social system” (Heaven, 1983, p. 203). Heaven’s (1983) study found that group membership consensus has a profound impact on prejudice amongst South Africans. Heaven (1983) argues that individuals interact with others in terms of their membership to their social and ethnic groups.

3.3.2 Stereotypes

As discussed, prejudice involves beliefs and expectations about all members of the particular group. These beliefs are known as stereotypes. Gender stereotypes are “stereotypes concerning the traits supposedly possessed by females and males, and that distinguish the two genders from each other” (Baron & Byrne, 2003, p. 242).

3.3.3 Prejudice based on gender

With regards to sexual attitudes and behaviour, the most important form of prejudice is based on gender. Sexism can be defined as prejudice based on gender. Sexism can take two forms. Hostile sexism is the view that “women, if not inferior to men, have many negative traits” (Baron & Byrne, 2003, p. 241). Benevolent sexism suggests that “women deserve protection, are superior to men in various ways, and are truly necessary for men’s happiness” (Baron & Byrne, 2003, p. 241). The existence of both these forms of sexism indicates that as a result of men having held a dominant position for a great length of time, women have come to be seen as inferior in many ways. Both men and women subscribe to these views (Baron & Byrne, 2003). This research attempted to explore these types of views.

3.4 The Relationship Between Attitudes and Behaviour

Once attitudes are acquired, they influence behaviour (Baron & Byrne, 2003). However the strength of this influence is dependent on a number of factors. Studies indicate that the origin of the attitude will determine the extent of the influence on behaviour. “Attitudes formed on the basis of direct experience often exert stronger effects on behaviour than ones formed indirectly, through hearsay” (Baron & Byrne, 2003, p. 130). The second influential factor is the strength or intensity of the attitude. The third factor which influences the relationship between attitudes and behaviour is attitude specificity, or “the extent to which attitudes are focused on specific objects or situations rather than general ones” (Baron & Byrne, 2003, p. 132).

3.5 Theoretical Framework of the Relationship Between Attitudes and Behaviour

Various theories have been developed in order to explain how attitudes impact on an individual's behaviour. However for purposes of this research, two predominant theories will form the theoretical framework of the study. These are the theory of reasoned action and the attitude to behaviour process model. These two theories provide the means to explain the relationship between sexual attitudes and sexual behaviours of young people. The theory of reasoned action is applicable when individuals have had an opportunity to think about their sexual relationships and then come to a decision regarding their sexual behaviour. The attitude to behaviour process model illustrates how sexual attitudes and behaviours are related when the individual has no time to reflect and comes to a quick decision. Therefore the two theories complement each other and can be used to explore and understand many of the sexual situations which students may find themselves in.

3.5.1 The theory of reasoned action or theory of planned behaviour

The theory of reasoned action, or theory of planned behaviour (Ajzen & Fishbein, 1980; Ajzen, 1991; as cited in Baron & Byrne, 2003) argues that when an individual decides to engage in a particular behaviour, a logical sequential process is followed. Behavioural options and the pros and cons of each are considered. A decision is then made whether or not to act. This decision is reflected in behavioural intentions which are determined by three factors. 1) Attitudes toward a behaviour (positive and negative evaluations of consequences), 2) subjective norms (whether others will

approve or disapprove), and 3) perceived behaviour control (how well the individual feels they will be able to perform the behaviour).

3.5.2 The attitude-to-behaviour process model

The theory of reasoned action or planned behaviour assumes that the individual will have time to reflect on the situation. Fazio's (1989; as cited in Baron & Byrne, 2003) attitude-to-behaviour process model is more applicable in situations where the individual has to react quickly. According to this theory, "some event activates an attitude, the attitude, once activated, influences our perceptions of the attitude object. At the same time, knowledge about what's appropriate in a given situation ... is also activated. Together, the attitude and this previously stored information about what's appropriate or expected shape our definition of the event. This perception, in turn, influences our behaviour" (Baron & Byrne, 2003, p. 134).

3.5.3 Critique of models

While these two models do provide an understanding of the relationship between attitudes and behaviour, they are somewhat limited in a developing country such as South Africa. These models tend to be rather individualistic. The individualistic perspective assumes that people are "... the source and arbiter of (their) own thinking and action ... (d)isengaged from ties to nature, society, and history, the modern subject is less a bounded, fragile, restricted being than an autonomous, self-conscious, unperturbable agent" (Kerdeman, 1998: 257). From this point of view, an individual's understandings are independent from the world in which they live: from contexts such as politics, culture and gender. Therefore, any intervention strategies or studies informed by an individualistic point of view need not take into account the context in

which people live. This must be kept in mind when examining the results of this study, as well as when interventions are created based on this study. MacPhail (1998) argues that surveys such as KAPB (which are based on models such as those presented above), while providing valuable information on the transmission of HIV/AIDS, do not pay enough attention to the contexts in which knowledge, attitudes and behaviour are constructed. She suggests that perceptions, beliefs and norms should be explored qualitatively, and that the social contexts in which the youth's behaviour occurs should be examined. For this reason, the current research should be used to inform more qualitative interventions and studies which can probe further into the reasons behind the sexual behaviour of university students, looking at the contexts in which behaviour occurs.

4.0 LITERATURE REVIEW

4.1 Sexual Behaviour

Studies conducted amongst American high school and university students have revealed that the number of students engaging in sexual activity has increased steadily between 1950 and 2000 (Caron & Moskey, 2002). Students who graduated in the year 2000 were more likely to have more than one sexual partner than students who graduated between 1950 and 1999. Pettifor, Rees, Steffenson, Hlongwa-Madikizela, MacPhail, Vermaak, and Kleinschmidt (2004), conducted a study in South Africa which assessed the sexual attitudes and behaviours of a wide cross-section of South Africa's youth. Due to its recent administration and applicability, this paper was selected as the core reading for this study. Pettifor et al (2004) found that 89% of the 20-24 year olds in their survey reported having engaged in penetrative sex. They also found that of those respondents who had engaged in penetrative sex, 83% had had penetrative sex in the twelve months prior to the study. This high percentage is indicative of a large number of people in the high risk age group (age 15-24 years) engaging in high risk sexual behaviour (Pettifor et al, 2004).

Research also indicates that the average age of first penetrative sex is 17 years (Pettifor et al, 2004). Pettifor et al's (2004) study also found that 8% of their respondents had had sex at the age of 14 years or younger, thus increasing the risk of HIV infection at a younger age, and exposing individuals to more partners who may be HIV positive. According to Pettifor et al (2004), only 35% of the respondents who had engaged in sexual intercourse had had one lifetime partner. 26% of the

respondents in the 20-24 years age group reported that they had had more than one partner in the last twelve months.

In a study on condom use, Pettifor et al (2004) found that only 50% of the sexually experienced respondents aged 20-24 had used a condom during their last sexual experience. Despite this high incidence of non condom use, respondents were aware that they should use condoms all the time. This is an indication that although individuals are aware how to prevent HIV infection, they are not putting this knowledge into practice. The majority of them are not using condoms, and are having unprotected penetrative sex with more than one partner.

Despite the research which indicates that South Africans are engaging in high risk sexual behaviour, Pettifor et al's (2004) study found that 28% of the respondents aged 20-24 considered themselves at no risk for HIV infection, 38% considered themselves at small risk, 15% considered themselves at moderate risk, and only 17% considered themselves at high risk. They therefore do not appear to equate their high risk sexual behaviour with a high risk of HIV/AIDS infection. Only 29% of these respondents had had an HIV antibody test (Pettifor et al, 2004).

Young South African women have also started to take risks with their sexual behaviour due to social pressure. "Sex is viewed as the attrition of female resistance by male persuasion, and by asserting that sex was unexpected or 'just happened' women maintain societal definitions of femininity but also place their sexual health in jeopardy" (McPhail, 1998, p. 72). Women do not discuss sexual histories with their partners. Condoms are not carried or used. Women are not assertive in their

relationships and this often leads to unsafe sexual practices within these relationships (McPhail, 1998).

McPhail (1998) found that South African men are engaging in casual promiscuous behaviour. A Namibian study found that men are willing to use force in order to engage in this behaviour (Becker, 2001). Vanwesenbeeck, Bekker, and van Lenning (2003) supported Becker's (2001) argument with the results of their international study. They discovered that men exhibit a large amount of aggression and violence towards women, especially when related to chauvinistic attitudes. Pettifor et al (2004) reported that the results of their study supported the idea that "gender power imbalances exist in sexual relationships" (p. 73). Their female respondents stated that it was harder to refuse unwanted sex, or negotiate condom use with the predominantly older men who they were engaging in sexual intercourse with. This power imbalance could be as a result of the more traditional gender attitudes which exist amongst South Africans. These traditional gender attitudes centre around the idea that in a sexual relationship, the man is in a position of power, while the woman must obey him without question.

4.2 Sexual Attitudes

Caron and Moskey's (2002) study in the United States found that between 1950 and 2000 there has been a steady decrease in negative attitudes towards premarital sex among American high school students. Students who graduated in 2000 had more accepting attitudes towards sexual relationships outside of the context of marriage, and towards birth control. They were also more likely to discuss sex with their parents, friends, or boyfriend/girlfriend (Caron & Moskey, 2002).

Projects in South Africa have attempted to establish whether the changes in sexual attitudes which appear to be occurring in the United States are happening locally. South African Football Association official, Sphelele Mlangeni was involved in a South African project aimed at changing sexual attitudes and behaviours. He stated that “we soccer players used to think we were such heroes when we were embraced by many women. We were not heroes, we were fools! ... It is not just young men who are affected. We older men were happy to mislead each other” (Gilman, 2001, p. 4). It is apparent from studies such as this one that South Africans too are becoming more accepting of premarital and promiscuous sex.

Local studies by McPhail (1998), Varga (1997), and Becker (2001) have found that chauvinistic attitudes exist amongst both men and women. These will be discussed further with regard to chauvinistic attitudes’ relationship with sexual behaviour.

4.3 The Relationship Between Sexual Attitudes and Sexual Behaviours

The relationship between sexual attitudes and sexual behaviour is apparent, but extremely complex. Various studies have been conducted, both locally and internationally, which examine the relationship between the two. These studies have found that attitudes appear to have a direct impact on sexual behaviour.

“Clearly, all sexual behaviour is mediated, facilitated, and/or justified by cognitions and beliefs” (Vanwesenbeeck et al, 1998, p. 326). Hynie and Lydon (1996) argue that sexual attitudes predict sexual behaviour, as well as contraceptive behaviour. For the purposes of their study, they measured attitudes in terms of emotional response to sexual stimuli, ranging from the most negative attitude (ertophobic) to the most

positive attitude (ertophilic). In their study, they found that women with negative sexual attitudes engaged in poor contraceptive behaviour. Women with moderately positive sexual attitudes used contraceptives more consistently, and used more effective contraceptives. Women with extremely positive sexual attitudes were not good contraceptive users, and engaged in high-risk sexual behaviour. “This suggests that a positive orientation toward sex may promote effective and consistent contraceptive practices, but that being extremely ertophilic may result in disinhibition of high-risk sexual behaviour” (Hynie & Lydon, 1996, p. 132).

Adler and Hendrick’s (1991) international study supported Hynie and Lydon’s (1996) findings. Their study used questionnaires to attempt to identify the variables which are related to contraceptive behaviour. They argued that “romantic, passionate love was positively correlated to contraceptive behaviour ... (while game-playing love) ... was inversely related to contraceptive behaviour, indicating a tendency for women whose attitudes support the idea of multiple, superficial relationships, to be poor contraceptive users” (Adler & Hendrick, 1991, p. 307). This study once again suggests that sexual attitudes have a direct relationship with sexual behaviour. This relationship is examined in this research in order to obtain a clearer picture of the sexual attitudes and sexual behaviours at UKZN, Westville campus.

McPhail (1998) argues that sexual attitudes are entrenched in South African society. As discussed earlier, there exists a double standard of sexual behaviour which encourages men to engage in casual, promiscuous sex, while disapproving of the same behaviour in women. A study conducted by Shefer and Ruiters (1998) discovered that there exists the idea that men “need sex; are focused on sex; are ‘ever ready’ to have

it' and that it is ultimately a biological urge outside of their control" (p. 41). However, sex for women is supposed to represent a loving relationship. Men feel that they cannot control their urges and may therefore force women to engage in sexual intercourse. Women, however, feel ashamed when they succumb to a man's advances, and therefore do not seek out the contraceptive advice they may have access to. It can therefore be seen how these chauvinistic attitudes have led to an increase in high risk sexual behaviour.

A study conducted by Varga (1997) found that "a possessive and chauvinistic attitude towards women has been seen to fuel the problem of male violence and disregard for safety and respect" (p. 90). Kaufman (1994) argues that in many societies, masculinity is associated with "a man's capacity to exercise power and control" (p. 39). Therefore, in order to live up to this 'ideal masculinity', men may even be prepared to resort to violence in order to maintain power in the relationships. In a local study conducted by Becker (2001), several of the participants stated that they felt the need to resort to violence in order to assert control over their girlfriends. "You can beat her because *you are the man*. She must understand that I am *the man*. I am the boss" (Becker, 2001, p. 12). These attitudes towards masculinity can thus lead to high risk sexual behaviour.

Vanwesenbeeck et al (1998) found in their international study that "the social incompetence and insensitivity of perpetrators of sexual aggression has often been found in the context of strong adversarial sexual beliefs and strong endorsement of rigid, traditional sex-role stereotypes and rape myths" (p. 318). Nightingale and Morrissette (1993) identify popular rape myths as including "'it really didn't happen',

‘women like rape’, ‘it happened but no harm was done’, ‘women provoke it, ‘women deserve it’, and ‘when women say no they really mean yes’” (p. 2). Burt (1990) found a correlation between believing rape myths and holding adversarial stereotypical beliefs and the acceptance of gender violence. Goodrich, Rampage, Ellman, and Halstead (1988) outline three gender-based assumptions which underlie rape myths: 1) men believe that they should always have the privilege and the right to control women’s lives, 2) women believe that when anything goes wrong in a relationship, they are to blame, and 3) women believe that men are not merely desirable or enjoyable, but essential for their well-being.

4.4 Summary

It is apparent from both and international studies that both men and women hold stereotypical attitudes towards the role of men and women within society and these attitudes appear to result in high risk sexual behaviour. This has a direct impact on the number of South Africans affected by HIV/AIDS.

5.0 SPECIFIC RESEARCH QUESTIONS

1. What are the sexual attitudes predominantly held by students on the Westville campus of the UKZN?
2. What sexual behaviours are the students on the Westville campus of UKZN engaged in?
3. Are certain sexual attitudes related to certain sexual behaviours?

6.0 HYPOTHESIS

It is hypothesised that:

1. Both male and female students who hold attitudes relating to sexual prejudice will present with high risk behaviour with regards to HIV/AIDS.
2. Both male and female students who hold attitudes unrelated to sexual prejudice will present with low risk behaviour.

7.0 METHOD

7.1 Ethical Clearance

Ethical clearance to conduct this study was obtained from the Ethical Clearance Committee on 19 April 2004. The ethical clearance number is 04102A.

7.2 Sampling Strategy

Purposive sampling was utilised. Second and third year psychology students at the University of KwaZulu Natal, Westville campus were approached during their lectures and asked to participate in the research. These students were targeted as they fall within the 15-24 year age group which has a high risk of HIV infection (Pettifor et al, 2004). Both male and female students who agreed to participate in the research were issued with a questionnaire. As only second and third year psychology students were targeted, the results are not generalisable to the entire university population. However, the results can be used to inform intervention programmes which will be implemented on campus.

7.3 Instruments

Two measures were administered. The first measured sexual attitudes, the second sexual behaviour.

7.3.1 The Revised Attitudes Towards Sexuality Inventory

The Revised Attitudes Towards Sexuality Inventory (Patton & Mannison, 1998) was constructed in Australia to measure sexual attitudes, with a focus on sexual coercion

(See Appendix 3). The scale consists of 40 statements to which the respondents have to choose a response ranging from *strongly agree* to *strongly disagree*. It takes between five and ten minutes to complete. The inventory measures three types of attitudes: attitudes towards sexual coercion and assault, sexuality, and gender roles. High scores on the items measuring attitudes toward sexual coercion and assault indicate a greater acceptance of rape myths and sexual coercion. If an individual obtains higher scores on the items measuring attitudes towards sexuality suggests that they hold less traditional attitudes towards sexuality. High scores on the items measuring attitudes towards gender roles indicates that the individual holds more traditional attitudes towards gender roles (Patton & Mannison, 1998). The total scores for each factor were obtained by calculating the average of the items that comprise the factor. On a scale from 1-7, scores around 4 indicate indifference while 5 and above indicate greater acceptance of rape myths and sexual coercion, more traditional attitudes towards gender roles, and less traditional attitudes towards sexuality.

With regards to reliability, the Chronbach alpha for the inventory was 0.85, and for the three factors, the alphas were 0.85, 0.79, and 0.68 respectively (Patton & Mannison, 1998).

As the scale was developed for use in Australia, a pilot study was conducted to ensure that there were no expressions or words used that are not applicable or appropriate for the South African context.

7.3.2 The Sexual History Questionnaire

The Sexual History Questionnaire (Cupitt, 1998) was “devised to assess the degree to which an individual’s sexual behaviour is putting him or her at risk of infection by HIV, the virus that leads to AIDS” (p. 106). (See Appendix 4). The scale was created in the United Kingdom. It consists of four sections. Section A establishes whether the respondent has engaged in penetrative sex, and whether this was protected sex or not. It also asks whether they have sex with men, women, or both. Section B establishes the details of sexual encounters over the past month. Cupitt (1998) argues that as self-reporting of sexual behaviour has been criticised as being unreliable, she decided to include Section C. Section C asks for details about the most recent time the individual had sex. Interpersonal and situation variables are probed. Section D establishes the extent to which the respondent has been in contact with HIV/AIDS counselling, people suffering from HIV/AIDS, and asks them to assess their own level of HIV/AIDS risk. The inventory consists of a combination of yes/no, multiple choice, numerical (which require numerical responses such as “In the last month how many sexual partners have you had?”), and 5-point scale questions. It takes between five and ten minutes to complete.

Cupitt (1998) found that the questions in this inventory had an interclass correlation of 0.80 ($p < 0.001$), which indicates a high level of reliability.

As the scale was developed for use in the United Kingdom, a pilot study was conducted to ensure that the expressions or words used were applicable and appropriate for the South African context.

The results of the two questionnaires were compared in order to establish if there was any correlation between particular sexual attitudes and particular sexual behaviours for the participants. The relationship between gender and attitudes towards sexual behaviour were initially examined, however, as no significant difference was found, the rest of the results are reported in terms of the entire sample. The study aimed to establish the behaviours and attitudes of the students at the university as a whole, not in terms of gender. The interventions which could be created as a result of this study should be aimed at the entire university population.

7.4 Procedures

Prior to the final administration of the questionnaires, a pilot study was conducted with 20 male and female second year students who volunteered to assist with the pilot study. These students did not complete the questionnaire in the final study. After completing the questionnaire, the participants were asked for feedback about the questions: did they make sense to them, did any questions make them feel uncomfortable, and why. Their responses were taken into consideration when the final questionnaires were compiled. Examples of these recommendations include:

- More appropriate wording of some of the questions and statements.
- The inclusion of some more commonly used contraceptives (i.e. the injection).

These recommendations were taken under consideration, and it was decided to effect the suggested alterations. This ensured that despite the scales being created for Australian and British participants, they were appropriate for South African respondents.

The two scales took between ten and fifteen minutes in total to complete. Students were asked to sign informed consent. All of the respondents were age 18 years or above and so were able to sign this form. The form emphasised the confidentiality of their personal details (See Appendix 1). They were also asked to fill in a form regarding their demographic information (See Appendix 2). Of the approximately 400 students approached, 142 agreed to participate in the research. Of the 142 questionnaires handed out, 31 were discarded as they were incomplete. 111 valid forms were therefore analysed.

7.5 Analysis

The data was analysed using SPSS version 11.5. The relevant attitudes and behaviours were identified and analysed using a correlational, quantitative analysis. These results were then analysed to determine which attitudes were related to which behaviours. A detailed outline of the tests conducted follows:

- Descriptive Statistics or Frequency tables were used to ascertain the measures of central tendency (Mean) to indicate the location of the distribution, as well as measures of dispersion (standard deviation, minimum, maximum) to show the dissimilarity of the values.
- Independent-Samples T Tests were conducted to compare the means for two groups of cases.
- One-Way ANOVA procedures were used to produce a one-way analysis of variance for a quantitative dependent variable by a single factor (independent) variable. Analysis of variance was then used to test the hypothesis that several means were equal.

- Pearson Chi-square tests were used to analyse data in a contingency table (the number of individuals in each group that fall in each category).
- The One Sample Chi-Square Test was used to tabulate a variable into categories and computes a chi-square statistic. This enabled the observed and expected frequencies in each category to be compared and to test either that all categories contained the same proportion of values or that each category contained a user-specified proportion of values.

8.0 RESULTS

8.1 Predictor-Criterion Variable Relationship Between Gender and Sexual Attitudes

Table 1

Group Statistics – Relationship Between Gender and Sexual Attitudes

		N	Mean	Std Deviation
Gender				
Attitude	Male	13	156.307	22.7683
	Female	94	169.829	15.4868

Table 2

Independent Samples Test – Relationship Between Gender and Sexual Attitudes

		T-test for Equality of Means		
		t	df	p
Attitude	Equal variances not assumed	-2.076	13.578	0.057

Tables 1 and 2 indicate that the level of attitude is not significantly different between males and females at the 5% level ($p>0.05$). As their level of attitude is not significant, the differences between the genders were not focused on in the following statistics.

8.2 Sexual Behaviours of Entire Sample

Table 3

Chi-Square Test - Selected History Questions

	Chi-Square	df	p
Sexual Encounter	11.036	1	0.001
Penetrative Sex	4.766	1	0.029
Age of First Sex	93.642	7	.00
Unprotected Sex	0.327	1	0.567
Number of Sexual Partners in Last Month	122.725	3	0.000
Type of Sex During Last Sexual Encounter	38.048	5	0.000
Self Assessment of Risk	60.63	4	0.000
HIV Antibody Test	9.811	1	0.002

8.2.1 Sexual encounter

Figure 1

Sexual Encounter (n=111)

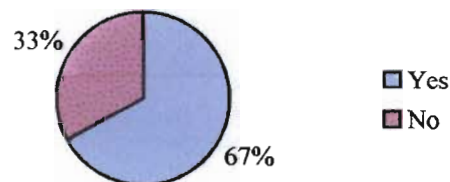


Table 3 indicates that of the 111 respondents, a significant number had had a sexual encounter / sexual contact of some kind ($p < 0.05$). This difference is at the 0.01 level of significance. More than double the number of respondents had had a sexual encounter than those who had not had a sexual encounter. Figure 1 illustrates this in terms of percentages: 67% of the respondents had had a sexual encounter.

8.2.2 Penetrative sex

Figure 2

Penetrative Sex

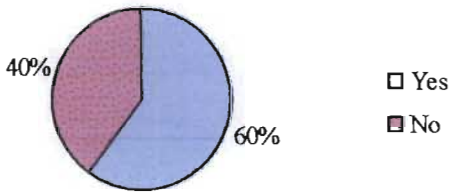
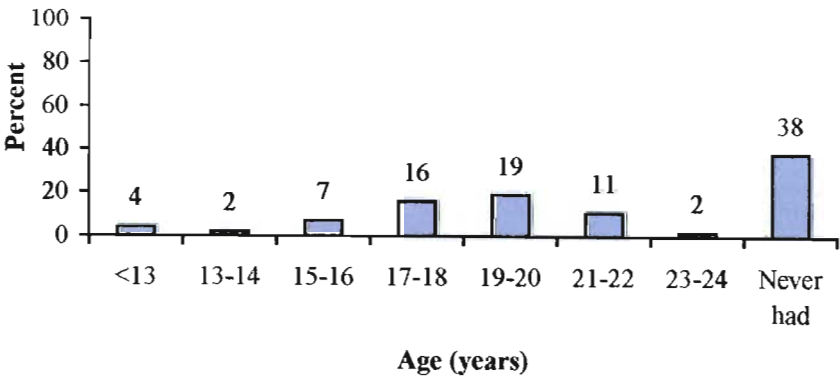


Table 3 indicates that a significant number of the respondents had engaged in penetrative sex ($p<0.05$). This difference is at the 0.05 level of significance. Figure 2 shows that 60% of the respondents had engaged in penetrative sex.

8.2.3 Age of first penetrative sex

Figure 3

Age of First Penetrative Sex (n=111)

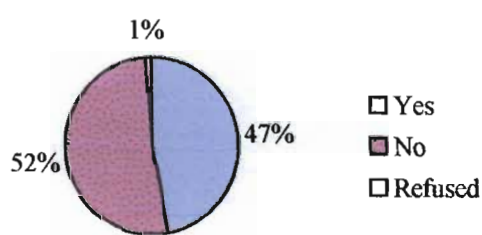


35% of the respondents had first engaged in penetrative sex between the ages of 17 and 20 years old, while 4% had first engaged in penetrative sex when they were younger than 13 years old (see Figure 3). These responses were significantly different ($p < 0.05$). The difference is at the 0.01 level of significance (see Table 3).

8.2.4 Unprotected penetrative sex

Figure 4

Unprotected Penetrative Sex (n=111)



While 60% of the total respondents had engaged in penetrative sex (see Figure 2), a lesser percentage (47%) of the total respondents had engaged in unprotected penetrative sex (See Figure 4). Table 3 indicates that nearly half of the respondents had engaged in unprotected penetrative sex, however this difference is not significant ($p > 0.05$). Figure 4 illustrates this in terms of percentages: 47% of the respondents had had unprotected penetrative sex.

8.2.5 Number of sexual partners in previous month

Figure 5

Number of Sexual Partners in Last Month (n=111)

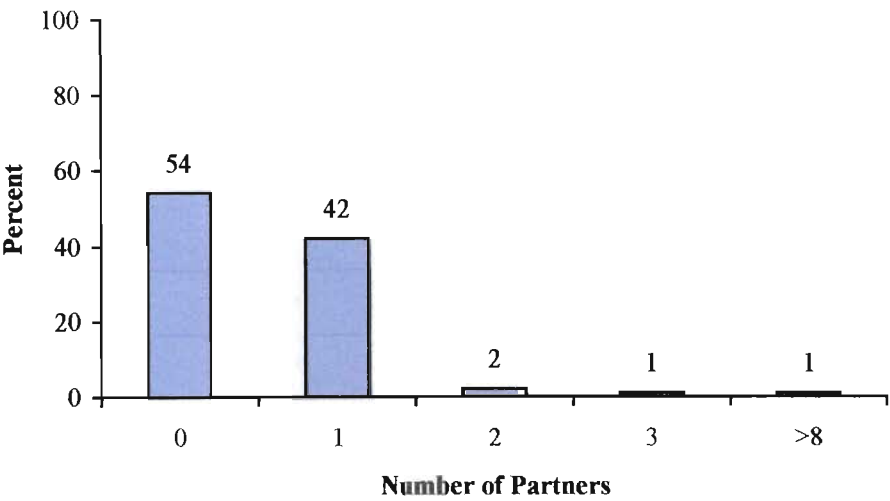


Table 3 shows that there are significant differences in the responses per category with regards to number of sexual partners in the previous month ($p<0.05$). These differences are at the 0.01 level of significance.

Figure 5 indicates that more than half of the respondents had not had a sexual encounter in the month prior to answering the questionnaire. Less than half had had one sexual partner, while a minority had had 2, 3, or more than 8. A large number of the respondents had had one or no sexual partner in the previous month.

8.2.6 Type of sex during last sexual encounter

Table 4

Chi-Square Test - Type of Sex During Last Sexual Encounter (n=74)

	Chi-Square	df	p
Unprotected Vaginal Sex	.059	1	.808
Vaginal Sex With A Condom	.130	1	.718
Unprotected Anal Sex	45.14	1	.000
Anal Sex With A Condom	63.06	1	.000
Oral Sex	.941	1	.332
Other Forms of Nonpenetrative Sex	9.941	1	.002

Figure 6

Type of Sex During Last Sexual Encounter (n=74)

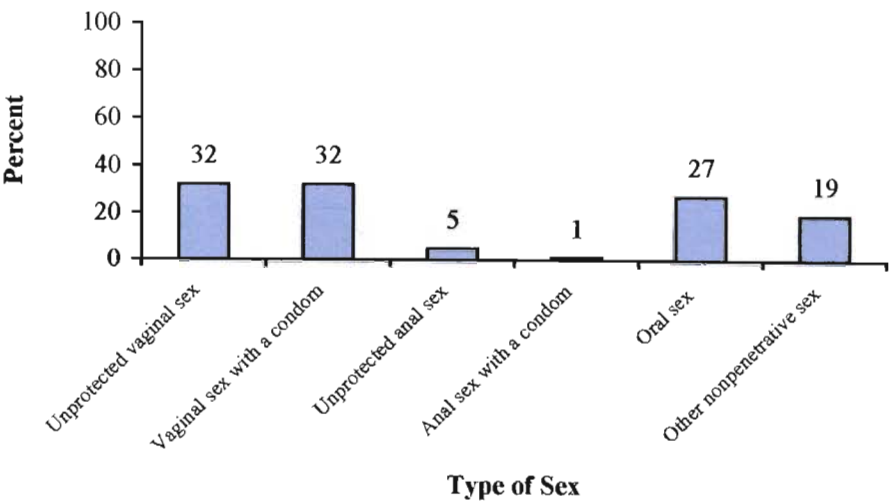


Table 4 indicates that during their last sexual encounter, a significant number of the respondents had not engaged in unprotected anal sex or anal sex with a condom

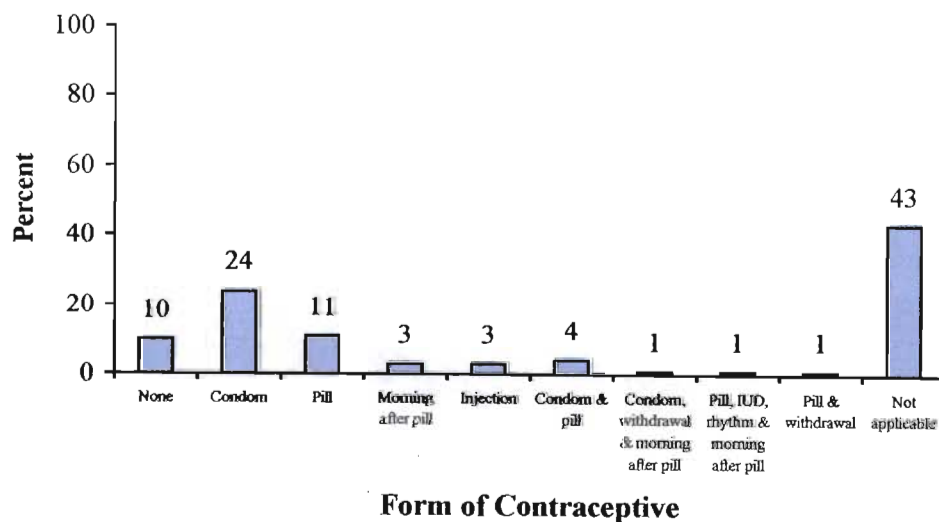
($p < 0.05$). This difference is at the 0.01 level of significance. A significant number of the respondents had not engaged in other forms of nonpenetrative sex ($p < 0.05$). This difference is at the 0.05 level of significance.

Figure 6 shows that the majority of the respondents (64%) engaged in vaginal sex during their last sexual encounter. A number of the respondents had engaged in more than one type of sex during their last sexual encounter (e.g. “vaginal sex with a condom” and “oral sex”), therefore the tally of the percentages is more than 100%. This was done for ease of analysis of the various categories.

8.2.7 Form of contraceptive used during last sexual encounter

Figure 7

Form of contraceptive used during last sexual encounter (n=111)



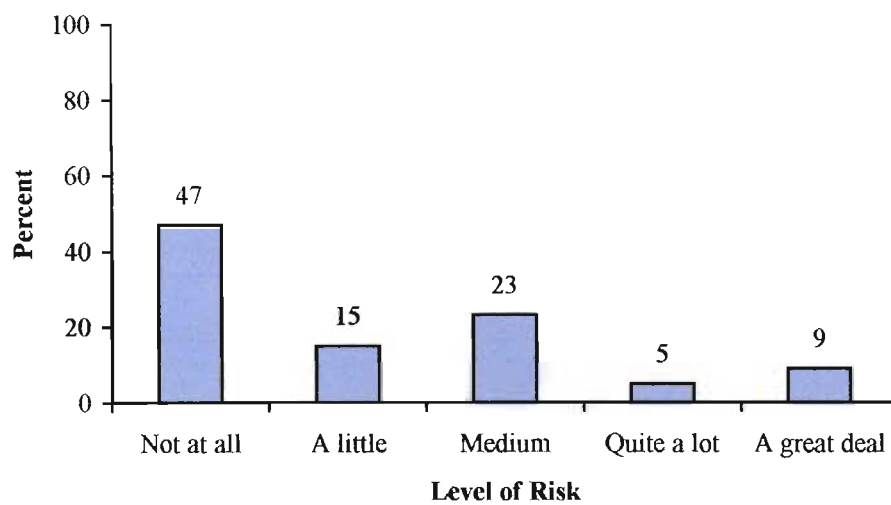
With regard to contraceptive use during their last sexual encounter, 10% of the respondents did not use any form of contraceptive, while 29% used a condom (see Figure 7). These responses are significantly different ($p < 0.05$). The difference is at the

0.01 level of significance (see Table 3). Three categories were utilised to obtain the figure of 29% condom use - “condom”, “condom and pill”, and “condom, withdrawal and morning after pill”.

8.2.8 Self-assessment of HIV/AIDS risk

Figure 8

Self Assessment of Risk of HIV/AIDS



Respondents were asked to assess their own level of risk of HIV/AIDS infection. A large number considered themselves to be at no risk at all. Only 9% considered themselves to be at a great deal of risk (see Figure 8). Table 3 indicates that the difference in the responses were significant at the 0.01 level of significance. The relationship between high risk behaviour and self assessment of risk is examined in section 8.3.5.

8.2.9 HIV antibody test

Figure 9

HIV Antibody Test

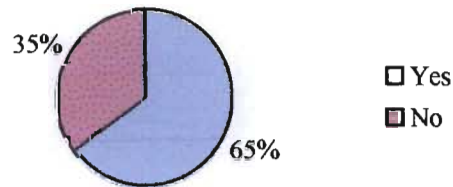


Table 3 indicates that a significant number of the respondents had had an HIV antibody test ($p < 0.05$). This difference is at the 0.01 level of significance. Figure 9 indicates that 65% of the respondents had had an HIV antibody test.

8.3 Sexual Attitudes of Entire Sample

The total scores for each factor were obtained by calculating the average of the items that comprise the factor. On a scale from 1-7, scores of around 4 indicate indifference. For the Sexual Coercion and Assault factor, scores of 5 and above indicate low acceptance of rape myths, sexual coercion and assault. For the Sexuality Issues factor, scores of 5 and above indicate less traditional attitudes towards sexuality issues. For the Gender Roles factor, scores of 5 and above indicate more traditional attitudes towards gender roles.

Table 5

Descriptive Statistics - Attitudes

	N	Minimum	Maximum	Mean	Std Deviation
Sexual Coercion & Assault	109	3.33	7.00	5.5833	0.77745
Sexuality Issues	111	2.50	6.00	4.1847	0.76479
Gender Roles	111	1.60	7.00	4.4775	1.03333
Valid N (listwise)	109				

8.3.1 Attitudes towards sexual coercion and assault

Table 5 indicates that the mean on the Attitudes Towards Sexual Coercion and Assault scale was 5.5833. This suggests that the majority of the respondents presented with low acceptance of rape myths, sexual coercion and assault.

8.3.2 Attitudes towards sexuality issues

Table 5 shows that the mean on the Attitudes Towards Sexuality Issues scale was 4.1847. This indicates that the majority of the respondents were indifferent with regards to their attitudes towards sexuality issues.

8.3.3 Attitudes toward gender roles

On the Attitudes Towards Gender Roles scale, Table 5 shows that the mean is 4.4775. This suggests that the majority of the respondents were indifferent with regards to their attitudes towards gender roles.

8.4 Relationship Between Sexual Attitudes and Behaviours of Entire Sample

8.4.1 Attitudes towards sexual coercion and assault

Table 6

*Descriptive Statistics – Attitudes Towards Sexual Coercion & Assault * High Risk*

Sexual Behaviours

		N	Mean	Std Deviation
Sexual Behaviour				
Sexual Encounter	Yes	71	5.5798	0.81375
	No	38	5.5899	0.71513
Penetrative Sex	Yes	65	5.5590	0.81260
	No	44	5.6193	0.73012
Unprotected	Yes	50	5.5433	0.80553
Penetrative Sex	No	58	5.6250	0.76237

Table 7

*Independent Samples Test - Attitudes Towards Sexual Coercion & Assault * High*

Risk Sexual Behaviours

Sexual Behaviour		T-test for Equality of Means		
		t	df	p
Sexual Encounter	Equal variances assumed	-0.064	107	0.949
	Equal variances not assumed			
Penetrative Sex	Equal variances assumed	-0.396	107	0.693
	Equal variances not assumed			
Unprotected Penetrative Sex	Equal variances assumed	-0.541	106	0.590
	Equal variances not assumed			

For the above t-test, the dependent variable is Attitudes Towards Sexual Coercion and Assault.

Table 8

*Oneway ANOVA - Attitudes Towards Sexual Coercion & Assault * High Risk Sexual Behaviours*

Sexual Behaviour		F	p
Age of First Penetrative Sex	Between groups	0.776	0.608
Number of Sexual Partners in Last Month	Between groups	0.021	0.979

8.4.1.1 Sexual encounter

Tables 6 and 7 show that there is no significant difference in attitudes towards sexual coercion and assault between those who have had a sexual encounter and those who have not ($p>0.05$).

8.4.1.2 Penetrative sex

Tables 6 and 7 indicate that when comparing those respondents who have had penetrative sex and those who have not, there appears to be no significant difference in their attitudes towards sexual coercion and assault ($p>0.05$).

8.4.1.3 Age of first penetrative sex

Table 8 indicates that there is no significant difference in the attitudes towards sexual coercion and assault when comparing the age of first penetrative sex ($p>0.05$).

8.4.1.4 Unprotected penetrative sex

Tables 6 and 7 suggest that there is no significant difference in the attitudes towards sexual coercion and assault between those respondents who have had unprotected penetrative sex, and those who have had penetrative sex ($p>0.05$).

8.4.1.5 Number of sexual partners in last month

Table 8 shows that when comparing the respondents in terms of the number of sexual partners in the previous month, there is no significant difference in their attitudes towards sexual coercion and assault ($p>0.05$).

8.4.2 Attitudes towards sexuality issues

Table 9

*Descriptive Statistics – Attitudes Towards Sexuality Issues * High Risk Sexual Behaviours*

		N	Mean	Std Deviation
Sexual Behaviour				
Sexual Encounter	Yes	73	4.138	0.74260
	No	38	4.2730	0.80845
Penetrative Sex	Yes	67	4.0970	0.75309
	No	44	4.3182	0.77171
Unprotected	Yes	52	4.0072	0.67628
Penetrative Sex	No	58	4.3356	0.80799

Table 10

*Independent Samples Test - Attitudes Towards Sexuality Issues * High Risk Sexual Behaviours*

Sexual Behaviour		T-test for Equality of Means		
		t	df	p
Sexual Encounter	Equal variances assumed	-0.877	109	0.382
Penetrative Sex	Equal variances assumed	-1.499	109	0.137
Unprotected Penetrative Sex	Equal variances assumed	-2.437	108	0.016

For the above t-test, the dependent variable is Attitudes Towards Sexuality Issues.

Table 11

*Oneway ANOVA - Attitudes Towards Sexuality Issues * High Risk Sexual Behaviour*

Sexual Behaviour		F	p
Age of First Penetrative Sex	Between groups	0.570	0.779
Number of Sexual Partners in Last Month	Between groups	1.233	0.308

8.4.2.1 Sexual encounter

Tables 9 and 10 indicate that with regards to attitudes towards sexuality issues, there is no significant difference between those who have had a sexual encounter and those who have not had a sexual encounter ($p > 0.05$).

8.4.2.2 Penetrative sex

Tables 9 and 10 suggest that the attitudes held by the respondents with regards to sexuality issues do not differ when those who have had penetrative sex are compared to those who have not had penetrative sex ($p>0.05$).

8.4.2.3 Age of first penetrative sex

Table 11 shows that when comparing the age of first penetrative sex, there is no significant difference in their attitudes towards sexuality issues ($p>0.05$).

8.4.2.4 Unprotected penetrative sex

Tables 9 and 10 indicate that there is a significant difference in attitudes towards sexuality issues between those who have had unprotected penetrative sex and those who have not ($p<0.05$). Those who have had unprotected penetrative sex hold more traditional attitudes towards sexuality issues than those who have not had unprotected penetrative sex. This difference is at the 0.05 level of significance.

8.4.2.5 Number of sexual partners in last month

Table 11 indicates that there is no significant difference in the attitudes towards sexuality issues when comparing the respondents in terms of the number of sexual partners they had had in the previous month ($p>0.05$).

8.4.3 Attitudes towards gender roles

Table 12

*Descriptive Statistics – Attitudes Towards Gender Roles * High Risk Sexual*

Behaviours

		N	Mean	Std Deviation
Sexual Behaviour				
Sexual Encounter	Yes	73	4.5507	1.05239
	No	38	4.3368	0.99415
Penetrative Sex	Yes	67	4.5881	1.06736
	No	44	4.3091	0.96685
Unprotected	Yes	52	4.4885	1.07478
Penetrative Sex	No	58	4.4552	1.00859

Table 13

*Independent Samples Test - Attitudes Towards Gender Roles * High Risk Sexual*

Behaviours

Sexual Behaviour		T-test for Equality of Means		
		t	df	p
Sexual Encounter	Equal variances assumed	1.035	109	0.303
Penetrative Sex	Equal variances assumed	1.397	109	0.165
Unprotected Penetrative Sex	Equal variances assumed	0.168	108	0.867

For the above t-test, the dependent variable is Attitudes Towards Sexuality Issues.

Table 14

*Oneway ANOVA - Attitudes Towards Gender Roles * High Risk Sexual Behaviour*

Gender Roles		F	p
Age of First Penetrative Sex	Between groups	0.567	0.781
Number of Sexual Partners in Last Month	Between groups	0.377	0.770

8.4.3.1 Sexual encounter

Tables 12 and 13 indicate that with regards to attitudes towards gender roles, there is no significant difference between those who have had a sexual encounter and those who have not ($p>0.05$).

8.4.3.2 Penetrative sex

Tables 12 and 13 show that there is no significance difference in attitudes towards gender roles when comparing those who have had penetrative sex and those who have not ($p>0.05$).

8.4.3.3 Age of first penetrative sex

Table 14 indicates that there is no significant difference in attitudes towards gender roles when comparing age of first penetrative sex ($p>0.05$).

8.4.3.4 Unprotected penetrative sex

Tables 12 and 13 indicate that when comparing those respondents who have had unprotected penetrative sex with those who have not, there is no significant difference in their attitudes towards gender roles.

8.4.3.5 Number of sexual partners in last month

Table 14 shows that when comparing the respondents in terms of number of sexual partners in the previous month, there is no significant difference in their attitudes towards gender roles ($p>0.05$).

8.4.4 Relationship between self-assessment of risk and HIV antibody test

Table 15

*Crosstabulation – Self Assessment of Risk * HIV Antibody Test*

		HIV Antibody Test		Total
		Yes	No	
Self-assessment of Risk				
Not at all	Count	22	30	52
	% of total	20.0%	27.3%	47.3%
2	Count	7	10	17
	% of total	6.4%	9.1%	15.5%
3	Count	6	19	25
	% of total	5.5%	17.3%	22.7%
4	Count	0	6	6
	% of total	0.0%	5.5%	5.5%
A great deal	Count	3	7	10
	% of total	2.7%	6.4%	9.1%
Total	Count	38	72	110
	% of total	34.5%	65.5%	100.0%

Table 16

*Chi-Square Test - Self Assessment of Risk * HIV Antibody Test*

	Value	df	p
Pearson Chi-Square	6.204 ^a	4	0.184

^a 3 cells (30.0%) have expected count less than 5. The minimum expected count is 2.07.

Table 17

*Crosstabulation 2 - Self Assessment of Risk * HIV Antibody Test*

		HIV Antibody Test		Total
		Yes	No	
Self-assessment of Risk				
	Count	22	30	52
Not at all	% within Antibody Test Question	57.9%	41.7%	47.3%
	Count	7	10	17
2	% within Antibody Test Question	18.4%	13.9%	15.5%
	Count	6	19	25
3	% within Antibody Test Question	15.8%	26.4%	22.7%
	Count	0	6	6
4	% within Antibody Test Question	0.0%	8.3%	5.5%
	Count	3	7	10
A great deal	% within Antibody Test Question	7.9%	9.7%	9.1%
	Count	38	72	110
Total	% within HIV Antibody Test Question	100.0%	100.0%	100.0%

Figure 10

Relationship Between Self Assessment of Risk and HIV Antibody Test (n=111)

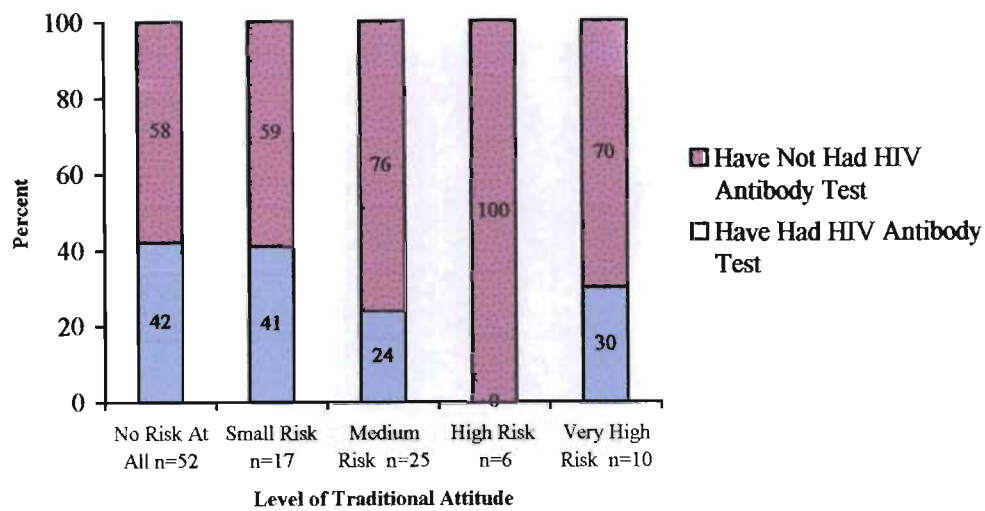


Figure 10 indicates the following:

- Of those respondents who considered themselves at no risk at all from HIV/AIDS, the majority had not had an HIV antibody test.
- Of those respondents who considered themselves at small risk from HIV/AIDS, the majority had not had an HIV antibody test.
- Of those respondents who considered themselves at medium risk from HIV/AIDS, a greater number of them had not had an HIV antibody test.
- Of those respondents who considered themselves at high risk from HIV/AIDS, all of them had not had an HIV antibody test.
- Of those respondents who considered themselves at very high risk from HIV/AIDS, the majority of them had not had an HIV antibody test.

Despite the above figures, Tables 15, 16, and 17 indicate that the association between self assessment of risk and whether they have had an HIV antibody test is not statistically significant ($p>0.05$).

8.4.5 Relationship between self-assessment of risk and unprotected penetrative sex

Table 18

*Crosstabulation – Self Assessment of Risk * Unprotected Penetrative Sex*

		Unprotected Penetrative Sex		Total
		Yes	No	
Self-assessment of Risk				
Not at all	Count	26	26	52
	% of total	23.9%	23.9%	47.7%
2	Count	7	10	17
	% of total	6.4%	9.2%	15.6%
3	Count	9	16	25
	% of total	8.3%	14.7%	22.9%
4	Count	2	3	5
	% of total	1.8%	2.8%	4.6%
A great deal	Count	7	3	10
	% of total	6.4%	2.8%	9.2%
Total	Count	51	58	109
	% of total	46.8%	53.2%	100.0%

Table 19

*Chi-Square Test – Self-Assessment of Risk * Unprotected Penetrative Sex*

	Value	df	p
Pearson Chi-Square	3.856 ^b	4	0.426

Figure 11

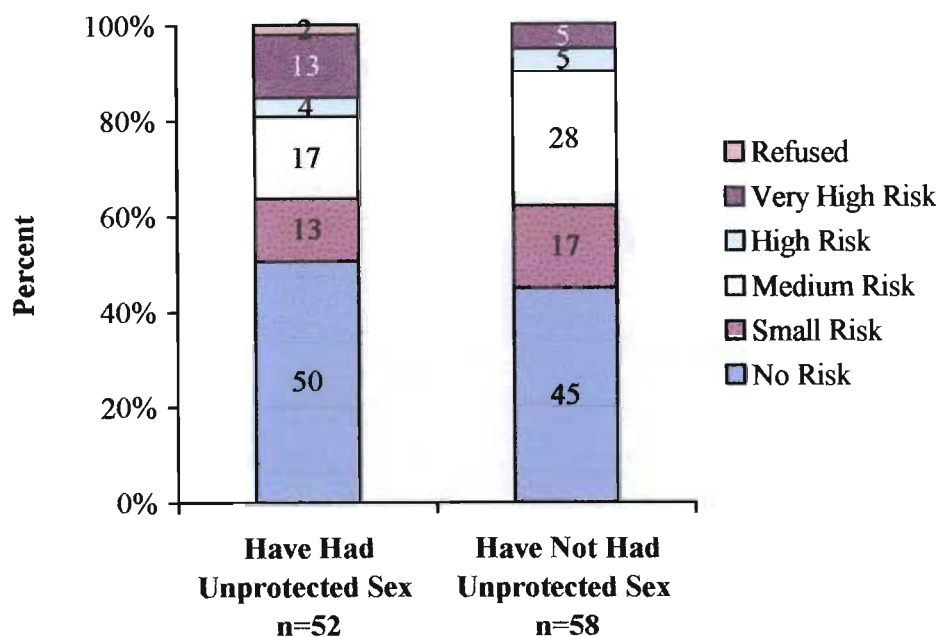
Relationship Between Self Assessment of Risk and Unprotected Penetrative Sex

Figure 11 shows that of those respondents who may be considered as engaging in high risk sexual behaviour and not using condoms, 50% consider themselves to be at no risk for HIV infection, 13% consider themselves at small risk, 17% consider themselves at medium risk, 4% consider themselves at high risk, and 13% consider themselves at very high risk. Of those who have not engaged in unprotected penetrative sex, 45% consider themselves to be at no risk for HIV infection, 17%

^b 3 cells (30.0%) have expected count less than 5. The minimum expected count is 2.34.

consider themselves at small risk, 28% consider themselves at medium risk, 5% consider themselves at high risk, and 5% consider themselves at very high risk.

Figure 11 and table 18 therefore indicates that a large number of those respondents engaging in high risk sexual behaviour do not consider themselves to be at risk for HIV/AIDS infection. Despite these figures, table 19 indicates that the association between self-assessment of risk and condom use is not statistically significant ($p>0.05$).

8.4.6 Relationship between HIV antibody test and Unprotected Penetrative Sex

Table 20

*Crosstabulation –HIV Antibody Test * Unprotected Penetrative Sex*

		Unprotected Sex		Total
		Yes	No	
HIV Antibody Test				
Yes	Count	22	17	39
	% of total	20.0%	15.5%	35.5%
No	Count	30	41	71
	% of total	27.3%	37.3%	64.5%
Total	Count	52	58	110
	% of total	47.3%	52.7%	100.0%

Table 21

*Chi-Square Test - HIV Antibody Test * Unprotected Penetrative Sex*

	Value	df	p
Pearson Chi-Square	2.024	1	0.155

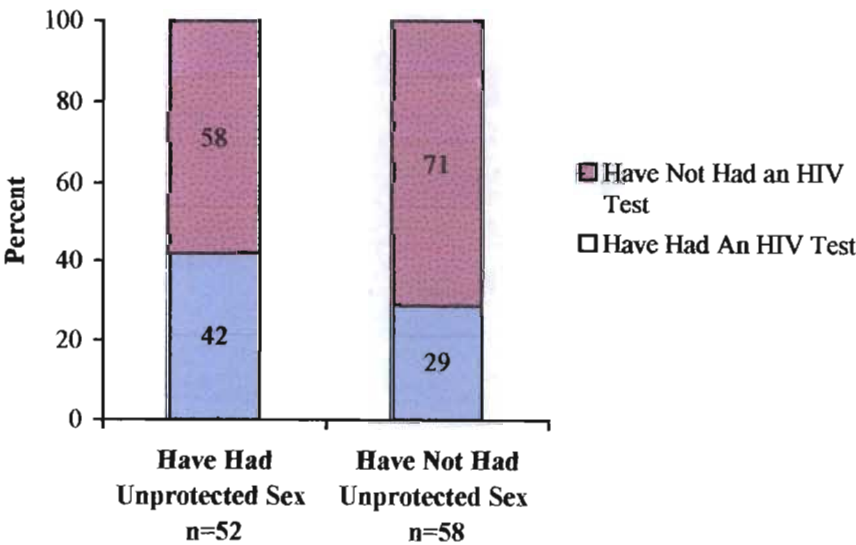
Table 22

Crosstabulation 2 - HIV Antibody Test * Unprotected Penetrative Sex

		Unprotected Sex		Total
		Yes	No	
HIV Antibody Test	Count	22	17	39
Yes	% within Unprotected Sex Question	56.4%	43.6%	100.0%
	Count	30	41	71
No	% within Unprotected Sex Question	42.3%	57.7%	100.0%
	Count	52	58	110
Total	% within Unprotected Sex Question	47.3%	52.7%	100.0%

Figure 12

Relationship Between HIV Antibody Test and Unprotected Penetrative Sex



Tables 20, 21 and 22 indicate that the association between unprotected sex and having had an HIV antibody test is not statistically significant ($p>0.05$). There is no significant difference in the number of respondents who use condoms and have gone for the test, and those that use condoms and have gone for the test. Table 22 makes this clear.

It is, however, important to note that of those respondents who have had unprotected penetrative sex, and therefore exposed themselves to the risk of HIV infection, only 42% reported having an HIV antibody test (see figure12).

9.0 DISCUSSION

9.1 Sexual Behaviour

A vast majority of the students at UKZN, Westville campus, appear to be engaging in high risk sexual behaviour. Nearly half of the respondents had engaged in unprotected penetrative sex at some time, which is consistent with McPhail's (1998) argument that condoms are not commonly used in sexual relationships. In this study, almost half of the respondents had engaged in unprotected penetrative sex during their last sexual encounter (Figure 2, p. 29). Only 29% had used a condom (Figure 7, p. 33).

Therefore, of the 70% of the respondents who had engaged in penetrative sex during their last sexual encounter (Figure 7, p. 33), less than half of them had used a condom. This is consistent with the research conducted by Pettifor et al (2004), which found that 50% of the sexually experienced respondents aged 20-24 had used a condom during their last sexual experience. What was of additional concern about the results of the current research study is that 10% of the respondents reported not using any form of contraceptive at all (Figure 7, p. 33). Students are thus engaging in high risk sexual behaviour, despite having attended workshops on HIV/AIDS in their first and second years of study.

This study found that 35% of the respondents had first engaged in penetrative sex between the ages of 17 and 20 years (Figure 3, p. 29). This is consistent with prior research, which found that the average age of first penetrative sex is 17 years (Pettifor et al, 2004). 4% of the students at UKZN, Westville campus had had penetrative sex for the first time when they were younger than 13 years (Figure 3, p. 29). This figure

is slightly lower than that obtained by Pettifor et al (2004) who found that 8% of their respondents had had sex by the age of 14 years.

The students at UKZN, Westville campus, who participated in this study, reported that in the last month, less than half of those who reported being sexually active had had one sexual partner in the previous month, while a small minority (4%) had had two, three, or more than eight partners in the previous month (Figure 5, p. 31).

Although a direct comparison with Pettifor et al's (2004) study is not possible on this point, they did report that 26% of their sexually experienced respondents had had more than one partner in the year prior to completing the questionnaire. The results of this study therefore appear to be consistent with this prior research.

One of the reasons for this high risk behaviour is that despite efforts to increase sexual education with projects such as Lovelife, there continues to be widespread resistance, lack of understanding, and lack of awareness regarding high risk sexual behaviour and its relationship with HIV/AIDS (Pettifor, 2004). In many South African cultures, open discussion of these topics is discouraged and frowned upon. Students feel that they are unable to approach anyone for help with any misunderstandings they may have, and this is resulting in continued high risk sexual behaviour (Faulkner, 2003). This may be one of the reasons for the high risk sexual behaviour which was reported in this study.

Despite this high risk behaviour, only 14% of the respondents considered themselves to be at a high risk ("quite a lot" or "a great deal") for HIV infection (Figure 8, p. 34). This is consistent with prior research which suggests that 17% of young people aged 20-24 consider themselves at high risk (Pettifor et al, 2004). 47% of the respondents

considered themselves to be at no risk at all, compared with 28% in Pettifor et al's (2004) study, 15% considered themselves at small risk compared with 38% in prior research (Pettifor et al, 2004), and 23% considered themselves at moderate risk compared with 15% in prior research (Pettifor et al, 2004). While these figures may be due to the fact that the majority of the respondents in the current study had had an HIV antibody test (65%, Figure 9, p. 35), compared to only 29% of the respondents in Pettifor et al's (2004) study, the finding that many students do not consider themselves at risk of HIV/AIDS infection is still significant. Despite exposure to HIV/AIDS and sexuality education, it appears that these students still do not equate their own unprotected sex with the possibility of becoming infected with HIV/AIDS. The education on campus does, however, appear to result in a greater number of individuals going for HIV antibody tests than in the general population of South Africans aged 20-24. This is apparent when the results of Pettifor et al's (2004) study are compared with the results of the current study.

9.2 Sexual Attitudes

9.2.1 Attitudes towards sexual coercion and assault

The majority of the respondents had a low acceptance of sexual coercion and assault (Table 5, p. 36). This means that the majority of the students who participated in the study do not believe in rape myths such as that women falsely report rape to call attention to themselves, or that women really want men to force them to have sex. It also means that the majority of the respondents do not believe that men have a right to pressure women to have sex (Patton & Mannison, 1998). This is not consistent with research conducted by Pettifor et al (2004), which found that power imbalances

between men and women are still affecting young people's sexual behaviour in South Africa today.

This inconsistency may be due to the influence of various sexual violence awareness programmes which students have been exposed to. Students may be more aware of rape myths and less tolerant of sexual coercion. This may account for the difference between their attitudes and those of the South Africans who comprised the sample in Pettifor et al's (2004) study.

9.2.2 Attitudes towards sexuality issues

The majority of the respondents were clustered around the indifferent range of the scale of attitudes towards sexuality issues (Table 5, p. 36). This is an indication that the majority of the respondents were indifferent to statements such as: "A woman's decision to have an abortion is a good enough reason to have one", and "Contraceptives should be readily available to teenagers". Those who agreed with these statements hold less traditional attitudes towards sexuality issues, while those who disagreed with them hold more traditional attitudes towards sexuality issues (Patton & Mannison, 1998).

This even distribution may be related to the cultural diversity on the campus. Different cultures have varying beliefs on issues such as abortion and condom use. These beliefs, values, norms and practices must be taken into account when attempting to change students' sexual attitudes and behaviours. Parents who still adhere to traditional values with regard to sex do not feel it is culturally appropriate to discuss sex with their children. The youths' behaviour is therefore influenced by their

peers and negative sexual behaviour which they observe in the community. As discussed in the Conceptual Framework, attitudes and behaviours can be acquired through observational learning. Behaviours and attitudes are reinforced by social comparison. If others in the students' communities are behaving in a particular way, it is likely that they will follow them (Baron & Byrne, 2003). This process is reinforced by peer pressure which is especially influential amongst the youth. Poor condom use and other high risk sexual behaviours may thus be encouraged amongst peer groups (Visser, Schoeman & Perold, 2004). "The help-seeking behaviour (with regards to sexual behaviour and HIV/AIDS) of youth ... cannot be understood in isolation, divorced from its socio-cultural context" (van der Riet & Knoetze, 2004, p. 238). It is interesting to note that despite the cultural backgrounds of the majority of the students, they did not hold extreme attitudes towards sexuality issues. This may be as a result of the HIV/AIDS and sexuality education provided on campus which attempts to balance students' attitudes and encourage them to consider for themselves what they believe is correct, rather than just following their cultural beliefs or their peers without question.

9.2.3 Attitudes towards gender roles

The majority of the respondents were indifferent with regards to attitudes towards gender roles (Table 5, p. 36). They were therefore indifferent about statements such as: "Being whistled at in public is like getting a compliment", "Sexual education probably leads to experimentation and increased sexual activity", and "Male and female homosexuality is a threat to many of society's institutions" (Patton & Mannison, 1998). This result is not consistent with local research conducted by McPhail (1998), Varga (1997), and Becker (2001), who found that a vast majority of

both men and women hold chauvinistic attitudes. This discrepancy could be as a result of the psychology students being exposed to courses in their academic programme, which address gender roles and stereotypes.

The results obtained are also not consistent with research conducted by Pettifor et al (2004), who discovered that gender power imbalances exist in a vast majority of the sexual relationships which South Africans aged 20-24 are engaged in. The participants in Pettifor et al's (2004) study stated that it was difficult for young women to negotiate condom use or refuse unwanted sexual advances as the men felt it was not a woman's place to do this. The power imbalance which exists may be a result of the gender stereotypes which Pettifor et al (2004) argue are prevalent amongst South African youth. This research study suggests that these more traditional attitudes towards gender roles may not be as prevalent among the students at UKZN, Westville campus due to continued education regarding gender roles.

9.3 The Relationship Between Sexual Attitudes and Sexual Behaviours

9.3.1 Attitudes towards sexual coercion and assault

Those respondents who displayed a greater acceptance of sexual coercion and assault were no more likely to have had a sexual encounter, had penetrative sex, had a sexual partner when younger than 13 years, had unprotected penetrative sex, or to have had more than eight sexual partners, than those respondents who displayed a lower acceptance of sexual coercion and assault (Tables 6, 7 & 8, p. 37-38). Therefore, it can be argued that attitudes towards sexual coercion and assault have no significant relation to high risk sexual behaviour. This is inconsistent with research conducted by

Becker (2001) who stated that the majority of the participants in his study felt that it was acceptable to resort to sexual violence to assert control over women. These same participants readily engaged in high risk sexual behaviour. Vanwasenbeeck et al (1998) and Burt (1990) also found that individuals engaging in high risk sexual behaviour were more likely to endorse rape myths. The inconsistency between prior research and the present study may be due to the education received at UKZN, Westville campus.

9.3.2 Attitudes towards sexuality issues

Those respondents who displayed more traditional attitudes towards sexuality issues were no more likely to have had a sexual encounter, had penetrative sex, had a sexual encounter at a young age, or to have had a high number of sexual partners than those respondents who displayed less traditional attitudes towards sexuality issues. There was, however, a significant difference between the two when it came to unprotected penetrative sex (Tables 9, 10 & 11, p. 39-40). Therefore, attitudes towards sexuality issues appear to have a significant impact on high risk sexual behaviour with regards to condom use. Traditional attitudes towards sexuality issues appear to result in lower rates of condom use, which is the most high risk sexual behaviour of all those measured in this study.

One of the reasons for this could be that those students with more traditional attitudes towards sexuality issues are not likely to feel able to discuss condom use with others. They do not feel comfortable purchasing condoms, or approaching their partner to discuss using condoms and so are less likely to use condoms. They are therefore at a higher risk of HIV/AIDS infection because of a lack of knowledge about HIV/AIDS

and uninformed beliefs about condoms (Faulkner, 2003). Studies have shown that those individuals with more traditional values are five times more likely to present with inconsistent condom use and sex with multiple partners than those with less traditional values (Hines & Caetano, 1998; as cited in Faulkner, 2003). Those students who have less traditional attitudes towards sexuality issues are more open about issues such as condom use and would therefore be more likely to use them. The two groups therefore do not differ with regards to age of first penetrative sex, or number of sexual partners in the previous month, but when it comes to discussing issues such as contraceptives, the difference between the two groups becomes apparent.

The results obtained are consistent with research conducted by Hynie and Lydon (1996). They found that women with negative sexual attitudes engaged in poor contraceptive behaviour, while women with moderately positive sexual attitudes used contraceptives more consistently and more effectively. Most of the respondents in the current study fell in the moderate range of the sexual attitudes, and those who fell in the moderately positive range were less likely to engage in unprotected penetrative sex.

9.3.3 Attitudes towards gender roles

Prior research has argued that attitudes towards gender roles play a significant role in sexual behaviour, particularly with regards to high risk sexual behaviour.

Vanwesenbeeck et al (1998) found that perpetrators of sexual aggression are likely to hold rigid, traditional sex-roles stereotypes. Varga (1997) argued that chauvinistic attitudes are related to a disregard for safety and respect, which leads to high risk sexual behaviour. This research is not, however, supported by the current study. This

research found that there was no significant difference between those respondents who held more traditional attitudes towards gender roles and those who held less traditional attitudes towards gender roles with regard to sexual encounters, penetrative sex, unprotected penetrative sex, age of first penetrative sex and number of sexual partners in the previous month (Tables 12, 13 & 14, p. 42-43). This research therefore appears to suggest that attitudes towards gender roles are not a contributing factor with regard to high risk sexual behaviour.

Prior research suggests that there exists a system of double standard which has been applied to male and female sexual behaviour. Many people believe that women should “be sexual but not too sexual, wait for men to turn on sexual feelings, and be sexy but not too sexy” (Faulkner, 2003, p. 176). Modesty, faithfulness, and virginity are considered feminine ideals, and women who talk about sex, enjoy sex, or initiate condom use are considered promiscuous and labelled a ‘slut’ or ‘whore’. Men on the other hand may have multiple sexual partners and this is considered by some to be acceptable behaviour. These men may even be labelled a ‘stud’. Pettifor et al (2004) found these attitudes to be prevalent in the general South African population. However, this system of double standard does not appear to be prevalent among the students at UKZN, Westville campus. It therefore does not appear to affect the students’ sexual behaviour as much as it does in the general South African population.

The discrepancy between prior research and this study may once again be related to the campus setting. The students have been exposed to courses concerning gender issues. This may have resulted in the minority of students who did hold more

traditional attitudes towards gender roles engaging in less risky behaviour than those with less traditional attitudes towards gender issues.

9.3.4 The relationships between self-assessment of risk, having had an HIV antibody test, and engaging in high risk sexual behaviour

A large number of the respondents in this study who considered themselves at small risk from HIV/AIDS had not had an HIV antibody test (Figure 10, p. 47). This implies that it is not merely those students who have had an HIV/AIDS antibody test who consider themselves at a low risk of HIV/AIDS infection. On the other end of the scale, of those students who considered themselves at high or very high risk for HIV infection, very few had had an HIV test (Figure 10, p. 47). They may consider themselves to be at high risk due to the fact that they have not had an HIV antibody test and so are unsure about their status. However, what is alarming about these statistics is that these individuals are more than likely engaging in high risk sexual behaviour despite believing that they may be HIV positive. This is placing their sexual partners at a high risk of contracting HIV/AIDS.

The relationship between high risk behaviour (specifically unprotected penetrative sex) and self assessment of risk was analysed. It was found that 50% of the respondents who had engaged in unprotected penetrative sex, and therefore exposed themselves to risk of HIV infection, did not consider themselves at risk for HIV infection (Figure 11, p. 49). This is consistent with research conducted by Pettifor et al (2004), who found that 62% of HIV infected South Africans reported that they thought their chances of contracting HIV/AIDS was small or nothing. This is an

indication that South Africans are not equating their own high risk sexual behaviour with the possibility of contracting HIV/AIDS.

While education on campus has had an impact with regards to attitudes towards gender roles and sexuality issues, it does not appear to have affected their perception of their own risk of HIV infection. Education programmes are prevalent in the media and on campus but students do not appear to be applying this knowledge to their own experiences. This could be as a result of the stigma and fear surrounding HIV/AIDS. Students appear to not want to discuss HIV/AIDS when it relates to themselves, and try to dismiss it as not being their problem. Many students do not believe that they are at risk of contracting HIV/AIDS. According to Herek & Capitanio (1999), many people believe that HIV/AIDS only affects people of a different race or class to themselves. Many heterosexuals incorrectly associate HIV/AIDS solely with homosexuality or bisexuality and therefore do not believe they are at risk (Herek & Capitanio, 1999). Injecting drug users are also seen as being at higher risk than those who do not inject drugs. "HIV/AIDS has become a stigmatised disease partly because of its association with already stigmatised groups" (Capitanio & Herek, 1999, p. 1144-1145). People do not consider themselves at risk because of these preconceived ideas and therefore do not apply the knowledge they gain to their own sexual experiences. They do not get tested for HIV/AIDS because they believe they are in a 'low risk group' or a 'safe category'. And yet their perceptions of what constitutes a low risk group may be incorrect (Worthington & Myers, 2003). These prejudicial beliefs allow individuals to feel safe from HIV/AIDS as they convince themselves that it cannot affect them.

Although it may be tempting to believe that the above figures may be influenced by the fact that those who had engaged in high risk sexual behaviour consider themselves at low risk because they have had an HIV antibody test, this does not appear to be the case. The relationship between high risk sexual behaviour (unprotected penetrative sex) and whether the respondents had had an HIV antibody test was examined. An alarming 58% of those who had engaged in unprotected penetrative sex had never had an HIV antibody test (Figure 12, p. 51). This means that 58% of the respondents who have engaged in high risk sexual behaviour do not know their status and therefore, if the sexual behaviour statistics are examined, could possibly be infecting their subsequent sexual partners. This is an alarming statistic for a country such as South Africa which has such a high rate of HIV/AIDS infection.

These statistics can be related to students' fear of knowing their status. Students would rather not know their HIV/AIDS status as if they did, they would have to face the consequences of that knowledge. Individuals have reported experiencing acute fear when considering being tested for HIV/AIDS. This results in them deciding not to be tested (Faulkner, 2003). Both men and women express fear about being tested for HIV/AIDS (Lichtenstein, 2004). If they do not know their status, they do not have to face the possible consequences. This is a form of denial of the possibility that they may be infected with HIV/AIDS.

10.0 SUMMARY STATEMENT OF MAJOR FINDINGS

The findings of the study show that:

- The majority of the students are engaging in high risk sexual behaviour
 - Many of the students are engaging in unprotected penetrative sex.
 - A number of the students are first engaging in penetrative sex at a very young age.
- The majority of the students have a low acceptance of sexual coercion and assault.
- The students were mostly indifferent in their attitudes towards sexuality issues.
- The majority of the students were indifferent with regards to attitudes towards gender roles.
- Attitudes towards sexual coercion and assault do not appear to be related to sexual behaviour.
- Attitudes towards sexuality issues appear to be related to condom use.
 - More traditional attitudes towards sexuality issues were related to poor condom use.
- Attitudes towards gender roles did not appear to be related to sexual behaviour.
- Those students engaging in high risk sexual behaviour do not generally consider themselves to be at risk for HIV/AIDS infection and have not had an HIV antibody test.

11.0 LIMITATIONS OF THE STUDY

- The students volunteered to participate in the study, which could mean that a particular kind of person was providing the information. However, as many of the results were supported by prior research, this did not appear to be a significant problem.
- First year students could also have been targeted in order to provide a more holistic understanding of the student populations' behaviours and attitudes.
- The subjects were sampled from the psychology department, which means that the results of the study cannot be generalised to the entire campus. In addition to this, they are only from UKZN, Westville campus, which means the results cannot be generalised to other universities. However, the results can be used to create intervention programmes at this particular campus. They can also be used to inform future research at other institutions, as well as inform intervention programmes which other institutions may implement.
- The results obtained rely on self reported information, which may have resulted in the respondents providing socially desirable answers. This is especially true due to the sensitive nature of this research. It was attempted to combat this by emphasising the confidentiality of the information. The respondents were also not asked to provide their names on the form.

12.0 RECOMMENDATIONS

Based on the exploration of the relevant issues pertaining to sexual attitudes and behaviours, it appears necessary to:

- Add courses to all curricula and create workshops in order to better equip students with knowledge about HIV/AIDS and the dangers of high risk sexual behaviour as well as conduct more interactive intervention programmes in the form of discussion groups which will provide students with the opportunity to address their misunderstandings and fears around HIV/AIDS (van Dyk, 2001).

These courses and workshops should focus on:

- High risk sexual behaviour and the consequences of this.
 - How to deal with peer pressure. This appears to be a factor in the high rate of high risk sexual behaviour.
 - Helping students to apply their knowledge about HIV/AIDS to themselves. The respondents did not appear to engage in low risk sexual behaviour, despite reporting that they felt they were at high risk for HIV/AIDS infection.
 - Addressing the students' fears about being tested for HIV/AIDS.
 - Include a course on sexual attitudes which addresses the stereotypical attitudes and acceptance of rape myths which appear to be present among the students.
- It does appear that education programmes are working to some extent with regards to attitudes towards gender roles and sexual coercion. These programmes also need to focus on attitudes towards sexuality issues as these attitudes appear to have a direct impact on condom use. The courses should include:

- Respect for and understandings of other cultural and social groups. The prejudicial ideas that HIV/AIDS only affects one particular class or group should be challenged. This could be done through focus groups comprising of students from various cultural backgrounds.
- Inform students of the resources available on campus where they can obtain help with regards to their sexual relationships and any where they can address any fears or queries they may have.
- Conduct qualitative studies which will provide more detailed information around the issues raised in this study. The reasons why students are engaging in high risk sexual behaviour despite holding more balanced attitudes towards sexual coercion and assault, and gender roles, need to be explored.

13.0 CONCLUDING COMMENTS

This study has provided the following valuable insights into the sexual attitudes and behaviours of students at UKZN, Westville campus.

- The majority of the students are engaging in high risk sexual behaviour, many of them despite feeling that they are at high risk of HIV/AIDS infection.
- The majority of the students appear to hold less traditional attitudes towards gender roles, sexuality issues and sexual coercion.
- These attitudes are not necessarily translating into behaviour change.
- The reasons for this need to be investigated and addressed in a more qualitative manner with the students so that their opinions can be explored.
- The issues raised in this study can be used to inform and this further research.
- It is only by engaging with the students that these issues can be resolved.

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15.0 APPENDICES

15.1 Appendix 1: Consent and Confidentiality Form

This study is being conducted in order to determine the sexual attitudes and behaviours which are present among the students at the University of KwaZulu/Natal. It would be greatly appreciated if you could complete the questionnaires attached. However, participation in this study is voluntary.

The results of this study will be used for research purposes but your personal details will remain strictly confidential.

Please sign below to indicate that you are willing to participate in the study.

15.2 Appendix 2: Demographic Information

Please provide the following details by marking the appropriate answer with an X:

1. Gender:

- a. male ____
- b. female ____

2. Are you a student at the University of KwaZulu-Natal?

- a. Yes ____
- b. No ____

3. Age:

- a. Younger than 18 ____
- b. 18 ____
- c. 19 ____
- d. 20 ____
- e. 21 ____
- f. Older than 21 ____

4. Level of study:

- a. first year of undergraduate study ____
- b. second year of undergraduate study ____
- c. third year of undergraduate study ____
- d. fourth year of undergraduate study ____
- e. none of the above ____

5. Racial / Cultural Group:

- a. African ____
- b. Indian ____
- c. Coloured ____
- d. White ____
- e. Other (please specify) _____

15.3 Appendix 3: The Revised Attitudes Toward Sexuality Inventory (Patton & Mannison, 1998)

NB: ALL QUESTIONS IN THE QUESTIONNAIRE MUST BE ANSWERED UNLESS INSTRUCTED TO DO OTHERWISE.

This page asks you about your attitudes toward a number of sexual issues. Please give your honest opinion by circling one of the following options:

SA Strongly agree
A Agree
MA Mildly agree
N Neutral / Indifferent
MD Mildly disagree
D Disagree
SD Strongly disagree

- | | | | | | | | |
|---|----|---|----|---|----|---|----|
| 1) Some girls will only respond sexually if a little force is used. | SA | A | MA | N | MD | D | SD |
| 2) Women falsely report rape in order to call attention to themselves. | SA | A | MA | N | MD | D | SD |
| 3) Engaging in sex, e.g., for athletes, does not affect their energy and concentration. | SA | A | MA | N | MD | D | SD |
| 4) A woman's decision to have an abortion is a good enough reason to have one. | SA | A | MA | N | MD | D | SD |
| 5) A girl will often pretend she doesn't want intercourse because she doesn't want to seem loose, but she's really hoping the guy will force her. | SA | A | MA | N | MD | D | SD |
| 6) In the majority of rapes, the woman already has a bad reputation. | SA | A | MA | N | MD | D | SD |
| 7) Children should be encouraged to accept the practice of masturbation. | SA | A | MA | N | MD | D | SD |

SA Strongly agree
 A Agree
 MA Mildly agree
 N Neutral / Indifferent
 MD Mildly disagree
 D Disagree
 SD Strongly disagree

- 8) Easily accessible abortion will probably cause people to become unconcerned and careless. SA A MA N MD D SD
- 9) There's nothing wrong with a little sweet talk to get what you want. SA A MA N MD D SD
- 10) A woman cannot be forced to have intercourse against her will. SA A MA N MD D SD
- 11) The primary goal of sexual intercourse should be to have children. SA A MA N MD D SD
- 12) Sexual inaccessibility of a man's partner is a common cause of child sexual abuse in the home. SA A MA N MD D SD
- 13) It's not okay for a guy to pressure for more sex even if he thinks the girl led him on. SA A MA N MD D SD
- 14) Normal males can commit rape. SA A MA N MD D SD
- 15) Children should be ignored if found playing "doctors & nurses" or other games of sexual exploration. SA A MA N MD D SD
- 16) It doesn't hurt children to have a little bit of sex play with their older relatives. SA A MA N MD D SD
- 17) If the couple have dated for a long time, it's only natural for the guy to pressure her for sex. SA A MA N MD D SD
- 18) Women who are raped are usually a little to blame for the crime. SA A MA N MD D SD

SA Strongly agree
 A Agree
 MA Mildly agree
 N Neutral / Indifferent
 MD Mildly disagree
 D Disagree
 SD Strongly disagree

- | | | | | | | | |
|--|----|---|----|---|----|---|----|
| 19) The elderly in nursing homes should have as much sexual access to each other as they want. | SA | A | MA | N | MD | D | SD |
| 20) Contraceptives should be readily available to teenagers. | SA | A | MA | N | MD | D | SD |
| 21) Even if the guy gets sexually excited, it's not okay for him to use force. | SA | A | MA | N | MD | D | SD |
| 22) Rape is usually planned & premeditated. | SA | A | MA | N | MD | D | SD |
| 23) Masturbation is a normal sexual activity throughout life. | SA | A | MA | N | MD | D | SD |
| 24) Women should receive preferential treatment right now to make up for past discrimination. | SA | A | MA | N | MD | D | SD |
| 25) If a guy spends a lot of money on a girl, he's got a right to expect a few sexual favours. | SA | A | MA | N | MD | D | SD |
| 26) Forcing a woman to have sex when she doesn't want to is rape. | SA | A | MA | N | MD | D | SD |
| 27) A woman who initiates a sexual encounter will probably have sex with anybody. | SA | A | MA | N | MD | D | SD |
| 28) Being whistled at in public is like getting a compliment. | SA | A | MA | N | MD | D | SD |
| 29) You can't blame a guy for not listening when a girl changes her mind at the last minute. | SA | A | MA | N | MD | D | SD |

SA Strongly agree
 A Agree
 MA Mildly agree
 N Neutral / Indifferent
 MD Mildly disagree
 D Disagree
 SD Strongly disagree

- 30) No woman harbours a secret desire to be raped. SA A MA N MD D SD
- 31) Sexuality education probably leads to experimentation and increased sexual activity. SA A MA N MD D SD
- 32) Intoxication among women is worse than among men. SA A MA N MD D SD
- 33) A girl should give in to a guy's advances so as not to hurt his feelings. SA A MA N MD D SD
- 34) Rape has nothing to do with an uncontrollable desire for sex. SA A MA N MD D SD
- 35) Male & female homosexuality is a threat to many of society's institutions. SA A MA N MD D SD
- 36) If there are rules about corporal punishment in schools, they should apply equally to boys and girls. SA A MA N MD D SD
- 37) If a girl engages in kissing or non-genital touching and lets things get out of hand, it is her own fault if her partner forces sex on her. SA A MA N MD D SD
- 38) A woman who claims she was raped by a man she knows can be described as a "woman who changed her mind afterward". SA A MA N MD D SD
- 39) Most adults who contract HIV/AIDS get pretty much what they deserve. SA A MA N MD D SD
- 40) No clubs should be allowed to refuse membership or conditions of membership on the basis of gender. SA A MA N MD D SD

16.4 Appendix 4: Sexual History Questionnaire (Cupitt, 1998)

NB: ALL QUESTIONS IN THE QUESTIONNAIRE MUST BE ANSWERED UNLESS INSTRUCTED TO DO OTHERWISE.

Instructions: This questionnaire asks questions about your recent sexual history. Some words used in this questionnaire may not be familiar to you, or you may not be sure of their exact meaning. The following definitions may be helpful: *Vaginal sex* is sex in which the penis enters the vagina. *Oral sex* is sex in which the mouth or tongue is in contact with the genitals. *Anal sex* is sex in which the penis enters the anus, or back passage. *Penetrative sex* is sex in which the penis enters the vagina or anus. *Nonpenetrative sex* includes oral sex, and also many other forms of sex such as sexual massage, sexual touching, and mutual masturbation. *Protected sex* refers to penetrative sex with a condom or oral sex with a latex barrier or condom. A *regular partner*, for the purposes of this study, is someone with whom you have had sex more than once. A *sexual encounter* refers to sexual contact involving any of the above definitions.

Mark your answers with an X next to the appropriate response. Should there be any confusion, please ask for help or clarification.

Section A

1. Have you ever had a sexual encounter (any sexual contact)?
 - a. Yes ____
 - b. No ____

2. Who do you have sexual contact with?
 - a. only men ____
 - b. mostly men ____
 - c. equally men and women ____
 - d. mostly women ____
 - e. only women ____
 - f. I have not had sexual contact with anyone ____

3. Have you ever had penetrative sex (sex in which the penis enters the vagina or anus)?
 - a. Yes ____
 - b. No ____

4. If you have had penetrative sex, at what age did this first occur?
 - a. younger than 13 years ____
 - b. 13-14 years ____
 - c. 15-16 years ____
 - d. 17-18 years ____
 - e. 19-20 years ____
 - f. 21-22 years ____
 - g. 23-24 years ____
 - h. older than 24 years ____
 - i. not applicable ____

5. Have you ever had unprotected penetrative sex (penetrative sex without a condom)?
 - a. Yes ____
 - b. No ____

Section B

The following questions relate to your sexual encounter(s) over the last month. This includes nonpenetrative sex such as oral sex and mutual masturbation.

If you have not had a sexual encounter in the last month please move on to Section C.

If you have never had a sexual encounter please move on to Section D.

6. In the last month how many sexual partners have you had?
- a. 1 ____
 - b. 2 ____
 - c. 3 ____
 - d. 4 ____
 - e. 5 ____
 - f. 6 ____
 - g. 7 ____
 - h. 8 ____
 - i. more than 8 ____
7. How many regular sexual partners (people with whom you have had sex more than once) did you have in the last month?
- a. 0 ____
 - b. 1 ____
 - c. 2 ____
 - d. 3 ____
 - e. 4 ____
 - f. 5 ____
 - g. 6 ____
 - h. 7 ____
 - i. 8 ____
 - j. more than 8 ____

8.

- a. Approximately how many times have you had sexual contact with a regular partner (someone with whom you have had sex more than once) in the last month?
- i. 0 times ____
 - ii. 1-3 times ____
 - iii. 4-6 times ____
 - iv. 7-9 times ____
 - v. 10-12 times ____
 - vi. 13-15 times ____
 - vii. 16-18 times ____
 - viii. 19-21 times ____
 - ix. more than 21 times ____
- b. Approximately how many times did you have penetrative sex (sex in which the penis enters the vagina or anus) with a regular partner (someone with whom you have had sex more than once) in the last month?
- i. 0 times ____
 - ii. 1-3 times ____
 - iii. 4-6 times ____
 - iv. 7-9 times ____
 - v. 10-12 times ____
 - vi. 13-15 times ____
 - vii. 16-18 times ____
 - viii. 19-21 times ____
 - ix. more than 21 times ____
 - x. not applicable ____
- c. Approximately how many times did you use a condom with a regular partner in the last month?
- i. 0 times ____
 - ii. 1-3 times ____
 - iii. 4-6 times ____
 - iv. 7-9 times ____
 - v. 10-12 times ____
 - vi. 13-15 times ____
 - vii. 16-18 times ____
 - viii. 19-21times ____
 - ix. more than 21 times ____
 - x. not applicable ____

9.

- a. Approximately how many times have you had sexual contact with other partners in the last month?

- i. 0 times ____
- ii. 1-3 times ____
- iii. 4-6 times ____
- iv. 7-9 times ____
- v. 10-12 times ____
- vi. 13-15 times ____
- vii. 16-18 times ____
- viii. 19-21 times ____
- ix. more than 21 times ____

- b. Approximately how many times did you have penetrative sex with other partners in the last month?

- i. 0 times ____
- ii. 1-3 times ____
- iii. 4-6 times ____
- iv. 7-9 times ____
- v. 10-12 times ____
- vi. 13-15 times ____
- vii. 16-18 times ____
- viii. 19-21 times ____
- ix. more than 21 times ____

- c. Approximately how many times did you use a condom with other partners in the last month?

- i. 0 times ____
- ii. 1-3 times ____
- iii. 4-6 times ____
- iv. 7-9 times ____
- v. 10-12 times ____
- vi. 13-15 times ____
- vii. 16-18 times ____
- viii. 19-21 times ____
- ix. more than 21 times ____

Section C

The following questions refer specifically to your last sexual encounter.

If you have never had a sexual encounter, please move on to Section D.

10. How long ago was your last sexual encounter? Please mark with an X.

- a. Less than a week ago ____
- b. Between one week & one month ago ____
- c. Between one month & three months ago ____
- d. Between three months & six months ago ____
- e. Between six months & one year ago ____
- f. More than one year ago ____

11. What kind(s) of sex did you have during your last sexual encounter? Please answer yes or no to the following activities:

- a. Unprotected vaginal sex:
 - i. Yes ____
 - ii. No ____
- b. Vaginal sex with a condom:
 - i. Yes ____
 - ii. No ____
- c. Unprotected anal sex:
 - i. Yes ____
 - ii. No ____
- d. Anal sex with a condom:
 - i. Yes ____
 - ii. No ____
- e. Oral sex:
 - i. Yes ____
 - ii. No ____
- f. Other forms of nonpenetrative sex (such as massage & mutual masturbation):
 - i. Yes ____
 - ii. No ____

12. What gender was your partner on your last sexual encounter?

- a. Male ____
- b. Female ____

13. During your last sexual encounter did you or your partner mention using a condom?

- a. You ____
- b. Your partner ____
- c. Neither ____
- d. Both ____

14. During your last sexual encounter did you or your partner mention not using a condom?

- a. You ____
- b. Your partner ____
- c. Neither ____
- d. Both ____

15. Was s/he a regular sexual partner (a partner with whom you have had sex more than once)?

- a. Yes ____
- b. No ____

16. If s/he was a regular sexual partner, have you discussed practicing safer sex with this partner (using condoms, latex barriers, or having nonpenetrative sex)?

- a. Yes ____
- b. No ____
- c. Not applicable ____

17. If you had heterosexual vaginal sex during your last sexual encounter, did you use a form of contraceptive? Please mark one or more with an X:

- a. The condom ____
- b. The pill ____
- c. The diaphragm or cap ____
- d. IUD (the coil) ____
- e. Spermicidal sponge or creams ____
- f. The rhythm (calendar) method ____
- g. The withdrawal method ____
- h. The morning after pill ____
- i. Other (please specify) _____
- j. None ____
- k. Not applicable ____

18. With this partner, have you discussed what kind of sex you like and don't like?

- a. Yes ____
- b. No ____

Using the scale below, write a number beside each statement (19-20) to indicate how you felt:

1	2	3	4	5
not at all				a great deal

19. How much did you feel like having sex on this occasion? ____

20. How much did you feel like having unprotected sex on this occasion? ____

21. With this partner on this occasion, how able did you feel to express your wishes regarding sex? ____

Section D

Using the same scale answer the following, more general question (22):

1	2	3	4	5
not at all				a great deal

22. How much at risk do you consider yourself from HIV/AIDS? ____

23. Have you ever had an HIV antibody test?

a. Yes ____

b. No ____

24. To your knowledge, do you know or have you known anyone personally with HIV/AIDS?

a. Yes ____

b. No ____

25. Please feel free to add anything which you feel may give a clearer picture of your answers to this questionnaire.
