

UNIVERSITY OF KWAZULU-NATAL

Implementation of the Universal Test and Treat (UTT) strategy by health promoters at the University of KwaZulu-Natal, Howard College Campus.

by

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Abstract

This study explored the effectiveness of the implementation of Universal Test and Treat (UTT) policy in reducing or eliminating the spread of HIV infection at the University of KwaZulu-Natal, Howard College Campus. HIV infection is a major health issue in the province of KwaZulu-Natal, with more than 1.6 million people living with HIV. The most infected population group is between (15-49) years and the epidemic spread is estimated to be increasing by 2.3% annually. The UTT policy aims to reduce HIV infection through expanding prevention and treatment preferences.

This study is informed by one theoretical framework. The P-Process model, a tool for planning strategic evidence-based health communication programmes. The model was advanced by Johns Hopkins University in 1982. This model is currently used to design, implement, evaluate/assess, innovative and creative behaviour change communication strategies and programmes aimed at reducing the incident of HIV infection. The model enabled the researcher to explore the implementation of the UTT approach and the communication strategies used. Then, lastly, assess participation in HIV testing at Howard Campus.

The study made use of two semi-structured interviews and one focus group discussion with the health promoters at the university. The study found that the communication strategies adopted when implementing the UTT policy were effective in motivating the university community to attend health programmes. However, few people signed up for HIV testing. In addition, the health promoters faced challenges which resulted into the UTT policy not getting people tested.

Keywords: Health promotion, Universal Test and Treat policy, HIV/AIDS, HIV testing, University of KwaZulu-Natal.

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Abbreviations

AIDS	Acquired-Immuno-De_ciciency-Syndrome
ART	Antiretroviral-Therapy
CHASU	Campus-HIV/AIDS-Support-Unit
FTF	First-Things-First
HIV	Human-Immunode_ciciency-Virus
IBM	Information-Behavioural-Motivational
P-Process Model	Planning-Process Model
PEP	Post-Exposure-Prophylaxis
PrEP	Pre-Exposure-Prophylaxis
STDs	Sexual-Transmitted-Diseases
STIs	Sexual-Transmitted-Infections
SBCC	Social-Behavioural-Change-Communication
TVET	Technical-Vocational-Education-Training
HEAIDS	The Higher-Education-Training-HIV/AIDS-Programme
UNAIDS	The Joint United-Nations Programme on-HIV/AIDS
USB	Universal-Serial-Bus
UTT	Universal-Test and-Treat
UKZN	University of-KwaZulu-Natal
VCT	Voluntary-Counselling-Testing
WITS	Witwatersrand
WHO	World-Health-Organisation

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CHAPTER ONE

Introduction and background

1.1 Location of this study

This study is conducted at the University of KwaZulu-Natal, Howard College Campus. The data is obtained from health promoters; the health practitioners/nurses at the university Wellness Clinic and peer educators at the Campus HIV/AIDS Support Unit (CHASU). The health promoters implemented the UTT policy to reduce the rate of HIV infection among UKZN students and staff members.

1.2 Problem statement

HIV infection is a major health issue in the province of KwaZulu-Natal (KZN), South Africa. The pandemic spread is ranked the highest in the province of KwaZulu-Natal when compared to other provinces in the country. Hence, it is estimated that HIV infection increases by 2.3% annually. Moreover, the most infected population group is between the ages of (15- 49) years (Department of Health Province of KwaZulu-Natal UTT 2016).

A study by Buldeo and Gilbert (2015), found that universities are sexualised spaces which contribute to factors leading to the pressure of sexual activities. In addition, Gameda, Gandile and Bikamo (2017), stated that university students are vulnerable to HIV infection because of their age, ambition and experience of new events. Mutinta *et al.* (2012) in a study within South African universities noted that students are vulnerable to HIV infection and the determinants included personal beliefs about long-term relationships, a drive for material wealth, attitudes towards sex for variety, a lack of satisfaction from relationships, levels of trust and attention, and pursuit of the long-term goal of marriage. Verheij, Jansen and Jansen (2010) found that many students do not use contraceptives when engaging in sexual intercourse, resulting from negative perceptions about contraceptives, especially condoms. The students argued that condoms limit sexual pleasure, contain diseases, make females thinner, prohibit the exchange of body fluids and males cannot get rid of their sperms in a natural ways. This study carries on from previous studies on HIV infection conducted at the University of KwaZulu-Natal. However, this study aims to explore the effectiveness of the implementation of the Universal Test and Treat (UTT) policy in

reducing or eliminating the spread of HIV infection at the University of KwaZulu-Natal, Howard College Campus.

The Universal Test and Treat (UTT) policy is introduced by the World Health Organisation (WHO) in the year 2016. The WHO is an agency of the United Nations that is concerned with international public health. It has 150 offices around the world and headquartered in Geneva, Switzerland (WHO 2018).

The UTT was adopted in South Africa in September 2016, following an announcement by minister of health Dr. Aaron Motsoaledi. The key message of the Universal Test and Treat strategy is to be “a game changer in HIV prevention” with an emerging and currently adopted HIV prevention approach that combines both protection as well as prevention methods to reduce HIV infection (Department of Health Republic of South Africa 2016:1). From the protection aspect, the UTT strategy aims at the provision of treatment to all HIV infected individuals irrespective of their CD4 count¹. Whilst from the prevention aspect, it aims to increase HIV testing to ensure that those who are HIV negative can continue utilising preventative measures to remain HIV negative and those who are positive can obtain immediate access to treatment. Therefore, it is predicted that UTT will eliminate HIV infection in South Africa within 10 years, considering that the country has the largest HIV infected population in the world (Department of Health Province of KwaZulu-Natal UTT 2016).

The overall goal of the UTT policy is to reduce the incidence of HIV infection in the country, South Africa, through expanding prevention and treatment preferences. This includes recalling all HIV positive patients who are not receiving treatment to get treatment immediately, to increase access to universal testing and treatment, to ensure adequate drug availability, to increase the number of doctors and nurses who deal with HIV in clinics, to improve the quality of care to all HIV positive patients, to promote and communicate HIV related matters. Lastly, to monitor the care provided to patients and evaluating the health outcomes (Department of Health Province of KwaZulu-Natal UTT 2016). However, when exploring the implementation of

¹ CD4 count is like a snapshot of how well your immune system is functioning. This depends on the white blood cells that fights infection, if they are more that means an individual is less likely to be infected by diseases. CD4 count, retrieved from <https://www.hiv.va.gov/patient/diagnosis/labs-CD4-count.asp>

Universal Test and Treat policy's the goal was to identify the promotion and communication strategies adopted to increase HIV testing and providing treatment to assess reduction on the incidence of HIV infection at the university.

This study is relevant as it strives to address one of the predominant health challenges in South Africa. The study explores the effectiveness of the implementation of UTT policy in reducing or eliminating the spread of HIV infection at the University of KwaZulu-Natal, Howard College Campus. Given that the UTT policy is a relatively new strategy in the country, exploring what has been done at UKZN since its adoption would provide opportunities for increasing the effectiveness of the implementation of the UTT policy.

1.3 Objectives of and need for the study

This study is relevant as it strives to address one of the predominant health challenges in South Africa. Given that the UTT policy is a relatively new strategy in the country, exploring the policy's implementation and participation in HIV testing since its adoption would help provide the strengths and weaknesses.

This study explores the Universal Test and Treat (UTT) policy as a global strategy to lead in reduction of the incident of HIV infection and potentially terminate HIV infection (WHO 2018). In 2016, as a Bachelor of Arts Honours student at the University of Limpopo (Turfloop Campus), the researcher observed that a certain HIV prevention programme offered incentives such as universal serial bus (USB), pens and diaries to attract students and university employees to test for HIV. This strategy proved effective in galvanising the targeted population to participate. However, Cameron and Van Der Merwe (2012) caution that ethical consideration should be exercised when gifts are given to students to lure them into HIV testing within higher education institutions. Cameron and Van Der Merwe noted that offering expensive prizes such as bags, cars and computers to pressure students into participating in HIV testing is unethical.

In addition, this study is not interested in finding out the HIV infection rates of students and staff members at the university. But focus on participation in HIV testing because that is one of the UTT's objectives in reducing HIV infection (Department of Health Province of KwaZulu-Natal UTT 2016).

According to Mulaudzi, Everatt, Richter and Heywood (2002), many South Africans possess negative perceptions about HIV infected individuals. Therefore, discrimination towards persons living with HIV/AIDS is quite high and is widespread. Qwana *et al.* (2001) argues that the stigma and discrimination of all people living with HIV/AIDS can encourage those people to hide their status from their families and the public while they continue to engage in high risk sexual behaviour.

This study aimed to explore the following these objectives:

- To explore UTT policy implementation and communication strategies used.
- To assess participation in HIV testing on campus.

1.4 Research questions

1. How is the UTT implemented by the health promoters at Howard College?
2. Which communication strategies are used to attract people to participate on the UTT policy?
3. What is the progress in HIV testing within Howard campus?

1.5 Structure of Dissertation

Chapter one has outlined the problem statement and background of the study. There is increasing incident of HIV infection among people aged 15- 49 in the province of KwaZulu-Natal. This age bracket is inclusive of university students and staff members. The researcher chose the University of KwaZulu-Natal, Howard College campus as the location of the study because several studies affirm that students at universities are vulnerable to the HIV epidemic. The chapter concludes by stating the study objectives and research questions.

Chapter two presents a literature review on various studies, particularly in the field of health communication. This is important to making explicit links to the study's aim, rationale, objectives and questions. The chapter defines key concepts of this study, provides support and evidence of the research and, the gaps the study intends to address.

Chapter three presents the theoretical framework of the study. The study adopted the P-Process Model. The concepts guided and provided informed scientific approach for the study and explained the phenomenon under investigation.

Chapter four discusses the research methodology employed, including the epistemological assumption, theoretical approach, research design, sampling techniques, data collection and data analysis. The chapter provides rationale/motivation for selecting the approach as well as the challenges/limitations of the study.

Chapter five presents the findings and discussion of the qualitative data collected using two semi-structured interviews and one focus group discussion. The chapter applies thematic analysis to present the findings obtained.

Chapter six presents the conclusion and recommendations of the study.

Before moving onto the next chapter, which is the literature review, the researcher believes that it is important to first explain terms which will be used interchangeably throughout the study. The terms programme, intervention, campaign and strategy are used interchangeably. Furthermore, the term 'health promoters' is used in the study to refer to the University of KwaZulu-Natal's health care workers. These could apply to both the nurses and peer educators who promote HIV testing through the UTT implementation at the University of KwaZulu-Natal.

CHAPTER TWO

Literature review

2.1 Introduction

This literature review outlines the importance of health promotion on the prevalence of HIV/AIDS rates among students in institutions of higher learning in South Africa. The chapter discusses factors that contribute to the incidence of HIV infection among students and the importance of HIV prevention and protection strategies in the elimination or reduction of HIV infection rates within university settings. The chapter finally presents students' perceptions on HIV testing. The incidence of HIV infection remains high in the province of KwaZulu-Natal, with 1.6 million people living with HIV. The most infected population is between the age brackets of 15- 49 years (Department of Health, KwaZulu-Natal UTT 2016). This population age group, as earlier mentioned, is inclusive of university students and staff members, usually aged 18- 35.

This chapter begins by presenting the HIV prevalence in South Africa in general and then focuses on the youth as the centre of this study. The chapter narrows the focus to students attending higher education institutions. It then moves to health promotion programmes such as, the Universal Test and Treat policy, peer education programmes and other HIV interventions aimed at distributing information and educating the youth about HIV with a view of encouraging them to take part in HIV testing. This is followed by the need for HIV/AIDS campaigns in higher education institutions, students' perceptions of sexual risk behaviour and prevention strategies. The role of health promotion, particularly in HIV and the involvement of university management in addressing the epidemic, students' perceptions on HIV testing and counselling are discussed too. Finally, the chapter addresses the importance of health promotion and the necessity of assessing health promotion campaigns. This helps in determining the strength and weakness in implementing programmes and identifying more effective strategies in future.

2.2 HIV prevalence in South Africa

According to the World Health Organisation (WHO), South Africa ranks number one in terms of the world HIV infected population, with an estimated 7.1 million people living positively with HIV (WHO 2018). The province of KwaZulu-Natal alone has an estimated 1.6 million people between the ages 15-49 living with HIV. This constitutes about 15.8% of the province's total population. New HIV infections per year in the province are estimated at 2.3% in comparison to the national incidence of 1.8%. HIV is a devastating health issue in the country, particularly, in the province of KwaZulu-Natal with the highest HIV positive population with the youth constituting a large percentage of the population (Department of Health Province of KwaZulu-Natal UTT 2016).

HIV is an acronym for Human Immunodeficiency Virus. It targets the immune system and weakens one's defense systems against infections. The virus then destroys and damages the function of immune cells, making infected individuals gradually become immuno-deficient. This immunodeficiency results in infections such as cancer, Tuberculosis and other fast killing diseases that people with healthy immune systems are able to fight off (WHO HIV/AIDS 2017).

Moreover, there are over one million people in the world who succumb to HIV/AIDS annually (UNAIDS 2016).

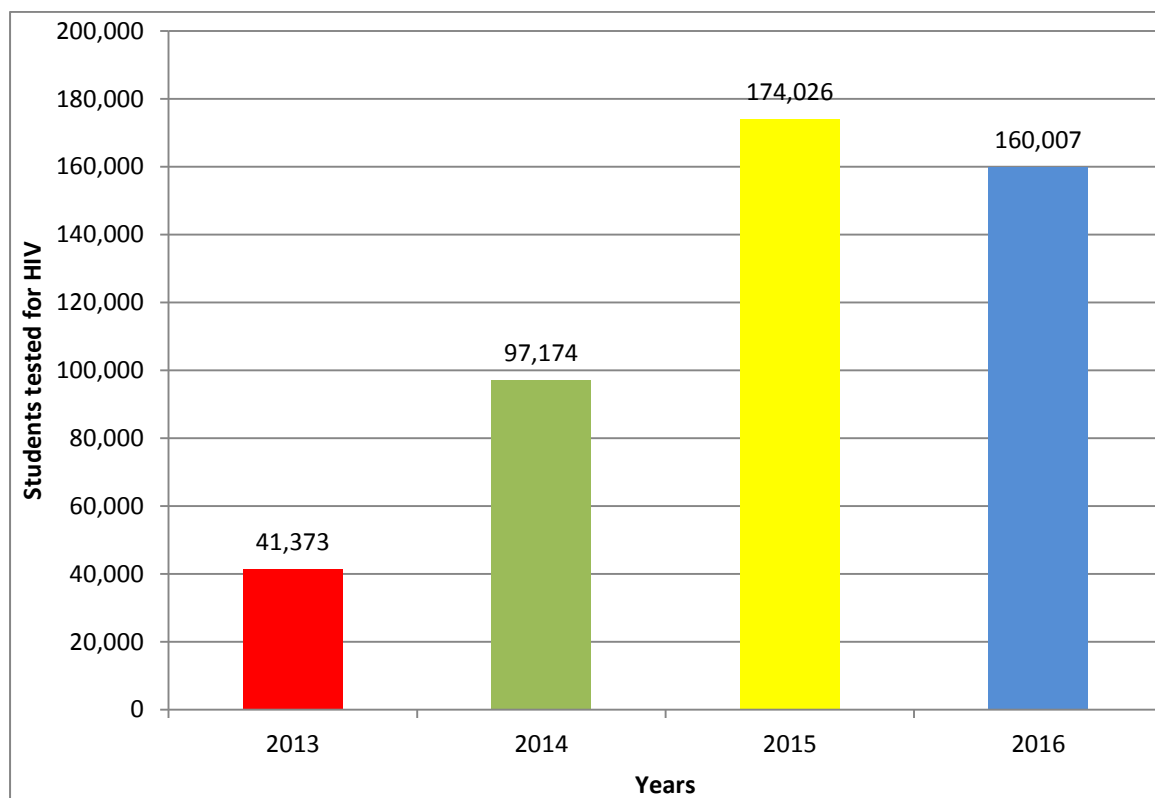
2.3 The prevalence of HIV among students

South Africa has 26 universities and 110 campuses with an estimated 1.3 million students. In addition, the country has 50 Technical and Vocational Education and Training (TVET) colleges spread across, 244 campuses with an estimated student population of 710 000 (HEAIDS Annual Review Report 2016). So far, there are very few individuals who participated in HIV testing within all the various campuses. This is portrayed in the First Things First (FTF) programmes that were held in different campuses from 2013 - 2016 to encourage students and staff members to test for HIV, screen for TB and STIs.

According to the HEAIDS Annual Review Report (2016), about 41,000 students tested for HIV in South Africa in 2013. The progress in 2014 is estimated at 97,000

students who tested and 174, 000 by 2015. Over a three year period, there was a progressive increase in HIV testing across Universities and TVET colleges. but a decline in 2016 to 160, 000 students who got tested for HIV. This decline was attributed to external factors such as the repetitive #FeesMustFall student protests spread across various universities in the country. The unrest meant that several health promotion activities, including HEAIDS, were either postponed or cancelled. The decline is in addition attributed to changes in international funding priorities for HIV. The Global Fund grants to universities, which were closed in 2016, constraining the implementation of various activities (HEAIDS Annual Review Report 2016).

Figure 2.1: HIV Testing in Higher Education in South Africa (SA)

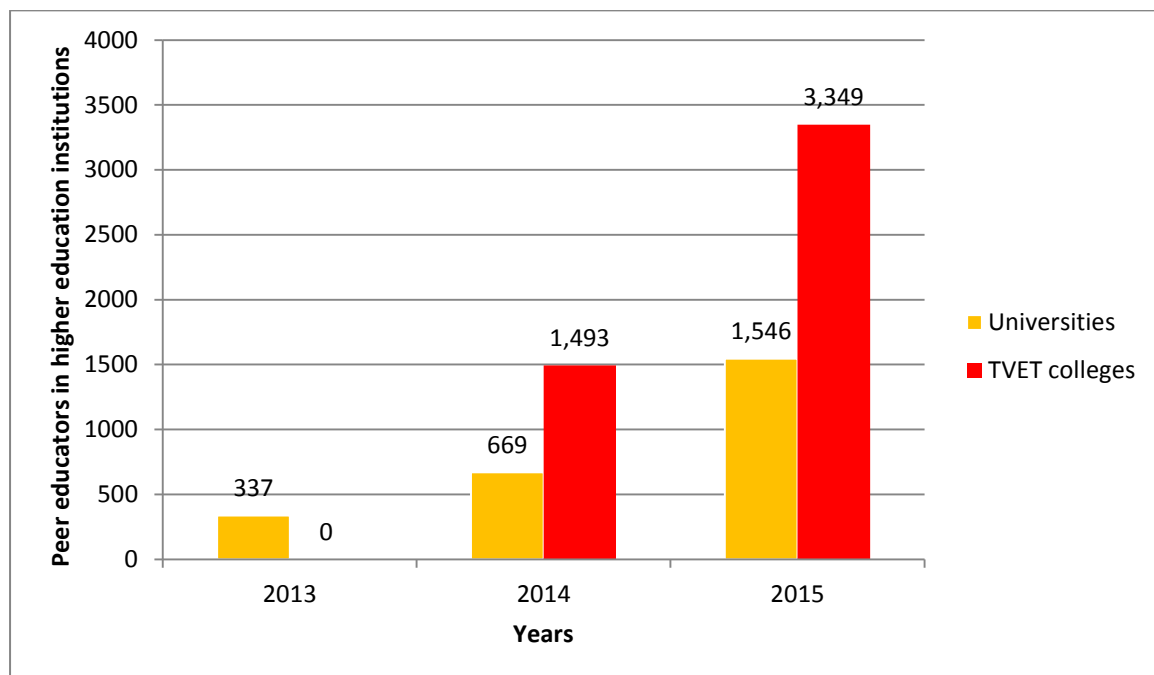


Source: HEAIDS Annual Review Report (2016:15)

The progress in the number of students who tested for HIV during the First Things First (FTF) programme from 2013 to 2016 is driven by the number of peer educators trained and placed on campuses. In 2013, few students tested for HIV and there

were few or no peer educators present in higher education institutions at that time. When more peer educators were employed in subsequent years, the number of students who participated in HIV testing increased.

Figure 2.2: Number of trained peer educators at universities and TVET colleges in SA



Source: HEAIDS Annual Review Report (2016:17)

According to HEAIDS Annual Review Report (2016:17), “peer education programmers are regarded as one of the successful forms of behavioural change and communication to reach and influence young people”. The intention in introducing peer educators in higher education institutions is to educate young people, work with them within their context to constitute change and development (HEAIDS Annual Review Report 2016). By examining both bar graphs, there is evidence of increasing pattern on HIV testing when peer educators are placed in higher education institutions, see from the years 2013 to 2015. This is evidence that the introduction of peer educators in higher education has a potential influence to increase participation in HIV testing within South African campuses. Therefore, peer educators are influential in scaling up the process of HIV testing. The above graphs elucidate the fact that when more peer educators are available in higher education institutions, more students are likely to participate in HIV testing. The long-term

implication of this is that the spread of HIV infection will be eliminated and terminated among students or the youth of this country.

A study on empowering peer educators in higher education institutions to deal with HIV and AIDS, revealed that students benefited from participation in the peer education programmes (Vember 2016). The study was situated in South Africa's metropolitan area. The students gained knowledge on HIV/AIDS, practiced safe sexual behaviours, including making a choice to abstain. These were achieved because the peer educators persevered in what they intended to achieve. They allowed sharing of knowledge and experiences from participants and demonstrated commitment to facilitate behavioural change (Vember 2016). Similarly, other studies have found that students' knowledge on HIV/AIDS improved significantly after participating in peer education programmes and demonstrating self-efficacy for limiting HIV risk behaviours (Mahat and Scoloveno 2010); (Mahat, Scoloveno, De Leon and Frenkel 2008).

It can be argued therefore that the introduction of peer education within the higher education institutions has played an essential role in combating the spread of HIV among students. This is evident from the above findings obtained by various researchers who conducted research on the necessity of peer education programmes to inform and educate young people about sexually transmitted infections (STIs), including HIV. The following sections elaborate more on health promotion programmes for the youth, particularly students in higher education institutions.

2.4 Health promotion programmes

2.4.1 Universal Test and Treat (UTT) policy

The Universal Test and Treat (UTT) policy is perceived to be one of the new promising preventions for HIV transmission. It provides prevention and protection methods to both HIV positive and negative individuals to reduce HIV infection. It is a new strategy in which HIV testing is prioritised for faster linkage to care and immediate initiation of antiretroviral treatment (ART) to maintain the health of HIV infected individuals and consequently reducing its spread (Hayes *et al.* 2014).

“The UTT policy allows health practitioners to display remarkable ability to adapt structured protocols in order to deliver a more distributed model of care that effectively retains clients along the HIV care continuum” (Wademan and Reynolds 2016:56). Wademan and Reynolds (2016) conducted their study on ethnographic insights on the implementation of the Universal Test and Treat policy conducted in Western Cape Province, South Africa. The health practitioners felt they possess moral and relational obligation to provide best service to their clients. The health practitioners transformed from a technical imaginary to one of social, emotional and physical responsibility to their clients. More patients within the HIV care retained in continuum because the health practitioners responded to the clients’ personal needs and created intimate relationships with them. Moreover, Wademan and Reynolds proposed that any scale-up of HIV treatment and prevention programmes must consider the essential services health practitioners provide to clients. In addition, health practitioners’ training ought to be continuous, with the provision of equitable remuneration and occasional monitoring of health professionals’ performance to achieve successful health outcomes (Wademan and Reynolds 2016).

Boyer *et al.* (2016) conducted a study that presented findings on ART uptake and factors associated with ART initiation among HIV positive individuals. Individuals were selected then linked to care in the trial clinics and were eligible for ART at their first clinic visit within the setting of an ongoing Universal Test and Treat cluster randomised trial in rural KwaZulu-Natal, South Africa. The results showed that ART uptake was high, with more than four to five individuals initiating treatment within their first three months of entering care. The findings of the study suggested a more speedy initiation in very sick patients to boost their health and avoid the epidemic spread.

The above study further revealed resistance to ART initiation among individuals with higher CD4 counts when compared to those with $CD4 \leq 100$ cells/mm³ within the first month of entering care. According to the healthcare professionals, resistance was caused by the lengthy period of time wasted in assessing the impact of the epidemic and to counsel patients before initiating HIV treatment (Boyer *et al.* 2016).

2.4.2 HIV programmes or interventions

The increasing rates of HIV infection among South African students could be an indication that previous HIV/AIDS intervention programmes have not achieved as expected. Masculinity and high-risk practices of sexuality have been pointed as a possible explanation. HIV infection within South African students has been on the increase accruing to power dominance and force in intimate relationships. For instance, most males are stronger and more influential in heterogeneous relationships. They decide whether contraceptives can be used or not. They are dictators in relationships. If this is resolved, hopefully there will be equality and no violence as well as the opportunity to understand and respect ones' wish or idea on the use of contraceptives during sexual intercourse (Van Staden and Badenhorst 2009).

Wademan and Reynolds (2016) noted that healthcare practice should go beyond mechanical actions and pay attention to establishing rapport between caregivers and clients. This would lead to a smooth talk on clients' issues regarding HIV testing and initiating treatment. There is a need for a long-term and trustful relationship with clients, so that they are gradually convinced to test for HIV and immediately initiate treatment.

Students attending universities in South Africa hail from diverse backgrounds, both culturally and socially. Their level of awareness and exposure to HIV/AIDS and other sexually transmitted infections (STIs) may vary (Reddy and Frantz 2011:167). Therefore, this calls for HIV/AIDS and STIs awareness in universities. Information and education materials on HIV/AIDS have to be cognisant of the positive, negative and multifaceted beliefs in relation to this scourge. Hence an effective campaign should cover the country's linguistic and cultural diversity. This has been a major challenge in many South African HIV/AIDS awareness campaigns. In many cases, interventions that have proved successful in other countries are applied to the South African context in vain. A case in point is the indiscriminate adoption of HIV/AIDS prevention messages used in the western countries (Verheij, Jansen and Jansen 2010).

HIV/AIDS interventions and prevention programmes tend to be underpinned by reductionist views of the dissociation between knowledge and behaviour. By so doing, a separation of the interface between sexual identity, education and HIV/AIDS is created. Further, the complex nature of the social and cultural discursive fields in which youth receive and interpret messages and how they understand, experience and use the knowledge while constructing, performing and playing out their sexual identities is left unattended (Baxen and Breidlid 2004).

2.4.3 Peer education for students

“Peer education programmes are means of addressing youth’s sexual and reproductive health, and form part of the effective strategies to educate and empower them” (Mahat, Scoloveno, De Leon and Frenkel 2008:362). Peer education programmes play a crucial role in improving knowledge and, therefore, have helped in addressing risk behaviour. Nurses and peer educators have to think strongly when adopting peer education programmes in schools and community centres. They can play an essential role in planning and implementing programmes as they are knowledgeable about youth’s growth, development and risk taking behaviours. Peer educators should keep in mind the needs of the targeted population, their social norms and cultural background. Further, involving parents and public figures in programme planning that would help sustain and achieve positive behaviour change (Mahat *et al.* 2008). Ergene, Cok, Tumer and Unal (2005) concur that peer education is a useful platform to share information about HIV/AIDS and can be an effective strategy for students’ knowledge and evokes positive attitude towards eliminating and terminating HIV/AIDS.

According to Mahat and Scoloveno (2010), peer education programmes elevate knowledge of HIV/AIDS among students and their self-efficacy to limit risk behaviours. Mahat and Scoloveno stated that most students are educated about HIV transmission through unprotected sexual intercourse with an infected individual, sharing needles to take drugs and from HIV infected mother to unborn baby. Nonetheless, students are unaware of other ways the epidemic is transmitted, such as anal and oral intercourse, sharing crack pipes and razors (Mahat and Scoloveno 2010).

A study on the impact of peer education on HIV/AIDS behavioural change among secondary school youth, revealed that the peer education programme encouraged abstinence, faithfulness to one partner, condom use, and HIV testing among students. The study further proposed that peer education programmes be integrated in extracurricular activities, with teachers getting additional training to become peer educators. Peer educators should be both in schools and for the youth in communities (Odundo, Anjuri and Odhiambo 2013).

Activities of peer educators in school settings which exist over a lengthy period are essential in establishing peer norms about healthy lifestyles and supporting adoption of healthy sexual behaviour (Merakou and Kourea-Kremastinou 2006). Merakou and Kourea-Kremastinou (2006) conducted a study to evaluate peer education in HIV prevention in schools. They discovered that after the peer education intervention, students seemed to be well versed with knowledge on HIV. Nevertheless they still portrayed discriminatory attitude and bias over drug users, men who have sex with men and people living positively with HIV. In this regard, the peer education intervention was inadequate in addressing discrimination or stigmatisation against people living positively with HIV, drug users and homosexual men. On the other hand, it was successful in empowering students to adopt less risky sexual behaviour. Many students stated that they have made changes in their sexual behaviour because of the fear of contracting HIV.

Even though the students have changed or are willing to change their risky sexual behaviour to healthier sexual practices, they were concerned about the use of condoms. They noted that condoms made sex less enjoyable and the peer educators did not have adequate training or experience to discuss condoms favourably to the students. Some students believed that condoms are more useful with occasional partners (one- night partners) rather than stable partners (Merakou and Kourea-Kremastinou 2006). This implies that peer educators should integrate sexually active individuals who possess knowledge and experience on condom use or other contraceptives, since several studies have found that young people are not attracted/prepared to use condoms (Verheij, Jansen and Jansen 2010; Phaswana-Mafuya and Peltzer 2007; Hoque and Ghuman 2012).

Merakou and Kourea-Kremastinou (2006) assumed that the students in their study were not concerned about HIV infection when they were in a steady relationship. However, to be monogamous in a short-term relationship is not an effective method of HIV prevention. So, the method of being faithful to one partner to prevent HIV infection becomes unreliable when people engage in short-term relationships or stay unmarried. Therefore, peer educators ought to emphasise abstinence as well as use of contraceptives when addressing young people.

2.5 HIV prevention programmes

There is a need to examine existing beliefs and practices about sex, to enable the creation of appropriate education material. Interventions implemented at a national level should not be applied exactly at a province or community level. The demographics and levels of literacy differ. Interventions on HIV/AIDS within university settings should be planned and customised to this peculiar setting. This requires understanding of the culture and experiences of students. In addition, students should be allowed to take part in the planning and implementation of the intervention (Baxen and Breidlid 2004).

“Social construction of gender undermines safe sex amongst young people in townships” (Campbell and MacPhail 2002:335). Therefore, peer education programmes have the potential to contribute two key processes impacts among young people on sexual health. First is the collective and critical renegotiation of sexual and social identities in a manner that is less damaging to young people’s sexual health. Second is the development of young people’s empowerment to implement more health enhancing ways of being (Campbell and MacPhail 2002).

Van Wyk *et al.* (2008) conducted a study on rapid appraisal of substance abuse and HIV awareness messages in poster communication to disadvantaged youth in South Africa. The authors found that the words used on the poster were confusing and the message was obscure. This indicates that words in HIV/AIDS messages should be carefully selected, taking into consideration the target population and their level of literacy. Simple and straight forward words should be used. Only a section of the audiences was able to understand that the message was about sex, alcohol, drugs and incident of HIV infection among the youth. However, some of the participants

noted that the poster was capable of perpetuating the risk of contracting HIV because of the suggestive pictures used.

Furthermore, after a discussion about the poster, some participants wanted to change their behaviour to safer sexual practices even after consumption of alcohol or other drugs. Young female participants revealed that the models in the poster dressed in a provocative way capable of increasing rape. Others reported that the picture was appropriate and depicted the reality among young people (Van Wyk *et al.* 2008).

The choice of colours in the poster was attention grabbing. Participants emphasised the need for “yes do” messages in HIV/AIDS campaign messages, especially for the youth to know what to do and not to do to eliminate the spread of HIV infection (Van Wyk *et al.* 2008). This implies that HIV/AIDS messages should not adopt narrative approaches or use the fear appeal. Messages should instead be straight forward on what is expected of audiences after reading and understanding the message, such as abstain, be faithful and use contraceptives, condom, for every sexual intercourse.

Thato and Penrose conducted a study which examined the effectiveness of a Brief, Peer-Led HIV Prevention programme on information, motivation, behavioural skills and AIDS prevention behaviours amongst Thai college students (Thato and Penrose 2013). The findings of the study demonstrated how theoretical variables could be utilised to develop an intervention aimed at students. The authors discovered that the intervention was able to “increase the students’ knowledge of AIDS prevention behaviour, motivate positive attitudes towards AIDS prevention behaviour, and increased normative support for and intentions to perform HIV and STI prevention behaviour” (Thato and Penrose 2013:36). Thus HIV/AIDS intervention aimed to motivate behavioural change should strive to take the three following variables into considerations, the attitude toward AIDS prevention behaviour, subjective norms, and behavioural intentions to perform HIV preventive behaviour. In a post-intervention, the students depicted a sustained improvement in knowledge for AIDS prevention, making it easier for them to have positive attitudes towards HIV/AIDS prevention and, adopt and sustain the HIV/AIDS prevention behaviour (Thato and Penrose 2013).

HIV information is crucial as it forms part of the key components in developing an intervention, especially for new and uninformed populations. People need to be aware that even engaging in unprotected sex with their partners and friends is also risky for contracting HIV. They should endeavour to use protection at all times (Thato and Penrose 2013).

2.6 Students' perception about HIV prevention strategies

Moodley (2007) in a study on University of KwaZulu-Natal students' perceptions about the ABC prevention strategy, discovered that the ABC campaign left out important information. The campaign was not effective because the plan and design did not incorporate students' ideas and their contributions to the message. The author proposed that when planning and designing intervention on campus, students should be involved to give their input to the interventions so it can be effective (Moodley 2007). The above study has been carried out on how audiences understood and interpreted messages, and students' perceptions and use of contraceptives. This implies that University of KwaZulu-Natal students are susceptible to the incidence of HIV infection.

University students are aware of HIV prevention messages within their campuses, but hardly engage in discussions about abstinence, being faithful and using condoms. Students' responses to communication and media strategies to prevent and protect HIV infection have revealed that the majority of students perceived the use of condoms as a more realistic HIV prevention method and that only few students practiced abstinence. The few students who were abstaining had a reason for that, such as the fact that their religious moral practices upheld that pre-marital sex is sinful. HIV/AIDS prevention programmes should also aim at evoking sexual related discussions with audiences (Mulwo and Tomaselli 2009).

Hoque and Ghuman (2012) conducted a study on contraceptive use in the era of HIV/AIDS among university students of KwaZulu-Natal, South Africa. The authors discovered that most students are sexually active and only a few of them use condom as their major contraceptive to prevent HIV transmission. Unavailability of other contraceptives was one of the reasons that most students were not utilising contraceptives during sexual intercourse. Other students reported that they did not

think of contraceptives or that their partners did not want to use such. This implies that there was not sufficient supply of contraceptives to the entire sexually active population. In addition, the majority of sexually active students were unwilling to use condoms as contraceptives.

2.7 Youth's vulnerability to HIV infection

Young people who have not reached their mid-twenties form part of a generation that is extremely susceptible to HIV infection. Gender difference is one of the susceptibilities of young people to HIV infection. Most HIV/AIDS cases and infections emerge from people at the age 15 years onwards, more especially among young girls than boys. This has led to the prevalence of HIV infection among young women several times higher than young men in selected parts of the world. This constitutes of young women between the ages of 15-24 years old (Kelly 2004). In South Africa, adolescent girls and young women aged between 15-24 years have an HIV prevalence that is nearly four times greater than that of men of their same age. In 2016, young women comprised 37% of HIV infections in the country (HIV/AIDS in South Africa 2017). According to Harrison, Newell, Imrie and Hoddinott (2010), this population group constitutes the world's highest HIV dominance.

Many students in higher institutions are sexual active and this is not a geographic issue as it occurs into various campuses across the world. By the time learners finish high school, most of them are already sexually active. Universities therefore become a fertile ground for exploring, continuation and maintaining sexual practices (Gemedda, Gandile and Bikamo 2017, Buldeo and Gilbert 2015, Van Staden and Badenhorst 2009).

2.7.1 Lack of HIV information

One of the reasons students are vulnerable to HIV infection is the lack of information about the epidemic (Gemedda, Gandile and Bikamo 2017). Conversely, Caetano, Llnhares, Pinotti, Maggio Da Fonseca, Wojitani and Giraldo (2010) noted that, the number of partners in a relationship is also one of the factors leading to the acquisition of STIs and HIV/AIDS. A considerable number of students may use condoms or contraceptives during sexual intercourse. The few students who practice unprotected sex increase the chances of contracting and spreading HIV especially where multiple partners are involved.

To reduce HIV transmission among South African students, there should be “adequate health literacy and focussed health education to ensure students understand the transmission, prevention, early diagnosis and adherence to treatment for HIV” (Taylor, Jinabhai, Sathiparsad and De Vries 2014:247).

Fennie and Laas (2014) conducted a study on HIV/AIDS related knowledge, attitudes and risky sexual behaviour among South African university students. The study featured participants from the faculty of Health Psychology, Life Skills and Health Education modules. All of the participants had knowledge about HIV transmission, yet some still practiced unprotected sex. This indicates that knowledge alone does not motivate or encourage behaviour change. There is a need for health promotion programmes to adopt strategies that lead to behaviour change rather than disseminating messages only. The audiences should be involved in writing the messages, come up with effective strategies to establish behaviour change, implement the strategies and assess the outcome to advance the strategy and achieve better results in future. Some students do undergo HIV testing and they are willing to test in the future. This indicates that people, especially the youth, who have knowledge about contraction the virus are willing to test and continue to maintain their behaviour if they are negative or quickly take medication if tested positive (Fennie and Laas 2014).

2.7.2 Cultural beliefs and violence

Men and boys are more responsible for the spread of HIV infection across the world and the epidemic was first discovered in them (Kelly 2004). Cultural and economic arrangements in societies allow men more sexual latitude. Various cultures encourage or demand a higher-risk of sexual behaviour among boys and men. For instance, it is regarded as ethical, moral or as a norm within some African cultures for men to have two or more wives, polygamy. However, women are denied or deemed to be possessed by evil spirits, unethical, immoral and disrespectful if they wish or happen to marry two or more men (Kelly 2004). “By responding to these cultural norms and expectations, many boys and young men would be in less risk of HIV infection and achieving the reduction or termination of the epidemic incidence rate within the youth would be possible” (Kelly 2004:62).

Some cultures and expectations encourage men to feel obliged, against their better judgement, to experiment and take risks as well as to abuse women. Hence, interventions should also seek to address gender inequalities. In addition, there should be efforts to replace false sexual images of manhood with one that finds expression and fulfilment in a more respecting and caring attitude towards girls and young women. Furthermore, there should be a platform where boys and young men can openly speak about sexuality and the challenges they come across (Kelly 2004).

Maughan-Brown, George, Beckett, Evans, Lewis, Cawood, Khanyile and Kharsany (2018); Pettifor *et al.* (2016); Ranganathan *et al.* (2016) argued that adolescent girls and young women are highly infected by HIV/AIDS in South Africa, particularly in the province of KwaZulu-Natal. This is because girls and young women are sexually active, reported to be pregnant and become HIV positive at an early age.

Moreover, intimate partner violence and gender inequality in relationships are found to accelerate the prevalence of HIV on young women in South Africa. This is because condom use is compromised. Condom use is predominantly determined by male partners, not female partner. Hence it is likely to happen that men initiate condom use after a diagnosis of HIV and STI or be inconsistent in condom use (Jewkes, Dunkle, Nduna and Shai 2010).

2.7.3 Age-disparate

Among other factors, age-disparate is discovered as a risk for HIV infection for adolescent girls and young women. Many young women preferred age-disparate compared to age similar relationships, where the male partners were five or more years older than the females. Most of the males happened to have concurrent relationships. The young women involved in age-disparate partners were deemed to be HIV infected when compared to those with age similar partners (Maughan-Brown *et al.* 2018). Moreover, HIV interventions aimed at addressing age-disparate could reduce the probability of onward transmission of HIV risk among young women. Further, age-disparate partnerships and HIV risk infections should be considered carefully when developing interventions for HIV/AIDS (Maughan-Brown *et al.* 2018).

2.7.4 Perceptions about HIV

Young women perceive HIV as an epidemic that cannot be contracted easily and they never regard themselves as vulnerable to contract the epidemic. However, severely bad sexual practices and characteristics observed from this population group were believed to perpetuate the spread of HIV infection. The population lacks HIV knowledge, engage in sexual intercourse when they are drunk or intoxicated by drugs. Therefore, unprotected sexual intercourse contributed to significantly higher odds of being HIV infected (Pettifor *et al.* 2016).

There is conflicting views about the incidence of HIV amongst adolescents and young people in the township of Khutsong, South Africa. Certain people in the community do consider themselves as vulnerable to HIV infection, while others are in high levels of denial. The group who felt vulnerable felt that the epidemic is a problem in their community and personal experience with AIDS had forced them to acknowledge that it exists. Amongst the participants of the study, more young women than men stated that HIV was a real problem in their community (MacPhail and Campbell 2001). The above studies prove that HIV is common in the country even though certain people are in denial.

In Africa, South Africa is one of the countries where HIV epidemic has hit the hardest. The epidemic is prevalence among young women and men. Women are more likely to be infected with HIV compared to men (Pettifor *et al.* 2005).

2.7.5 Financial support

It is essential to understand the determinants leading young women to be highly susceptible to HIV infection, for an effective intervention to be developed. Most young women are sexually active, with two or more sexual partners and engage in more than two sexual partners in their past twelve months. In some cases, young women often engaged in sexual intercourse with non-casual partners in exchange for money, gifts or both. Meanwhile they are in a steady relationship with their casual partners. Therefore, young women are believed to increase probabilities of being HIV positive. In a number of rural areas in South Africa, where economic opportunities are circumscribed, young women engage in transactional sex for money to fulfil their needs and wants, hence placing themselves at higher risk for HIV infection (Ranganathan *et al.* 2016).

According to Mabaso, Sokhela, Mohlabane, Chibi, Zuma and Simbayi (2018), addressing social, cultural and structural factors would culminate the incidence of HIV infection among adolescent girls and young women. These include providing information about HIV to adolescent girls and young women and encouraging sexual partners within the same age range and marriage, especially to HIV negative and faithful partners.

Tapping from the drive for material wealth and other factors, Zitha, Thobejane and Mulaudzi (2017) discovered factors leading to “blesser-blessee”² relationships amongst female students at a rural university setting in Limpopo province. The authors stated that university life is a challenge and a daunting task for students with no guidance and support from parents. Students who are financially insecure suffer academically, physically and emotionally. Therefore, some students end-up in a blesser-blessee relationship. Blessers play a huge role in the lives of university students by buying them food, clothes and other material benefits in exchange for sex. The study found that the majority of the female students chose to date men with money and older age gap. This leads to the increase of HIV infection among the female students when contraceptives are not used as these blessers are often married husbands with wives and children or perhaps having multiple sex partners (Zitha, Thobejane and Mulaudzi 2017).

2.7.6 Independence and social environment

Another reason young people are susceptible to HIV infection is the increase of numbers of infection occurrences during schooling or shortly afterwards. Most students studying at tertiary institutions happen to stay misuse their independence while staying on campus residences or rent certain places (Yako, Mnwana and Mayeye 2015).

Moreover, university lifestyle often challenges the socially accepted behaviour pattern as they become exposed to cultural differences which differ from their values, such as the view of sexual practices (Yako, Mnwana and Mayeye 2015).

² “A blesser is a modification of a sugar daddy, a married man who wants entertainment from young girls in exchange for a good time and a blessee is a young female who is blessed by gifts, favours, entertainment and money, in exchange of giving the blesser a good time which includes sexual favours” (Zitha, Thobejane & Mulaudzi 2017:10).

Van Staden and Badenhorst (2009) stated that tertiary institutions offer sexual exploration and freedom for sexual intercourse for many young people. Many students become sexually active in tertiary institutions. Being away from parents may lead students to experimentation and risk taking on various sexual practices that may seem appealing. Similarly, Mengistu, Melku, Bedada and Eticha (2013) noted that most of the youth initiate sexual intercourse before the age of 18 years old before pursuing their careers in higher institutions. Joining the university environment flourishes their sexual activities. “About fifty six percent of students in Madawulabu University, Southeast Ethiopia, practiced unprotected sex. Most of the students were sexually active because of falling in love, peer pressure and the need to get money or other benefits from their sexual partners” (Mengistu *et al.* 2013:3)

2.8 Factors contributing to students’ risky behaviour

“Universities are sexualised spaces where the pressure to be sexually active is exacerbated by many influencing factors” Buldeo and Gilbert (2015:2). Factors that contribute to high HIV exposure to university students are their age, ambition, experience of new events and other contextual driven factors, such as substance use which is a predisposing factor for risky sexual behaviour. Furthermore, university students do not perceive themselves as vulnerable to HIV infection. They are often less interested in using sexual protective methods (Gemeda, Gandile and Bikamo 2017). White *at el.* (2009) high school learners and university students are sexually active and their prevalence of HIV infection is too high.

Furthermore, multiple sexual partners, casual/benefit based relationships and number of sexual friends was associated as risky behaviour for contracting HIV and other STIs. It is believed that insufficient HIV information related to increase of HIV and STIs (Mengistu *et al.* 2013). Therefore, it was proposed that there should be “student clubs, designing and implementing awareness rising and, risk reduction activities and promoting peer education through intervention” (Mengistu *et al.* 2013:6).

In addition, Mutinta (2012) conducted a study on student sexual risk behaviour, risk and protective factors and their responses to the Scrutinise campus campaign at the University of KwaZulu-Natal. It was found that students are highly vulnerable in contracting HIV. The Scrutinise campus campaign did not discourage students to

engage in sexual intercourses but instead encouraged them to use condoms correctly to prevent HIV infection. In addition, Mutinta *et al.* (2012:353) in a study of individual determinants of students' sexual risk behaviour at a South African university noted that "sexual risk behaviour is influenced by various factors such as personal beliefs about long-term relationships, attitudes toward sex for variety, a drive for material wealth, a lack of satisfaction from relationships, trust issues and attention, and pursuit of the long-term goal of marriage".

2.8.1 Early-age sexual intercourse

According to (Fennie and Laas 2014), a number of students start engaging in sexual intercourse when they are 15 years old. This implies that HIV/AIDS teaching should be taught in elementary schools and parents should play a critical role in teaching their children about HIV/AIDS at a younger age. In their study, the majority of the students reported that condoms are the best preventing method for HIV infection and that they also receive HIV/AIDS information from health centres, internet, television, schools/universities and churches

2.8.2 Influence of drugs

A considerable number of women and men who consume alcohol on a regular basis had irregular partners and hardly used condoms with their partners This practice leads to the perpetuation of the HIV infection if one partner becomes HIV positive (Peltzer 2003).

2.8.3 Multiple and concurrent relationships

University students within a particular campus in South Africa have been found having concurrent relationships. The students having multiple sexual partners did not consider themselves to be at a higher risk of contracting HIV, yet some of them barely used condoms or other contraceptives during sexual intercourse. Meanwhile, students with one sexual partner considered their risk of contracting the virus lesser than those with two or more partners, while all of them did not use contraceptives frequently. In addition, the majority of the students never tested (Pretorius and Raijmakers 2006). This indicates that the groups of students, those with one partner and those with multiple partners, are at a higher risk of contracting HIV in case one of the partners contract the epidemic and infect others.

2.8.4 Prostitution

A study conducted on Tswana-speaking students to find their perceptions of HIV/AIDS and poverty, revealed that most South African women and children who speak Tswana are poor and their way to get money includes selling their bodies and engaging in unprotected sex with multiple partners, thus increasing the spread of the virus. Some of the people know that HIV is transmitted through exchange of body fluids like blood and semen, yet they still practice unprotected sex. They blamed poverty instead of taking responsible action to prevent its transmission by using condoms and other prevention methods. This illustrates that there is much to be done to encourage people to start using HIV prevention methods instead of practicing unsafe sex and blame poverty when they contract HIV (Schutte 2003).

2.9 Reactions to condom use

A large number of students at the University of Limpopo, Turfloop Campus, appeared to use condoms when engaging in sexual intercourse. Nonetheless, some students preferred not to use condoms. They believed that condoms contained certain diseases inside them. Furthermore, the male students mention that condoms prevented them from impregnating. Also, there were female students who did not support condom use. They believed that females who use condoms get thinner. This group of students, both male and female, agreed that by using a condom, there is no transmission of body fluids necessary for fluid levels in both partners (Verheij, Jansen and Jansen 2010).

In addition, the above study revealed that male students had multiple girlfriends. This poses a high risk of HIV infection to students who do not use HIV preventive methods. Some students believed that HIV/AIDS is curable, others said traditional healers can cure the pandemic and others believed that HIV is cured by engaging in sexual intercourse with a negative child or a virgin. In addition, this group of students believed there are ethnic groups who are resistant to HIV infection. These beliefs could turn to motivate individuals who are HIV positive to seek for younger and virgin partners who are HIV negative to engage in unprotected sexual intercourse with them or practice unsafe sex, with the conviction that the HIV/AIDS can be cured. This can only translate into continued HIV infection (Verheij, Jansen and Jansen 2010).

University students frequently engage in concurrent relationships and practice sex with all their partners. In most cases, the male students happen to be the ones who often practice this behaviour than female students. Furthermore, some students are not in favour of condom use, as a result they practice unprotected sex and that could lead to the spread of STIs, including HIV (Phaswana-Mafuya and Peltzer 2007).

In addition, there are misconceptions on contraceptives, for instance, distrust on condoms, that one should use two condoms to prevent pregnancy and HIV and, that contraceptive pills cause infertility, cancer and deformed babies (Warenius *et al.* 2007).

The youth is the more vulnerable population for HIV infection either from South Africa or across the world. This shows lack of knowledge, care and support as well as effective interventions or programmes on HIV aimed for young people. When many young people become HIV infected, it would become very difficult or impossible for governments, Non-Government Organisations and other parties to achieve an HIV free generation in the future. One of the steps to achieve free HIV generation involves eliminating and terminating the incidence of HIV infection among the youth, particularly through health sexual behaviour, zero HIV infection from mother to unborn babies and on injection of drugs. Several studies in health communication have been carried out on how the audiences understood and interpreted the messages, and on students' perceptions and use of contraceptives. Yet no study has been conducted to examine the effectiveness of the implementation of UTT policy to increase HIV testing within South African higher education institutions.

2.10 The role of universities on HIV/AIDS awareness

Dunne and Somerset (2004) conducted a research on health promotion within university settings. They noted that when first year students moved out of their homes to universities, where they are not looked after and protected by their parents. Adopting a healthy university lifestyle becomes difficult for students.. The students were equipped with information about different medical conditions to be aware of illness symptoms and to help others in case of emergencies.

Furthermore, health campaigns were adopted; aimed at HIV prevention, raising awareness, education, challenging discrimination and conversation stimulus (Dunne

and Somerset 2004). Dunne and Somerset (2004) found that students lack knowledge on how HIV is transmitted and they also find it difficult to abstain or practice protected sexual intercourse in higher education institutions during the absence of parents or guardian. Lack of HIV knowledge and peer-pressure cause them to engage in risky sexual intercourse.

This raises the importance of educating students about HIV prevention and protective methods, such as using males and females condoms, medical male circumcision, use of antiretrovirals such as Pre-exposure prophylaxis (PrEP) for HIV-positive people with HIV-negative partner, Post-exposure prophylaxis for HIV (PEP), warn people who inject and share drugs to stop and promote the importance of being faithful to one partner.

An average number of students in South Africa are aware that if they had engaged in unprotected sexual behaviour, they have to go for HIV testing or take HIV prevention measure to eliminate chances of being infected. Nonetheless, some of them do the opposite by being ignorant and unconcerned of contracting the epidemic (Fennie and Laas 2014). This implies that even though people know how to prevent and treat HIV, they still lack the motivation to take the right steps to fight the spread of HIV infection.

Young students, especially first entering, do not have much information about HIV/AIDS when compared to senior students, those who are enrolling for their second level and onwards. One of the causes is the inadequacy of school programmes and lack of teachers' training to educate learners about the epidemic. As a result, there is absence of basic information about HIV/AIDS for students joining universities for the first time. There is a need for HIV/AIDS to be taken serious and be taught to every individual, including children or students. If children are not taught how HIV/AIDS is contracted and prevented, it will be highly impossible to reach an HIV free generation (Bezuidenhout and Summers 2007).

Most teachers' face the culture of silence surrounding HIV/AIDS. One of the reasons HIV/AIDS continue to spread is when people deny their positive status. Others choose to blame circumstances and isolate themselves instead of seeing help (Bezuidenhout and Summers 2007). "Teachers must recognise factors leading to

HIV infection in their surrounding communities and be able to address them in classes” (Bezuidenhout and Summers 2007:315).

Warenius, Pettersson, Nissen, Höjer, Chishimba, and Faxelid (2007) noted that parents and teachers are not talking openly with the young generation about sexuality because young people are not anticipated to practice premarital sex. This silence becomes a huge challenge for older people to talk about sex related matters with younger people. As a result, young people failed to access information and services they needed related to sexuality, such as access to information about contracting of STIs including HIV, the importance and use of contraceptives.

Nonetheless, young boys and girls have a higher degree of awareness pertaining to the safe days of menstrual cycle to avoid pregnancy. Demonstrating great knowledge on human reproduction than consequences involved in unsafe sexual intercourse (Warenius, Pettersson, Nissen, Höjer, Chishimba, and Faxelid 2007).

Universities should not only carry out research about HIV/AIDS, but produce students who are well equipped to fight the epidemic in societies. This would help prevent the incidence of HIV infection and make the societies to accept those who are infected as normal human beings to get rid of discrimination and stigmatisation (Bezuidenhout and Summers 2007).

Ogunlela (2013:1-8) conducted a study on “perceptions among the use of female condom to prevent HIV/AIDS among students at the University of KwaZulu-Natal, Howard College Campus. The study found that there were insufficient promotions on the uptake and use of female condoms”. Therefore, female students felt that there was an urgent need for promotion of female condoms. The students noted that the government, the university management as well as clinic staff members were not doing much. This result in the questioning of the effectiveness and validity of female condoms, and perhaps limit the use of female condoms (Ogunlela 2013).

According to the University of KwaZulu-Natal HIV/AIDS policy, the university is located in one of the provinces where HIV incidence is high. That makes it difficult for the institution to provide outstanding service (UKZN HIV/AIDS policy 2005). Mutinta (2012) found that students at the University of KwaZulu-Natal are highly vulnerable to HIV infection. A study on Scrutinise Campus Campaign discovered that the campaign did not discourage students from engaging in sexual intercourse but

instead encouraged them to use condoms correctly to prevent HIV infection. Madu and Karl (1999) found that South African students in tertiary institutions do not use condoms during sexual intercourse for various reasons. All this supports the necessity of conducting a study aimed at assessing participation on HIV testing at Howard campus to eliminate the conundrum of HIV infection.

2.11 Students' perceptions on HIV testing and counselling

HIV testing and counselling is a key component for HIV prevention and encouraging people to take treatment. Unfortunately many students who are at risk of contracting HIV do not test (Hou si 2009). A study conducted to explore the Health Belief Model and first-year students' responses to HIV/AIDS and Voluntary Counselling and Testing (VCT) at the University of the Witwatersrand (WITS), South Africa. It was found that the students were willing to know their HIV status. Nonetheless, many students did not test because of fear, the perceptions of being HIV positive and how their friends and families would think or react if the results are positive.

Buldeo and Gilbert (2015) noted that certain students who underwent HIV testing have disclosed their status to others and that was a major concern that demotivated other students to go for HIV testing because of the feelings of shame, fear, rejection and denial after tested HIV positive. The practice of disclosing HIV status can be positive or negative when it comes to motivating people to test for HIV. Disclosing your HIV status can be good to motivate people to know their HIV status, however certain people will be afraid to test because of the feeling of rejection or discrimination if the results are positive. This emphasises the need for brave individuals who tested HIV negative and positive to motivate people to go for HIV testing. These people could be the pillars in educating people to stop stigmatisation, emphasise the importance of taking treatment, and practicing safe sex.

Similarly, Van Dyk and Van Dyk (2003) found that one of the main reasons students did not test for HIV was fear. They were afraid of the positive results. This however does not mean students engage in sexual intercourse and practice unprotected sex. HIV is not only transmitted through sexual behaviour, but in various ways such as parent to child transmission, sharing needles or syringes, and breast milk from a person who is HIV positive and so on. That makes it difficult for many people to be confident and assume he/she is HIV negative, especially when living in a country

which has the highest HIV/AIDS population in the world (WHO 2018). Thus interventions promoting the importance of HIV testing should aim to address the fear of being HIV positive and state the importance of knowing your status as well as the advantages of getting support and treatment when one is HIV positive.

Pretorius and Raijmakers (2006) state that students are willing to take care of HIV positive individuals as well as to love and socialise with them. This depicts a positive way of addressing stigma to HIV/AIDS among students or the youth. However, this cannot be entirely true as there is no evidence that the students in the study knew people who are HIV infected which they have helped or live with.

In addition, not every student who tested for HIV did so because it is a right thing to do for their health. Other groups of students tested for HIV because it was a requirement as surety for loans, insurance applications and blood donations. This shows that there is much to be done to encourage students to frequently test for HIV and avoid unprotected sex. Due to the requirement to undergo HIV testing for other reasons, many of the students never returned for HIV testing in future (Pretorius and Raijmakers 2006). Other reasons for students not returning for HIV testing included “poor post-test counselling, lack of enough counsellors, long queues, lack of privacy, one-way symmetrical communication, no opportunity to ask questions and lack of properly trained counsellors” (Pretorius and Raijmakers 2006:312).

Attracting youth’s attention to undergo HIV testing is a huge challenge, especially in most African countries. The reasons for this vary and range from fear, inaccessible or unaffordable testing sources. Some students committed homicide or suicide when they discovered that they were HIV positive. This made it difficult for others to test for HIV (Lawrence 2002).

2.12 The importance of health promotion

Several countries, governments and organisations are uniting to fight the HIV epidemic by educating communities about how it can be transmitted, prevented and treated. Although HIV infection is a perpetuating health issue in South Africa and around the world, it can be prevented and treated, but it is not curable.

Anti-retroviral treatment has become a major focus for many activists in previous years. There is increase pressure for free distribution of anti-retroviral treatment for

women who are expecting, to prevent new-borns from contracting HIV (Phaswana and Karl 2003). Free HIV/AIDS treatment is now accessible in South Africa. This calls for more efforts to educate and motivate people to approach health facilities and consequently access free treatment.

High HIV/AIDS prevalence has necessitated parents to talk to the youth about prevention. Parents are encouraged to talk about HIV/AIDS with their children in homes, schools and communities. Awareness on HIV/AIDS should start at home with parents or guardians engaging in discussions about the epidemic with their entire household. Parents have to learn about HIV/AIDS and play an influential role in guiding and teaching their children to stay away from habits or practices that could lead them into contracting the disease (Wilbraham 2009).

In a country where there is a high rate of HIV infection, like South Africa (WHO 2018), health promotion becomes pivotal to educate the population about prevention and treatment of HIV/AIDS. The following section defines and explains the evolution of health promotion as the term has been used interchangeably over times. Public health promotion is critical in educating and informing individuals about health related issues that could cause harm to their lives. If the information is understood and used correctly it can prevent and eliminate the spread of diseases including HIV or other health issues. According to Raczynski and DiCemente (1999:7), “public health programmes can be traced back to the 20th century when medical science advanced to develop effective treatments and preventive vaccines for infectious diseases”. Raczynski and DiCemente identified four phases to describe the public health developmental stages from the early 1800s until mid-1970s. The initial phase is labelled as sanitary reform, which had a life-span of a century, from the 1800s to early 1900s. This stage brought an effective notion of public hygiene to understand disease prevention and health protection.

Secondly is preventive phase, which focused on child and family health and the protection of services. Thirdly is therapeutic phase. This phase started in the 1930s until the mid-1970s and brought an increasing enchantment and the belief in the possibilities of technology as a means to prevent diseases. In the last phase of public health development, there was anarchy as the public noticed the limitations and the delivery of increasingly sophisticated and expensive technological

interventions to fewer numbers of people to inherent health protection, care and promotion (Raczynski and DiCemente 1999). Health promotion interventions incorporate both health communication and social marketing to be effective. Health communication and social marketing are indispensable to inform and persuade target audiences to change behaviour (Edgar, Volkman and Logan 2011).

Kline and Huff (2007:4-5), defined “health promotion as the aggregate of all purposeful activities designed for personal and public health through a combination of strategies”. Health promotion strategies include the competent implementation of behaviour change strategies, health education, health protection measures, risk factor detection, health enhancement, and health maintenance (Kline and Huff 2007). Dines and Cribb (1993) defined health as the absence of disease and that health promotions should be designed to achieve the following: 1) involve the population as a whole, 2) to be directed towards the action on the determinants or the cause of health, 3) combine diverse but also complementary approaches or methods, 4) aim at effective and concrete public participation and 5) health professionals should play a crucial role in nurturing and enabling health promotion. In concurrence, Williams (2002) defined health promotion as a joined term which incorporates practices aimed to prevent the spread of diseases, encourage harmony and well-being.

Currently, the only way to reduce or stop the spread of HIV infection is through prevention and protection. These terms cannot be used interchangeable or as synonym, hence in this study, the terms mean two separate things and distinct to one another. HIV prevention refers to the actions a person adopts to avoid contracting the epidemic, for instance abstinence and, the use of condom and PreExposure Prophylaxis (PrEP) during sexual intercourse. Whereas HIV protection refers to the act of taking antiretroviral medicines (ART) after being exposed to the epidemic to avoid being infected. One of the examples would be Post-Exposure Prophylaxis (PEP). PEP only applies in emergency situations and works within 72 hours after exposure (HIV Prevention 2018).

University of KwaZulu-Natal HIV and AIDS Programme held a Zazi Campaign on the 28th of September 2018 at Westville campus. South African women and girls were encouraged to know their value and strength to overcome adversity. This was meant to enhance self-confidence and taught them to know their responsibilities and have

these in mind as early as possible. The campaign explained HIV prevention methods which were PREP (pre-exposure prophylaxis) and PEP (post-exposure prophylaxis). The women and girls were also encouraged to continuously use condoms, as that is not merely a responsibility for men. HIV negative students were inspired to maintain their status and those who were positive inspired to access the available help, such as counselling and collect ARV (Zazi campaign at University of KwaZulu-Natal).

2.13 Health promotion evaluation/assessment

Health promotion evaluation is an essential component for understanding the success or failure of a programme or an intervention. The evaluation process should incorporate the participant's verbal and written feedback. Furthermore, evaluation should include reflecting on all previous stages to determine the strength and weakness of an implemented plan or programme. It is also important to evaluate both the strengths and challenges of an intervention (Nies and McEwen 2001). In the UNAIDS Strategic Guidance for Evaluating HIV Prevention Programmes (2010:5), "there is an urgent need to continue to accumulate credible evidence about what works and what does not work to avert HIV infections in particular populations and settings and, apply the lessons learnt in programmes to practice". This can only be achieved by assessing the interventions and this is what this study aims to achieve.

2.14 Conclusion

This section covered previous studies conducted in various higher education institutions, internationally and nationally. The information contains HIV infection matters among students in higher education institutions. Various studies have found that students are highly vulnerable to contract HIV because of unprotected sexual intercourse. This led to the need for health promotions to discover the determinants which make students susceptible to HIV infection, including the practice of unprotected sexual behaviour. HIV/AIDS campaigns are being implemented in various campuses across the world and the major problem is that the pandemic is still perpetuating, and some of the reasons include the inability to engage students when planning and executing interventions. Lastly, young people are afraid of HIV testing and there is a need to address the fear, motivate people to know their status and practice health sexual behaviour.

CHAPTER THREE

Theoretical framework

3.1 Introduction

The current study used the P-Process model, a strategic communication for addressing the public. Applying the model helps explore UTT implementation and communication strategies used. Then, lastly, assess participation progress in HIV testing.

This chapter is presented in sections. The first section discusses the use of strategic communication in HIV prevention, with emphasis on the key elements that guide the design and implementation of an effective intervention using a systematic approach. The second section discusses the origin and key constructs of the P-Process model as the study's theoretical framework. Lastly, the section contains discussions on studies adopted the P-Process model.

The researcher argues that by following strategic communication campaigns for HIV/AIDS prevention, the P-Process model is useful to be employed to achieve the objectives of this study..

3.2 Strategic Communication

This chapter first explains strategic communication, particularly, the development of strategic communication campaigns for HIV/AIDS prevention. According to Hallahan, Holtzhausen, Van Ruler, Verčič and Sriramesh (2007), strategic communication is defined as a purposeful use of communication by an individual or an organisation to fulfill a mission. Thus, the role of strategic communication is to examine organisational communication from an integrated and multidisciplinary perspective by extending ideas and issues grounded in various traditional communication disciplines. This involves six relevant disciplines in the development, implementation and assessment of communications which are: management, marketing, public

relations, technical communication, political communication and informational/social marketing campaigns.

Management communication and marketing communication are crucial for reaching and mobilising the targeted population to take part in adopting the proposed behaviour. Management communication requires the campaign designers to design effective HIV testing campaigns, making sure the messages are tailored to change people's HIV-related behaviours for the better and motivate them to go for HIV testing. Consequently, the environment will support behaviour change and address psychological determinants of behaviour. The design of the campaign messages have to be theory-driven based on the variables that determine desired health behaviour (Swanepoel 2010). Designers for HIV/AIDS messages should carefully select appropriate words to avoid publishing posters with confusing and obscure messages. Moreover, bright and attractive colours should be used to grab attention. The messages have to be precise and straight forward, inclusive of 'yes do' messages rather than applying 'do not' messages all the times and leaving the audience unsure of what is right. For instance messages ought to be as clear and state that: abstain, have one partner and use contraceptives when practicing sex (Van Wyk *et al.* 2008).

Marketing communication focuses on consideration of audience segmentation and targeting of messages (Swanepoel 2010). This would help find how the health promoters selected their audiences and knowing the right medium to send their messages.

Designers for HIV/AIDS messages have to take into consideration the targeted population and their level of literacy or education so that their messages can be read and understood and making sure the desired goals are achieved (Van Wyk *et al.* 2008).

Management communication and marketing communication are two essential disciplines which this study follows to explore the selection of the communication channels and messages to promote HIV testing. By exploring how the health

promoters designed and implemented the Universal Test and Treat policy, this study will be able to assess participation in HIV testing.

3.3 Strategic communication in fighting HIV/AIDS

Strategic communication is a promising strategy in initiating positive response towards the HIV/AIDS epidemic. It enables the addressing of both social and behaviour change through communication. Strategic communication has proven to be a highly effective approach in other areas of public health, yet it remains under utilised in the area of HIV/AIDS prevention (McKee, Bertrand, Becker-Benton and Becker 2004). It works as an approach to design and implement programmes that intend to increase the impacts on social and behaviour change communication (SBCC). The programmes then become effective both in capturing the attention of intended audiences and influencing their behaviour and social norms. When strategic communication is applied in HIV/AIDS interventions, it should start with the vision to avoid HIV, followed by motivating people towards adopting a healthier behaviour pattern (McKee, Bertrand, Becker-Benton and Becker 2004).

Maibach, Kreps and Bonaguro (2002) argue that the best public health strategy available for HIV/AIDS prevention is strategic communication. This is more so because of the absence of an effective technique for vaccinating the public against contracting the epidemic. The adoption of strategic communication campaigns is crucial to help targeted audiences recognise HIV risk, convey appropriate strategies for minimising risk and motivate them to implement the proposed strategies. Furthermore, a well-designed campaign plays an instrumental role in facilitating social and behavioural change.

In recent years, the global response to the HIV/AIDS epidemic has taken many forms. Governments have mobilised national HIV/AIDS control committees. Health sectors have responded with intensified prevention activities, such as care, treatment and support, and the integration of HIV/AIDS prevention into curriculum in schools. Within health-related interventions or programmes, communication is considered an important component for educating the public, shaping their attitudes and

perceptions, creating a demand for health services and improving provider-client interaction (McKee, Bertrand, Becker-Benton and Becker 2004).

“For information to change people’s behaviour, people should first feel susceptible and be concerned about their well-being” (MacPhail and Campbell 2001:1619). MacPhail and Campbell (2001) conducted a study in Khutsong Township South West of Johannesburg, South Africa. The study confirmed that the members of the township were aware of HIV and they accumulated the information from media, school, peers or parents. However, there were conflicting views in the community on the vulnerability to HIV infection. Some people denied the presence of AIDS-related deaths, arguing that HIV/AIDS was not present in their location. This implies that even though other people are aware of HIV, they still feel not susceptible to the epidemic. That is why there is a need for HIV prevention interventions to adopt behaviour and social change communication to fight against HIV infection by exposing and explaining if people in a particular context are vulnerable to the epidemic. Then distribute information of the available methods to fight against the incident of HIV infection.

Khidir, Psaros, Greener, O’Neil, Mathenjwa, Mosery, Moore, Harrison, Bangsberg and Smit (2018) conducted a study on developing a safer conception intervention for men aged 20- 45 years living with HIV in KwaZulu-Natal province, South Africa. The authors developed an educational cognitive behavioural therapy intervention involving three core sessions and two follow-up sessions with HIV positive men to engage them in reproductive health. The interventions introduced a comprehensive education on safer conception strategies, encouraged the men to adopt an explicit plan to implement safer conception strategies and practice behavioural skills training to support the men on their journey to begin implementing healthy baby plan. The study demonstrated that the men were enthusiastic for reproductive health programming and showed interest in modifying their HIV-risk behaviour to protect their new-borns from contracting HIV. Furthermore, they valued the environment of privacy at clinics and felt it was conducive for participating in safer conception counselling. This proves that communication campaigns aimed at behaviour and social change can eliminate the spread of HIV. The targeted population should be engaged in planning and their inputs be considered.

Strategic communication is crucial in HIV prevention. Information, behavioural and motivational (IBM) skills model was introduced in a school- based programme to reduce HIV risk behaviour among 259 grade 11 learners in two high schools in Alexandra township and Johannesburg, South Africa. The IBM model was implemented in the schools for multiple times, this resulted in the learners to have positive attitudes on acquiring HIV information and they gained lot of knowledge.

The improvement involved awareness on how HIV is transmitted (Ndebele, Kasese-Hara and Greyling 2012).

A study which involved HIV positive people who participated in an HIV stigma programme within North West province, South Africa. The study involved 18 participants aged 27- 52 years and living with HIV. Social and behaviour change communication was considered as far reaching, complex and powerful in influencing people's health behaviour since they are responsible for making daily decisions about their health. Furthermore, it was noted that social and behaviour change communication holds the key to people's immediate, prolonged life or death outcomes (Chidrawi, Greeff and Temane 2014).

The following discussions explain how strategic communication is designed and implemented to motivate people towards adopting a certain behaviour, is discussed. In this case, the desired behaviour is HIV testing to prevent the epidemic from spreading.

3.4 Key element guide to design and implement a strong programme

3.4.1 A systematic approach

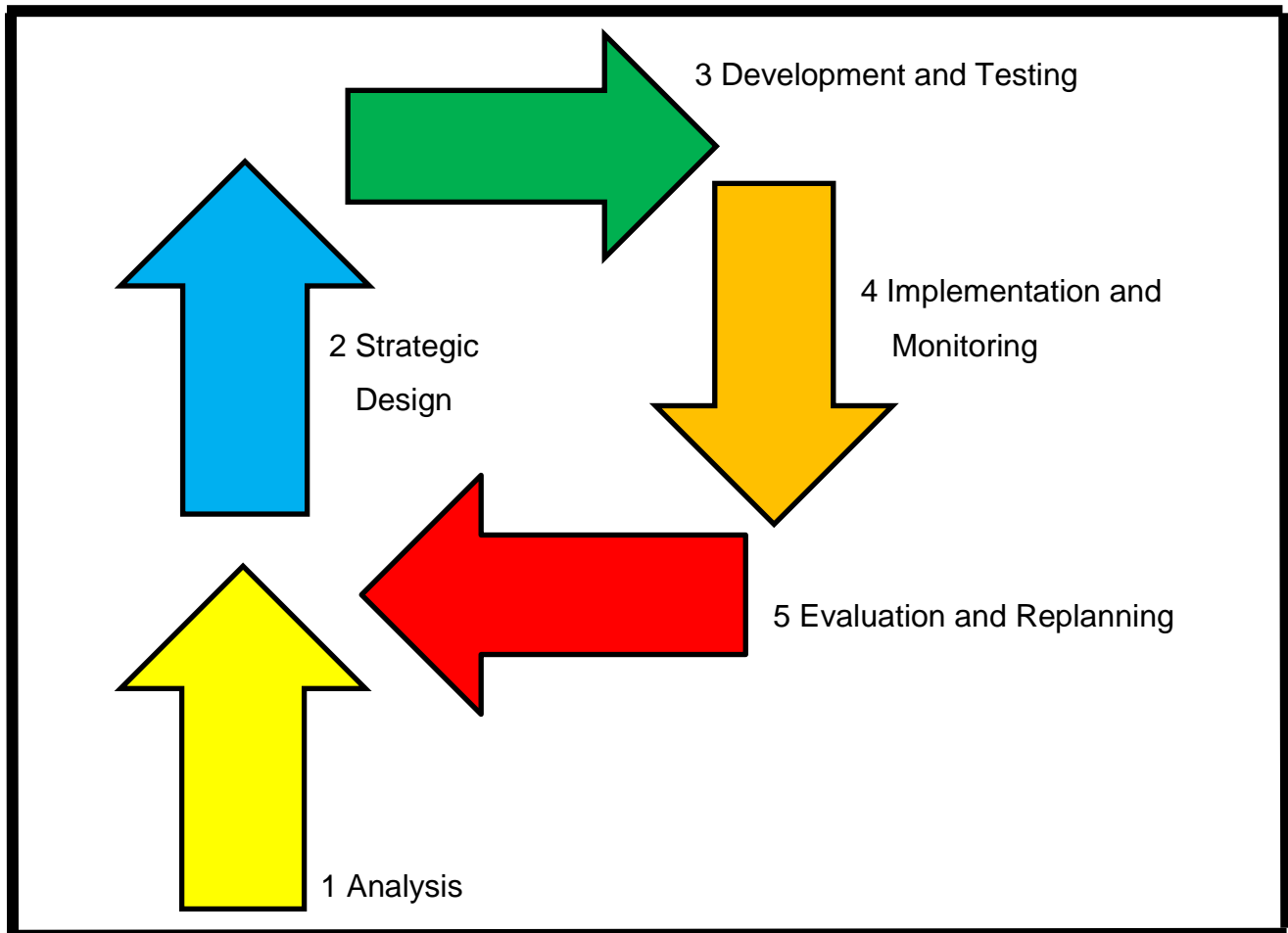
Many programmes currently use the systemic approach to design and implement interventions of social and behaviour change communication. Systematic approach refers to a sequence of steps used to guide the planning and implementation of a programme in which the elements of the design and execution are interspersed with data collection and analysis that inform decision making. The Centre for Communication Programmes at John Hopkins Bloomberg School of Public Health has promoted the P-Process model as a useful model to guide planning and

implementation of health promotion programmes (McKee, Bertrand, Becker-Benton and Becker 2004).

3.5 The P-Process model

The P-Process model was developed in 1982 (Johns Hopkins University 2014). According to Johns Hopkins University (2013:4), the P-Process model serves as “a tool for planning strategic, evidence-based health communication programmes”. The letter ‘P’ of the P-Process model stands for planning. Many communication scholars used the P-Process model to design, implement, evaluate innovative and creative behaviour change communication strategies and programmes aimed at reducing the incident of HIV infection, reproduction health, prevent the spread of transmittable diseases and reduce maternal mortality (Johns Hopkins University 2014). Hence in this study, it was used to explore how the health promoters’ designed and implemented the Universal Test and Treat (UTT) programme to motivate students to voluntary test for HIV as that is one of the programme’s objectives to reduce HIV transmission (Department of Health Province of KwaZulu-Natal UTT 2016).

The P-Process model



Source: The New P-Process Steps in Strategic Communication (2003)

The P-Process model is one of the most respected tools used in designing Social and Behaviour Change Communication (SBCC), stakeholder participation and continuous capacity strengthening. It functions as a step-by-step framework designed to guide communication professionals as they develop strategic communication programmes (The New P-Process Steps in Strategic Communication 2003). It serves as a step-by-step road map that leads communication professionals from a loosely defined concept about changing behaviour to a strategic and participatory programme with measurable impact on the intended audiences (The New P-Process Steps in Strategic Communication 2003).

The P-Process model consists of five steps, namely: inquire, strategy design, create and test, mobilise and monitor, and lastly, evaluate and evolve. It is important to

recognise that the P-Process model can be used as an implementation process, also as a research process to understand and assess the effectiveness of an intervention/HIV strategy (The P-Process 2013). It is key to design a successful communication strategies aimed at strengthening public health worldwide (The New P-Process Steps in Strategic Communication 2003).

Burleigh and Kalscheur (2012) assessed the used of social and behaviour change communication (SBCC) for HIV prevention in Namibia. The first step involved an assessment of behavioural aspects of the epidemic and SBCC efforts of organisations working in HIV prevention with young and adults in work environment, schools and communities, as well as national prevention campaigns. The assessment showed that there was no positive behaviour changes related to the prevention of HIV as was expected. The SBCC approach was remarkably successful in improving knowledge of HIV prevention rather than changing behaviours and social norms. Second, the SBCC approaches used were aimed at reaching large audiences through posters, handouts and group mobilising. It was noted that these approaches were effective in changing knowledge but less effective in encouraging interaction on changing behaviour and social norms.

Furthermore, the assessment of HIV prevention programmes further portrayed that there should be focus on behaviours such as abstinence, delayed sexual debut, low and inconsistent condom usage and low rates of HIV testing. For SBCC to be implemented effectively, it was proposed that there should be rapid assessment to find significant weaknesses so the field staff could ensure quality of SBCC (Burleigh and Kalscheur 2012). This finding proves that social and behaviour change communications should be assessed, especially when adopted in HIV prevention, to discover weakness and come-up with effective strategies to ensure quality.

In a study on peer education, gender and the development of critical consciousness: participatory HIV prevention by South African youth (Campbell and MacPhail 2002). Peer educators have two tasks, first is to educate the youth about HIV epidemic and teach them about the importance of being HIV negative. When HIV prevention programmes are implemented, the people felt that the peer educators suggested that they are HIV positive and this made it difficult to remain motivated.

Continuation from the above study by Campbell and MacPhail, the authors examined peer education programme factors they believed to limit the development of youth's HIV prevention in school settings. It was found that peer educators lessons omitted social content of sexuality or the impact of gender relations impact the use of contraceptives. However, there was a smooth discussing about sexual intercourse, but not on same sex gender because the peer educators had no knowledge on that aspect. Further, the male peer educators were dominant, taking decisions and left the females feeling bullied when challenged their male colleagues (Campbell and MacPhail 2002).

3.5.1 Step 1=inquire/analysis

This step requires formative research with the targeted audience. The aim is to gather knowledge, attitudes, beliefs and the reasons why the targeted participants would participate on a programme. The designers and planners have to study the demographic, sociological, economic, epidemiological and other relevant aspects of their targeted population. This helps to acknowledge what the audiences already know. Then, assess the policies and programmes that are put in place. Further, to learn about the active and available communication channels. Making sure all viewpoints are presented in all gender differences and note down the understanding of the problem statement (The P-Process 2013).

The analysis step is concise. The important aspect here is the problem statement, the people involved, their culture, existing programmes and policies, and the available communication channels. The analysis takes place in two formats, the situation analysis and audience/communication analysis. The situational analysis results in an in-depth description of health and development programmes to be addressed. It determine the issue at hand and the causes of problems, seek factors to inhibit or facilitate the desired changes, establish problem statement and gather the audiences' needs and priorities. On the other hand, the audience/communication analysis carries out a detailed audience and communication analysis. This includes participatory analysis, social and behavioural analysis and, assessing the

communication and training needs (The New P-Process Steps in Strategic Communication 2003).

3.5.2 Step 2=design your strategy

It is the creation of a plan that helps achieve the intended goal. This includes audience segmentation, communication objectives, programme approaches, recommended channels, a work plan, monitoring and evaluation plan (The P-Process 2013). The strategic design follows the following steps; 1) establishing communication objectives. The objectives should be specific, measurable, appropriate, realistic and time-bound (SMART). 2) Development of the programme approach and positioning. This allows choosing a behaviour change model that is suitable for the programme, then states the underlying assumptions and approach, give an explanation on why and how the programme is anticipated to bring health behaviour and position the programme to benefit the audience. 3) Determining the communication channels and selecting the appropriate one for the targeted audiences. 4) Development of an implementation plan, it helps to have a work schedule to monitor progress, knowing all those who are included and that they are aware of their roles and responsibilities. 5) The last one is monitoring and evaluation plan. It is useful to monitor the programme implementation and audience reaction to it and, measure the design outcomes and assess the impact (The New P-Process Steps in Strategic Communication 2003). In this study, the researcher explores if the health promoters uses communication channels which are suitable to the all the targeted audience, using languages which they will understand and motivate them to take part in the Universal Test and Treat policy.

3.5.3 Step 3=Create and test/Development and testing

This step consists of developing concepts, messages and participatory processes. The objective is to be creative to evoke the emotions of the audiences. Four things to be kept in mind.1) development of guidelines, toolkits, manual for counseling, job aids for service providers and so on.2) Testing of concepts with stakeholders and representatives of the audiences to be reached.3) Revise to allow to make changes based on the pretest results.4) Retest to ensure revisions are done well and make

final adjustment (The New P-Process Steps in Strategic Communication 2003). This step allows for testing the proposed plan before the execution, this is meant to prevent failure and overcome challenges that might occur. (The New P-Process Steps in Strategic Communication 2003).

3.5.4 Step 4=Mobilise and monitor/Implementation and monitoring

Implementation is meant to emphasis maximum flexibility, participation and training, while monitoring includes making sure all activities are executed as planned and unwanted problems are identified and addressed as quickly as possible. The following tasks needs to be executed; 1) produce and disseminate, it consists of developing and circulate the plan to all the stakeholders and involving maximum media coverage. 2) Training of trainers and field workers; 3) mobilising key participants; 4) manage and monitor programme; 5) adjusting the programme based on monitoring (The New P-Process Steps in Strategic Communication 2003). This helps focus on how the health promoters disseminated their messages to invite the participants and how effective was the communication channels to grab the audiences' attention.

3.5.5 Step 5=Evaluate and evolve/Evaluation and replanning

This step measures how well a programme achieves its intended objectives. It provides full explanation on why a programme is effective or not. The first task in this step is to measure the outcomes and assess impact; that is to determine if the desired change has occurred in the attitude, knowledge and behaviour among the targeted audience. Then determining the results; making sure everyone involved in the programme to be aware if the programme was positive or not. Then determine the future needs; noting down what to be done in the future to improve the programme. Last task is to revise/redesign programme; that is a good evaluation will show if the programme implemented was weak or where it needs revision in design processes, material or the entire strategy (The New P-Process Steps in Strategic Communication 2003).

In this study the P-Process model was used in the conceptual framework for these three following reasons; 1) to formulate questions that intended to explore how the Universal Test and Treat is implemented to increase HIV testing among students and staff members at the University of KwaZulu-Natal, Howard College Campus; 2) to assess the HIV testing participation from the year 2017 and 2018.

The application of the P-Process model in this study was because it is used as a tool to design social and behaviour change communication. It functions as a step-by-step framework designed to guide communication professionals as they develop strategic communication programmes (The New P-Process Steps in Strategic Communication 2003). The P-Process develops and address public health programmes through health communication. This involves programmes such as aimed at preventing infectious diseases, including HIV (Health Communication Capacity Collaborative 2013). Hence, the model was crucial to explore the effectiveness of the implementation of UTT policy in reducing or eliminating the spread of HIV infection at the University of KwaZulu-Natal

3.6 P-Process model in health communication

Onigbanjo-Williams and Iwuagwu (2015) used Delphi Technique and the P-Process model to successfully assess the health communication programmes implemented in Nigeria. Their survey was useful to provide insights at that current state and future strategies to strengthen health communication programmes in the country. When assessing the technical and knowledge capacity, Onigbanjo-Williams and Iwuagwu were able to identify the limitations and challenges faced when implementing health communication programmes. The findings were crucial for strengthening the design and implementation of future health communication programmes.

Moreover, the limitations found when using the Delphi Technique and P-Process model were low capacity in the implementation of programmes, not enough financial resources and poor execution of health communication programmes. Health communication programmes should be able to raise funds for better design and implementation and apply good communication skills. There is a need to transform

and strengthen collective and a collaborative effort to implement an effective health communication programmes (Onigbanjo-Williams and Iwuagwu 2015).

In this study, the P-Process model came after considering the t advantages which are aligned to the achievement of the aim of this study. The P-Process model provided steps to explore the design and implementation of the policy in persuading and motivating the health promoters' target to participate in HIV testing.

3.7 Conclusion

This chapter discussed the importance of P-Process model to explore how the health promoters implemented UTT policy at Howard Campus. Furthermore, it explained the P-Process model's origin, development, constructs, advantages and disadvantages, and most importantly, how it has been selected to yield the desired outcomes of the study. The theoretical framework is used as a lens to gather and interpret the collected data. Furthermore, this process had to be aligned with the methodology of the study to achieve or answer the mentioned research questions.

CHAPTER FOUR

Methodology

4.1 Introduction

This study focuses on a health promotion implementation, the Universal Test and Treat (UTT) policy, which the World Health Organisation (WHO) proposed as a global strategy aimed at reducing the incident of HIV infection and might, potentially, eliminate HIV infection as a major public health problem (WHO 2018). This chapter describes the methodological approach and methods utilised to conduct the study. It critically engages with previous studies within the field of health communication to draw lessons and comparisons. The chapter further provides an overview of methodological approaches used by distinct researchers in the field of health communication to address HIV infection in South Africa. Of importance are regions where the population is highly vulnerable to HIV infection such as the province of KwaZulu-Natal (Department of Health Province of KwaZulu-Natal UTT 2016).

The following table provides a logic guide line of the study methodology.

4.2 Methodology map

Methodology Map	
Epistemological assumption	Interpretive tradition
Theoretical perspective	Qualitative
Research design	Case study
Sampling technique	Nonprobability sampling Purposive sampling
Data collection	In-depth or semi-structured interview Focus group discussion
Data analysis	Thematic analysis

According to Govender cited in Tomaselli (2018), methodology serves as an engine of a research/project and it enables the researcher to study reality. Tomaselli (2018) describes methodology as the section which narrates the journey undertaken to complete a project. The narrative clearly describes the rationale for the selection of certain courses of actions and seeks to enable the readers to make full sense of the research, including the context as well as the circumstances under which it was undertaken.

Before discussing the procedures taken to collect data of this study, it is vital to first declare the position of the researcher as this helps understand the presentation and analysis of the findings. This is essential for the reader to understand how the researcher view reality, read the collected data and discuss it to contribute to the body of knowledge. The position of the researcher was interpretive, that is one of the epistemological assumptions.

4.3 Epistemological assumption

Epistemology is a term coming from the Greek word Episteme (Trochim 2000) that relates to how we come to know reality.

According to Coll and Chapman (2000); Cousins (2002), epistemology raises questions such as what the relation between the knower is and what is known? How we get to know what is known? What we deem as knowledge. There are several epistemological assumptions, such as positivist, transformative, pragmatic and so forth. However, this study employs interpretive tradition.

4.4 Interpretive tradition

Neuman (2013) noted that interpretivist worldview aim to study social action with a purpose. This makes it possible to learn a person's reasons or motives which shape his/her feelings and guide decision making to behave in a particular manner.

Since the aim is to explore the effectiveness of the implementation of Universal Test and Treat (UTT) policy in reducing or eliminating the spread of HIV infection at the University of KwaZulu-Natal, Howard College Campus. Being interpretive allowed the researcher to explain how the UTT policy was implemented. Furthermore, to explain the participation in HIV testing by looking at the statistics of people who tested.

4.5 Research approach

This study made use of the qualitative approach to explore the implementation of the UTT policy. A qualitative approach helped gather data in words. This would help the researcher to explore the health promoters' steps adopted when implementing the policy in depth, openness and in details. The researcher's decision on the approach should be the philosophical assumptions of the study; procedures of inquiry or design and specific research method for data collection, analysis and interpretation (Creswell 2013). Terre Blanche, Durrheim and Painter (2006) noted that qualitative research allows the researcher to explore selected issues in depth, openness and detail.

Moreover, a qualitative study aims to answer questions of why things are the way they are and how they came to be like that (Babbie 2007). Similarly, Burns and Grove (1998:35) identify "qualitative research as inductive, holistic, emic, subjective and process-oriented methods used to comprehend, interpret, label and develop a theory on a phenomenon or a setting and is a systematic, subjective method used to describe life experiences and give them meaning". In addition, Denzin and Lincoln (2011) stated that the word qualitative suggests an emphasis on qualities of entities and meanings that are not experimentally examined or measured in terms of quantity, intensity, amount and frequency.

Certain researchers who conducted their studies on health promotions with the intention to explore the health promoters' perceptions and experiences when designing and implementing interventions to reduce the incidence of HIV infection used qualitative approach. This incorporates the work of Peu and Mthobeni (2013) and Kolisa (2016). Peu and Mthobeni adopted the qualitative approach in their study to explore and describe the challenges met by health promoters whilst rendering

health promotion in certain communities. The approach is useful to collect rich descriptive data from the participants (Peu and Mthobeni 2013). Kolisa (2016) utilised the qualitative approach when conducted a study to assess oral health promotion services offered as part of mental and child health services in the Tshwane Health District, Pretoria, South Africa.

Mutinta *et al.* (2012) conducted a study to explore determinants of students' sexual risk behavior at a South African university. Their study made use of the qualitative approach. By applying the qualitative approach, the study was able to identify factors leading to students' sexual risk behavior. Nota (2015) also employed the qualitative approach in a study based on HIV prevention at the University of KwaZulu-Natal. However, the approach was limited to gather preliminary findings then a quantitative approach was also employed to the study and that resulted to a mixed method approach.

The reasons this study relied solely on a qualitative approach was because the research questions were open-ended questions intended to gather intentions, motivations and experiences from the participants. The following are the research questions asked to gather answers when conducting this study.

1. How is the UTT implemented by the health promoters, nurses and peer educators, to increase HIV testing among students at Howard College?
2. Which communication strategies are used to attract people to participate on the UTT policy?
3. What is the state of progress in HIV testing within Howard campus?

4.6 Research design

Research design refers to the plan of the study and the what, how and why of data production. It is necessary for the design to be appropriate to the research questions. The design and questions should be tailored to meet the intended study goal and objectives (Green and Thorogood 2004). In most cases, qualitative studies involve a language of cases and contexts, interpretations or meaning of a specific cultural

group, examine social processes and cases in their context (Neuman 2013). This study utilised a case study design.

Case study design is adopted to identify a form of inquiry which is on experience or social survey. It allows the researcher to gather rich amount of information pertaining the case studied. The information could be of an individual, an event, an institution or a national society. A case study refers to a research that is undertaken to investigate few cases or one in considerable depth. The role of the researcher is to construct cases out on naturally occurring events or social situations and implies qualitative analysis of the data. It is argued that case study design aims to capture cases in their uniqueness, rather than generalisation or developing a theory. Case study designs are good to study humans within their context (Gomm, Hammersley and Foster 2000).

The adoption of case study design was useful because the present study explored the implementation of the Universal Test and Treat policy which is an event that took place at the University of KwaZulu-Natal, Howard College Campus. Further, case study was crucial to understand the health promoters' experiences on the policy implementation.

According to Yin (2014:13), "case study designs are the preferred strategy when 'how' or 'why' questions are being posed and the investigator has little control over events and when the focus is on a contemporary phenomenon within some real-life context". Meaning, case studies are suitable to examine current events, while the relevant behaviours of the participants cannot be manipulated. Gerring (2007:17) stated that a case study research employs "triangulations-which are multiple sources of evidence or that the research investigates properties of a single phenomenon".

Case study design produce complex explanation or interpretations in a form of an unfolding plot or rather a narrative story about an event or people. The timing becomes vital to the explanation. Much emphasis is on the sequence of events; that is what occurred first and what followed. This helps to understand how an issue evolves, a conflict emerges or a development of a social relationship (Neuman 2013). The current study was based on an event that was taking place when the

researcher conducted the study. The study was conducted on a real-life context. The two case study design question which are the 'why' and 'how' led to the answers on why the health promoters implemented the policy at the university and how the policy was implemented.

Welman, Huysamen, Kruger and Mitchell (2005) noted that a case study research is used to understand something new and something difficult or not easy to understand in nature. On the current study, case study design was essential to understand the health promoters' motivation and experiences on their selection of the communication channels, language used and other means of attraction. Then explore if these reached and grabbed those audiences intention. Furthermore, to assess the UTT policy's progress in increasing participation in HIV testing on campus.

Case study designed is used in this study because it allows gather depth information about the Universal Test and Treat policy, an event or programmes implemented on natural environment. Further, this study used qualitative approach and the case study design is one of the designs in qualitative approach. To explore the implementation of the UTT policy and find the intentions and motivation to adopt the policy was better understood using the case study design.

University of KwaZulu-Natal, Howard College Campus, had approximately 30 health promoters at the Campus HIV/AIDS Support Unit, including university students. From the 30 peer-educators, the researcher proposed to include 10 peer educators to participate in the study. The selection was going to be based on their experiences on the Universal Test and Treat implementation as well as their participation from the year 2016 when UTT was introduced in South Africa till 2018 the year which the data was collected and the study was completed. The selection also depended on the available number of the participants who were willing to participate since participation in the study was voluntarily. The targeted participants had the right to withdraw from the study whenever they felt like doing so and there was no punishment nor did negative implementations put in place to affect or jeopardise their work or careers.

At first, the researcher intended to assess participation in HIV testing from the year 2016, when the UTT was first implemented in South Africa till 2018 where this study is conducted. However, because of the findings that the UTT was first implemented at the University of KwaZulu-Natal in 2018. This resulted in assessing participation in HIV testing from the year 2017 and 2018.

4.7 Population and sampling

According to Bless, Higson-Smith and Kagee (2006), the population refers to the entire set of objects or people the researcher wants to determine certain characteristics. Similar to Welman, Huysamen, Kruger and Mitchell (2005) a population is made up of the study object and it involves a person, a group, an organisations, human products and events or conditions which people are exposed to. The research problem needs to relate to the population and that the population encompasses the total collection of all units of analysis about which the researcher wishes to make conclusions. Neuman (2013:241) “the population is an abstract idea of many cases which a researcher draws a sample from and to which the results from the sample are generalised”. The population of this study was the health promoters of the Universal Test and Treat policy.

Sampling refers to “the selection of a subset of a population for inclusion in a study and if it is done properly, it provides valid, reliable, useful results and at the same time save money, time and effort” (Daniel 2012:1). Moreover, sampling should clearly identify inclusive and exclusive criteria for participation in the study and there should be reason for inclusion and exclusion of the elements (Daniel 2012). Additionally, sampling is done to avoid two types of possible sampling mistakes; the first mistake is to conduct sampling in a sloppy or improper manner. In order to avoid this from happening, the researcher needs to be meticulous and systematic during the sampling process. Then the second mistake is choosing a type of sample which is inappropriate for the study’s purpose. To avoid this, the researcher needs to choose a sampling strategy that matches the study’s purpose and data to answer the research question (Neuman 2013).

The population of the study was the university nurses and peer educators, this led to two categories of the sampling criteria. The first sampling category incorporated the health practitioners/nurses and the second category was the peer educators. The reason for choosing these two groups was because they all worked together on the implementation of the Universal Test and Treat policy at the university. They all played a critical role and it would be indispensable for the programme to be executed without the presence or involvement of each of these groups. They possessed different skills and expertise required for the programme to be executed smoothly.

On the selection criteria for the peer educators, the researcher proposed to adopt purposive sampling. Purposive sampling is a non-probability sample utilised based on the characteristics of the population as well as the objective of the study. This sampling is also known as judgmental, selective, or subjective sampling. Moreover, there are seven types of purposive sampling, however, expert sampling was intended to be used for this study. The critical aspect of expert sampling is that it is used when a researcher seeks knowledge from experts in the topic of study (Crossman 2018).

Nevertheless, what was proposed at the beginning of the project was never achieved. The selection criteria for the peer educators completely changed when the data was collected. This was because of several postpones and unavailability of the peer educators to participate. Many of the peer educators were students, it was hard to get in touch with them and agree on a particular date to meet. They raised issues such as having too much work, had to read and prepare for tests, writing assignments and so for. This delayed the data collection process for one month and two weeks. The hope for meeting all targeted participants was lost and the intention of finishing the project within the anticipated time period was in doubt.

After that long delay, the peer educators happened to have one last programme which they had to implement on campus. This became the only opportunity to meet the peer educators and collect data. The peer educators' leader proposed that we meet after their last programme and they were all told to remain behind. After their programme which lasted long hours than expected, many of the peer educators refused to remain behind and to participate in the study. Some of them said they

were using the university buses (which operated on a fixed schedule) to get home and they had to leave, others said they had to go prepare for tests, write assignments and so on. This led to the inclusion of nine peer educators (five males and four females) who sacrificed one hour of their precious time. The proposed selection criteria was never employed and none of the peer educators had more than one year experience in the Universal Test and Treat policy implementation since it began to be implemented at the university in the year 2018.

4.8 Data collection

Table: Data collection

Data collection				
Sample	unit	Age	Location	Objectives
Two separated Semi- structured interviews	Two nurses	30-45 years	UKZN Wellness Clinic	Implementation of UTT. Mobilising strategies. Motivation to encourage HIV testing. Challenges and perceptions to improve UTT.
One Focus group discussion (FGD)	Nine peer educators	20-30 years	CHASU	Motivation to implement UTT. Design and implementation process. The targeted population. Challenges and opportunities of UTT.

This study used two qualitative data collection tools, two semi-structured interviews and one focus group discussion to generate data from the targeted population in order to explore how the UTT policy was implemented to reduce HIV infection by health promoters through expanding prevention and treatment preferences at the University of KwaZulu-Natal, Howard College campus.

Two semi-structured interviews were conducted with two health practitioners (nurses) from the University of KwaZulu-Natal, Howard College Campus Wellness Clinic. A semi-structured interview falls under qualitative data collection strategy, it allows the researcher to ask informants a series of predetermined but open-ended questions. The advantage is that researcher has more control over the topics to be discussed of the interview than in unstructured interviews (Ayres 2008).

The reason for interviewing only two nurses was because there were few nurses at the clinic and only two of them took part in the Universal Test and Treat (UTT) policy implementation. Those two nurses who assisted in the UTT implementation, the first one was responsible for HIV testing and the second one was responsible for HIV counseling, either pre-counselling or post-counselling. According to Welman, Huysamen, Kruger and Mitchell (2005), if the population is the targets for acquiring data for the study, they become the unit of analysis. Therefore, having those two nurses assisted in collecting certain data meant to answer the research questions.

Both of the nurses were females and there was no balance in gender selection. The gender representative among the unit of analysis is called sample statement (Welman, Huysamen, Kruger and Mitchell 2005). The two female nurses worked in the implementation of the UTT policy. As a result, the sampling criterion was non-probability sampling technique which is availability sampling. An availability sampling is a “non-probability sampling procedure in which elements are selected from the target population on the basis of their availability and convenience to the researcher” (Daniel 2012:82). Neuman (2013) noted that availability sampling is also called accidental, convenience or haphazard sampling. Furthermore, the age, race and work experience selection was not considered as the participants were already been selected based on their availability and relevance to the study.

Two semi-structured interviews were conducted with the two health practitioners/nurses, during their work hours at the university Wellness Clinic. Two separate dates were selected to interview each interviewee in a specific day. The interviewees chose the specific dates and time for the interviews. This was because they were unable to participate during their lunch time or when finished working. The researcher had to ask the director at the Wellness Clinic to replace the nurses on their duties when they participated in this study for semi-structured interview. Conducting interviews with the nurses took a long delay. There were times when we had to postpone the interview schedules because of various reasons, such as emerging meetings, work overload, closing of the clinic during holidays.

Semi-structured interviews are useful to gather data that involves human actions, interactions, behaviour and how they result from and impact one another (Babbie 2007). According to Green and Thorogood (2004), interviews are data collection methods to produce data in qualitative health research. During the interview process, the researcher sets the agenda in terms of the topic and questions to be answered, but the interviewee's responses determined the kinds of information produced about those topics. The interview allows interviewees to have plenty of time to develop their own interpretations of the issues important to them. Moreover, interviews are crucial when trying to understand human behaviour and ask open-ended question. Mitchell and Jolley (2012:487) stated that "open-ended questions require essay or long answers and the respondents are free to respond with their own words". The authors further identified two advantages for semi-structured interview; firstly, it avoids putting words on the participants' mouth. Secondly, it finds out the beliefs or opinions on the respondents' answers (Mitchell and Jolley 2012). The rationale for choosing open-ended questions in this study was to allow the interviewees to discuss and elaborate their experiences and perceptions in relation to the questions being asked. Both the semi-structured interviews were recorded using a smart device. Only the voices of the participants and the researcher were recorded.

The researcher had 30 minutes to interview each of the nurses and all the data was collected through recording. There was enough time for both the interviewer and interviewees to ask questions, rephrase it if necessary, provide information and

create a smooth interview as possible. While the interviewee had the chance to decode the questions being posed, generate and provide accurate answers. More importantly, the interview processes were a form of learning to the researcher as he had to learn new clinical terms and collect the intended data of the study.

The rationale for choosing semi-structured interviews to obtain data from the two nurses was because of the following reasons. First the questions asked were the same for both nurses, and the aim was to gather their different experiences, intentions and motivation. The information collected was sensitive. Then, the semi-structured interviews made it easy for the interviewees to discuss and elaborate their experiences and perceptions regarding the questions asked. Then, to understand each of the interviewees' verbal and non-verbal communication response.. Lastly, the interviewees had to be conducted at the nurses' work place, on a separate time schedule because they had to be replaced on their duties as nurses to take part in the study.

The researcher also conducted a focus group discussion with the peer educators, which occurred once and lasted for one hour. After the focus group discussion the participants were served with refreshments, juice and biscuits. They all appreciated the refreshments and were joyful. This was not meant to force the targeted participants to partake in the study, they had the option to deny or withdraw from the study at any point without any consequences.

The focus group discussion was used to collect data from the peer educators. Focus group discussion is an advantage in a way that it offers an opportunity to observe a large amount of interaction from various individuals in a certain topic at the same time. Focus group discussions do not only generate information, but also answer questions (Morgan 1997). Focus group discussion allows a researcher to gather data from a group of people gathered within one context in a manner that is very quick and cost effective rather than interviewing individuals separately. They provide opportunities for clarification of responses, follow-up questions and for the probing of responses. It opens a platform to receive participants' experience in their own words and the researcher can observe the nonverbal responses such as gestures, frowns,

smiles which supplements the verbal responses (Stewart, Shamdasani and Rook 2007).

One focus group discussion was conducted with nine (9) peer-educators. The nine peer educators were between the ages of (20-30) years. Five of them were males and four females. The focus group discussion was conducted at University of KwaZulu-Natal Campus HIV&AIDS Support Unit (CHASU) on the 10th of October 2018, from 15:00 till 16:00.

The focus group discussion instruments incorporated open-ended questions which required essay or long answers for the participants to discuss and share their experiences. According to Struwig and Stead (2013), participants use their own words when the researcher asked open-ended questions. All the participants of this study were given a fair chance to participate through verbal discussion on their experiences and perceptions answering the open-ended questions asked. The research topic was on the peer educators planning, designing and implementation of the Universal Test and Treat policy which they occasionally implemented to motivate and test HIV among the university students and staff members.

Focus group discussion was used to collect data from the nine peer educators. It became an advantage in a way that it offered an opportunity to observe a large amount of interaction from the various participants discussing one topic at the same time. The researcher managed to gather data from a group of people gathered within one context in a manner that is very quick and cost effective rather than interviewing individuals separately. There were opportunities for clarification, follow-up questions and for the probing of responses. The researcher was able to observe the nonverbal responses such as gestures, frowns, smiles which supplemented the verbal responses. If it was not for the focus group discussion, the researcher would have failed to meet the peer educators separately and have enough time to collect data as they were hard to reach.

The researcher read and explained the consent form to the participants before the interview and focus group discussion began. The researcher used IsiZulu and English when collecting data. The researcher and the participants were able to

understand and speak these two languages fluently. The two languages made it easier for the data collection to be smooth and without a translator. The interviews and focus group discussion was recorded using a smart device. Only the voices of the participants and the researcher were recorded.

Vukapi (2015) noted that qualitative studies include any information that can be captured which is not numeric in nature. The two semi-structured interviews and one focus group discussion was vital to explore the implementation of the UTT policy and, the experiences and motivation of the health promoters. The data that was collected using the mention two qualitative data collection tools, then analysed and interpreted using thematic analysis.

4.9 Data analysis

In qualitative research, the process of data analysis does not begin after data is collected, however, it initiates before then once the data is collected it becomes a continuous process. Further, data analysis is about interpretation of the collected data for drawing conclusions that reflect on the interests, ideas and theories that initiated the inquiry (Babbie, 2007). Bless, Higson-Smith and Kagee (2006) argued data analysis is conducted with the aim to detect consistent patterns of the data, such as the consistent of two or more variables.

The conceptual framework was useful and suitable to this study. The adoption of the Theory of Reasoned Action and P-Process model came after considering the theory and model constructs and advantages which are aligned to the achievement of the aim of this study. The theory explained perceptions and motivations of promoters on how to improve the implementation of the policy in the future. Meanwhile, the P-Process model provided steps to explore the design and implementation of the policy in persuading and motivating the health promoters' target to participate in HIV testing.

This study employed an interpretive thematic analysis. Thematic analysis is a qualitative research analyses tool which involves looking through the data that is collected to identify any ideas, words that are recurring. This allows the researcher

to group the ideas into themes and discuss further. This method enabled the researcher to understand and interpret the collected data. The thematic analysis was adopted to analyse data collected from the two groups of participants, which were the nurses and peer educators.

This study employed Braun and Clarke interpretive thematic analysis and its six phases. The researcher created the themes from the data collected from the health promoters. The themes were created in relation to the research questions, key ideas from the data set which portrayed patterned response that led to the answering of the research questions, recurrence and ideas which gave description of the data set, so that the reader could understand the findings.

4.10 Interpretive Thematic analysis

Phases of Thematic Analysis	
Phase	Description of the process
Familiarise yourself with data	Transcribing data (if necessary), read and re-read the data, jotting down key ideas.
Generating initial codes	Coding only interesting features of the data in a systematic fashion across the entire data set, collating data which is relevant to each code.
Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
Reviewing themes	Checking in the themes work in relation to the coded extracts and the entire data set, generating a thematic map of the analysis.
Defining and naming themes	Ongoing analysis to refine each theme and the overall story the analysis tells, generating clear definitions and names for each theme.

Producing the report	The final opportunity for analysis. Selection of vivid, compelling examples, final analysis of selected extracts, relating to research question and literature, producing a scholarly report of the analysis.
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Source: Braun and Clark (2006:87)

According to Attride-Stirling (2001), data analysis helps evaluate research and compare or synthesise it with other studies in similar topic. Rubin and Rubin (2011) noted that data analysis leads to discovering themes and concepts embedded through the collected data.

Moreover, themes reside in the researcher's mind as she/he thinks about the data and creating links for the reader to understand (Anzul, Downing, Ely and Vinz 2003). "Thematic analysis differs from other data analysis methods such as thematic decomposition analysis. Thematic analysis reflect reality and to unpick or unravel the surface of reality" (Braun and Clarke 2006:81). The Keyness of a theme does not only depend on recurrence of an idea (Clarke and Kitzinger 2004). "A theme captures something important about the data in relation to the research question and represent level of patterned response or meaning within the data set" (Braun and Clarke 2006:82).

The following section discusses how the findings are being transformed to themes, using the six phases of thematic analysis by Braun and Clarke.

4.10.1 Phase one and two: Transcribing and coding

On these phases, the researcher transcribed all the data recorded during the data collection from the health promoters. They came-up with words to label the data. The data with similar or recurring information was then given codes. The researcher also used the study's research questions to develop other codes.

4.10.2 Phase three: Searching for themes

The themes of this study developed from the codes. By using the established codes the researcher created themes which seemed to be relevant to the study objectives. The themes interpret the finding of this study.

4.11 Validity of the study

Validity helps to establish the truthfulness, credibility or believability of findings (Neuman 2013). This should be a concern to all qualitative researcher while designing a study, analysing results and judging the quality of the study (Patton 2015). Validity in field research comes from your analysis of the data as accurate representations of the social world (Neuman 2013). In qualitative studies replication is not a criterion because the acquired information or experience cannot replicate and the unit of data collection or essential aspects of the field change. This means the social events or context change, the members could be different, the individual researcher differs and so forth (Golafshani 2003).

Qualitative research use terms such as credibility, neutrality or confirmability, consistency or dependency and applicability or transferability as a criteria for quality (Guba and Lincoln 1994). The terms dependability or confirmability are used to describe the idea of reliability, then credibility and transferability describe validity (Golafshani 2003). Dependability refers to the level or extent to which the research findings, to directly show what was found and using which data collection methods (Babbie 2007).

This study proposed to use scientific procedures throughout all the distinct phases of data collection to produce trustworthy and quality findings. The researcher followed all the above mentioned steps when collecting the data. Nevertheless, there was one slight change, which was the selection criterion for the peer educators to participate in the focus group discussion. The cause was out of the researcher's control and the option was to consider participants who were available and willing to participate in the study. The participants were part of the targeted population and their participation does not discredit nor disqualify the quality and trustworthy of this study. All the data was obtained through transparent and honest manner, following the academic research procedures and analyses using well known and suitable data analysis method.

4.12 Ethical consideration

The permission to conduct this study was given by the University of KwaZulu-Natal ethics committee on the 3rd of August 2018. Before conducting the two semi-structured interviews and focus group discussion, the researcher obtained gatekeeper letters to gain access to the University of KwaZulu-Natal Wellness Clinic and Campus HIV/AIDS Support Unit. The aim and the objectives of the study was explained to all the participants of this study. The participants were given a consent form which was clearly explained to them before participating in the study.

Each participant/interviewee, referring to the nurses, was given a stipend of R100 after participating in the study. This was meant to show appreciation for participating in the study as well as for fee for transport to get home since the participants happened to use the university buses to get home which are free of charge. The participants were not told about the stipend before they were interviewed, however they were alert that there will be a reward after the interviews on the consent form for participating in the study. They were not going to receive the reward if they decided to withdraw/cancel the interview process. The consent form, gatekeeper letter and ethical approval was sent via email to the nurses in one month before the interviews. The researcher found that both the nurses never read the consent form, before the interviews began, the interviewer read the consent form to the participants.

Emanuel, Wendler and Grady (2000) proposed seven requirements that systematically elucidate ethics of clinical research studies: 1) value-enhancement of health or knowledge derived from the research; 2) scientific validity; 3) fair subject selection and the potential for and distribution of risks and benefits; 4) favorable risk-benefit ratio, minimise risks and enhance potential benefits to individuals and knowledge gained for society; 5) independent review, the research must be review and approved; 6) informed consent, the participants must be informed about the research and be willing to voluntary consent; 7) respect for enrolled subjects, they should have privacy protected, opportunity to withdraw and their well-being monitored. The authors concluded that these ethics are universal, although they may change depending on the conditions which the research is conducted.

Providing stipend to the nurses was ethical and the following authors support the act of compensating research participants. Polacsek, Boardman and McCann (2017) conducted a study on ethical and practical consideration when compensating research participants. These authors aimed to review and discuss the ethical and practical considerations in regard to paying patient and caregiver participants in nursing research and propose a set of guiding principles pertaining payment of participants. The following table presents the few key consideration and guiding principles for compensating research participants by Polacsek, Boardman and McCann (2017).

Before the data was collected from the two groups of participants of this study a consent form was distributed to all the participants. The participants were given enough time to go through the consent form and ask questions were they needed clarity. The researcher also read the consent form to the participants and explained it using English and isiZulu before collecting data. The participants were asked if they were willing to voluntarily take part in the study. The choice of the two languages was because all the participants and the researcher knew the languages very well.

4.13 Conclusion

This chapter explained the methodology of the study. It explained all the reasons the researcher used the university health promoters as the participants of the study and the reason behind the samplings criteria and technique employed for data analysis. The chapter critically engaged with previous studies within the field of health communication and provided the overview on how other methodological approaches used in similar studies to eliminate and terminate the incident of HIV infection in various counties, including South Africa where this study was conducted.

Chapter five

Research findings and discussion on the implementation of Universal Test and Treat (UTT) policy

5.1 Introduction

This chapter presents findings which interprets how the health promoters implemented the Universal Test and Treat policy's promotion and communication strategies adopted to increase HIV testing at the university. Then assess if the communication strategies adopted were effective to motivate the university population to voluntarily participate in HIV testing. HIV testing is one of the UTT policy's objectives to reduce HIV infection (Department of Health Province of KwaZulu-Natal UTT 2016).

The findings are interpreted using an interpretive thematic analysis. According to Clarke and Braun (2013), interpretive thematic analysis is an essential method adopted in qualitative studies to identify, analyse and report patterns from the collected data. Moreover, it designs, organises and explains data in much rich details. It is also useful to interpret aspects of the research topic.

Following is a table that explains the themes that emerged from the data that was collected using the semi-structured interviews and focus group discussion. The table and rest of this chapter fall under the continuation of the six steps of thematic data analysis discussed in chapter four.

The table emerged after transcribing and reading the data collected from the health promoters. The table presents finding obtained when explored the implementation of the Universal Test and Treat policy. That was done using the P-Process model since it functions as a step-by-step framework designed to guide communication professionals as they develop strategic communication programmes (The New P-Process Steps in Strategic Communication 2003). By adopting the P-Process model, the researcher was able to explore the step taken to implement the policy at the university. To create questions intended to explore if the UTT policy was implemented using the step by step guide of the P-Process model. This resulted in collecting data which explored the implementation of the UTT policy. The researcher

created themes from the collected data and that is how useful the P-Process was for the study.

5.2 Phase four and five of thematic analysis: Reviewing, defining and naming themes

Reviewing	Defining	Naming
Initiation of UTT at UKZN	It involved the year which UTT was introduced at the university, its stakeholders and targeted population	The necessity of UTT implementation at the University of KwaZulu-Natal (UKZN)
Achieving UTT objectives	The objectives which the health promoters strived to achieved at the university	Health promoters' objectives when implementing UTT
Communication channels and languages used	The strategies, communication platforms and language used to reach and motivate people to participate	Communication channels, languages and strategies to enhance participation
HIV testing sites	The various locations used for HIV testing	HIV testing sits
Challenges when implementing UTT	The barriers the health promoters came across when implementing UTT	Challenges when implementing UTT

Perceptions to improve UTT	The opportunities the health promoters thought might improve the UTT implementation	Opportunities to improve UTT implementation
HIV testing progress	The statistics of HIV testing between the year 2017 and 2018	Assessing the effectiveness of HIV testing progress

The above table presents the reviewing, defining and naming themes of the study. The seven themes are based on exploring the Universal Test and Treat (UTT) policy implementation, the communication strategies used to reach and persuade targeted audiences. Then, lastly, assess participation in HIV testing at the University of KwaZulu-Natal, Howard College Campus.

5.3 Analysis

The first theme the researcher created from the collected data is “the necessity of UTT implementation at the University of KwaZulu-Natal (UKZN)”. This theme explains the importance of adopting the policy. . The health promoters were not controlled or monitored when implementing the policy, yet they were devoted and passionate to implement the policy.

The second theme is “health promoters’ objectives when implementing UTT”. This theme begins the process of exploring the implementation of the UTT policy. The first step of the P-Process model involves knowing the problem or writing the problem statement. By knowing the problem, it becomes easy to make objectives to find solutions that address the problem. Therefore, health promoters had objectives to protect and prevent the incident of HIV infection.

The third theme is “communication strategies to enhance participation”. The second and third steps in the P-Process model deals with the audience segmentation, communication channels, approaches which are appropriate for the targeted audiences. Also the creation of the messages. By adopting the model, the study was able to explore the communication strategies used. Then assess if the selection of

these aspect was effective to attract the targeted audience and motivate them to test for HIV.

The forth theme is “HIV testing sites”. The forth step in the P-Process model deals with the implementation and monitoring. The health promoters noticed that there were challenges when their targeted audiences had to undergo HIV testing at public locations.

The fifth theme is “challenges when implementing UTT”. These are challenges the health promoters had experienced, and prevented achieving their objective or not reduce HIV infection.

The sixth theme is “Opportunities to improve UTT implementation”. The researcher was able to find perceptions of the health promoters on how to enhance the implementation of the policy.

The seventh theme is “assessing the effectiveness of HIV testing progress”. The last step of the P-Process model evaluates/assess the effectiveness of a programme. The theme explain how effective the Universal Test and Treat policy was in getting people to test for HIV at the university.

The P-Process model was useful in collecting data which lead to the themes which answers the research questions. Following is an in-depth discussion on the themes.

5.4 Discussion

5.4.1 The necessity of UTT implementation at UKZN

“We started to implement UTT at the University of KwaZulu-Natal at the beginning of the year 2018” (Peer educator No 1, 4th of October 2018).

In two years after the Universal Test and Treat policy was adopted in the country, South Africa. The health promoters were then able to implement the policy at the University of KwaZulu-Natal, Howard College. Adoption of the policy was proposed by the university stakeholder, which is the Department of Health. The department offered support to the health promoters to effectively implement the policy. The implementation of the policy at the university came after the realisation that universities consist of young and old individuals.

The reason for adopting the Universal Test and Treat policy at the university is that the health promoters felt that people at the university are vulnerable to HIV epidemic. It is because people, especially students, had opportunities to be away from home. That enables them to engage in risky behaviour without being seen or stopped by anyone.

Furthermore, implementation of the UTT policy at the beginning of the year revealed that the policy was truly targeted at any person within the university. Including students that are joining the university for the first time and returning students. Implementing the policy at the beginning of the year was a wise move. The health promoters were able to start reaching the few people who were present when the university opened, during the registration period and when lectures commenced.

“Our target is not specific, because the information we share is meant for everyone, including students, university staff members as well as surrounding community members. However, we put much effort to reach many first entering” (Peer educator No 2, 9th of October 2018).

At the University of KwaZulu-Natal, Howard College Campus, the implementation of the Universal Test and Treat policy targeted all people with distinct age groups. This includes students and employees between the age brackets of 17-60 years old. This created the impression that not only students are vulnerable to HIV infection but the entire university community. The target population further suggests that there was interaction among the community members and that integrated risk behaviours leading to HIV infection. During the focus group discussion with the peer educators, they emphasized that much effort is put to reach first entering students. The reason was the perception that most first entering students did not have comprehensive and correct knowledge on HIV.

Similarly, Reddy and Frantz (2011), noted that South African university students lack knowledge on HIV infection. Therefore, that calls for HIV/AIDS and STIs awareness in universities. Moreover, students residing at university for the first time are required to manage freedoms they never had before. University environment offers opportunities to be sexually active and if the students lack experience to make good and risk away decisions, they engage in risk sexually behaviour and drugs use (HIV Prevalence and Related Factors 2010).

In this study, the peer educators believed that first entering students were more vulnerable to HIV infection than returning students. At the beginning of the year, a First Things First programme was held. The first entering students became the most targeted group since most returning students were not present by that time.

It is crucial for students joining the university for the first time to be taught about HIV. This helps to welcome them in the new environment with vast knowledge on how to behave or maintain health sexual behaviour. Moreover, the implementation of the HIV programmes throughout the year was a good strategy to reach as many people as possible. The people had an opportunity to consult to the health promoters when they are free or have challenges.

5.4.2 HIV prevention programmes linked to UTT

“At the beginning of the year, we implemented the First Things First programme that we usually host in February or March annually. We then host another programme before the semester ends. We usually host two or more HIV prevention campaigns in the first semester and do the same in the second semester. The aim is to educate people about HIV and encourage them to go for HIV testing in every three months. In a year we often have four or more HIV prevention programmes. The programmes are similar or falls under the Universal Test and Treat policy” (Peer educator No 6, 10th of October 2018).

The UTT policy was not a stand-alone programme to tackle HIV infection, but it integrated or worked with other established health promotion programmes for it to be effective. Programmes such as First Things First, Isidayi, WeTheBrave, Young Heroes, Health4Women, PreP4Life and My Future First from Anova Health Institute and other institutions. The peer educators implemented the First Things First programme at the beginning of the year to welcome new and returning students to the university and continuously promote HIV prevention. The notion was significant to educate people about HIV/AIDS, motivate them to test, show them where to consult and so on. It did not end there, several interventions were then implemented throughout the course of the year. Peer educators believed that having multiple interventions/programmes was crucial to endlessly galvanise, educate and motivate people to participate in UTT policy, prevent HIV infection, test for HIV every after three months and initiate treatment when found HIV positive.

Having different programmes and strategies aimed at HIV preventions is crucial in reducing the epidemic spread. Furthermore, it could help overcome one's weaknesses, though, there should be relevant objectives. Harrison, Newell, Imrie and Hoddinott (2010) conducted a study on eight HIV prevention approaches tailored for (15-24) years youth in South Africa, to find out what approaches worked. There were four lessons learnt, first lesson was moving beyond individual level and focus on social and structural factors linked to HIV risk. Second was adopting approaches suitable for youth. Third was to change social norms on HIV risk and emphasis protective behaviour. Fourth was to engage the context and population differently, applying peer educators.

The approaches used at the University of KwaZulu-Natal, Howard College Campus involved peer educators who dealt much on the mobilising and testing tasks while the nurses approached individuals who consulted at the clinic and motivated them to test for HIV. Both the peer educators and nurses worked together in implementing UTT policy at the university. This indicated the health promoters concern about HIV infection and their willingness fight it through adopting various strategies for encouraging health sexual behaviour and providing treatment. This depicts love, care and passion for their work.

5.4.3 Health promoters' objectives when implementing UTT policy

In order for the Universal Test and Treat policy to reach its goal, there are several objectives to be achieved. UTT objectives involve: recalling all HIV positive patients that are not receiving treatment to get treatment immediately, increasing access to universal testing and treatment, ensuring adequate drug availability, increasing the number of doctors and nurses who deal with HIV in clinics, improving the quality of care to all HIV positive patients, promotion and communication of HIV related matters and, lastly, monitoring the care provided to patients and evaluating the health outcomes (Department of Health Province of KwaZulu-Natal UTT 2016).

Although there are several objectives of UTT policy, at the university the policy offered promotion and communication on HIV related matters, and HIV testing. The following are the objectives as stated by the health promoters.

5.4.3.1 Sharing HIV related information

The peer educators at the University of KwaZulu-Natal played an essential role to promote and communicate HIV matters. They shared information on HIV prevention methods, educated the population about the signs of HIV/AIDS, explained the importance of HIV testing and continuously test after three months and so forth. The university's population was aware of the UTT policy. The health promoters devoted much effort to get the people to know about their promotion programmes, including the Universal Test and Treat policy. The health promoters were self-motivated to fight HIV at the university and they were also supported by other stakeholders, such as health department.

“Us as peer educators we promote and communicate HIV related matters. We find objectives useful to inform our targeted population about HIV prevention methods, motivate them to go for HIV testing. Those with HIV negative results we encourage them to maintain that status and those with positive status we motivate them to initiate treatment and practice health sexual intercourse or to abstain” (Peer educator No 2, 10th of October 2018).

This was not a surprise as the tasks link to the duties of peer education programme. According to HEAIDS Annual Review Report (2016:17), “peer education programme is regarded as one of the successful forms of behaviour change communication to reach and influence young people”. Further, they are influential in scaling up the process of HIV testing (HEAIDS Annual Review Report 2016). Students learn a lot of experiences and benefit from participating in peer education programmes. They gain knowledge on HIV/AIDS, change their behaviour to practice safe sexual intercourse or abstinence. Peer educators have to be patient and persistence to achieve their goals (Vember 2016).

The introduction of peer education programmes within the higher education institutions has played an essential role to combat the spread of HIV among students when examining students' participation in HIV testing at the university. Students are motivated to change their sexual behaviour and there is constantly improvement in their HIV testing (to be discussed later on the chapter).

5.4.4 Pre-counselling and Post-counselling when testing for HIV

Nurse no 1 interviewed in this study emphasised the importance of pre-counselling and post-counselling when testing HIV status. She said pre-counselling helped to motivate students to test for HIV. When students consulted at the university clinic, most of them did not intend to go for HIV testing. Hence, during the pre-counselling, students were told about how important it was to know their HIV status, the HIV prevention methods, the availability of treatment and so forth. This was helpful to motivate students to test for HIV. Also, the post-counselling step encouraged HIV positive people to initiate and continue to adhere to treatment.

5.4.5 Communication strategies used to enhance participation

Communication leads to behavioural prediction and change. Thus effective communication induce favourable attitudes, norms, perceived behavioural control and behavioural skills (Albarracin, McNatt, Klein, Ho, Mitchell and Kumkale 2003). For effective communication to be achieved there is a need for selection of appropriate communication channels to reach the targeted audiences for behavioural change. If this is not achieved, there is a possibility for HIV prevention programmes to be unsuccessful. There is also a necessity to choose a right language that could be read and understood by the targeted audiences.

“When mobilizing, we use posters, flyers, wear branded T-shirts, Face-to-face approach and social networking sites such as UKZN website page, Facebook, Instagram and WhatsApp. Most of our posters are placed where most students pass or where they attend, for instance lecture hall (Shepstone building), library, bus shelters and on buses, and in the students residences. This is meant to reach as many people as we can and we usually reach many people. The language used was English” (Peer educator No 5, 10th of October 2018).

(As mentioned before) “Only face-to-face approach is used. The language vary, this depends on the patient. English is used to students who do not understand IsiZulu and Xhosa” (Nurse No 1, 4th of October 2018).

This study revealed that the health promoters at the university used various channels to reach the population. They integrated interpersonal and mass-media platforms. Mass-media platforms were adopted by the peer educators to mobilise the university

community members to take part in the UTT policy. They made use of posters, branding, social-networking sites which enabled to reach almost everyone on-campus and off-campus or the surrounding community members.

“When mobilizing, we use posters, flyers, wear branded T-shirts, Face-to-face approach and social networking sites such as UKZN website page, Facebook, Instagram and WhatsApp. Most of our posters are placed where most students channels and pass or where they attend, for instance lecture hall (Shepstone building), library, bus shelters and on buses, and in the students residences” (Peer educator No 5, 10th of October 2018).

“I use face-to-face approach to the patients consulting at the clinic. The language vary, this depends on the patient. English is used to students who do not understand African languages. The most commonly used African languages channel and are IsiZulu, IsiXhosa, IsiSwati and so on, depending on the language of the patients” (Nurse No 1, 4th of October 2018).

Mckee, Bertrand and Becker-Benton (2004) argued that to reach large mass audiences, mass communications are one of the effective tools. The nurses relied on face-to-face communication with people consulting at the university clinic. All the communication channels were imperative to reach and disseminate information to prevent HIV infection.

If it was not for counselling, most people would have not undergone HIV testing. Peer educators were useful to mobilise, educate and motivate. Nevertheless, the nurses’ mobilising strategy appeared to be much effective than that of peer educators. The nurses approached people consulting at the clinic, who were basically in need for help, trusted the nurses, and engaged in one-on-one communication in private settings.

Despite the effectiveness of the communication channels and the languages used for the recipients to understand, ask questions and be motivated to participate. The peer educators said although people received the HIV information, most of them were still afraid or not motivated to test for HIV. In order to persuade the people to test for HIV, sometimes, they gave away incentives, food parcels and so on.

5.4.6 Compensation

“Many students lack motivation to attend our programmes and to go for HIV testing. We attract most of students by providing refreshments or incentives when we host a programme. Incentives such as pens, USB, T-shirts and sweets, invite artists and other sought of entertainment. For our programmes to be effective we should consistently provide these to attract many people as possible” (Peer educator No 2, 10th of October 2018).

The compensation strategy was the drive to persuade the university community, especially, the students to test for HIV. The peer educators said when they provided offerings, people came in many numbers and participated in their programmes, including testing for HIV. This shows that the peer educators have had a great challenge to attract people to take part in their programmes.. This comes with no surprise because most of the people are busy. The students have to attend classes, study, do assignments, and pay attention to their personal issues. This also includes the university staff members.

Nevertheless, health promoters have to be strategic and be the drivers of behavioural and social change. Cameron and Van Der Merwe (2012) argued that there should be ethical consideration when gifts are given to students to test for HIV. The authors stated that giving expensive prizes such as bags, cars, computers to pressure students to engage in health programmes is unethical.

The strategy adopted by health promoters at the University of KwaZulu-Natal, Howard College Campus, to provide incentives is viewed unethical by the above others. However, the peer educators made it clear that the community members were told that participation in the UTT programmes was voluntary and that they were free to quit at any time. Furthermore, all the community members were above 18 years and they were matured to make proper decisions and participating in UTT programmes was crucial for their health.

5.4.7 HIV testing sites

“We use Campus HIV/AIDS Support Unit (CHASU) building as well as mobile tents which are placed at Shepstone and Student Union (SU) buildings” (Peer educator No 4, 10th of October 2018).

“I conduct the HIV testing at the university Wellness Clinic” (Nurse No 1, 4th of October 2018).

This study discovered that at the university, there were different sites for HIV testing. The peer educators used Campus HIV/AIDS Support Unit (CHASU) building where they were located. They also used mobile tents which were placed on crowded locations and the nurses used the university Wellness Clinic to encourage people to participate in HIV testing. These sites suited different personality traits of the targeted participants. Those who were shy and afraid of people had the opportunities to visit CHASU building and Wellness Clinic where people would not know the purpose of consultation. The mobile tents turned to be useful to those who were brave.

Availability of permanent testing sites was an advantage for the university community members to consult at any time of the year and test for HIV whenever they felt like or when they became suspicious of infection symptoms. The tents where only placed during the times of mobilising, where incentives, food and entertainment was provided. This method distinguished people who tested to receive gifts and those who tested because they cared about their health.

5.4.8 Challenges when implementing UTT

Following are challenges the health promoters faced then they implemented the Universal Test and Treat policy at the University of KwaZulu-Natal.

5.8.1 Stigma and privacy

Many people know the importance of HIV testing and most of them are willing to test, but because of self-stigma and social stigma, they are afraid to test (Hou si 2009). The current study discovered that the health promoters were strategic to have testing sites which accommodated people who were afraid of social stigma and those who were not. Self-stigma was one of the issues the health promoters had to deal with

through pre-counselling in order to motivate people to test. When the health promoters were asked if they provided HIV self-testing kits they said “no”. The targeted population had to approach the health promoters to test or buy themselves HIV self-testing kits.

This study proposes that HIV self-testing kits be considered as one of the strategies to be considered in the future. The crucial part is for people to test, whether it was a self-test or not because that is not an issue. This is because the aim is to reduce HIV infection rather than to focus on recording the statistics of HIV results, as the health promoters do. This strategy should be applied to distribute free HIV self-testing kits and people be informed to make informed or wise decisions after obtaining their HIV results.

Makusha, Knight, Taegtmeyer, Tulloch, Davids, Lim, Peck, Van Rooyen (2015) noted that people aged 16 years and above should be familiar with HIV self-testing kit and utilise it. This will prevent HIV infection. If people find themselves HIV positive they will access treatment, care and support and psychological support services.

5.4.8.2 Lack of motivation to test for HIV

It became clear that even though various strategies were applied during the implementation of the UTT policy, some of university community members were not motivated to test for HIV. Perhaps there should be additional strategies to be applied for all targeted population to participate.

Moreover, the issue of having the entire university community to participate in HIV testing will continue to be an issue. This is because HIV testing in South Africa is voluntary and everyone has the right to deny or refuse testing. Adams, Hansen, Fox, Taylor, Van Rensburg, Mohlahlane and Sikkema (2011) conducted a study on the correlates of HIV testing among abused women in South Africa. The women tested for HIV because they wanted help from the police. Further, the authors found that a woman may not test for HIV if the partner says she is not at risk from him and that a woman who tested may fail to disclose her status to an abusive partner.

People who never tested for HIV significantly hold negative attitudes than those who tested. They are less likely to view the beneficial outcomes from testing, they have stigma, regard HIV positive individuals as dirty, and that they should feel ashamed and guilty, and never be let to work with children (Kalichman and Simbayi 2003).

This shows that people who do not test for HIV in the above study did not have sympathy to HIV positive people regardless of how they became infected. This paints a picture which depicts those who deny HIV testing as stubborn and fail to take responsibility for their health.

5.4.8.3 Unavailability of treatment

Cato Manor Community Health Centre is run by Provincial and eThekweni Municipality. It is situated at Umkhumbane (Mayville) in Ethekwini District. So far the centre serves a population of 70 000 people (Cato Manor Community Health Centre). The Health Centre is 6.9 km away from the University of KwaZulu-Natal, Howard College Campus. To walk there, it will take approximately 1 h 29 minutes (Google Maps). The health practitioners at the health centre had additional work to attend to the HIV positive patients coming from the university. This, however, could lead to long queues and even poor service delivery.

Unavailability of HIV treatment at the university was a huge set back and failed the health promoters in achieving one of UTT objectives. The HIV positive individuals were misfortune and had to go through the bizarre experience of skipping classes, cost on travelling to the clinic, having their HIV status being known by other health practitioners and establish new relationship with them, and being exposed to other people. There is doubt that those who were impatient, shy and did not afford to travel to the clinic were able to initiate treatment or continue to adhere to treatment. Furthermore, the nurses and peer educators were not responsible to make follow ups to check if the HIV positive individuals initiated treatment or not.

5.4.9 Opportunities to improve UTT implementation

5.4.9.1 Mobilisation

The peer educators viewed the lecturers as powerful and influential candidates to dismiss and motivate students to attend UTT programmes. They believed it would help reach many students who attend lectures and have the opportunity to discuss

UTT with their classmates and friends. Furthermore, introducing HIV prevention lectures to the university curriculum would help educating students about the epidemic and to prepare them to make informed decisions when engaging in sexual intercourse.

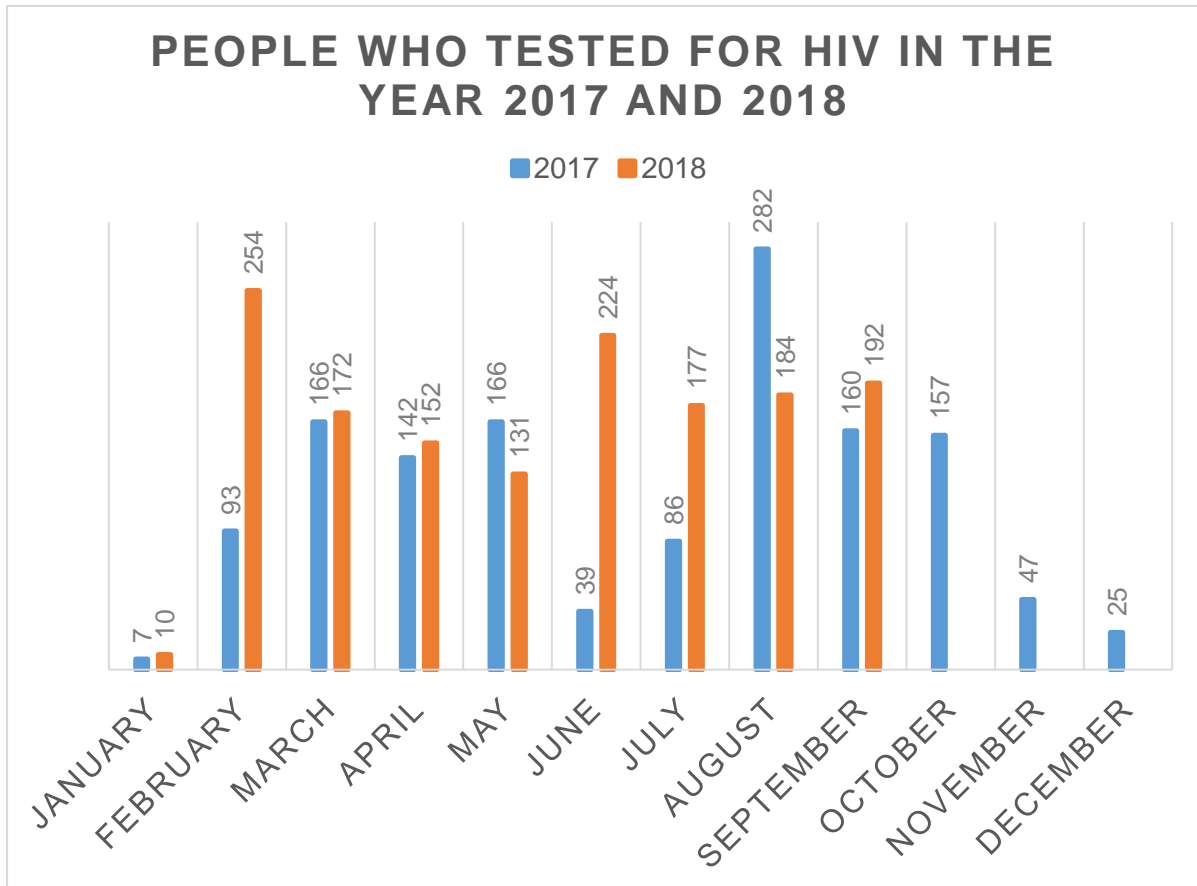
5.4.9.2 Provision of HIV treatment

If the Wellness Clinic and Campus HIV/AIDS Support Unit (CHASU) at the university provided HIV treatment, all the HIV positive patients would have had easy access to treatment. This was going to save time and cost for travelling. The university health practitioners were going to be able to establish and maintain relationships with the patients, monitor their adherence to treatment and, constantly, motivate them to practice safe sexual intercourse.

If the university Wellness Clinic was able to provide ARVs to its patients before, even now they can be able to do so. This issue requires immediate solution, because some of the university community members, such as students, are not from the area. It might be hard for people to ask for directions to the Cato Manor Community Health Centre because the university does have a health centre. This would create suspicions that they are HIV infected. Further, even though free transport could be offer, social stigma would still be a challenge and it will be hard for the patients to travel.

5.4.10 Uptake of HIV testing at UKZN

5.4.10.1 Statistics of people who participated in HIV testing in the year 2017 and 2018



This bar-graph portrays the number of people who participated in HIV testing from the year 2017 and 2018 at the University of KwaZulu-Natal, Howard College Campus. The graph shows participation in all 12 months in the year 2017. Meanwhile in 2018 it covered the period from January to September were the last data of the dissertation was collected.

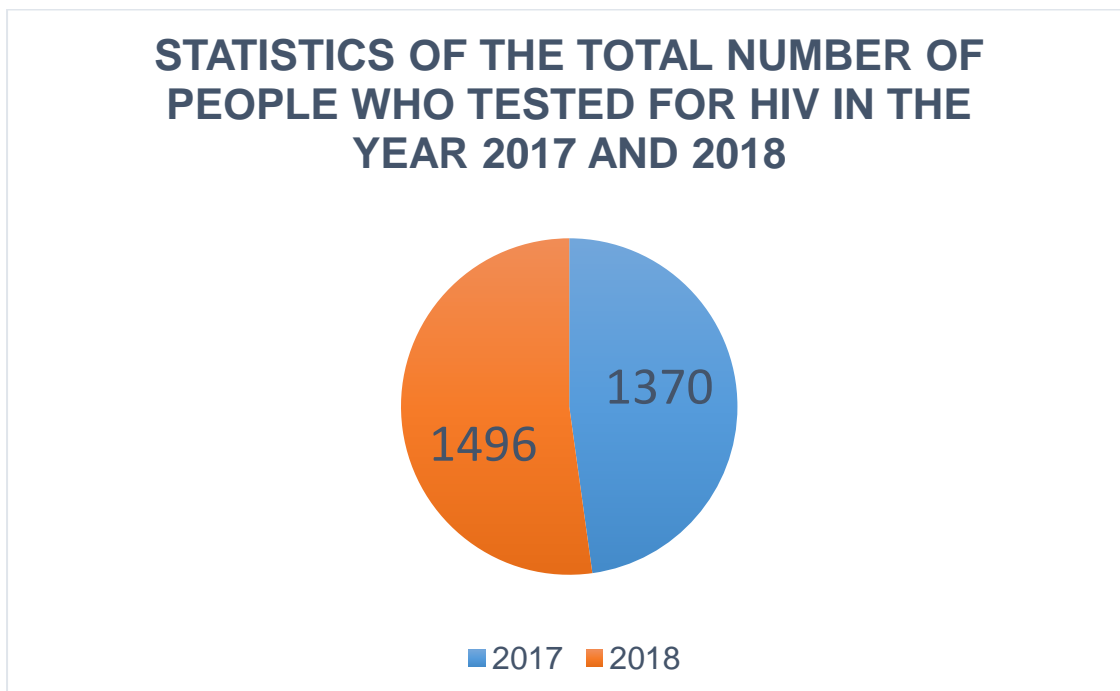
At the beginning of both years, few people tested and the reason was because many people were at their homes at that time, since lectures usually begin in February. In both years, from January to September, year 2018 had many people who tested for HIV when compared to 2017, excluding only two months which are May and August. This proved that the implementation of UTT in 2018 had somehow made a little

progress to get more people to test for HIV at the university, Howard College Campus.

In the year 2017, the highest participation in HIV testing took place in August. Yet in 2018 the highest participation in HIV testing was in February, then followed by June. These were the times when the peer educators mobilised and implemented mobile tents at the crowded locations. The results reveal that most of the targeted population for HIV testing became motivated to test during peer educators' mobilisation programmes and the fear of social stigma was a minor issue.

People were encouraged to undergo HIV testing once-every after three months. Therefore, if one individual participated in HIV testing in every three months, it was not specified that it was one individual or three. This made the data of annual HIV testing participation to be regarded as worthless, unlike monthly participation which it portrayed separate individuals who test in that month.

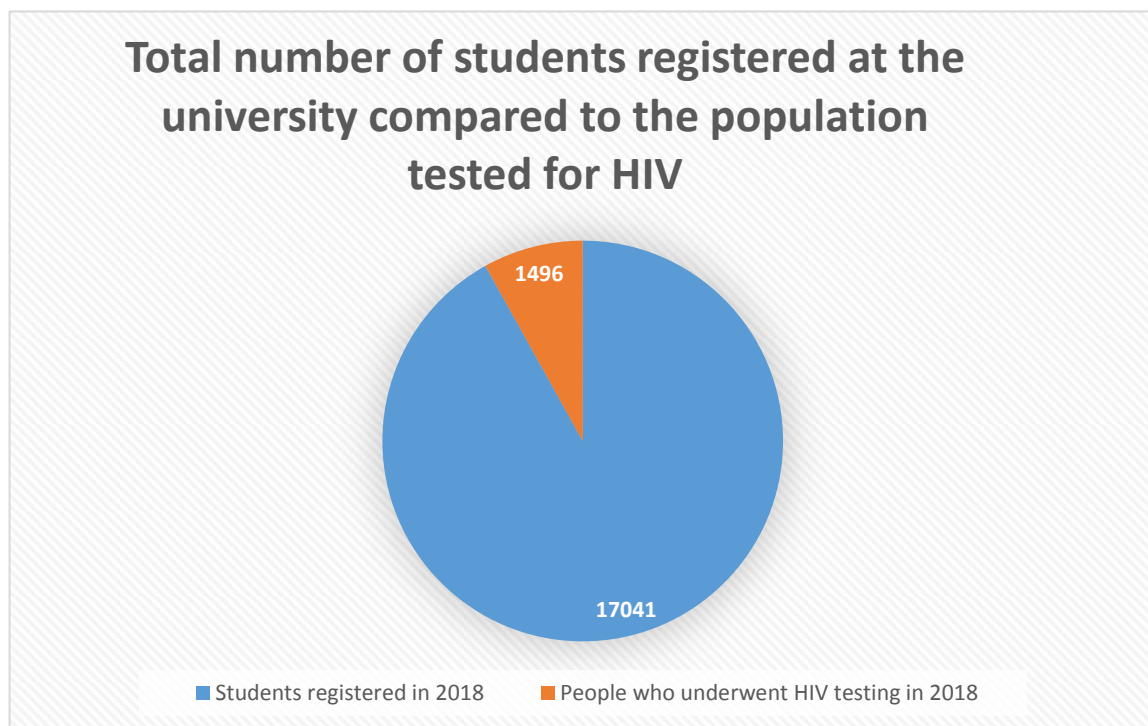
5.4.11 Pie-chart comparing HIV testing in the year 2017 and 2018



The above Pie-Chart illustrates the sum (total) number of people who tested for HIV at the University of KwaZulu-Natal, Howard College Campus in the year 2017 and 2018. In the year 2017, participation took place in all 12 months of the year, yet in

the year 2018 participation was calculated from January to September. In the year 2017 there were 1370 people tested for HIV at the university. Nevertheless in the year 2018 there were 1496 people who tested for HIV.

5.4.12 Pie-chart illustrating people who tested for HIV and students who were registered at the university in 2018



The University of KwaZulu-Natal, Howard College Campus registered 17 041 students in the year 2018. From those students, there was 1 496 people participated in HIV testing from January till September 2018. This revealed that many people at the university were not testing and there is too much to be done to improve HIV testing. To reduce the incident of HIV infection in the university, the Universal Test and Treat policy has to bring effective strategies which would motivate or persuade people to test. This would help reduce the spread of the epidemic as HIV testing is one of the UTT policy's objectives to eliminate and terminate the HIV epidemic (Department of Health Province of KwaZulu-Natal UTT 2016). Moreover, the total number of the university staff member was not included. The reason for not adding the total number of the university staff members, permanent or contract, was

because other workers had permission to working within various campuses under the university. For instance, a lecturer was able to lecture within two or more campus.

5.5 Conclusion

This study employed qualitative approach to collect data from the health promoters. Two separated semi-structured interviews were held with two nurses and one focus group discussion with nine peer educators. The participants were labelled to identify their contribution to the study. Indeed the six phases of thematic analysis by Braun and was helpful to analyse the data. It was found that there was a necessity for the implementation of the Universal Test and Treat policy, there health promoters strived to achieve fewer objectives at the university unlike when it is compared to other community settings, the health promoters worked together to motivate and persuade the community population using various communication channels and strategies attract people to test for HIV and, practice safe and health sexual intercourse. Moreover, the health promoters came across various challenges which made the implementation of the policy to be not effective. This led to poor participation in HIV testing at the university, even though HIV testing progress was little high in the year 2018 than the previous year which was 2017.

CHAPTER SIX

Conclusion of the study

6.1 Conclusion

This study was conducted at the University of KwaZulu-Natal which is located within KwaZulu-Natal province where there is high prevalence of HIV in South Africa. The most infected and vulnerable population group include people within the ages of (15-49) years old. The epidemic is estimated to increase by certain percentage in every year (Department of Health Province of KwaZulu-Natal UTT 2016). Based on previous studies that were conducted at the University of KwaZulu-Natal, such as students sexual risk behaviour, risk and protective factors and their responses to Scrutinise Campus Campaign by Mutinta (2012) and perceptions of the ABC prevention strategy by Moodley (2007), which found the university students to be vulnerable to HIV infection and lacked HIV information. The researcher took initiative to conduct this study at the university.

This study aimed to explore the effectiveness of the implementation of the Universal Test and Treat (UTT) policy in reducing or eliminating the spread of HIV infection at the University of KwaZulu-Natal, Howard College Campus.

The dissertation intended to achieve the following objectives:

- To explore UTT policy implementation and communication strategies used.
- To assess participation in HIV testing on campus.

There were four research questions for this study and they are presented as follows:

1. How is the UTT implemented by the health promoters, nurses and peer educators, to increase HIV testing among students at Howard College?
2. Which communication strategies are used to attract people to participate on the UTT policy?
3. What is the state of progress in HIV testing within Howard campus?

The above research questions were guide the researcher when conducting this study and to focus only on aim and objective rather than to deviate from the aim, goal and purpose.

The study further assess the effectiveness of the implementation of the Universal Test and Treat policy in terms of persuading people to test for HIV. It was found that few people undergone HIV testing at the university, however, there was increase in the percentage of people who tested in the year 2018 when compared to year 2017 which the policy was not implemented.

The study used the P-Process model as theoretical framework. The P-Process model is adopted and frequently used in Health promotion to prevent the incident of HIV infection. In this study, the model is employed as it suited the aim and objectives of the study. The theoretical framework was used as a lens to gather and interpret the collected data. Furthermore, it was aligned with the methodology of the study to achieve or answer the mentioned research questions.

The methodology section of the study was useful to collect data in an ethical and effective manner to answer the study's research questions. A qualitative approach enabled the research to conduct semi-structured interviews and focus group discussion with the health promoters or participants of the study.

It was found that there was a necessity for the implementation of the Universal Test and Treat policy at the university. The health promoters used various communication channels to reach and disseminate the policy's information, using languages understood by their targeted population. The policy was not only intended to the university students, but to the university employees as well. The health promoters said apart from the communication channels and languages used, they provided incentives such as T-shirts, food, bring different types of entertainment and other strategies to galvanise their targets to attend UTT programmes and Test for HIV.

The health promoters worked together to motivate and persuade the community population using various communication channels and strategies to attract people to test for HIV and, practice safe and health sexual intercourse. Moreover, the health

promoters came across various challenges which made the implementation of the policy to be not effective. This led to poor participation in HIV testing at the university, yet, participation in HIV testing progress was little high in the year 2018 than the previous year which was 2017.

The information gathered in this was very critical in preparation and planning future health communication programmes aimed at reducing the incident of HIV infection. The study outcomes could assist the university health promoters to create plans or seek help to overcome their challenges. The outcomes could also help health communication planners and designers to implement an effective intervention to fight against the spread of HIV or other perpetuating diseases. It is with no doubt that HIV infection is extremely high in the country and many people die because of the epidemic. So, new innovative health communication programmes are constantly developed to reduce or stop HIV infection, but for programmes to be effective. They should be programmes placed to assess or evaluate the health communication programmes since the pandemic is transmitted to distinct age groups, people in different communities who speak different languages and have access to certain communication channels or platforms.

6.2 Limitations of the study

The researcher had a great challenge when he had to meet the participants of the study. This led to changes when collecting the data for the study. There was a complete change in how the researcher proposed to collect the data. The procedures might not be scientific or acknowledge, but this was the only option to collect the data because of the deadline for the dissertation. Also some of the health promoters were students who were completing in the year 2018 and postponing the data collection process could lead to a long delay where new participants have to be assigned and allow them to have much experience in the implementation of the Universal Test and Treat policy.

The intended number of the participants was not reached and the data was not gathered within the estimated time period.

6.3 Recommendations

The University of KwaZulu-Natal should have ethical and practical consideration for compensating participants. The participants loved the rewards for participating in the study and this would have motivated them to participate in time and in large numbers.

The University of KwaZulu-Natal should provide HIV treatment, rather than referring patients to the nearest community health care centre. This would save time and cost for traveling and social stigma.

There is a need for this study to be conducted in a large and distinct context, this would help trace the effectiveness of the UTT policy to explore challenges when implementing the policy and bring effective strategies.

The targeted population of the Universal Test and Treat policy should be included in the design and implementation for the policy to be effective.

Assessing the effectiveness should be conducted annually, like on other health interventions, to see if there is reduction in HIV infection.

The health promoters should also use communication channels or platforms which depicts readership or viewership, to see if the targeted population is motivated to participate in their programmes or not.

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Project title: Implementation of the Universal Test and Treat (UTT) strategy by nurses and health promoters at the University of KwaZulu-Natal, Howard College campus.

Objectives of and need for the study

- To identify the communication channels and language used by the health promoters, then assesses both aspects in terms of target audience selection and the effectiveness in reaching those audiences.
- To assess the UTT policy's progress in increasing students' participation in HIV testing on campus.

Research question

1. How is the UTT implemented by the nurses and health promoters on campus to increase HIV testing among students at Howard College campus?
2. What specific interventions has been designed and implemented by the nurses and health promoters at Howard College campus?
3. What has been the motivation/intention of students in response to the UTT approach at Howard College campus?

Interview questions (Based on Theory of Reasoned Action to ask the nurses)

1. What role do you play during the Universal Test and Treat (UTT) implementation?
2. What is the intended number of students you want to participate, please explain?
3. How often does a person is required to participate in the programme and why?
4. Have you had students who wanted to participate in the programme for many times? If yes, how do you feel about that and what were their motivations for participating?
5. If some students never come back or refuse to participate, what do you think is the reason for that?
6. What are usual complaints participants have? If any, how do you address them?
7. Do you think the targeted population have or lack motivation to participate in UTT?
8. During the implementation, what challenges do you come across? If any, where do you report them and what was the solution?

9. Do you wish to make changes on the programme or have you changed the way you implemented the programme since its started to be implemented on campus?
10. Do you record their participation, if you do how? (they do record and I will ask follow-up questions)
11. Which individuals have the access to the participation results and why?
12. How do you assess the progress of the programme?

Focus group discussion questions (Based on P-Process for Peer-educators)

1. Apart from other health interventions, why there is UTT on campus and who proposed it?
2. What is the targeted population and why?
3. What is the programme's goal?
4. How do you intend to achieve the UTT objectives?
5. Who is involved in the UTT planning?
6. When does the planning takes place and for how long?
7. Which communication channels are used for mobilising and why?
8. Which language do you use, please explain?
9. Are you able to view the viewership or readership of the audience who received the message, if not, do you intend to know and have you tried to make it possible?
10. When is the UTT implemented and why?
11. Which venue do you use?
12. Individual's HIV results are confidential, does the venue provide privacy, please explain?
13. How do students feel about the venue, have they ever said something about it.
14. What are the steps for HIV testing?
15. For how long does it takes to do the HIV testing process?
16. How many of you work in the programme (per day) and how long does the HIV testing process last?
17. How do you make sure that only you and the client know the results?
18. One of the UTT's objectives is to provide immediate treatment to infected individuals, how do you do that making sure others are not suspicious and that the process with the clients does not take longer than usual?
19. What challenges do you come across when implementing UTT?
20. If you do, where do you report the challenges and are they addressed?
21. Do you think the intervention needs to be improved, please explain?
22. Do you know when you have reached you objectives? If you do, what impact indicators are appropriate to measure the degree to which the objectives were met?

23. What worked well in your last programme and what could be done differently next time?

03 August 2018

Mr Sandile Sydwell Nkosi (218084871)
School of Applied Human Sciences – CCMS
Howard College Campus

Dear Mr Nkosi,

Protocol reference number: HSS/0631/018M

Project Title: Implementation of the Universal Test and Treat (UTT) strategy by nurses and health promoters at the University of KwaZulu-Natal, Howard College Campus

In response to your application received 08 June 2018, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Approval Notification – Expedited Application

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

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

Yours faithfully



.....
Professor Shenuka Singh (Chair)

/ms

Cc Supervisor: Dr Eliza Govender
Cc Academic Leader Research: Dr Maud Mthembu
Cc School Administrator: Ms Ayanda Ntuli

Humanities & Social Sciences Research Ethics Committee

Professor Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

Telephone: +27 (0) 31 260 3587/8350/4557 Facsimile: +27 (0) 31 260 4609 Email: ximbap@ukzn.ac.za / snymanm@ukzn.ac.za / mohunp@ukzn.ac.za

Website: www.ukzn.ac.za



100 YEARS OF ACADEMIC EXCELLENCE

Founding Campuses:  Edgewood  Howard College  Medical School  Pietermaritzburg  Westville

24 May 2018

Sandile Sydwell Nkosi (SN 2218084871)
School of Applied Human Sciences
College of Humanities
Howard College Campus
UKZN
Email: govendere1@ukzn.ac.za

Dear Sandile

RE: PERMISSION TO CONDUCT RESEARCH

Gatekeeper's permission is hereby granted for you to conduct research at the University of KwaZulu-Natal (UKZN), towards your postgraduate degree, provided Ethical clearance has been obtained. We note the title of your research project is:

"Exploring the effectiveness of the implementation of the Universal Test and Treat (UTT) strategy by health promoters at the University of KwaZulu-Natal, Howard College campus".

It is noted that you will be constituting your sample by conducting interviews, and/or focus groups with campus clinic nurses and peer educators on the Howard College campus.

Please ensure that the following appears on your notice/questionnaire:

- Ethical clearance number;
- Research title and details of the research, the researcher and the supervisor;
- Consent form is attached to the notice/questionnaire and to be signed by user before he/she fills in questionnaire;
- gatekeepers approval by the Registrar.

You are not authorized to contact staff and students using 'Microsoft Outlook' address book. Identity numbers and email addresses of individuals are not a matter of public record and are protected according to Section 14 of the South African Constitution, as well as the Protection of Public Information Act. For the release of such information over to yourself for research purposes, the University of KwaZulu-Natal will need express consent from the relevant data subjects. Data collected must be treated with due confidentiality and anonymity.

Yours sincerely



MR SS MOKOENA
REGISTRAR

Office of the Registrar

Postal Address: Private Bag X54001, Durban, South Africa

Telephone: +27 (0) 31 260 8005/2206 Facsimile: +27 (0) 31 260 7824/2204 Email: registrar@ukzn.ac.za

Website: www.ukzn.ac.za


1910 - 2010
100 YEARS OF ACADEMIC EXCELLENCE

Founding Campuses:  Edgewood  Howard College  Medical School  Pietermaritzburg  Westville

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL
For research with human participants

INFORMED CONSENT RESOURCE TEMPLATE

Information Sheet and Consent to Participate in Research

Date: 30 May 2018

Greeting: Dear Administrator

My name is Sandile Sydwell Nkosi from the Faculty of Humanities, Masters of Social Sciences in Centre for Communication, Media and Society at UKZN, Howard College Campus.

Dissertation title: Implementation of the Universal Test and Treat (UTT) strategy by nurses and health promoters at the University of KwaZulu-Natal, Howard College campus.

Contact details:

Cell no 0791355055

Email address: sydwellking@yahoo.com

You are being invited to consider participating in a study that involves implementation of the Universal Test and Treat (UTT) policy at UKZN, Howard College Campus. The aim and purpose of this research is to assess how the UTT is implemented by identifying the language and communication channels used to reach the students and the specific strategies used to motivate students to go for HIV testing on campus. The study is expected to enroll 12 participants, ten peer educators from Campus HIV/AIDS Support Unit (CHASU) and two nurses from the campus Wellness Clinic. It will involve the following procedures; two separate interviews with the nurses and two focus groups with the peer educators. The duration of your participation if you choose to enroll and remain in the study is expected to be an hour or two with the nurses and three to four hours with the peer educators. The study is not funded.

The study will not involve any risks, but obtaining information or experience on the implementation of UTT on campus. The researcher hopes the study will create the following benefits; find how effective is the language and communication channels used and the strategy to motivate students to test for HIV. The researcher believes the UTT policy should be effective enough to motivate students to test for HIV and know their HIV status. Therefore, UTT will achieve its predicted goal which is to eliminate HIV infection in South Africa within 10 years since the country has the largest HIV infected population in the whole world (Department of Health Province of KwaZulu-Natal UTT 2016).

The researcher will note down the participants' information and perhaps record the information from the participants during the interviews and focus groups.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number HSS/0631/018M).

In the event of any problems or concerns/questions you may contact the researcher at (0791355055/sydwellking@yahoo.com) or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Participation in this research is voluntary and participants may withdraw participation at any point, and that in the event of refusal/withdrawal of participation the participants will not incur penalty or loss of treatment or other benefit to which they are normally entitled. The researcher will terminate the participant from the study if he/she denies others a chance to share their experiences, causing threat and disorder, and so forth that will distract the researcher from obtaining information.

Participation to the study is free of charge. Refreshments will be provided during the focus groups (with the peer educators) because of the lengthy period of participation and stipend of R100 for each participant after interviews (with the nurses), for transport to get home.

The participants will not be requested to give their names, cell numbers and so forth, only their gender, age and experience in implementing will be required. Further, the participants will be named using numbers, such as participant no1, in order to identify them and know which person has contributed a particular information. The information will be written on a notebook and perhaps recorded and be kept for revision after gathering the information from participants. The data will be collected second semester between September and October, dates will be confirmed.

CONSENT

I () have been informed about the study entitled Implementation of the Universal Test and Treat (UTT) strategy by nurses and health promoters at the University of KwaZulu-Natal, Howard College campus by Nkosi Sandile Sydwell.

I understand the purpose and procedures of the study (add these again if appropriate).

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at 0791355055/sydwellking@yahoo.com.

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact: +27312601813 Dr Eliza Govender (Supervisor).

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

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Additional consent, where applicable

I hereby provide consent to:

Audio-record my interview / focus group discussion	YES / NO
Video-record my interview / focus group discussion	YES / NO
Use of my photographs for research purposes	YES / NO

Signature of Participant

Date

Signature of Witness
(Where applicable)

Date

Signature of Translator
(Where applicable)

Date

IKOMIDI LEZENQUBONHLE KWEZOCWANINGO LEKOLISHI LEZESINTU ESIKOLENI SEZIFUNDO NGENHLALO YOMPHAKATHI (HSSREC)

ISICELO SOKUGUNYAZWA NGOKWEZENQUBONHLE
Okocwaningo olusebenza ngabantu

OKUKULEKELELA EKWAKHIWENI KWEFOMU LOKUVUMA

Umbhalo Wemininingwane Nokuvuma Ukubamba Iqhaza Ocwaningweni

Usuku: 30 uNhlaba 2018

Ukubingelela: Mnumzane/Nkosikazi othandekayo

Igama lami ngingu- Sandile Sydwell Nkosi wase Faculty of Humanities, Masters of Social Sciences in Centre for Communication, Media and Society at UKZN, Howard College Campus.

Sihloko sembalu: Implementation of the Universal Test and Treat (UTT) strategy by nurses and health promoters at the University of KwaZulu-Natal, Howard College campus.

Uyamenywa ukuba ubambe iqhaza ocwaningweni olumayelana neUniversal Test and Treat (UTT) policy eUnyuvesi yakwaZulu-Natali, Howard College Campus. Inhloso nempokophelo yalolu cwaningo ukucwaninga ukuthi iUTT isebenzisa luphi ulimi kanye nezindlela zokuxhumana nabafundi ukuze bagqugquzeleke ukuba bahlole ingculazi lapha enyuvesi. Ucwaningo lulindeleke ukuthi luthinte lokhu: isibalo sabazobamba iqhaza 12, esizindeni ngasinye bazoba babili abahlengikazi emtholampilo yasenyuvesi kuphinde kube khona abefundisi bezimpilo (peer educators) abayishumi abazobe beseCampus HIV/Aids support unit. Luzobandakanya lezi zinqubo ezilandelayo: izingxoxo nabahlengikazi bobabili ngezikhathi ezahlukene kanye nezigxoxo ezimbili nabafundisi bezimpilo abayishumi. Ukubamba kwakho iqhaza uma uvuma futhi uhlala ocwaningweni kulindeleke ukuthi luthathe amahora amabili nabahlengikazi bese kube amahora amane nabafundisi bezimpilo. Ucwaningo alunalo uxhaso.

Ucwaningo ngeke lube nangcuphe noma ukungaphatheki kahle kepha luzobe lidinga ulwazi mayelana nokubaluleka kweUTT lapha enyuvesi. Ucwaningo luzoletha lezi zinzuzo ezilandelayo: ukuphenya ukuthi ulimi kanye nezindlela zokuxhumana ezisetshenziswayo zinomthelela ekugqugquzeleni abafundi ukuba bahlole ingculazi. Ucwaningo lunenzuzo kobambe iqhaza ngoba unethemba lokuthi iUTT izosebenza ngendlela yokuthi ikwazi ukugqugquzela abafundi ukuba bahlole ingculazi. Okuzozuzwa ngocwaningo ukuthi iUTT izokwazi ukunciphisa isibalo sabantu abanengculazi lapha eNingizumu Afrika kwemnyaka eyishumi (Department of Health Province of KwaZulu-Natal UTT 2016).

Ucwaningo alunayo ingcuphe kepha umcwaningi uzozibhala phansi izingxoxo ezizobe ziphakathi kwakhe nabantu abazobe bebambe iqhaza kulolu cwaningo.

Lolu cwaningo luhloliwe ngokwenqubonhle lwagunyazwa i-UKZN Humanities and Social Sciences Research Ethics Committee (inombolo yokugunyazwa_____).

Uma kunezinkinga noma imibuzo/ukukhathazeka ungaxhumana nomcwaningi lapha (0791355055/sydwellking@yahoo.com) noma i- UKZN Humanities & Social Sciences Research Ethics Committee, kuleminingwane elandelayo:

**EZOKUPHATHWA KWEZENQUBONHLE KWEZOCWANINGO EKOLISHI LEZESINTU ESIKOLENI
SEZIFUNDO NGENHLALO YOMPHAKATHI**

Ihlovisi LezoCwaningo, iKhempasi i-Westville
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Ucingo: 27 31 2604557- Fax: 27 31 2604609
I-imeyili: HSSREC@ukzn.ac.za

Ukubamba iqhaza kulolu cwaningo akuphoqelekile, ababambe iqhaza bangayeka noma yinini futhi uma bengathandi noma beyeka ukubamba iqhaza ngeke bahlawuliswe ngalokho noma baphelelwe ukwelashwa noma balahlakelwe yinoma yikuphi okunye abebekuzuza okufanele bakuthole. Ukubamba iqhaza akukhokhelwa. Abazobe bebambe iqhaza bazothola iziphuzo ngenxa yokuthi izingxoxo kulindelekile ukuthi zingase zithathe iskhathi eside kuneslindlekile. Phezu kwalokho abahlengikazi kanye nabazobe bebambe iqhaza bazothola isibonelelo saR100 ozobalekelela uma sebegoduka.

Abazobe bebambe iqhaza angeke baphoqekele ukuba bakhiphe imininingwane yabo.

UKUVUMA (Hlela ngendlela obona ifanele)

Mina (Igama) ngazisiwe ngocwaningo olunesihloko esithi (bhala imininingwane) luka (bhala gama lomcwaningi/oqoqa ulwazi).

Ngiyakuqonda okuphokophelwe nokuyimigomo zalolu cwaningo (kubhale lokhu futhi uma kunesidingo).

Nginikeziwe ithuba lokuphendula imibuzo mayelana nocwaningo futhi ngithole izimpendulo ezingigculisayo.

Ngiyaqinisekisa ukuthi ukubamba kwami iqhaza kulolu cwaningo akuphoqelekile futhi ngingayeka noma yinini nokuthi lokho ngeke kube nomthelela kwengikuzuzayo engijwayele ukukuthola.

Ngazisiwe ngazo zonke izinxephezelo noma ukwelashwa okutholakalayo uma ngilimala ngenxa yokuphathelene nocwaningo.

Uma ngineminye imibuzo/ukukhathazeka noma kukhona engidinga kucaciswe mayelana nocwaningo ngiyakuqonda ukuthi ngingathintana nomcwaningi (bhala imininingwane).

Uma nginemibuzo noma ukukhathazeka ngamalungelo ami njengobambe iqhaza, noma ngikhathazekile nganoma yiluphi uhlangothi locwaningo noma abacwaningi ngingathintana nabe:

**EZOKUPHATHWA KWEZENQUBONHLE KWEZOCWANINGO EKOLISHI LEZESINTU ESIKOLENI
SEZIFUNDO NGENHLALO YOMPHAKATHI**

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Ukuvuma okwengeziwe, lapho kudingeka khona

Ngiyavuma ukuthi kwenziwe lokhu:

Kuqoshwe ingxoxo yami/yeqembu	YEBO/CHA
Kuqoshwe ngevidiyo ingxoxo yami/yeqembu	YEBO/CHA
Kusetshenziswe izithombe zami ngezinhloso zocwanningo	YEBO/CHA

Ukusayina kobambe iqhaza

Usuku

Ukusayina Kowufakazi
(Uma kunesidingo)

Usuku

Ukusayina Kohumushayo
(Uma kunesidingo)

Usuku