The social construction of HIV risk and implications for HIV testing health practices amongst sexually active youth at a South African university

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Declaration of originality

I, **Betty Chebitok,** declare that:

1. The research reported in this thesis, except where otherwise indicated, is my original work.
2. This thesis has not been submitted for any degree or examination at any other university.
3. This thesis does not contain another persons' data unless explicitly acknowledged as being sourced from other persons.
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    (a) Their words have been re-written, but the general information attributed to them has been referenced.

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[redacted]

Signed**……………………………………….** Date**……23 August 2021………..**

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Signed……………………………… Date**……25 August 2021………..**

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Dedication

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Abstract

The dominant discourses related to HIV and AIDS in South Africa still construct HIV as a huge threat, and position sexually active youth between the ages of 15-24 years as at risk of, and living with, HIV. While an effort to manage HIV infection through practising safer sex is relevant to mitigate sexual transmission, it can be challenging to control the sexual practices of youth, or persuade them to condomise, if they do not prioritise this form of sexual risk. This should leave HIV testing as their primary self-protective strategy (and a priority health issue), but this is not necessarily the case. Research suggests that sexually active youth are not engaging actively in HIV testing. This study addressed this issue by investigating how sexually active university students aged 18-24 years at the University of KwaZulu-Natal on the Pietermaritzburg campus constructed HIV risk; how they constructed and positioned themselves and others in relation to HIV risk; how their constructions and positioning worked, and what they achieved by using them in this way, in relation to their own practice of HIV testing. Convenience, purposive and snowball sampling methods were used to recruit five male and 15 female student participants. In-depth interviews were conducted with all participants, and the data were analysed discursively.

The findings of this study were that the majority of participants constructed HIV as an immense and overwhelming threat in terms of its prevalence in South Africa and on the Pietermaritzburg campus, and a few others constructed it as being a minimal threat. Their justifications for these constructions drew on existing discourses in advertisements, the mass media, educational awareness programmes, health research, interactions with health care providers and peers, and their experiences of health care on, and off campus.

In terms of participants' positioning in relation to HIV risk, most of them positioned themselves as being at risk but not at fault, but rather as potential victims of health policies that treat HIV using antiretroviral therapy, rendering it invisible in the 'everyday' life. Some of these participants referred to their experiences of a partner cheating, or the possibility of them cheating, and exposing them to risk situations, while others attributed their risk to other people's destructive behaviours, such as at risk of a violent rapist; an unknown male figure who is positive, and at risk from non-sexual transmission routes, such as exposure to contaminated blood, or 'touching others'. This positioning adopted by these participants positions them as unable to defend themselves against

HIV, and as victims. A consequence of this positioning is that other people are made responsible for creating one's HIV risk, and one is dependent on these people to avoid HIV transmission. In terms of participants' engagement with HIV testing, their testing practices suggest that they do not test regularly, and that testing is not part of their management of HIV risk. Those who reported testing did it in a crisis. They were concerned about being infected with HIV after engaging in unprotected sex, or concerned about being betrayed by a partner and being exposed to HIV risk, or concerned about symptoms related to having AIDS.

This study concludes that although most participants constructed and positioned themselves as being aware of how serious the threat of HIV is in their setting, they distanced themselves from this risk. This relates to the negative identity of being HIV positive, having a visible sickness, with a body severely affected, wounded, degraded, and attacked, which then also puts one at risk of stigma. In this situation, the positions which are available to them are limited, and the discourses that are available in their context limit their health actions and practices, particularly their engagement with HIV testing as a protective practice. It is as if prioritising HIV prevention through testing does not help them in the development of their desired identity. In fact, it seems to generate a negative HIV identity, and this works to undermine the value of HIV testing in their everyday life. Thus, their avoidance of HIV testing is one of their many small actions to protect themselves from the negative identity, and from knowing it, and others from associating it with them.

To address this avoidance of HIV testing, this study recommends that health interventions need to focus on subtle aspects of HIV risk amongst youth, such as the cultural meanings they attach to it, their positioning in relation to it, and their ways of responding to it through testing in terms of what informs their practices, and how and why their processes around testing are maintained and sustained (and what they are), rather than simply enhancing students' knowledge and improving coverage in the HIV testing services on, and off Pietermaritzburg campus. More discursive qualitative research on the topic of HIV risk and HIV testing amongst students across the University of KwaZulu-Natal campuses is suggested to understand how HIV testing strategies and interventions on its campuses have worked. In view of this, this study provides baseline information within which the findings of subsequent work could be compared.

Keywords; HIV risk, HIV testing, social constructionism, discourse analysis, students, South Africa

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List of acronyms and abbreviations

ABC	Abstain, Be Faithful and Condomise
AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
CHASU	Campus HIV and AIDS Support Unit
CRHCS	Commonwealth Regional Health Community Secretariat
ELISA	Enzyme-linked immunosorbent assay
HCT	HIV counselling and testing
HEAIDS	Higher Education HIV/AIDS Programme
HIGHER HEALTH	Higher Education and Training Health, Wellness and Development Centre
HIV	Human immunodeficiency virus
HIVST	HIV self-testing
HPCSA	Health Professions Council of South Africa
HSRC	Human Sciences Research Council
HTS	HIV testing services
IEC	Information, education and communication
IHME	Institute for Health Metrics and Evaluation
LGBTQIAP	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, and Pansexual
SABSSM	South African National HIV Prevalence, Incidence, Behaviour and Communication Survey
SANAC	South African National AIDS Council
STIs	Sexually transmitted infections
TB	Tuberculosis
TVET	Technical and Vocational Education and Training College
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary counselling and testing
WHO	World Health Organisation

CHAPTER ONE: INTRODUCTION

1.1 Background of this study

The human immunodeficiency virus (HIV), which is a virus that attacks one's immune system, and the acquired immune deficiency syndrome (AIDS), which is the latter phase of HIV infection, have long been conceptualised as an epidemic in the medical discourse. The Joint United Nations Programme on HIV/AIDS [UNAIDS] (2015) defines an epidemic as the occurrence of an infectious illness affecting many people, more or less at the same time, or possibly within an ample contiguous space of time. This highlights the medical and technical characteristics of the disease and its spread. However, the way the HIV and AIDS epidemic is defined in this study goes beyond this biomedical definition. Drawing on the assumptions of the discursive approach, this study argues that cultural meanings, perceptions, understandings, common sense knowledge, and practices associated with the spread of, and prevention of HIV, particularly HIV testing, are not pre-given or fixed, or simple, or unmediated, or directly observable reality as positivist approach assumes, but rather actively constructed in everyday interactions, and thus constitute social realities (too multiple to name).

Several researchers define HIV as an infectious condition whose predominant point of transmission (90%) is sexual (Blignaut et al., 2015; Department of Health, 2016; George et al., 2019; Johnson & Dorrington, 2020; Kharsany & Abdool-Karim, 2016; Mbelle et al., 2018; Parker et al., 2014; Simbayi et al., 2019; UNAIDS, 2015). The unprotected penetrative peno-vaginal and peno-anal sexual intercourse with a person living with HIV account for almost 85% of new infections (UNAIDS, 2015). This is followed by non-sexual routes, such as the exchange of blood from the mother to the child during pregnancy, at birth or breastfeeding, exposure to contaminated blood through blood transfusion or organ transplant, and multiperson use of injecting equipment (UNAIDS, 2015). This hierarchical classification of the HIV transmission routes, with the risks associated with sexual activity above other risk practices, constructs sexual relationships as entwined with HIV risk. This means that the ways in which people respond to this transmission are related to their constructions about HIV and sexual activity.

The dominant discourse in scientific health research constructs youth aged 15-24 years in South Africa as being a sexually active group and, consequently, as at increased risk of exposure to HIV, or continued transmission (Cilliers et al., 2018; Johnson & Dorrington, 2020; Kharsany

& Abdool-Karim, 2016; Linganiso & Gwegweni, 2016; Peltzer & Matseke, 2013; Pettifor et al., 2012; Ritchwood et al., 2019; South African National AIDS Council [SANAC], 2017; Van der Riet et al., 2018), including university students (Blignaut et al., 2015; Evans et al., 2018; Gwala, 2019; Heeren et al., 2013; Higher Education HIV/AIDS Programme [HEAIDS], 2010; Higher Education and Training Health, Wellness and Development Centre [Higher Health], 2020; Maughan-Brown & Venkataramani, 2018; Mbelle et al., 2018; Mthembu, 2017; Nene, 2014; Paul et al., 2014). The risky sexual activities and practices that youth in South Africa engage in include but are not limited to:

> Sex with multiple sexual partners, unprotected sex, high risk of sexual coercion and abuse, sexual intercourse under the influence of alcohol and substance use, high frequency of sex, age differences in relationships and transactional sex. (Department of Health, 2010, p.46)

The above patterns of sexual activities and practices are reported in some studies as being prevalent in South African universities (see Evans et al., 2018; HEAIDS, 2010; Heeren et al., 2013; Higher Health, 2020; Gwala, 2019; Maughan-Brown & Venkataramani, 2018; Mbelle et al., 2018; Mthembu, 2017; Mutinta et al., 2013; Nene, 2014; Paul et al., 2014). However, the prevalence of the above patterns of sexual practices in South African universities does not mean that students are not aware of HIV risk and prevention practices, or do not position themselves as being threatened by it, or the risk of contracting it, but rather, they are so much invested in sexual relationships, which is a different kind of prioritisation of self (Van der Riet et al., 2018). It is this form of investment in the self that creates the possibility for risk, given that heterosexual intercourse is considered the leading HIV transmission route amongst youth.

While an effort to address HIV risk through practising safer sex is relevant to mitigate sexual transmission of HIV amongst youth, which is the primary assumption behind the HIV prevention initiatives and policies in South Africa, it is not a straightforward process. One of the concerns is that sexual activity is not a condition that can be externally assessed because it is both a private affair, and a social and interactive event (Durojaiye, 2011; Mbelle et al., 2018; Pettifor et al., 2012). It is not then possible to ‘control’ their (youth) sexual practices or persuade them to condomise if they do not perceive their actions as problematic. In light of this, one of the possible practices youth could use to protect themselves from HIV infection is to engage actively and regularly with HIV testing. Several researchers have argued, based on studies of HIV risk and prevention through HIV testing, that receiving an HIV test service has a moderate positive influence on one's sexual behaviour (George et al., 2019; HEAIDS, 2010; Kabiru et al., 2013; MacPhail et al., 2009; Miller et al., 2017; Mohlabane et al., 2016; Pettifor et al., 2012; Ritchwood et al., 2019; Shisana et al., 2014; Walensky et al., 2011). In one of these studies (see George et al., 2019), focussing on the impact of HIV testing and antiretroviral therapy (ART) services on risky sexual behaviour amongst the key population of youth in the uMgungundlovu District in the KwaZulu-Natal province of South Africa, the participants who reported engaging actively in HIV testing also reported learning skills to support positive living. Such skills include negotiating safe sex in relationships, assessing HIV risk, proper nutrition, and changes in social norms. While the extent to which the activity of HIV testing influenced the skills gained by the participants in George et al.'s (2019) survey is unclear, it suggests the need to promote young people's readiness to engage in early and routine HIV testing as a primary solution to the threat of HIV.

The South African government has made some progress in terms of health messaging which intends to shape youth's responses to HIV risk through HIV testing. In its 2017-2022 National Strategic Plan (see SANAC, 2017), three major strategies and targets focussing on youth are highlighted. Firstly, scaled-up free HIV testing services. Secondly, routine HIV testing for all youth attending health care facilities irrespective of whether they engage in higher-risk practices and sexual behaviours, or show indicators of a possible HIV exposure. Thirdly, increasing knowledge and awareness of the threat of HIV and prevention practices. This focus on access to the HIV testing service, and increasing knowledge and awareness amongst youth seems to be drawing on the assumptions of the positivist approach. Within such a perspective, people are constructed as being accountable and able to make conscious and rational decisions to take health actions based on their adequate knowledge and information about risk (Ajzen, 1991; Brown, 1995; Glanz & Reimer, 2008).

The above three major strategies and targets suggest that youth in South Africa are well-informed about HIV risk and know that HIV testing is the appropriate health practice in response to it. An increase in knowledge and awareness about HIV amongst youth in South Africa is reported in the most recent South African National HIV Prevalence, Incidence, Behaviour and Communication Survey (SABSSM) conducted by the Human Sciences Research Council (HSRC) in 2017. In the HSRC survey (Simbayi et al., 2019), young people between the ages of 15-24 years are said to have significantly higher knowledge about HIV transmission and prevention practices compared to people aged 50 years and older. The age range of the participants of this study (18-24 years) falls within this subpopulation in South Africa constructed as being knowledgeable about HIV. It is, therefore, expected that this high level of knowledge and awareness should motivate youth in South Africa to engage actively and regularly in HIV testing, but this does not seem to be the case. Many studies in South Africa report that, youth aged 15-24 years are not engaging actively in HIV testing (Mabuto et al., 2019; Maughan-Brown & Venkataramani, 2018; Miller et al., 2017; Tenkorang, 2016), including university students (Blignaut et al., 2015; Haffejee et al., 2018; HEAIDS, 2010; Heeren et al., 2013; Kabiru et al., 2013; Paul et al., 2014). The consequence of this lack of engagement with HIV testing is that some youth in South Africa are undiagnosed. George et al. (2019), Miller et al. (2017), and Ritchwood et al. (2019) argued that people living with HIV but not aware of their status are likely to continue to engage in behaviours and sexual patterns that put uninfected persons at risk of HIV transmission. Being a very sexually active group, youth are, therefore, at high risk of exposure to HIV and, or continued transmission.

The critical questions that need to be addressed, therefore, are, "how and why is it that youth in South Africa do not engage actively in HIV testing, yet they are knowledgeable about HIV and have access to resources that support this health practice?" According to Maticka-Tyndale (1992), knowledge must become part of everyday social interaction to influence individual behaviour. Parker (1992) argued that in a discursive analysis, subjects, like the student participants, are viewed as investing in discourses, drawing on them and incorporating them into their talk, particularly those that reinforce or support their own identity, and this could be seen as functioning to create certain social practices about them in the conversation. Inspired by Maticka-Tyndale (1992) and Parker's (1992) arguments, this thesis argues that to understand the HIV testing practices of youth who are potentially at high risk of HIV infection based on their activities of unsafe sex, in terms of what informs their testing practices, and how and why their processes around testing are maintained and sustained (and what they are), one needs to do as follows. Firstly, to explore what youth know, have heard, or experienced about HIV risk. Secondly, to identify discourses that they draw on to describe, account for, or explain their constructions of, and positioning in relation to HIV risk. Thirdly, to point out their methods of addressing HIV risk, that is, their health practices, such as HIV testing, which is the focus of this study. This study, therefore, adopted a social constructionist approach to investigate the problem of HIV risk in relation to the HIV testing health practice amongst university students aged 18-24 years at a South African university. Before presenting ongoing debates on the problem of HIV and the practice of HIV testing amongst youth in general in

South Africa and globally, and university students, in particular, it is essential to note what is meant by the terms, youth and young people.

The UNAIDS Terminology Guideline released in 2015 defines youth and young people as relating to the period between 15-24 years of age, and the period between 10-24 years of age, respectively. South Africa's National HIV Testing Services (HTS) policy document released in 2016 draws on a similar construction of young people. Despite these differences in the age ranges, these terms are often used interchangeably in health research and interventions. For this reason, this study will use the terms, youth and young people, to cover the persons between the ages of 18-24 years, which reflects the age range of the university students who took part in this study.

Similarly, before exploring the various discourses on HIV risk and HIV testing practice apparent in health research, the global health reports, South Africa's National Health Reports, South Africa's National Health Policies, and accessible media health reports, it is important to note what is meant by the term, discourse. As a concept, a discourse has been defined in multiple interrelated, yet different ways in both linguistic and social research. Linguists define discourse as frameworks of meanings produced in language, and linguistic analysis of discourse as the analysis of the language used to describe an object, or a cultural practice (Stubbs, 1997). Michel Foucault, a well-known sociologist, defines discourse as:

> Ways of constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such knowledges and relations between them. Discourses are more than ways of thinking and producing meaning. They constitute the 'nature' of the body, unconscious and conscious mind and emotional life of the subjects they seek to govern. (Weedon, 1987, p. 108)

A general consensus in these two research fields (linguistic and social research) is that a discourse is a way of producing a particular kind of knowledge about a social phenomenon under study. Drawing on these definitions, a discourse in this study will be seen as entailing a way of actively constructing perceptions, meanings, knowledge, and understandings about HIV risk and HIV testing practices within a given historical, social, and cultural context.

This thesis begins with a synopsis of the extent of the problem of HIV and AIDS globally, in sub-Saharan Africa, and South Africa, and in its universities, in particular. In doing this, the epidemiological and demographic HIV and AIDS projections are drawn on.

1.1.1 HIV risk: A global synopsis

The modelling on HIV and AIDS prevalence for the period 1990-2019 constructs this disease as a global epidemic. By the end of 2019, the global epidemiological data on HIV and AIDS prevalence and trends estimated about 75.7 million people as having been infected with HIV or AIDS, and about 32.7 million people as having died due to AIDS-related illnesses, since it was first recognised in the United States of America at least in the mid to late 1970s (UNAIDS, 2020). The UNAIDS attributed these morbidities and deaths to the late diagnosis of HIV, low antiretroviral therapy (ART) coverage, and challenges related to linkage and retention in care.

The UNAIDS (2020) report also projected that about 38 million people were living with HIV or AIDS globally by the end of 2019. Out of this figure, about 1.7 million people were estimated to be newly infected in that year (2019). The UNAIDS (2020) projections also estimated that approximately 30% of the global total of people living with HIV in 2019, and nearly half of the global new HIV infections, are young people between the ages of 15-24 years. Within that age range (15-24 years), young women are disproportionately more affected by HIV infection compared to their male counterparts (UNAIDS, 2020). Many studies attribute the high HIV prevalence and incidence rate amongst youth to their limited prevention practices, particularly HIV testing (George et al., 2019; HEAIDS, 2010; Higher Health, 2020; Mabuto et al., 2019; Maughan-Brown & Venkataramani, 2018; Mbelle et al., 2018; Miller et al., 2017; Mohlabane et al., 2016; Tenkorang, 2016). The age range of the participants of this study (18-24 years) is part of this pool of potential people who might acquire HIV compared to older age categories, or living with it, and not engaging in HIV testing, and this is a part of this study’s rationale.

Furthermore, the UNAIDS (2020) report estimated about 690000 people as having died due to AIDS-related sicknesses in 2019. According to the UNAIDS (2020) modelled data, AIDS is still considered the leading cause of death amongst youth aged 10-24 years in Africa. The UNAIDS (2020) report further projected that about 7.1 million people living with HIV in 2019 had not been tested and were not aware of their status, and nearly half of this figure were youth between the ages of 15-24 years. Miller et al. (2017) argued that people who are infected with HIV but are not aware that they have been infected potentially transmit nearly 70% of the new HIV infections to others. This suggests that if people, particularly the key population of youth, could get tested for HIV regularly and, if positive, initiate ART treatment and adhered to it, and given information on effective options to reduce the risk of transmission and re-infection, such as correct and consistent condom use, many new HIV infections and AIDS-related deaths projected by the UNAIDS could potentially be avoided.

Moreover, the UNAIDS (2020) modelled data shows that the global burden of HIV and AIDS is in sub-Saharan Africa. The extent of the problem in this regard is explored in detail in the next section.

1.1.2 Overview of HIV risk in sub-Saharan Africa

Over the years, HIV infection has been constructed as a significant burden of disease in sub-Saharan Africa. The recent modelled data by the UNAIDS (2019) estimated about 25.5 million people as being infected with HIV or AIDS in sub-Saharan Africa, and 50% of this figure are younger than 18 years (UNAIDS, 2019). The UNAIDS (2019) modelled data also suggests that about three-quarters of the total number of people living with HIV or AIDS in sub-Saharan Africa (about 20.7 million) are in the East and the Southern region. The UNAIDS (2019) further noted that approximately 730000 of the HIV infections in the East and the Southern region were newly infected in that year (2019). This data constitutes a significant burden in providing health care, ART treatment, and support to people with HIV or AIDS. The consequence of this is that several people have succumbed to AIDS-related illnesses. The UNAIDS (2020) report estimates that about 300000 people in the East and the Southern region died due to AIDS-related sicknesses in 2019. This high HIV prevalence, incidence and AIDS-related deaths in the East and Southern regions of sub-Saharan Africa construct HIV and AIDS as an epidemic of grave proportions in these two regions.

Although many governments in the East and Southern regions of sub-Saharan Africa have officially declared HIV and AIDS as being a disaster that requires emergency action to slow down its transmission and mitigate its impact, the growing population of people living with HIV or AIDS and those who succumb to AIDS-related sicknesses in these two regions, is still concerning. Mulwo et al. (2012) argued that the slow pace of tackling the problem of HIV and AIDS in these two regions of sub-Saharan Africa is related to limited financial and human resources to support and sustain behaviour change, a prevalence of other diseases, poverty, hunger, political instability, tribal battles, and civil conflicts.

Moreover, the UNAIDS (2020) modelled data shows that the burden of HIV and AIDS in the Southern region of sub-Saharan Africa is unevenly distributed across countries, with South Africa and Swaziland being disproportionately affected. In the next section, I will discuss the current state of the problem in South Africa, which is the country where this study was undertaken. In doing this, the annual prevalence and incidence rates and AIDS-related deaths, and the findings of the recent SABSSM by the HSRC, are drawn on.

1.1.3 Contextualising HIV risk in South Africa

Over the course of several decades in South Africa, the population of people living with HIV or AIDS has steadily increased, to about 7.9 million people in 2017, according to the recent HSRC survey (Simbayi et al., 2019). This is a prevalence rate of approximately 14.6%, and significantly higher compared to the prevalence rate of 12.6% in 2012, and 10% in 2008 (Simbayi et al., 2019). This high HIV prevalence in the country has led to a potential rise in new HIV infections. The HSRC survey estimated about 231000 people as newly infected with HIV in 2017. This high HIV prevalence and incidences rates have also led to a parallel rise in AIDS-related deaths. The UNAIDS (2019) estimates about 72000 people as having died due to AIDS-related sicknesses in 2019 in South Africa. However, it is significant that this figure is the lowest point of mortalities observed in the last five years in South Africa, an indication of the remarkable progress made in terms of diagnosis and treatment of people living with HIV or AIDS. Still, youth are disproportionately affected by AIDS-related deaths in South Africa. The data on the percentage of fatalities published in the uMgungundlovu District Health Plan for 2018/2019-2020/2021 reported the three leading causes of death amongst youth as being AIDS-related illnesses (Department of Health, 2018). However, this data on the HIV prevalence and incidence rates, and AIDS-related deaths in South Africa is daunting, and gives a general sense of the full ramifications of the problem in the country. These ramifications are unevenly distributed across the country in terms of age, marital status, geographic location, race, province, and district.

1.1.3.1 Age

The HSRC survey reported that people between the ages of 15-49 years are disproportionately affected by HIV, with a prevalence rate of about 26.4% in 2017 (Simbayi et al., 2019). Of significance to this study is that students fall into this age range. Simbayi et al. (2019) also observed far higher new HIV infections in 2017 amongst youth aged 15-24 years (about 88400), and the prevalence was high amongst black African youth. A decline in condom use amongst youth might have contributed to these increases in HIV infections. In the HSRC survey, a large proportion of youth aged 15-24 years who reported being in concurrent sexual partnerships also reported never having used a condom in their most recent activity of sex, with 52.7% being female and about 40% being male (Simbayi et al., 2019). The age range (18-24 years) of the participants of this study is that of the subpopulation constructed as being burdened by HIV new infections and as not being proactive in condom use in South Africa, and this is a part of this study's rationale.

Several studies have also reported a significant decrease in condom use on first sexual intercourse amongst university students in South African universities (Evans et al., 2018; HEAIDS, 2010; Higher Health, 2020; Mbelle et al., 2018), including the University of KwaZulu-Natal students (Chebitok, 2017; Gwala, 2019; Moodley, 2007; Mthembu, 2017; Mutinta et al., 2013; Nene, 2014; Okelola, 2019). There are possible explanations for a decline in condom use among students in South African universities.

To explain the low rates of condom use amongst youth, Shisana et al. (2014) argued that health messages around condom use no longer receive considerable attention as they did a decade ago. Another possible explanation for a decline in condom use amongst youth given by Shisana et al. (2014) is that a drop in condom use mirrors the impact of risk compensation which comes with the increasingly available ART treatment, also called behavioural disinhibition, or treatment optimism. To elaborate on this, Shisana et al. (2014) argued that the hope inspired by the extensive availability of, and access to ART treatment might lead to a decrease in condom use. It is worth noting that there has been very little evidence to support the risk compensatory behaviours, and so it is likely that there is a more complex interaction between young people's sexual relationship factors and risk perception. Generally, most young people get as much sex as they can within parameters of what they think of as acceptable sex, and HIV does not figure in this at all. It may also be that those using HIV prevention services already have concerns about their health, and those at high risk of HIV are just not engaging in health services at all.

Although the impact of the expansion of other available HIV prevention options, such as oral pre-exposure prophylaxis and voluntary medical male circumcision, on condom use among university students in South Africa has not been studied much, such studies could also explain the low rates of condom use amongst youth in the country, and may impact how people think about HIV testing and how important it is.

The national HTS policy document recommends pre-exposure prophylaxis be incorporated in all entry points of HIV prevention, treatment and care services (Department of Health, 2016).

This is to allay stigma when the client is seeking HIV testing and pre-exposure prophylaxis services (Department of Health, 2016). To enhance their use, the current National Strategic Plan for 2017-2022 aims to enrol more than 85,858 HIV-negative people into pre-exposure prophylaxis by 2022, and young people have been the focus of this initiative based on their high risks of contracting HIV (SANAC, 2017). As of June 2020, an estimated 45000 people had been initiated into oral pre-exposure prophylaxis (Bekker et al., 2020). This figure is an indication of a relatively slow response to the government-promoted pre-exposure prophylaxis programming in South Africa. According to Bekker et al. (2020), the reasons for this low uptake, and uptake in the use of oral pre-exposure prophylaxis include structural, behavioural and/ or psychological factors.

The initial randomised trial conducted in South Africa among 191 young women to evaluate their responses to oral pre-exposure prophylaxis showed relatively high acceptability (95%), adherence (75%), and willingness to use them (Bekker et al., 2017). Bekker et al. (2017) attributed these to the minimal side effects of using them. Although Bekker et al.'s (2017) study reported high acceptability, adherence, and willingness to use oral pre-exposure prophylaxis, eight of their participants tested positive at the end of that research, which is an indication that pre-exposure prophylaxis does not offer 100% protection from HIV infection. Based on their findings, Bekker et al. (2017) recommended that pre-exposure prophylaxis should not displace the use of other effective HIV prevention practices (which may include regular HIV testing, condoms, sexual abstinence, lubrication, contraception, sexually transmitted infections [STIs] management and risk reduction counselling), but should be used as a supplement to these. The findings of this particular study suggest that the expansion of access to pre-exposure prophylaxis may lower condom use among youth in South Africa. This may relate to young people's perceptions of themselves as being at low risk of HIV infection when taking pre-exposure prophylaxis.

The epidemiology of HIV in South Africa indicates that approximately 90% of all new infections in sub-Saharan Africa (Dwyer-Lindgren et al., 2019), including South Africa (Auvert et al., 2006; Department of Health, 2016; George et al., 2019; Johnson & Dorrington, 2020; Kharsany & Abdool-Karim, 2016; Mbelle et al., 2018; Simbayi et al., 2019) are sexually transmitted. As part of the inclusive prevention effort, South Africa has directed its focus on the national roll-out of voluntary medical male circumcision programme, and the service is free of charge (SANAC, 2017). There is credible scientific evidence drawn from systematic reviews conducted in sub-Saharan Africa linking the removal of the foreskin with reductions in the risk of HIV transmission from women to men by 60% (Dwyer-Lindgren et al., 2019). A randomised controlled trial in South Africa which used a larger sample size of young male participants (3,274 men) aged 18–24 years to explore the effectiveness of voluntary medical male circumcision in reducing the risk of HIV infection (Auvert et al., 2006) also reported similar findings as Dwyer-Lindgren et al.'s (2019) study. In Auvert et al.'s (2006) study, participants who had been medically circumcised had a decreased risk of female-to-male transmission of HIV by up to 61%. Auvert et al.'s (2006) study concluded that if risky sexual behaviours are controlled among medically circumcised men, voluntary medical male circumcision can potentially offer protection from HIV risk of an equivalent nature to a high efficacy vaccine such as pre-exposure prophylaxis. Auvert et al. (2006) also found that men who had been circumcised did not use a condom consistently or seek health services more often. The main reason for the particularly low condom use in Auvert et al.'s (2006) study was related to participants' positioning themselves as being circumcised, which implied that their risk of contracting HIV through unprotected sexual intercourse was relatively low. Of significance to this study is that male students fall into the 15-24 years age range, which is the age group that took part in Auvert et al.'s (2006) study. Auvert et al.'s (2006) findings, therefore, suggest that the association of being medically circumcised with the reduced risk of HIV infection may lower condom use among young men in South Africa.

Moreover, there is compelling evidence from studies conducted among students in South African universities suggesting that students' acceptability of condoms has always been low. The HEAIDS (2010) survey on HIV prevalence and trends among students reported that a condom was likely to be used in casual sex, once-off sex, new sexual relationships, and discontinued in longer-term partnerships. The HEAIDS survey also reported that condom use with the most recent sexual partner was generally high (65%) among students aged 18–24 years, and 60% of those aged 25 years and older as compared to the general population. Relationship status partly explained this gap between the age range of condom use at last sex and consistent use. According to HEAIDS (2010), students aged 25 years and older were likely to be in long-term partnerships where condom use was likely to be discontinued. A decline in condom use and inconsistency in use is also reported in small scale studies among students at the University of KwaZulu-Natal (Chebitok, 2017; Gwala, 2019; Mthembu, 2017; Nene, 2014; Okelola, 2019).

There are substantial user-level and service-related challenges which affect actual condom use. The female condom is associated with feelings of irritation on the vagina, vulva, penis, or anus;

reduced feelings of pleasure from intercourse; and fears that it may slip into the vagina during intercourse (Beksinska et al., 2012). Beksinska et al. (2012) also noted that the outer ring is perceived as cumbersome. The male condom, on the other hand, is associated with diminished sexual enjoyment (Chebitok, 2017; Higgins et al., 2010; Jangu, 2014; Nene, 2014; Protogerou et al., 2013); feelings of irritation on the vagina, penis, or anus; and promiscuity and mistrust in the relationship (Protogerou et al., 2013). Free condoms are associated with low quality, bad smell, infections and ineffectiveness (Beksinska et al., 2012; Higgins et al., 2010; Jangu, 2014; Protogerou et al., 2013).

The low condom use, inconsistent use, or its absence in sexual activity is also constructed within the realm of gender, power and sexuality. According to Beksinska et al. (2012) and Higgins et al. (2010), women have limited ability to make independent decisions on sexual issues in heterosexual relationships. The socio-cultural norms challenging the acceptance of condoms also hinder actual use. According to Beksinska et al. (2012) and Jangu (2014), condoms are linked with decreased chances of marriage, which goes against the goal of many young African women. Other studies (Coates et al., 2011; Jangu, 2014) found that negotiating condom use was viewed as going against the cultural constructions of sexual activity as signifying procreation, and were hence avoided. All these issues associated with the male condom and the female condom may negatively impact on young people’s negotiation and actual use of a condom, creating a far higher risk of exposure to HIV in sexual activity.

A recent survey by Gwala (2019) on sexual practices of students at the University of KwaZulu-Natal sheds further light on this decline in condom use amongst youth in South Africa. Gwala (2019) attributed the low rates of condom use amongst the University of KwaZulu-Natal students to the nature of the activity of sex as an event that one cannot prepare oneself for, and in most cases, it is unplanned and spontaneous. While this lack of condom use in sexual relationships reflects a different prioritisation of the self, it creates the risk of HIV infection for youth (Van der Riet et al., 2018). Hence, an alternative practice that sexually active youth need to consider to protect themselves against HIV infection is to test regularly. HIV testing itself does not reduce one’s risk, but facilitates earlier access to care when one tests positive, to minimise negative treatment outcomes and encourage onward transmission prevention (Department of Health, 2016).

1.1.3.2 Marital status

The HSRC survey found that unmarried people were disproportionately affected by HIV infection, with a prevalence rate of about 1.07% compared to those who are married, whose prevalence rate was about 0.61% (Simbayi et al., 2019). This HIV prevalence, and trends in relation to people's marital status, are significant in relation to the student population of this study who are single/unmarried.

1.1.3.3 Geographic location

The HSRC survey found that people who are living in urban areas (geographic area or region surrounding a city or a town) were disproportionately affected by HIV infection, with a prevalence rate of about 0.58% compared to those living in rural areas (geographic area located outside towns and cities), whose prevalence rate was about 0.23% (Simbayi et al., 2019). Similarly, this HIV prevalence and trends in terms of where people live (place of residence) are significant in relation to the student population of this study who come from urban and rural areas.

1.1.3.4 Race

The HSRC survey found that the risk of HIV infection was not equally distributed across the four racial groups used to classify people in South Africa. The HSRC survey found that black Africans were heavily burdened, with a prevalence rate of about 16.6%, followed by coloureds, with a prevalence rate of about 5.3%, followed by whites, with a prevalence rate of about 1.1% (Simbayi et al., 2019). Indians/Asians were the least affected by HIV infection, with a prevalence rate of about 0.8% (Simbayi et al., 2019). Likewise, this HIV prevalence and trends in terms of people's race are significant in relation to the student population of this study who falls into these groups.

1.1.3.5 Province

The HSRC survey found that the risk of HIV infection was not evenly distributed across all of the nine South African provinces. The KwaZulu-Natal province had the highest prevalence of people living with HIV, with a prevalence rate of about 18.1% for individuals aged 15-49 years (Simbayi et al., 2019). Although this figure (18.1%) has receded from 27.6% reported in 2012 in this province (Shisana et al., 2014), this rate is very high if one was to compare it with the Northern Cape province, a least burdened province in South Africa, with a prevalence rate of about 8.3%. Correspondingly, this HIV prevalence and trends in relation to the most burdened province in South Africa are significant in relation to the student population of this study who comes from this province.

Within the KwaZulu-Natal province, the uMgungundlovu district has experienced an escalating prevalence of HIV infections than in the other eleven districts. A survey published recently in the Institute for Health Metrics and Evaluation [IHME] (2019, May 15) website argues that the uMgungundlovu district is at the epicentre of the global HIV epidemic, with a prevalence rate of about 29.7% for individuals aged 15-49 years. This high prevalence has also been reported in two recent large-scale surveys conducted in the uMgungundlovu district (George et al., 2019; Johnson et al., 2017), and in four government reports, namely, the Provincial Annual Progress Report for 2015-2016 (KwaZulu-Natal Provincial AIDS Council, 2017); the uMgungundlovu District Health Plan for 2018/2019-2020/2021 (Department of Health, 2018); the National Antenatal Sentinel HIV Prevalence Survey conducted in 2010 (Department of Health, 2011); and the two SABSSM surveys (Simbayi et al., 2019; Shisana et al., 2014). Likewise, this HIV prevalence and trends in relation to the most burdened district in the KwaZulu-Natal of South Africa are significant in relation to the student population of this study who comes from the uMgungundlovu district.

Given, as indicated in this particular section, that HIV infection poses a considerable health threat to people in South Africa, one response would be that people should personalise the risk of HIV and act to prevent it by engaging actively in HIV testing, but that has not necessarily been the case. Research has shown that the general population in South Africa is resistant to HIV testing (Department of Health, 2016; Fomundam et al., 2017; Mohlabane et al., 2016; SANAC, 2017; Venkatesh et al., 2011). Hence, it would be valuable and important to study this resistance to HIV testing in the population with a high HIV prevalence and is potentially at higher risk of contracting HIV, which is sexually active youth, and this is a part of this study’s rationale.

In the next section, I will discuss the HIV trends and HIV testing behaviour amongst university students in South African universities. This is needed to paint the picture of the current state of the problem of HIV risk and HIV testing practice in the university from which the sampled students for this study were taken.

1.1.4 HIV risk in South African universities

This study builds on two major national reports on the HIV trends and behaviour amongst university students in South Africa. The first of these is the survey by the HEAIDS (currently known as Higher Health) in 2007–2008 at 21 tertiary institutions in South Africa to establish the prevalence and trends of crucial HIV-related indicators (knowledge, attitudes, behaviours, practices) amongst staff and students. The second is the recent Higher Health 2019-2020 annual report on HIV, TB and STIs screening and mental health in South African tertiary institutions. The HEAIDS (2010) survey reported an overall national HIV prevalence rate of about 3.4% in South African tertiary institutions (public universities and Technical and Vocational Education and Training (TVET) colleges). Higher Health (2020) annual report, on the other hand, paints a slightly rosier picture, with 1739 students testing positive for HIV out of a sample of 155719 students who tested on the campus health clinics and related facilities (mobile testing tents, library lawns, etc.) in 2019, representing a prevalence of about 1.1% in South African tertiary institutions.

In the HEAIDS survey, the risk of HIV infection was reported as not evenly distributed in universities across provinces. The KwaZulu-Natal province was heavily burdened, with a prevalence rate of about 6%, the highest compared to universities in other provinces in South Africa. Amongst the universities in the KwaZulu-Natal province, the University of KwaZulu-Natal (which is the location of this study) had a higher prevalence of students living with HIV (about 5.6%) compared to the other universities in this province, and in other universities in South Africa. Out of a sample of 1593 of the University of KwaZulu-Natal students who took part in the HEAIDS survey, 675 were living with HIV. This is a prevalence rate of about 2.4% of the total student population in this University at the time of the study (2007-2008).

The university sector in South Africa has more female students (59%) compared to male students (41%) (Higher Health, 2020). Similarly, the risk of HIV is not equally distributed between male and female students in South African universities. The HEADS (2010) survey found that female students were disproportionately affected by HIV infection as compared to their male counterparts, with prevalence rates of 4.7% and 3.2%, respectively. The HEAIDS survey also found that female students between the ages of 20-24 years at the University of KwaZulu-Natal had a high prevalence rate of about 26% relative to their male counterparts, whose prevalence rate was about 12%. This figure (26%) is also significantly higher than female students in other universities in South Africa. The majority of undergraduate students at the University of KwaZulu-Natal are in the age range of 18-24 years, and thus fall into this range of 20-24-year-olds who are reported in the HEAIDS survey as having a higher HIV prevalence, and as being at risk of HIV. This was one of the motivations for focussing on this age range of young people in the university setting of the University of KwaZulu-Natal.

While the HIV prevalence rate of about 3.4% (HEAIDS, 2010), and 1.1% (Higher Health, 2020) amongst tertiary students in South Africa is significantly low compared to the national HIV prevalence in the equivalent age group, which is approximately 26.3% in the 15-49-year-olds in 2017, according to the recent HSRC survey, HIV infections still pose a considerable threat to students in South African institutions of higher learning. The students in South African universities, including the University of KwaZulu-Natal, are younger than 35 years (South African Council on Higher Education, 2017), with the majority (59%) being in their early 20s (between 20-24 years) (HEAIDS, 2010; Higher Health, 2020). The 20-24 years old age bracket is that of the subpopulation reported in several studies in South Africa as being very sexually active, and as being at risk of HIV infection, and as not engaging in HIV testing (Cilliers et al., 2018; Johnson & Dorrington, 2020; Kharsany & Abdool-Karim, 2016; Linganiso & Gwegweni, 2016; Maughan-Brown & Venkataramani, 2018; Mbelle et al., 2018; SANAC, 2017; Simbayi et al., 2019).

In terms of students' engagement with HIV testing in South African universities, Higher Health (2020) found that students were not engaging actively in HIV testing. Higher Health (2020) observed a significant decline in HIV testing practice from 123527 in 2018, to 72977 in 2019, representing a decline of about 41%. Higher Health (2020) attributed this decline to fewer activations (campaigns and activities), and 'First Things First' health and wellness days in universities, particularly during the opening weeks of the academic year, which are usually peak health promotion and HIV testing periods. Higher Health (2020) also observed that students who viewed themselves as being at risk of HIV infection were less likely to volunteer for testing. Higher Health (2020) attributed this to students' fear of an HIV diagnosis. Higher Health's (2020) also noted that about 12% of students who engaged in HIV testing in 2019 were first-time testers, and six out of 10 testers were female students. This skewed sex ratio in HIV testing uptake also echoes the observed hesitancy amongst male students to the use of health services (Higher Health, 2020). However, a different finding regarding male students' uptake of the HIV testing service is reported in Okelola's (2019) study conducted with students at the University of KwaZulu-Natal. Okelola's (2019) study reported that male students were more likely to take an HIV test compared to female students. Okelola (2019) attributed the HIV testing practices of male students to their engagement in risky sexual behaviour with multiple female partners. In this regard, their motivation for taking an HIV test was to determine if they were still HIV negative (Okelola, 2019). Okelola's findings suggest that this difference in HIV testing behaviour between young male and female students is not so much about gender, but rather about an individual's relative HIV risk. However, this lack of active and regular engagement with HIV testing is the focus of this study, taking a social constructionist approach to investigating the problem of HIV risk and HIV testing amongst students at the University of KwaZulu-Natal.

The university students' vulnerability to HIV infection poses a challenge for their futures and their families, peers, friends, learning institutions, and the government. In the next section, I will discuss these possible effects.

1.1.5 Challenges raised by HIV and AIDS for students

While the risk of acquiring HIV may be problematic for all people, it may be more challenging for a university student. Research has shown that university students at the undergraduate level face difficulties, ranging from financial, academic, to socio-cultural (Cilliers et al., 2018; HEAIDS, 2010; Kabiru et al., 2013), and receiving an HIV diagnosis during this period may add an extra burden. For university students, in general, an HIV diagnosis is a life-changing experience that comes with the physical, social, emotional, and financial burden, and may negatively affect their subsequent potential career development (Cilliers et al., 2018; Evans et al., 2018; Kabiru et al., 2013; Van der Riet & Nicholson, 2014). A university student living with HIV may spend extra money to get proper nutrition and maybe some physical exercises at the fitness centre, which is the recommended change in behaviour for people living with HIV (Health Professions Council of South Africa [HPCSA], n.d.). Students in the late stage of HIV (AIDS) may also experience challenges related to balancing their health needs and university demands, which may lead to drop-out, or lengthening the time to complete their studies (Mulwo, 2008). Increasing drop-out rates may create financial difficulties in universities because school fees are essential revenue sources (Mulwo, 2008).

Concerns are also being raised over mental health challenges experienced by young people living with HIV or AIDS, and how they affect their decisions to access ART treatment, care, choice of sexual partner, or change their behaviour. A young person living with HIV may experience low self-esteem, social withdrawal (Kabiru et al., 2013); worries about health and death (Evans et al., 2018; Pengpid et al., 2013); anger and denial (Department of Health, 2010; Kabiru et al., 2013); shock, shame, depression, and stress (Pengpid et al., 2013); and suicidal ideation, stigma, and discrimination (Govender & Schlebusch, 2013; Simbayi et al., 2007). In their study on mental health and HIV sexual risk behaviour amongst tertiary students in Limpopo, Pengpid et al. (2013) found that participants who tested positive for HIV experienced mental health issues (stress and anxiety), which negatively impacted on their urgency to change their sexual behaviour. Pengpid et al. (2013) further reported that participants who had been diagnosed with HIV reported engaging in risky practices, such as unsafe sex, alcohol abuse and cannabis use. This finding is similar to Patterson and Keefe's (2008) study on the application of the social constructionism approach as a basis for macro-level interventions in people living with HIV and engages in substance abuse in the United States of America. Patterson and Keefe (2008) found that people living with HIV were three times more likely to develop alcohol and other drug addictions at some point during their lives compared to those living without it. Patterson and Keefe (2008) attributed this to the stigma and discrimination that people who are living with HIV experience in society, which makes them feel socially isolated. In their attempt to address this isolation, people resort to binge drinking and substance use and abuse. Patterson and Keefe (2008) also argued that this might affect their adherence to ART treatment. Preventative practices, such as condom use, might also be lacking (Patterson & Keefe, 2008).

While there is no correct record of the AIDS-related deaths and illnesses in universities in South Africa, AIDS is still considered the leading cause of death amongst youth aged 10-24 years in Africa (UNAIDS, 2020), and this is especially the case in South Africa. The data on the percentage of mortalities published in the uMgungundlovu District Health Plan for 2018/2019-2020/2021 reported the three leading causes of death amongst youth as being AIDS-related illnesses (Department of Health, 2018). This might mean that fewer university students graduate and are not able to contribute to the economy of the nation, and this means what is invested in their educational process is wasted.

Given all the challenges raised by HIV and AIDS for students presented in this particular section, it might be expected that a university student would take the risk personally and act to prevent it at all costs through, for example, engaging in early and routine HIV testing. However, as earlier indicated, that has always not been the case. An investigation and exploration of university students' constructions of HIV risk and safety, what HIV risk and safety mean to them, and discourses they draw on when discussing risk and prevention, specifically HIV testing, might provide insight into this issue. For example, whether they talk about HIV as having severe consequences listed in the above studies (social, financial, mental, and emotional distress, death etc.), which might suggest that they are serious about it and could increase their need to adapt or engage in HIV testing as a protective practice; or whether they talk about HIV as not something serious, or a threat to themselves or others, which might reduce their need to engage in HIV testing.

In an attempt to encourage youth to respond to HIV risk through HIV testing, the National Department of Health has called for an effective partnership between researchers, private sectors, stakeholders, and civil society. As partner stakeholders, the South African institutions of higher learning have made considerable health messaging progress, a significant finding in the HEAIDS (2010) survey. In the next section, I will discuss the University of KwaZulu-Natal's (the locus of this study) commitment to managing HIV infections on its campuses.

1.1.6 University of KwaZulu-Natal's responses to HIV risk and HIV testing

According to Goldstein et al. (2003) and Patterson and Keefe (2008), individual or group responses to HIV may be understood through their social constructions of risk. Health promotion agencies at the University of KwaZulu-Natal, such as the University health care facilities (clinics), the Student Support Services, the HIV and AIDS Support Unit, and health researchers, tend to construct students as an 'at risk' group. As part of the University's responses to the risk of HIV amongst its students, it has invested a lot of money and effort in innovative programmes to encourage students to take on prevention, management, and caring roles. Young female students are in the spotlight in HIV prevention discourses, perhaps due to the well-established fact that young women are more vulnerable to HIV risk compared to their male counterparts (HEAIDS, 2010; Higher Health, 2020; Simbayi et al., 2019). The University's initiatives and programmes seem to be drawing on the information, education, and communication (IEC) health framework proposed by the SANAC, and supported by the National Department of Health. The primary goal of the IEC health framework is to encourage and sustain positive and healthy practices by increasing individual awareness (SANAC, 2017). In theory, knowledge and awareness about HIV and prevention are meant to translate to one's agency in making health decisions, such as taking charge over their sexuality, identifying and avoiding risky practices, and pursuing health-seeking behaviours like HIV testing, safer sex, voluntary medical male circumcision, adherence to pre-exposure prophylaxis and ART treatment (SANAC, 2017). The IEC health framework also functions as a social mobilisation approach, which is a way to raise public awareness around accepting and caring for people living with HIV (Department of Health, 2010).

The existing health promotion agencies which provide the HIV testing service to students across the University of KwaZulu-Natal campuses will now be presented. This is needed to give a background picture of the way the HIV testing service is being provided to students on campus, from advertising and health promotion, to the point where students receive actual service. These may contribute to how students construct HIV risk, HIV testing, and how they engage with HIV testing practice.

1.1.6.1 Campus HIV and AIDS Support Unit (CHASU)

The CHASU initiatives and programmes in South African public universities and TVET colleges are coordinated by the Higher Health managers and the campus health and wellness coordinators. The CHASU offices are on all five of the University of KwaZulu-Natal campuses. The primary goals of the CHASU are to: reduce myths, prejudice, stigma, and discrimination surrounding HIV and AIDS and HIV testing; increase awareness and acceptability of HIV testing; ensure that students have better access to health services that meet their specific needs; and influence their behaviour change (Higher Health, 2020). The campus health and wellness coordinators on the Pietermaritzburg campus recruit students, whom they call ‘peer education mentors’, as the key implementors of their programmes. The peer educators are trained in health-related areas, such as the HIV transmission routes, available treatment options, condom demonstration, STIs, human rights, communication skills, and the process of HIV counselling and testing.

The trained peer education mentors volunteer on a part-time basis to: provide quality, confidential, and localised HIV testing services to other students; facilitate referral to appropriate HIV prevention and management facilities on, and off campus; disseminate information about HIV and AIDS on campus; and organise and lead peer-risk prevention groups on campus. In theory, this array of health and wellness services are meant to increase students’ awareness of HIV risk and encourage them to take measures to minimise their risk. However, little is known about the short-term and long-term benefits of belonging to these peer-led risk support groups, their effectiveness, and their sustainability in HIV prevention amongst students. The use of peers as a means to pass health messages on, and to provide the HIV testing service to students on campus, illustrates how CHASU's initiatives draw on the peer-led approach to health education. There is overwhelming evidence suggesting that peer support services increase access to health-related services (Higher Health, 2020; HEAIDS, 2010; Mulwo, 2008; Musemwa, 2011), including HIV testing (Higher Health, 2020; Mohlabane et al., 2016; SANAC, 2017).

The CHASU attempts to use advertising methods such as posters, banners, and leaflets to 'sell' its health messages and the HIV testing service to students. In addition, students who engage in HIV testing are given incentives, such as a notebook, a pencil case, a pen, or a bag. The use of inducements to influence and encourage the uptake of health care services offered to youth in their habitat figures prominently in government and non-governmental health-related interventions. Research has shown that an incentivisation approach to health programmes targeting youth in South Africa encourages and increases the uptake of HIV testing (HEAIDS, 2010; MacPhail et al., 2009; Mohlabane et al., 2016; Pettifor et al., 2012). This study may help us understand whether and how students in this university make use of the CHASU's services to know their HIV status through testing.

1.1.6.2 Pietermaritzburg campus health clinic

The University of KwaZulu-Natal has health clinics on all its campuses. On the Pietermaritzburg campus, the University's health clinic has responded to the risk of HIV with a host of ongoing sexual health education programmes and HIV testing services directed at the student population. According to the National Department of Health (2016), HIV testing services (HTS) should be integrated with other health care services, such as family planning, treatment of tuberculosis (TB), STIs, and other communicable/non-communicable illness in both public, and private health sectors. This integration, which is sometimes referred to as the 'supermarket approach', aims to mitigate stigmatisation when the client is seeking the HIV testing service (Department of Health, 2016). However, this integration of the HTS service with other health care services in primary health care facilities seems to position the HIV testing process as exposing and risky compared to other health tests, so incorporating it with other health care services in a primary health facility is perhaps a way of de-emphasising it. The health care services and information offered together with the HIV testing service on the Pietermaritzburg campus health clinic include, but are not limited to fertility planning programmes; contraception, condoms and information; TB screening and treatment services;

STIs screening and treatment; pre-exposure prophylaxis; post-exposure prophylaxis; ART; HIV prevention and management services; voluntary medical male circumcision; and treatment of non-communicable diseases, such as headaches, abdominal pains, and minor injuries. By offering health services in this way, the Pietermaritzburg campus health clinic meets the National Department of Health's recommendation.

Like the CHASU's way of advertising its services, the campus health clinic uses mobile and outreach campaigns, posters, and the Department of Health's newsletters written in the local languages to meet the need for health services. This study may help us to understand how students construct these campus' health facility interventions, specifically HIV testing.

1.1.6.3 Student Support Services

The Student Support Services are available on all the University of KwaZulu-Natal's campuses. In the Pietermaritzburg campus, the Student Support Services are available in each College, which makes them convenient to students. The support services are provided by student psychologists, intern psychologists, registered counsellors, and qualified psychologists. The services are diverse, ranging from social, emotional and academic, career advice, to HIV and AIDS-related care and advocacy. The HIV support services range from dealing with an HIV positive status, decision making related to taking an HIV test and notifying a partner of positive status, managing sexual relationships, to facilitating referral to relevant HIV prevention and management services on, and off campus.

Similar to the CHASU and the Pietermaritzburg campus health clinic's way of promoting their services, the Student Support Services use brochures and pamphlets for advertising their services and providing health messaging to students. This study may help us to understand whether and how some students on the Pietermaritzburg campus use the Student Support Services to make health decisions related to knowing their HIV status through testing.

1.1.6.4 Mass communication resources

Lupton (1992) argues that mass communication resources in health promotion potentially influence the target audience's attitudes, beliefs, and health-related behaviours. On the University of KwaZulu-Natal campuses, students are exposed to many HIV and AIDS health messages through advertisements and awareness seminars. University students also have access to mass media that promote HIV-related health messages, such as television, radio, newspapers, and social media. Researchers have evaluated the effectiveness of mass communication in providing health messaging to students, and their responses to them at the University of KwaZulu-Natal (Kunda, 2008; Moodley, 2007; Mulwo, 2008). In particular, Moodley's (2007) study concluded that some students were not supportive of these health messaging programmes. Student participants in Moodley's (2007) study expressed a preference for a participatory approach, where they could become active agents in the HIV communication processes. Involving students actively in the conceptualisation of health messaging was also a recommendation of Kunda's (2008) study. As in Mulwo's (2008) work, the decision to comply with HIV prevention messages was primarily dependent on each participant's own sexual relationships, sexual histories, role in various social/peer groups, and their constructions of sex and sexual practices.

1.1.6.5 Intensifying second curriculum engagement

The second curriculum refers to an array of ongoing extramural learning opportunities provided by Higher Health managers, campus health and wellness coordinators, and peer educators to students in South African universities. In theory, this array of health and wellness services is meant to increase individual students' knowledge about health conditions (including HIV and AIDS), and equip them with skills related to self-assessment of risk, self-screening for HIV, and taking charge of their wellbeing (Higher Health, 2020). Higher Health (2020) further noted that many of the extramural learning engagements on campuses take the form of student dialogues and individual discussions, and on such occasions, students have the opportunity to take an HIV test. While there is no record or information on whether these learning and HIV testing activities are just a proposal, or have actually taken place on the Pietermaritzburg campus, they may contribute to how students construct HIV risk, and how they engage with testing practice. This study, therefore, may help us to understand whether some students on the Pietermaritzburg campus have participated in the extramural learning engagements in their context.

1.1.6.6 Integrating HIV in curriculum

According to Mulwo (2008), institutions of higher learning play a leadership role in research output, knowledge growth, knowledge dissemination, and policy development. The University of KwaZulu-Natal has taken a leadership role in responding to the risk of HIV amongst its students by integrating the topic of HIV and AIDS into its curriculum. The topic of HIV and

AIDS has received considerable attention from the staff and students in various disciplines. HIV and AIDS are integrated into the module's curriculum in various fields such as anthropology, criminology, philosophy, cultural studies, political science, psychology, sociology, ethics, history, legal studies, media studies, and others. The knowledge students acquire as a result of participating in these modules may contribute to how they construct HIV risk, what it means to them, and how they engage with HIV testing practice. There are also HIV and AIDS conferences, symposiums, and dialogues organised by this University on its campuses. The knowledge students acquire as a result of participating in conferences, conducting a research study, or reading other people's research, may contribute to how they understand HIV risk and how they engage with HIV testing practice.

The University of KwaZulu-Natal's HIV and AIDS policy released in 2005 is an example of the university's leadership role in addressing HIV and AIDS amongst students. In the next section, I will discuss the components of this University's policy document. This is needed to shed further light on this University's responses to HIV risk through HIV testing on its campuses.

1.1.6.7 University of KwaZulu-Natal's HIV and AIDS Policy

When one analyses the University of KwaZulu-Natal's HIV and AIDS policy document, it contains a number of sections presented below.

Firstly, is the section on obligations and responsibilities of the university. Under this is the clause which states that:

> The University of KwaZulu-Natal has an obligation to provide a safe working and study environment where employees and students living with HIV and AIDS are free from stigma and unfair discrimination, exposure to HIV is minimised, and to organise ongoing awareness and prevention activities for students and staff. (University of KwaZulu-Natal AIDS Programme, 2005, p.6)

The discourse contained in the above clause positions the University's management as being committed to protecting the human rights and dignity of the members of the University community (staff and students) who have HIV, and as prioritising HIV prevention efforts within the university.

Secondly, is the section on the obligations and responsibilities of students and staff. Under this is the clause which states that:

> Members of the University Community have the responsibility to protect themselves and others from HIV infection through all means possible and to become informed about all aspects of HIV/AIDS prevention, care and support, and alleviation of impact. Students and employees living with HIV and AIDS are ethically, morally and legally obliged to behave in such a way as to pose no threat of infection to others. They are urged to seek medical advice to ensure they live as healthy, normal and productive a life as possible. (University of KwaZulu-Natal AIDS Programme, 2005, p.7)

The discourse contained in this clause positions this University's management as making it an obligation for staff and students to educate themselves about HIV and AIDS, and take responsibility for their own, and other people's safety from HIV infection within the university, and seek treatment and medical advice if infected with HIV. It also positions those who have HIV as having obligations (legal, ethical, moral) to act in such a way that they do not knowingly transmit HIV to other people.

Thirdly, is the section on admissions and students. Under this is the clause which states that:

> The University of KwaZulu-Natal is opposed to HIV testing of prospective, or returning students, for the determination of admission, or readmission suitability generally, nor shall the HIV status of such students be deemed relevant for the purposes of the selection of such students to the University. (University of KwaZulu-Natal AIDS Programme, 2005, p.8)

The discourse contained in the above clause positions the University's management as not enforcing mandatory HIV testing on prospective, or registered students. It positions students as having the freedom not to be tested. It also positions a known HIV positive status of students as not being considered by the University's management in making decisions related to admission or readmission of any student.

Fourthly, is the section on confidentiality. Under this is the clause which states that:

> The University shall not coerce any staff or student to disclose their HIV status but will treat any disclosure of positive HIV status in strict confidentiality and prohibit

> discrimination and victimisation on that basis. (University of KwaZulu-Natal AIDS Programme, 2005, p.10)

The discourse contained in this clause positions an HIV diagnosis as making the student or staff vulnerable to stigma and discrimination. It also positions this university as being aware of this potential risk that the person is exposed to as a result of engaging in testing, and as being aware of the impact this exposure could have on the person's decision to engage in testing, and as being responsible for minimising these threats by not forcing anyone within the university to reveal their HIV status. This clause also positions this University's management as committed to maintaining the privacy and dignity of students and staff who voluntarily disclose their HIV positive status to the 'appropriate authority' (perhaps health care service provider).

Fifty, is the section on disclosure. Under this is the clause which states that:

> Voluntary disclosure of a staff member's or student's HIV status to the appropriate authority is encouraged and will be protected. Management will ensure an enabling environment in which the confidentiality of such information is ensured and that unfair discrimination is not tolerated. (University of KwaZulu-Natal AIDS Programme, 2005, p.10)

The discourse contained in this clause positions this University's management as encouraging students and staff to consider shared confidentiality in order to be offered the support and assistance they may require. This clause also seems to position the students and staff as not having a right not to reveal their HIV status to the 'appropriate authority', making them vulnerable. This is because research conducted with students in this University has shown that self-disclosure to other people could make the actor (the HIV infected person) exposed to the risk of being stigmatised and discriminated against by other people (HEAIDS, 2010; Pillay, 2020). This provides a context for interpreting the University's HIV and AIDS policy as being almost insensitive to the student or staff who goes for HIV testing, or even fosters pre-existing stigma and discrimination within the university community.

Sixthly, is the section on education and awareness. Under this is the clause which states that:

> The University shall continue to prioritise prevention interventions as key to mitigating the impact of the pandemic through initiatives and activities which inform staff and students of HIV and AIDS issues. This will include workplace programmes for staff,

> provision and promotion of Voluntary counselling and testing for staff and students in all campuses, increasing accessibility of condoms and treating sexually transmitted infections. (University of KwaZulu-Natal AIDS Programme, 2005, p.10)

The discourse contained in this clause positions this University's management as being proactive in preventing HIV risk amongst students and staff. It does this by ensuring access to HIV information, condoms, HIV testing service, scale-up awareness programmes, and treatment of STIs. This also positions students and staff as well-informed about the threat of HIV on campus, and as knowing that HIV testing is a protective practice against HIV risk. This construction and positioning seem to be drawing on the assumptions of the IEC health framework. This is because the focus is on increasing one's knowledge and access to HIV prevention resources, with the hope that these would translate into actual change in sexual and HIV testing behaviours.

The seventh section is on counselling, care, support and treatment. Under this is the clause which states that:

> The University shall provide within its budget access to basic treatment, care and support services. Staff and students will have access to free VCT services on-campus, and the University encourages staff and students to know their HIV status. (University of KwaZulu-Natal AIDS Programme, 2005, pp.10-11)

The discourse contained in this clause positions this University's management as being committed to ensuring that the HIV testing services, including the counselling before and after the test, and treatment, care and support services, are available to students and staff. It also seems to position the university community as being at risk of HIV, and as needing to know their HIV status through testing. It also positions the 'appropriate authority' as ensuring that the students and staff receive all the above services.

The eighth section is on universal precautions. Under this is the clause which states that:

> All blood and bodily fluids shall be treated as if they were potentially infectious, in order that no person is singled out and discriminated against and in order that all persons handling such blood and/or bodily fluids like blood and saliva or injecting equipment are protected. (University of KwaZulu-Natal AIDS Programme, 2005, pp.12-13)

The discourse contained in this clause positions this University's management as encouraging the HIV testing service providers to protect themselves from the threat of HIV in the line of duty. This also seems to position the students and staff as being risky, and the HIV testing service providers as being aware of this risk which they are being exposed to, and as being required to take caution to minimise this risk for themselves, particularly when handling the client's bodily fluid. Overall, this constructs the process of HIV testing as potentially risky not only to the client but also to the testing service provider.

The ninth section is on the integration of HIV and AIDS into the curriculum and research. Under this is the clause which states that:

> An integrated response to HIV and AIDS within the curricula of the University will be developed with the appropriate assistance and guidance of national norms and standards that are developed through a consultative process with other tertiary institutions and those with expertise within the University. The University is committed to undertaking extensive empirical and operational public health, biomedical and social science research on HIV and AIDS. Policies, plans and guidelines will be developed to support HIV & AIDS research underway and creates mechanisms, which encourage more research to be undertaken by staff and students at the University. (University of KwaZulu-Natal AIDS Programme, 2005, pp.13-14)

The discourse contained in this clause positions the University's management as being committed to integrating the topic of HIV and AIDS into its curriculum, and developing new fields of research (for example, in the form of students' theses and dissertations, and student and staff's academic papers for conferences and journals).

Finally, is a section on surveillance and evaluation. Under this is the clause which states that the University's AIDS Committee is responsible for providing advice, assessing the performance of the University's HIV and AIDS policy initiatives, and reporting these to the University's management to improve the quality of the HIV and AIDS services delivered to students and staff on campus (University of KwaZulu-Natal AIDS Programme, 2005). There is also a clause which states that the University's AIDS Committee is accountable for reviewing and updating the University's HIV and AIDS policy in line with the national and global HIV and AIDS developments, and keeping abreast of the national and international health guidelines and recommendations (University of KwaZulu-Natal AIDS Programme, 2005). Currently, these developments and guidelines would be, for example, South Africa's National Strategic Plan 2017-2022 targets for HIV, South Africa's National HIV and AIDS policy, the UNAIDS' 95-95-95 targets for ending HIV as a public health threat by 2030, and the WHO's 5C (consent, confidentiality, counselling, correct test results, and connection) principles for HIV testing, to mention a few. However, in my review of the University's HIV and AIDS policy, I noticed that no framework had been developed to monitor and evaluate students' responses to HIV prevention initiatives listed in it.

Overall, the University's effort to address HIV risk through HIV testing, in policy and other systematic and coordinated initiatives and responses to HIV risk and HIV testing on its campuses, have implications.

1.1.7 Implications of the University's responses to HIV risk and HIV testing

The various discourses identified in the University's HIV and AIDS policy document position this university as being understanding and accepting students as sexually active and at risk of exposure to HIV, and as being serious about the issue. The HIV prevention strategies, initiatives, and services being offered by the health promotion agencies on the University's campuses, and the integration of the topic of HIV and AIDS into the University's curriculum position this university as having sufficient human capacity and resources to support and sustain the HIV testing behaviour amongst its students, and as having wide-ranging support for those who test positive for HIV. This normalisation of HIV and the HIV testing service, and resource allocation in this University is in line with the recommendation of the National Department of Health to institutions of higher learning. According to the National Department of Health (2016, p.3), "access must be understood in its broad sense to cover aspects of availability, convenience, quality, affordability and acceptability to all those who need the service." As indicated in the above sections, access to the HIV testing service on the Pietermaritzburg campus is high. The testing service is being offered through several sites, such as the campus health clinic, the CHASU offices, and ad hoc mobile testing tents. All these initiatives construct this University as being on track in implementing the National Department of Health's proposal. In addition to this, the Pietermaritzburg campus is located in an urban setting and close to several public and private health care facilities that offer HIV testing services; another indication that access to the HIV testing service is not a problem to the Pietermaritzburg campus students.

This position by this University also constructs students of this University as knowing about HIV, as having skills to take charge of their wellbeing, as being aware that the university population is at risk of exposure to HIV, as aware that it is their responsibility to protect themselves from HIV (through their own agency or personal responsibility), particularly the ability to initiate and sustain a health practice like HIV testing, and as having adequate resources to support routine HIV testing behaviour and sustained behaviour change. There are several studies conducted with students in this University which have reported high levels of knowledge about the threat of HIV infection and self-protective practices (HEAIDS, 2010; Gwala, 2019; Mthembu, 2017; Nene, 2014; Okelola, 2019; Van der Riet & Nicholson, 2014). However, it is interesting that these high levels of knowledge and access to the HIV testing service on the Pietermaritzburg campus have had little impact on bringing about the necessary changes in students' approach to HIV risk and HIV testing. Some studies have found that students at the University of KwaZulu-Natal do not engage actively and regularly in HIV testing (HEAIDS, 2010; Gwala, 2019; Mthembu, 2017; Okelola, 2019; Van der Riet & Nicholson, 2014).

This section has shown that university students are aware of, and have access to the HIV testing services but are not taking up the services. The following section gives potential explanations for why there is a disjuncture between awareness of services and taking them up. It is worth noting that those explanations are not mutually exclusive.

1.1.8 Tension between knowledge and change in HIV testing behaviour

Maticka-Tyndale's (1992) work on the analysis of university students' constructions of HIV transmission and prevention practices in Montreal in Canada found that health messaging conveyed in educational campaigns and programmes are transformed by those receiving it. In line with this, it could be that the health messaging disseminated to the University of KwaZulu-Natal students is not being seen by the receivers (students) as being beneficial to them. On conducting a quantitative baseline evaluation of the fundamentals of Abstain, Be Faithful, and Condomise (ABC) amongst the University of KwaZulu-Natal students, Moodley (2007) found that students do not consider its health messages useful in HIV prevention. Similar findings are reported in another study conducted a year later amongst students in this same university (Mulwo, 2008). In Mulwo's (2008) study, the decision to comply with the ABC health messages depended on the participants' relationship status and the meanings attached to sex and sexual practices. A consistent finding is reported in a more recent study on the sexual practices of students at this university (Gwala, 2019). Gwala's (2019) study concluded that being in a romantic relationship is a significant predictor of students' sexual activities, which acts as a barrier to their engagement in sexual abstinence or condom use. Gwala's conclusion seemed to relate to the argument made by Van der Riet et al. (2018) that young people are so much invested in sexual relationships, which is a different kind of prioritisation of self. The consequence of this investment is that the risk of HIV is overridden. Lupton (1992) argues that an integral focus of health communication lies in analysing discourses that are intrinsic in public health messages. Thus, part of the rationale for this study was to identify the discourses drawn on by youth when talking about HIV risk in relation to their HIV testing practices. In doing this, the discourses inherent in health messages disseminated to students on campus, which may need to be reinvigorated by health promoters and interventionists, might be identified.

Secondly, students' avoidance of HIV testing speaks to the widely held assumptions about youth and their health practices. Much research has identified youth as being hesitant to visit public health facilities, particularly if they suspect they might have HIV based on their sexual practices (Evans et al., 2018; Haffejee et al., 2018; HEAIDS, 2010; Maughan-Brown & Venkataramani, 2018; Paul et al., 2014; Peltzer & Matseke, 2013; Pettifor et al., 2012; Ritchwood et al., 2019; Steinberg, 2008). In particular, Evans et al.'s (2018) study on knowledge about HIV, risk perceptions, and access to HIV health care services across six universities in the Gauteng province found that part of students' reluctance to HIV testing was linked with the stigma attached to accessing the service. In addition to HIV stigma is the multilayered fear, including the fear of being labelled 'HIV positive', the fear of being diagnosed with HIV, the fear of having to disclose to others in particular family members and friends, and the fear of having to be on medication for life (Goldstein et al., 2003; HEAIDS, 2010; Pillay, 2020; Steinberg, 2008). Young people who perceive themselves as *at* risk of HIV than HIV as *a* risk to them, are more likely to test for HIV and start ART treatment to avoid AIDS-related signs and symptoms that could 'sell them' to their peers (Haffejee et al., 2018). In this case, the fear of being stigmatised drives them to test for HIV. Therefore, part of the rationale for this study was to identify the discourses that promote and sustain students' engagement, or lack of engagement, with HIV testing, by investigating their constructions of HIV risk.

Thirdly, the integration of HIV testing services into the general health care services given to students on the Pietermaritzburg campus health clinic might create challenges for those accessing HIV testing. This is due to inflexible operational clinic hours. The campus health clinic does not operate for 24 hours, but from 9h00-15h00, and there is a one-hour lunch break (13h00-14h00). During its operational hours, the Pietermaritzburg campus health clinic receives many students and even staff members. The consequence of this is that students seeking health services (regardless of the service) might have to wait for an extended length of time to receive the service. This challenge related to long waiting periods to receive an HIV testing service, especially when that service is integrated into the primary health care services, was found in two South African studies (Mabuto et al., 2019; Mohlabane et al., 2016), and in the South African government's report (SANAC, 2017). This matter is also discussed in a systematic review of the issues that need to be addressed in order to improve the routine use of primary health care services in sub-Saharan Africa (Tylee et al., 2007). In view of this, inflexible clinic operational hours could affect HIV testing uptake amongst students, rather than their opposition to HIV testing *per se*.

Fourthly, it could be that students have limited skills about how to negotiate HIV testing in their relationship, and how to respond to their sexual needs. The participants in Paul et al.'s (2014) study at a South African university indicated that, while people involved in the HIV reduction campaigns on campus emphasised HIV testing as being one of the options for managing sexual transmission of HIV, they (health care promoters) did not give them (students) a straightforward explanation for how HIV testing prevents HIV, or provide advice on the stage in a sexual relationship in which HIV testing is recommended, and how to negotiate it. The participants also commented that they were left to interpret and decide how to negotiate HIV testing independently, and often they faced opposition from their partners. Nene's (2014) study at the University of KwaZulu-Natal reported that policymakers and parties involved in HIV prevention campaigns and programmes targeting students in this University have an inadequate understanding of young people's HIV risk perceptions and their prevention practices. Nene's (2014) study concluded that the HIV reduction programmes being offered on campus do not adequately provide a service that meets the needs of young university students. To address such kinds of issues reported in Nene (2014) and Paul et al.'s (2014) studies, Maticka-Tyndale (1992) recommended that health messaging targeting youth at the university should be designed to become part of their 'everyday' social interactions, or common sense knowledge.

The other explanation of why there is a disjuncture between awareness of HIV testing services and taking them up relates to the failings of a meta-/philosophy of what behaviour is. The positivist and post-positivist theories such as the social cognitive theory, the health belief model, the theory of planned behaviour, and the theory of reasoned action often are being adopted in the development of public health policy documents and public debate. Such approaches have also been adopted in health education initiatives to understand, explain, and predict HIV testing behaviour and intentions to test or not test for HIV amongst South African youth (Tenkorang, 2016), including university students (Buldeo & Gilbert, 2015; Heeren et al., 2013; Musemwa, 2015; Okelola, 2019; Ziki, 2015). Within such a perspective, the focus is on the individual's psychological process (cognition, thoughts and perceptions) (Ajzen, 1991; Brown, 1995; Glanz & Reimer, 2008; Jangu, 2014; Tenkorang, 2016). Seen in this way, positivist approaches focus on developing one's knowledge of the health issue, for example, HIV risk, with the assumption that this will translate into a perceived vulnerability to HIV infection, and consequently one will act to protect oneself through, for example, having an HIV test, but that has not always been the case.

Thus, with the loss of confidence in the effectiveness of positivist approaches in influencing actual change in HIV testing behaviour amongst the key affected populations (for example, sexually active youth), Lupton (1992) argued for a need for research approaches that focus on social, cultural, political and historical understandings of HIV risk and prevention in everyday interactions, and discourses drawn on by people to justify and rationalise their health practices and actions. In describing how knowledge is produced and sustained by social processes, Hall (1992) argued that all social practices have a discursive aspect or meaning. Applying Hall (1992) and Lupton's (1992) perspectives to this study, it is postulated that it is through identifying and defining discourses that students draw on when talking about their risk of HIV and HIV testing that one can understand how discourses facilitate and limit, enable and constrain what can be said by whom, where and when, which will allow us to understand how the practice of testing/not testing for HIV works amongst youth at a South African university. This is different from simply exploring their perspectives about HIV risk and HIV testing practice (as if these were unitary), as are assumed in many of the cognitive behavioural theories.

As indicated earlier, the above explanations on the tension between knowledge and change in HIV testing behaviour amongst youth are not a complete list of all potential explanations. Given the scope of this PhD thesis, I have limited my explanations to only one, which is the failings related to the meta-/philosophy about what behaviour ‘is’. The rationale behind this study, therefore, is based on the premise of social constructionism, which means that different ways of constructing an idea have different consequences for how people construct and maintain their understanding of it, and things in social life (Parker, 1992). This thesis, therefore, argues that given that youth who have knowledge about HIV risk, and about how to assess themselves in terms of their HIV status do not do so, if one examines the way in which they construct and maintain their understanding of risk (how they see this risk in relation to themselves and, or others) and the discourses drawn on, this might enable an understanding of their social practices, particularly why there is a lack of uptake of HIV testing. Also, inspired by Alldred and Burman’s (2005) definition of discourse analysis as an approach to understanding and interpreting verbal material that links with critiques of the positivist assumptions seemingly reinstating the agentic individual, this thesis argues that if one analyses discourses drawn on by student participants in their discussion of HIV risk and the positions they take in relation to this risk, this might enable a different perspective which perhaps explains the irrationality of their lack of HIV testing. This might enable the assumptions of the positivist frameworks that inform the development of public health policies and interventions to be identified, which require to be corrected through health messages. How the need for a discourse-analytic study of HIV risk and HIV test forms form the basis of this study’s aims, and rationale will be revisited in Chapter Two, presenting the study’s rationale, the objectives and the specific research questions.

The need for conducting this discursive study of HIV risk and HIV testing is discussed in the next section.

1.2 Significance of this study

Although a large body of both quantitative and qualitative research amongst students at the University of KwaZulu-Natal, other universities, and youth aged 18–24 years in South Africa exist, there is a paucity of discursive exploratory analysis of university students’ constructions of HIV risk in relation to their own practices of HIV testing. The focus has been on their perceived susceptibility to HIV risk and barriers to, or motivators for HIV testing. What distinguishes my study from this more common focus is my commitment to the social constructionist assumption that social practices (for example, HIV risk and HIV testing) cannot be understood outside of, or free from, the cultural meanings assigned to them in everyday interactions. To achieve this understanding, one needs to pay attention to university students’ ways of talking about, or otherwise representing HIV risk and HIV testing (such as phrases, terms, metaphors, representations, images, stories, and statements), and the sociocultural sourcing of their meanings or accounts (discourses) about HIV risk and HIV testing. Thus, this study might contribute to addressing the apparent gap in discursive research on the topic of HIV risk and HIV testing amongst sexually active youth at universities in South Africa.

This study also not only builds on, but also intends to go beyond the 2007–2008 HEAIDS survey, which was conducted in 21 universities in South Africa, to establish knowledge of HIV, the prevalence rate, and the trends of crucial risk indicators amongst staff and students. The significant finding in that survey was that the University of KwaZulu-Natal students were disproportionately affected by HIV risk compared to students in other universities in South Africa. This survey is over ten years old, and the HIV and AIDS field moves very quickly. For example, there are some new technologies in HIV prevention, such as oral pre-exposure prophylaxis, long-acting pre-exposure prophylaxis injection, and improved coverage in ART treatment. Given the above, the current state of the problem of HIV risk and HIV testing practice amongst students in this University is, therefore, unclear. On this basis, my study focused on HIV risk and HIV testing practice with a sample of students on the Pietermaritzburg campus of the University of KwaZulu-Natal. Its findings are expected to contribute to current knowledge about students' perceptions of HIV risk in their context, and their ways of responding to it, particularly HIV testing.

The Higher Health (2020) annual report showed that in 2019, there were 1085568 and 657133 students enrolled in South African public universities and TVET colleges, respectively. Although this is a reasonably small number relative to the country's total population of 59,62 million people as of 2020, July 9 (Statistics South Africa, 2020, July 9), people with university education form a critical group in any society. This subpopulation is often seen as being knowledgeable, as educated, and as a mobile group. Research has shown that sexual networks of university students, in particular, go beyond the university (Heeren et al., 2013). Thus, if preventative measures are not taken, students could potentially be dispersal agents for the spread of HIV. Therefore, working with university students as research participants for this HIV testing study may provide insight into whether they engage with HIV testing, why they do it or do not, and how they do it. This information may guide health promotion agencies and interventionists at the University of KwaZulu-Natal in developing health messaging and discourses related to HIV risk and HIV testing that better fit the lives of those to whom they are addressed (students on the Pietermaritzburg campus).

The section that follows provides a brief outline of this thesis' chapters.

1.3 Overview of chapters

In pursuit of the rationale, aims and objectives of this HIV risk and HIV testing research, the whole thesis is organised into seven chapters, in addition to this introductory chapter, as follows:

Chapter One presents an overview of the background to this study of HIV risk and HIV testing practice amongst youth in South Africa. In doing this, a broad synopsis of variations in HIV incidence rates, prevalence rates, and AIDS-related mortalities globally, in sub-Saharan Africa, and in South Africa and its universities, are presented. The University of KwaZulu-Natal's commitment to controlling HIV infections on its campuses is also discussed. Although I have justified the need to conduct this study throughout this thesis, the significance of this study is highlighted in this chapter.

Chapter Two outlines the rationale for conducting this study and briefly reviews its aims, objectives, and research questions.

Chapter Three presents a review of related literature, encompassing ongoing debates on the problem of HIV and the practice of HIV testing in the South African government policy documents, biomedical research, and social research. The social constructionist approach served as the conceptual framework of this study, and in this chapter, the four critical assumptions about knowledge shared by the social constructionist research, and how they relate to this study are discussed.

Chapter Four presents a comprehensive overview of the processes undertaken to implement the study. In doing this, the justification of the research paradigm, research design, research setting, the methods of recruiting participants, and the ethical considerations regarding this research is presented. In this chapter also, the processes involved in conducting interviews, analysing the data by following Parker's (1992) seven criteria for distinguishing discourses, how discourses were identified, and the methodological challenges and weaknesses encountered in conducting the research, are discussed. Although I have included my reflections throughout this thesis, in this chapter, I reflected upon what conceptions of knowledge I bring as a researcher to the interview inquiry, the assumptions I make about this study, and the kind of knowledge produced.

Chapter Five is the findings and analysis chapter. In that chapter, the findings of this study are presented and analysed along the lines of the three research questions of this study: (1) How do sexually active university students draw on different discourses to construct HIV risk? What discourses do they draw on to construct HIV risk?; (2) How do sexually active university students construct and position themselves and others in relation to HIV risk? What rationalisations or justifications do they give for their position?; and (3) How do sexually active university students' constructions of, and positioning in relation to HIV risk, relate to their practice of HIV testing? In presenting these findings, the effort has been made to organise them into themes that demonstrate the pattern of responses in participants' accounts in relation to the research question addressed.

Chapter Six is the discussion of the findings chapter. In that chapter, the significance of the findings presented in Chapter Five is discussed. This will be done by way of mapping the significance of the discourses drawn on by participants to construct, change, explain, elaborate on their understandings of HIV risk and positioning in relation to it, or defend their stance, and the implications of these (discourses) for their HIV testing practices. I have commented on the degree to which the discourses identified in this study are congruent, or in contrast, with those in the epidemiological and demographic HIV and AIDS projections, existing health and academic research with youth, the global HIV and AIDS reports, South Africa's National Health Reports, South Africa's National HIV Testing Policies, and the popular media health reports, reviewed in prior chapters. I also gave new insights in relation to the current research problem of HIV risk and HIV testing, and some potential ways forward.

This thesis concludes with Chapter Seven, mapping how each research question was addressed, followed by concluding remarks. It also provides an account of the contributions of this study and recommendations on ways to promote HIV testing and the frequency of testing amongst students on the Pietermaritzburg campus. The limitations of this study and suggestions for further research on the topic of HIV risk and HIV testing, are also proffered.

1.4 Synopsis of the chapter

This chapter gave a broad synopsis of the global and South Africa's picture of the course of the problem of HIV risk. The epidemiological data presented and review of the academic and health literature demonstrated that HIV continues to affect thousands of lives every day, and young people aged 15-24 years are at particularly high risk of HIV infection. Since this is a study on HIV risk and HIV testing practice amongst university students at a South African university, this chapter broadly explored the HIV trends, prevalence rate, and behaviour amongst students in South African universities. In doing this, the findings of the HEAIDS in the 2007–2008 survey, and of the Higher Health 2019-2020 annual report, were drawn on. The overview of statistics in the HEAIDS survey pointed to the variation in the HIV prevalence and incidence rates between sexes (female students), geographic location (universities in the KwaZulu-Natal province), and age (20-24-year old students). The majority of undergraduate students at the University of KwaZulu-Natal are in the age range of 18-24 years, and thus fall into this range of 20-24-year-olds who are reported as having a higher prevalence, and as being at risk of HIV infection. This was one of the motivations for focussing on this age range of young people in the university setting of the University of KwaZulu-Natal.

This chapter also discussed the University of KwaZulu-Natal's effort to address HIV risk and HIV testing through educational programmes and campaigns, health infrastructure, and the University's HIV and AIDS policy. These initiatives and policies suggest that this University is serious about the issue, and has sufficient human capacities and resources to support and sustain the HIV testing behaviour amongst its students. The initiatives also suggest that students of this University know about HIV, have skills to take charge of their wellbeing, and are aware that the university population is at risk of exposure to HIV, and that it is their responsibility to protect themselves from HIV infection. This knowledge and awareness are expected to enable students to locate, perceive, identify and label the threat of HIV and respond to it accordingly, through perhaps engaging in HIV testing. However, the reviewed literature specific to this University showed that this is not necessarily the case. Research has shown that students in this University do not engage actively in HIV testing. This suggests that the problem of HIV amongst students runs deeper than simply understanding their perceptions of risk and prevention methods. There could be a feature of HIV risk and HIV testing practice, which is socially constructed and has not been addressed in the dominant prevention initiatives. To address this gap, this study adopted the assumptions of social constructionism and argues that different ways of constructing HIV risk have different consequences for how university students construct and maintain their understanding of it and, therefore, HIV testing, and might enable an understanding of their social practices, particularly why there is a lack of uptake of HIV testing.

The next chapter gives an overview of the rationale or justification for this study, the aims, the specific objectives, and the research questions to further illustrate this research's background.

CHAPTER TWO: RATIONALE AND AIMS OF THE STUDY

2.1 Introduction

This chapter presents the rationale or justification for this study. The chapter also highlights the study's aims, the specific objectives, and the research questions. The key argument of the chapter is that although many pieces of research on HIV risk and the HIV testing practices amongst university students in South Africa exist, most of these studies have tended to focus on the use of the quantitative research design (such as the questionnaire) to investigate students' perceived susceptibility to HIV risk, descriptive barriers to, or motivators for HIV testing, and attitudes towards HIV testing. Most of them do this drawing largely on the assumptions of the positivist approach, which tends to construct knowledge as something intrinsic in people's cognition, rather than being socially constructed or inherent in the community and culture in which people are born and raised. Being influenced by the assumptions of the positivist approach, a lot of space is given to the influence of social factors on behaviour. However, these are perceived (not necessarily consciously) and processed by our brains, which then prime us toward or away from behaviours. This study, therefore, deviated from this more common focus of studying human behaviour into adopting a qualitative research design informed by a discursive approach to explore, identify, label and interpret discourses drawn on by student participants in their discussion of HIV risk and the positions they take in relation to this risk, and their implications for HIV testing practices in one university in South Africa. Therefore, the rationale behind this study is based on the assumption of the discursive approach, that discourses imply social action, which means that discourses structure and order people's lives in terms of behaviours, activities, and practices (Alldred & Burman, 2005). Given this understanding, this thesis argues that engaging in discursive analysis of university students' constructions of HIV risk and HIV testing and discourses they draw on potentially enables an understanding of their positioning in relation to HIV risk and HIV testing practice, and whether, or how they engage with testing as a protective strategy.

2.2 The rationale of the study

In addressing this theme, I start with MacQueen et al.'s (2001) definition of the notion of community, as a group of people with varied characteristics who are linked by social ties, share common interests, and meet from time to time to engage in joint action in geographical locations or settings. Inspired by this definition, the University of KwaZulu-Natal, which is this study's target location, is one such community, perhaps a closed one, composed of staff and students. The collective activities and social aspects that may bring the University of KwaZulu-Natal students together range from academic and non-academic responsibilities; language(s); belief systems; socio-cultural norms and values, to areas of social life in relation to the threat of HIV, such as sexual activities and practices, and health messaging on HIV prevention practices, such as HIV testing and condom use.

According to Van der Riet et al. (2018), sexual relationships are an integral part of youth's identities. University students, in general, are sexually active and likely to form sexual relationships with fellow students and beyond, a significant finding in Heeren et al.'s (2013) randomised controlled pilot survey of an HIV risk-reduction intervention amongst university students in sub-Saharan African universities. Heeren et al. (2013) noted that institutions of higher learning provide an extensive social network, creating several opportunities for students to make new sexual contacts, learn from, and influence one another. Heeren et al. (2013) observed that this expanded network of potential sexual partners promotes risky sexual practices, such as casual sexual partnerships, concurrency, and incorrect or non-condom usage. In South African universities, in particular, Heeren et al. (2013) presented these patterns of sexual practices as being high amongst South African citizens compared to international students. These patterns of sexual practices amongst university students in South African universities were also reported in the HEAIDS (2010) survey. The HEAIDS (2010) survey found that the patterns of sexual practices amongst students in South African universities include casual sexual partnerships, sexual experimentation, cross-generational sexual partnerships, transactional sexual partnerships, concurrency, and incorrect or non-condom usage. The HEAIDS (2010) survey further established that students tend to think that same-age peers do not pose nearly as high a risk as sex partners above 24 years old, the notion of trust in, and sexual relationships with, same-age peers as not risky.

Several studies conducted with students on the Pietermaritzburg campus of the University of KwaZulu-Natal (which is the locus of this study) also suggest that students engage in the above sexual activities and practices (Chebitok, 2017; Gwala, 2019; Kunda, 2008; Mthembu, 2017; Mulwo, 2008; Mutinta et al., 2013; Nene, 2014; Okelola, 2019; Van der Riet & Nicholson, 2014). Some studies also suggest that the above risky sexual activities and practices prevalent in South African universities in general, and on the Pietermaritzburg campus, in particular, are common in other African universities (Agardh et al., 2012; Durojaiye, 2008; Morley, 2011;

Nwachukwu & Odimegwu, 2011; Obidoa et al., 2012). This issue is significant because student participants in this study are not only South Africans but also youth from other African countries. This suggests that sexual activity is integrated into university students' identities in sexual relationships, and this creates the conditions for risk in relation to HIV.

Research has shown that the above patterns of sexual activities prevalent in South African universities and other universities in Africa tend to be influenced by peers and peer expectations (Durojaiye, 2008; Evans et al., 2018; Gwala, 2017; Maughan-Brown & Venkataramani, 2018; Mthembu, 2017; Mutinta & Govender, 2012; Mutinta et al., 2013; Nene, 2014). In these three studies, sexual activity was reported as being normalised on campus, and students appear under pressure to perform a sexual self and integrate this into their overall identity. In particular, Nene's (2014) study concluded that if a female student is not engaging in sexual relationships, she is often subjected to questioning, including being taunted as odd and out of tune with modern campus life. In such contexts, part of being accepted by a peer group is avoiding questioning by all means, whether about not being able to 'have, or hold on to' a sexual partner, or not being able to demonstrate sexual conquest, a significant finding in Van der Riet et al.'s (2018) study on the interaction of identity development and sexual relationships amongst youth in a rural area in South Africa.

Another way of understanding the university students' risk of exposure to HIV is through the more conventional concept of 'freedom' experienced in the context of the university. The homes of the majority of university students in South Africa are located far from their campuses, forcing them to find alternative accommodation in a hostel on campus or in a nearby private facility outside the university (Musemwa, 2011). In those places, students become exposed to new experiences, live a more independent life, and receive minimal supervision and influence from their parents, guardians, and lecturers (Musemwa, 2011). The consequence of this is that students have more freedom and can choose to engage in various risk-taking and pleasure-seeking practices, such as sexual experimentation, binge drinking, and substance use and abuse. Musemwa (2011) also noted that the problem of overindulgence in alcohol use and drug abuse limits one's ability to negotiate safer sex, which may increase their risk of HIV infection. Musemwa (2011) further argued that a female student who engages in alcohol use might experience sexual and physical abuse, which exposes her to the risk of HIV. A similar and consistent finding is reported in a recent South African study investigating the links between physical and sexual gender-based violence and the risk of HIV amongst women who use substances (Bonner et al., 2019).

Therefore, given the social dynamics of university students, such as their activities related to sex and sexual relationships, which create potential problems when there is a high HIV prevalence, and living away from home, and by implication, away from their parents who control their sexual behaviours, the alternative self-protective approach against HIV, is for students to prioritise HIV testing and engage actively in it, but that this is not necessarily the case. Research suggests that sexually active university students are not engaging actively and regularly in HIV testing (Blignaut et al., 2015; Gwala, 2019; Haffejee et al., 2018; Higher Health, 2020; HEAIDS, 2010; Heeren et al., 2013; Mthembu, 2017; Okelola, 2019; Paul et al., 2014). This generates the critical need to explore "how and why is it that university students in South Africa do not prioritise HIV testing as a protective strategy, yet they are potentially at high risk of HIV based on their activities of sex?". HIV testing is a 'protective' approach in the sense that testing frequently will mean earlier access to ART when you test positive (Department of Health, 2016). It is on this basis that this study was designed to engage members of the diverse student body of the University of KwaZulu-Natal community in an attempt to understand the meanings they assign to HIV risk; what social and cultural issues they associate this risk with, and how they locate themselves and others in relation to it; what discourses are drawn on to justify and rationalise their constructions and positioning; and whether and how they engage in HIV testing as a protective strategy. The findings of this study may help the interventionists to understand the underlying dynamics to be considered to improve HIV testing behaviour amongst sexually active youth at the University of KwaZulu-Natal in South Africa.

While there is no doubt, based on the findings of the HEAIDS (2010) survey, Higher Health annual report for 2019-2020, and the above studies conducted with university students in South Africa, that HIV is a risk for many university students in this country, and that some students seem to perceive it as not being a threat to them, which then reduces their need to engage in HIV testing practice, no more recent discourse-analytic research on this problem exists. Previous studies on HIV risk amongst students in other South African universities have given considerable attention to the trends in HIV risk behaviours (Blignaut et al., 2015; Buldeo & Gilbert, 2015; Heeren et al., 2013; Maughan-Brown & Venkataramani, 2018; Pengpid et al., 2013; Ziki, 2015).

Correspondingly, while a large body of both quantitative and qualitative HIV research amongst the University of KwaZulu-Natal students exists, for example, sexual risk behaviours and perceptions of HIV risk (Gwala, 2019; Mthembu, 2017; Mutinta & Govender, 2012; Mutinta et al., 2013); perceptions of, and uptake of HIV testing services as part of the universal test and treat programme at the Howard College (Okelola, 2019); patterns of disclosure of HIV-positive status to others (Pillay, 2020); and perceptions of the ABC prevention strategy (Moodley, 2007), there appears to be little, or no discursive analysis of sexually active students' constructions of HIV risk and implications for their health practices, specifically HIV testing. In most of the above studies, individual perception of HIV risk is being investigated in relation to facilitating, or impeding prescribed health actions, such as condom use and health practices, such as HIV testing, without considering that there might be interpretations of HIV risk and ways of responding to it, which are socially constructed. Hence, what distinguishes these earlier studies and the present study could be seen in the point made by Maticka-Tyndale (1992), who affirmed that the focus of the social constructionist research shifts to the construction of shared perceptions (not individualised perspectives) and positioning and discourses therein, which drives everyday action. This study concurs with this above view, and argues that it is through people's everyday discussions with each other about what they know, have heard, or experienced about HIV, that they construct their own perceptions and responses to the threat of HIV, that is, their health practices, such as HIV testing.

However, of the few studies that have specifically used the social constructionist perspectives to explore HIV risk and prevention amongst the University of KwaZulu-Natal students, most have addressed conversations about sexual risk and responsibility (Van der Riet & Nicholson, 2014); perceptions and management of HIV risk in sexual activity (Nene, 2014); and responses to HIV prevention initiatives (Kunda, 2008; Mulwo, 2008). The number of discursive studies on HIV risk and HIV testing amongst the University of KwaZulu-Natal students and other universities in South Africa may be small, partly due to their complexity, as they rely on providing an understanding of health, illness and behaviour through analysing spoken text and interpersonal communication between people in their social context. Therefore, I have adopted a discourse-analytic approach to build on, and extend the gains made by these previous discursive researches to promote greater knowledge of the discourses that are particularly valuable for initiatives and policies to promote HIV testing behaviour amongst the University of KwaZulu-Natal students.

Thus, to the possible question of why the use of the social constructionist approach in this study, I would like to answer it by aligning myself to the position taken by Alldred and Burman (2005), Maticka-Tyndale (1992), Parker (1992), and Lupton (1992). They all argued that exploring the taken-for-granted social processes, activities, and behaviours using a discursive approach gives a broader perspective when the aim of the research, like this one, is to examine, expose, and deconstruct the dominant positivist assumptions and structural issues seen in participants' accounts. In relating these arguments to this study, it is postulated that it is through analysing students' constructions of HIV risk and identifying the positions that they create and use as subjects, and the discourses that are drawn on in this positioning that one can potentially understand their social actions, specifically their practices in relation to HIV risk and HIV testing. Such analysis may also contribute to an understanding of what informs students' HIV testing practices in terms of whether, or how they engage with HIV testing as a protective strategy, and how and why their processes around testing are maintained and sustained (and what they are).

Lupton (1992) argued that in the field of psychology and illness, diseases are not mere biological entities but rather socially constructed phenomena. In line with Lupton's (1992) assertion, this study argues that by engaging in a discourse analysis of students' accounts, or their discursive practices related to HIV, one can refine some of the conceptual/analytic/theoretical tools in the field of psychology and illness, which one could use to study HIV risk and HIV testing health practice amongst youth at the university, and possibly some of the everyday ones too, in the effort to find ways of encouraging sexually active university students to prioritise HIV testing in their everyday life.

Another rationale of this study is drawn from Schneider and Ingram's (1993) argument that discourses influence policy plans, choice of policy tools, and justifications for legitimate policy choices. Hence, this process of identifying, describing, understanding and interpreting discourses at work in youth's constructions and positioning provides an opportunity to establish the taken-for-granted assumptions, including the implicit common sense knowledge about HIV risk and HIV testing that might require policymakers to engage with, and consider these discursive resources used by young people in order to develop and design HIV testing interventions that better fit their lives.

2.3 Aims of the study

The research aims of this discursive, qualitative and exploratory study are threefold. Firstly, to gain insight into how sexually active university students aged 18-24 years on the Pietermaritzburg campus of the University of KwaZulu-Natal construct HIV risk; secondly, how they construct and place themselves and others in relation to HIV risk; and thirdly how their constructions and positioning shapes and influences their health practice, specifically HIV testing.

2.4 Research objectives

The specific objectives of this research are to apply a discourse-analytic approach to:

1. Explore how sexually active university students draw on different discourses to construct HIV risk.
2. Investigate how sexually active university students construct and position themselves and others in relation to HIV risk.
3. Explore how sexually active university students' constructions of, and positioning in relation to HIV risk, relate to their practice of HIV testing.

2.5 Research questions

The following research questions grounded in the aims and objectives of this study were formulated:

1. How do sexually active university students draw on different discourses to construct HIV risk?
    a. What discourses do they draw on to explain or justify their position?
2. How do sexually active university students construct and position themselves and others in relation to HIV risk?
    a. What rationalisations or justifications do they give for their position?
3. How do sexually active university students' constructions of, and positioning in relation to HIV risk, relate to their practice of HIV testing?

According to Goldstein et al. (2003), the problem of HIV risk may be understood through social constructions that function to influence individual responses to it. In line with this, this thesis argues that university students' constructions of, and positioning themselves and others in relation to HIV risk, may shape and influence all their health practices like HIV testing. Thus, the first and second research questions were intended to set the framework for understanding participants' discursive meanings of HIV risk. That is, what they say, how they say it, and what discourses they draw on. As discussed in Chapter One, the University of KwaZulu-Natal students are exposed to health messaging in advertisements, the mass media, educational awareness programmes, health research, interactions with health care service providers and peers, and their experiences of health care on, and off campus. This might mean that they construct, understand, and position themselves and others in relation to HIV risk in a variety of ways depending on their knowledge, awareness, experience, and the interpretive repertoires available to them for reasoning about this risk. This study, therefore, explored how participants understand HIV. For example, whether they constructed it as a threat to themselves and others, as a limited risk to themselves and others, or whether they construct themselves as immune to it, what discourses they drew on to explain, rationalise, or justify their position, and what self they try to present to me as the researcher. The literature review will clarify that this is the present study's primary focus.

The third research question focused on how student participants' constructions and positioning worked, and what they achieved by using them in this way in relation to their practices of HIV testing. That is, whether and how they engage in testing as a protective strategy.

Having provided the impetus for conducting this discursive study of HIV risk and HIV testing amongst university students at a South African university and the gap it aims to fill, the next chapter reviews relevant literature related to the current knowledge and ongoing debates on this field, and their relevance and contributions to the current research problem.

CHAPTER THREE: LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

3.1 Introduction

This chapter aims to achieve two main goals. The first goal is to present ongoing debates on HIV risk and HIV testing inherent in the South African Government Health Policy documents, biomedical and social research, and health messages that could be informing students' constructions of HIV risk and their positioning on HIV testing. The second goal is to present social constructionism and its relevant assumptions that together constitute the theoretical framework of the study. The chapter has, consequently, been structured into three sections, as follows:

The first section begins with a review of the National HIV testing policies, undertaken from the discursive perspective to give a background of how HIV risk has been addressed through HIV testing over the years in South Africa. In conducting such a review, I hope to show how the HIV testing practice has been variously conceptualised in the past, for example, as voluntary counselling and testing, thereafter as HIV counselling and testing, and presently as HIV testing services; and what motivated these changes. It is to be noted that this shift in HIV testing discourse led to a review of the National HIV Testing Policy guidelines. In unpacking the content of these guidelines, the following key questions will be addressed: what are their underlying assumptions? What discourse is being drawn on? How is the subject whom they call the 'client' positioned? How are the policy practices and acts positioned? and How is the health care service provider constructed and positioned? The key conclusion to be laid bare in this aspect of the review is that the public health policies, specifically the HIV testing policies and intervention strategies, benefit the government and not the client who is the receiver of the health care service. This is because the government's focus, or reason for encouraging people to take an HIV test, is to lay the basis for HIV prevention and management. In line with Schneider and Ingram's (1993) argument that social constructions become entrenched in policy as messages that people absorb, it is part of the main interest of this study to explore how university students are making sense of these policies, and which aspects of these policies they are drawing on in their constructions and positionings in relation to HIV risk and HIV testing practice.

Drawing on the existing studies that have explored HIV risk and HIV testing amongst youth, including university students in South Africa and other African countries, the second section of this chapter examines the extent to which HIV risk and HIV testing health practice has been explored in research. The focus will be on how an HIV diagnosis and AIDS have been socially constructed, and some of the prominent discourses drawn on, and how these discourses might shape and influence young people's response to HIV risk through HIV testing. In particular, youth's constructions of HIV risk, which has become increasingly important to individual understanding, assessment, and responses to the threat of HIV, is explored. The key conclusion to be made clear from this part of the review is that although many pieces of research on HIV risk amongst university students in South Africa already exist, the focus has been on their perceived susceptibility to HIV risk and barriers to, or motivators for, HIV testing. However, the lesson to be learnt from this part of the review is that there could be a feature of HIV risk and HIV testing practice, which is socially constructed and has not been addressed in the existing research amongst university students in South Africa. I, therefore, hope to show the need for this study on the university students' constructions of, and positioning in relation to HIV risk, and how these relate to their HIV testing practices, and discourses they draw on to justify their position in terms of HIV risk, and therefore, HIV testing. In doing this, one may understand students' HIV testing practices, and what informs their practices in terms of whether, or how they engage with testing as a protective strategy, and how and why their processes around testing are maintained and sustained (and what they are).

The third section of the chapter will be devoted to specifying the conceptual framework underpinning this study. As this study is interested in exploring the social construction of HIV risk in relation to HIV testing health practice amongst the University of KwaZulu-Natal students, the social constructionist approach has been chosen to serve as its conceptual framework. Therefore, the chapter will review the four critical assumptions about knowledge in a social constructionist approach, and explain how these assumptions are applied in this study. I hope to show that, while the use of a discursive approach has specific value for the analysis of interviews with youth, this is not because of something intrinsic to the framework, but rather due to what it refuses to provide, which is stable meanings or objective reality about the problem of HIV risk and HIV testing.

These are the preliminary observations that appear necessary to be made before engaging directly with the review of the relevant literature for this study that now follows.

3.2 The history of the practice of HIV testing in South Africa

The South African government's policies on HIV are focused on responses to the threat of HIV and have, in themselves, been constructions of the risk. The government took on a leadership role in responding to HIV through policy development and implementation. The HIV and AIDS information, for example, incidence rate, prevalence rate, and policies to manage this epidemic, come mainly from the government documents and reports, such as the National Strategic Plan, the National HIV and AIDS Policy, the National HTS Policy, the SABSSM survey, the HEAIDS survey, to mention a few. In these policy documents and reports, HIV testing is positioned as an entry point to a comprehensive continuum of prevention, management, treatment, care services, social support and wellness for all. Thus, over the years, there have been discourses in the national health policy documents about how HIV testing services should be delivered to the general public, leading to a few rounds of reviews of the National HIV Testing Policy documents.

The first HIV and AIDS cases reported in South Africa are said to have occurred in the early 1980s amongst men who had sex with men (Butler, 2005; McNeil, 2019, August 27). During this period, HIV was constructed as a risk of this category of men, and measures to deal with it were also constructed exclusively within the health sector (Butler, 2005). The interventions and strategies revolved around the health care service providers wanting to intervene by making men who had sex with men change their lifestyle and sexual behaviours (Butler, 2005). However, as the HIV and AIDS epidemic progressed, different advisory institutions in the health and non-health sectors were formed to develop more comprehensive national health policies to control the spread and impact of this epidemic. The first advisory institution to be created was the South African National Advisory Group in 1991. McNeil (2019, August 27) noted that the health policies developed later that year (1991) did not necessarily comply with the legal and human rights approach to HIV testing. McNeil (2019, August 27) asserted that black South Africans were constructed as 'at risk subjects' in those health policies, which promoted racial segregation by the apartheid government, intentionally, or unintentionally. McNeil (2019, August 27) concluded that the interventions drawn on health policies developed by the South African National Advisory Group were not effective in reducing HIV new infections, but rather fostered pre-existing racial tension and the negative labelling of the black person.

However, when the new government was elected in 1994, under the late Nelson Mandela's leadership, the HIV epidemic was declared a national disaster, and discussions on measures that consider legal and human rights principles were prioritised (McNeil, 2019, August 27). McNeil (2019, August 27) further contended that the drafting of the national HIV and AIDS policies started in 1995. The policies guiding the HIV testing service emphasised initiatives, ranging from behaviour change, and human rights protection of people living with HIV, to voluntary counselling and testing, community support, and mass media education. Thus, in this section, how the HIV testing service has been conceptualised in the past in policy as voluntary counselling and testing, thereafter as HIV counselling and testing, and presently as HIV testing services, are discussed. In doing this, the focus will be on their underlying assumptions, the discourses they draw on, and the positioning of the client and the health care service provider. This is done to elucidate how HIV risk and the HIV testing health service have been constructed in policies around them.

3.2.1 Voluntary counselling and testing (VCT)

VCT, also called self-referred testing or client-initiated counselling and testing, began to be used in South Africa in 1995 as a concept appropriated to describe the practice of HIV testing (Department of Health, 2000). The VCT policy contains the assumption that an individual, couple, family or group present themselves to an HIV testing facility and request to be counselled and tested for HIV (Department of Health, 2000). This assumption seems to draw on the public response to disease and risk discourses, and positions the client as being agentive. According to the Department of Health (2000), the urgency to take an HIV test depends on the person personalising the threat of HIV, which is being influenced by one's activities of sex, functional state, or having symptoms suggestive of HIV.

A brief national protocol to guide the VCT services in health care facilities was developed in 2000 by the National Department of Health. According to the Department of Health (2000), the process of formulating this protocol was a lengthy one, involving a lot of consultations with a wide range of technical experts drawn from relevant areas of expertise and practice, such as the HIV and AIDS researchers, legal experts, and experts in ethics and human rights. This involvement of different experts seems to construct the VCT policy as a credible document. In particular, when one analyses the VCT policy document, it contains the following kinds of terms: a voluntary pre-test counselling, a voluntary test, and a voluntary post-test counselling (Department of Health, 2000), all of which prioritise the voluntary nature of the practice.

The phrase voluntary pre-test counselling assumes that the client will attend a VCT facility out of their own free will, and accept being given information on HIV risk, prevention practices and the benefits of being tested for HIV. This information is constructed as enabling the client to make an informed decision about whether to be tested for HIV. This also positions a voluntary subject as being agentive, as willing to hear, and as willing to change, and as willing to accept responsibility, and this aspect of the VCT policy as being grounded on the rational choice perspective. It is important to explore how students construct themselves and the practice of HIV testing. A question might be, for example, do they construct themselves as agentive and informed in terms of testing, or which factors discourage them from doing so, where the opposite is the case.

The phrase ‘voluntary test’ contains the assumption that a person might not volunteer to being tested. This condition of voluntariness constructs the client as having freedom over their own body and the option to opt out of the service if they do not want to be tested (Department of Health, 2000). Again, it is important to explore how students construct themselves and the practice of HIV testing. A question might be, for example, do they volunteer for HIV testing?

The phrase ‘voluntary post-test counselling’ contains the assumption that a client who, on their own free will, agreed to be tested for HIV, would also choose on their own accord to receive information on self-protective measures, and to be linked with care and support services if they tested positive for HIV (Department of Health, 2000). Likewise, it will be vital to see how students’ constructions of themselves and HIV testing relate to this construction of a responsible, agentive subject who is willing to engage in a medical process.

The phrase ‘voluntary HIV treatment’ contains the assumption that a person might initiate treatment if HIV positive (Department of Health, 2000). Related to that, the VCT policy urges the health care service providers to encourage the HIV infected body (client) whose CD4 count is greater than 350 cells and less than, or equal to, 500/mm3 to take up treatment immediately (Department of Health, 2000). This assumption seems to construct the HIV management through antiretroviral drugs in those days as not focussing on controlling the spread of HIV, but on prolonging the client’s life, which was done with the client’s agreement. It also constructs the HIV testing service as meant for a diagnostic purpose and the health care service provider as intervening to prolong the HIV infected person’s life.

Moreover, this emphasis on ‘voluntariness’ in relation to HIV testing, counselling, and treatment is could also be a consequence of trying to distance the current policy from the early (Apartheid) policy of mandatory testing for black South Africans as outlined above (see section 3.2 The history of the practice of HIV testing in South Africa).

Overall, the discourse contained in these phrases around the voluntary nature of the HIV testing practice appears to be that of a voluntary, prepared, responsible, agentive, and willing to engage in a medical process subject discourse.

In 2005 the phrase voluntary counselling and testing was changed to HIV counselling and testing.

3.2.2 HIV counselling and testing (HCT)

HCT, also called provider-initiated HIV counselling and testing, began to be used in South Africa in 2005 as a concept to describe the practice of HIV testing (Department of Health, 2010). The HCT policy contains a clause which states that a health care worker should inform all clients who receive health care services of the risk of HIV, and routinely offer and recommend an HIV test service to them, irrespective of the medical diagnosis. Under this is the assumption that everyone should be tested, and that if left up to people to decide on their own, this would not happen; therefore, it should be provider-initiated. Perhaps it is at this stage, and for this reason (that people should know their HIV status), that the ‘voluntary’ component of the VCT practice was taken away. The shift in discourse from VCT to HCT led to a review of the national VCT policy guidelines in 2005 by the National Department of Health. This review led to the formulation of the National HCT policy guidelines, and was released later that year (2005). The HCT policy discourse revolved around the significance of HIV counselling and testing as a risk prevention initiative in high-burden areas, and amongst youth in South Africa. The national HCT policy was updated further in 2010 by the National Department of Health, but the name did not change. When one analyses the two policy initiatives and documents (for 2005 and 2010), they contain the following kinds of terms: informed consent, confidentiality, pre-test counselling, and post-test counselling.

The phrase informed consent contains the assumption that a health care service provider is mandated to inform the clients of their risk of HIV and the benefits of testing, and ask them to grant permission to be tested for HIV (Department of Health, 2010). This positions the subject (client) as needing to be tested, and the health care service provider as being responsible for making this happen. It is important to explore how students construct the practice of HIV testing. A question might be, for example, do they construct testing as a service one needs to be informed about, and as something one is required to do? Do they see health care service providers as being responsible for ensuring that one gets tested for HIV?

The phrase confidentiality contains the assumption that the health care service provider is obliged not to share the health records of their client with other people unless with expressed consent from the client (Department of Health, 2010). This assumption constructs HIV as a stigmatised disease, and the health care services provider as being aware of this and its impact on testing. It will be part of the interest of this study to see how students' constructions of themselves and HIV testing relate to this construction of testing as stigmatising, and the subject as needing protection, and whether those who have gone for HIV testing are satisfied with how the ethic of confidentiality was maintained in the testing process.

The phrase pre-test counselling contains the assumption that the client should be given relevant information on the benefits of HIV testing, the testing procedures, interpreting the test result, and the potential risks of testing (Department of Health, 2010). This constructs the service as risky but also as needed by the client. It is important to explore how students construct the practice of HIV testing. A question might be, for example, do they construct testing as needing counselling before testing? Do they construct testing as a risky activity?

The phrase post-test counselling contains the assumption that if a client tests positive for HIV, s/he needs to be equipped with relevant information on management and prevention options, and skills to support positive living (Department of Health, 2010). Giving the client counselling after an HIV positive diagnosis seems to contain the assumption that one needs preparation, skills, and knowledge, and that one is now responsible for the management of their status, and their health, and other people's risk. Overall, this constructs the service as laying the basis for controlling the spread of HIV, and not for the clients' benefit to protect themselves from the threat of HIV. Once more, it is important to explore how students construct the practice of HIV testing. A question might be, for example, do they construct counselling after taking an HIV as needed by the client who tests positive? Do they see it as important and for the significant reasons listed above?

Although the practice of HIV testing in the HCT policy document was still constructed as voluntary and with informed consent, as stated above, it is useful to consider why the word ‘voluntary’ was taken off.

3.2.2.1 Possible explanations for the shift in discourse from VCT to HCT

According to the CRHCS (2002), the keyword in the VCT is ‘voluntary’, which means that whoever was interested in knowing their HIV serostatus should take responsibility for initiating the service without coercion. Thus, taking away the word ‘voluntary’ and replacing it with ‘HIV’ to describe the practice of HIV testing in the HCT policy document is perhaps a way of normalising the practice, and making it an everyday issue, rather than it being something that a person takes up on their own. However, if the HIV testing practice is seen in this way, as a ‘normal’ service and as almost a standard component of medical care, its adoption could create problems. Walensky et al. (2011) argued that the pre-test and post-test counselling services are minimal in a mandatory HIV testing situation, and may increase the risk of subjecting the client to potential social harm. Drawing on Walensky et al.’s (2011) argument, making the HIV testing service appear mandatory in the HCT policy could expose a client who tests positive to psychological distress, which is something this policy purports to prevent through pre-test and post-test counselling.

Some research has shown that despite the word ‘voluntary’ being removed in the HCT policy, and despite the availability of the VCT services since 2000, many South Africans still did not know their HIV status (Makhunga-Ramfolo et al., 2011). Makhunga-Ramfolo et al. (2011) noted that clients who were living with HIV but were not aware of their status and consulted their family practitioners, did not seek HIV testing services; hence the opportunities to test were lost. Against this background, the South African government adopted the WHO’s recommendations of 2007 to introduce provider-initiated counselling and testing (which is the HCT) in addition to client-initiated counselling and testing (which is the VCT), as an effective public health intervention to increase access to HIV testing service, normalise this practice, and increase uptake. As part of implementing this initiative, the HIV testing service was constructed as playing two roles.

Firstly, in helping the family practitioners to learn their client’s HIV status. This knowledge is constructed by Makhunga-Ramfolo et al. (2011) as allowing for appropriate clinical decisions to be made, such as monitoring the CD4 count of the clients who test positive in order for the disease to be treated when it is in early phases. In addition to this is giving clients information on ways to reduce transmission and re-infection. This suggests that this shift from VCT to HCT was nothing to do with the clients and was all about getting health workers to embrace HIV services as core and their responsibility. As Makhunga-Ramfolo et al. (2011) argued, in the early 2000s, HIV services had been an emergency response run by a separate team of HIV staff, often employed directly by the United States Agency for International Development. There was a lot of effort to bring HIV services into the wider health service fold and not have separate HIV teams. It was also the start of ART scale-up, and ART scale-up required health services to more proactively seek out clients, hence being provider-initiated (Makhunga-Ramfolo et al., 2011).

Secondly, the HIV testing service was constructed by Makhunga-Ramfolo et al. (2011) as helping all clients to know their status. This constructs the clients as needing to know their HIV status in order to take responsibility for their status, and the health care service provider as being responsible for telling them their HIV status and getting them to assume responsibility for protecting society from the HIV infection.

The shift from VCT to HCT discourse could have also been motivated by South Africa’s 2007-2011 National Strategic Plan targets for controlling the HIV and AIDS epidemic. This document’s targets contain the following four phrases: HIV and AIDS prevention; treatment, care and social support; legal and human rights; and monitoring, research and surveillance (McNeil, 2019, August 27). To achieve the above four targets, the assumption is that everyone needs to be tested for HIV and be given skills for HIV prevention so that they can take responsibility for their behaviour and HIV status. Perhaps, this shift in discourse may have been motivated by the need to increase access to HIV testing services and maximise testing opportunities so that the government can achieve the above four targets.

The launching of a massive HCT drive in April 2010 is another attempt by the government to meet the above four targets for controlling the HIV and AIDS epidemic in South Africa. According to McNeil (2019, August 2), the goal of this drive was to encourage 15 million people, especially the youth, to know their HIV status by June 2011, which appears to be drawing on the biomedical methods of HIV prevention and management framework. This is because the primary focus of this drive was to lay the basis for preventing the spread and transmission of HIV, and not necessarily a developing initiative of the people to know their HIV status.

The contributions of the CRHCS may have also informed the noted shift in discourses. In 2002, the CRHCS recommended that countries in the East, Central and Southern Africa regions need to review, harmonise, and improve their VCT policies, programmes, and guidelines. The aim was to expand HIV testing services to reach more people (CRHCS, 2002). The focus here is still on testing everyone for HIV so that they can take responsibility for their behaviour. The CRHCS's findings have been tabled at various HIV and AIDS secretariat forums in South Africa to provide the necessary policy framework. These forums include but were not limited to: the SANAC Trust, which was responsible for developing the National HCT Campaign Strategy; the National Department of Health, which is responsible for reviewing the National HIV Testing Policy; and the HPCSA, which is responsible for developing guidelines for good practise in connection with HIV for health care practitioners and researchers. Perhaps, as part of the harmonisation and improvement of the VCT policy, the HCT policy guidelines were formulated and implemented to keep abreast of the local and international guidelines and recommendations in the field of HIV testing.

The HCT policy released in 2010 was again reviewed in 2015. This review led to the formulation of the HIV Testing Services policy.

3.2.3 HIV testing services (HTS)

The HTS policy guidelines released in 2016 by the National Department of Health is the document that directs and guides the current HIV testing service delivery in private and public health facilities in South Africa. In the HTS policy, the "seek, test, treat, retain and suppress" continuum has been adapted to accompany the HIV testing service in health facilities. In this approach, the health care worker is mandated to inform all clients who receive health services of the risk of HIV (seek), and routinely offer and recommend an HIV test service to them regardless of the medical diagnosis (test), initiate ART treatment for those who test positive for HIV (treat), and ensure that they remain on ART treatment (retain), with the aim to reduce the amount of HIV in their blood (suppress) (Department of Health, 2016). All these initiatives construct the HIV testing service as a foundation for HIV prevention and management, and the health care service provider as significant in making this happen.

However, when one analyses the HTS policy initiatives, it contains several terms about HIV testing, including consent, confidentiality, counselling, correct test results, and connection. These terms are summarised as the 5Cs framework proposed by WHO (2015). Unpacking these terms and their assumptions is crucial for understanding the participants' constructions of HIV risk and how they engage with the HIV testing health practice.

3.2.3.1 Consent

The HTS policy document positions anyone above 12 years of age, and who has sufficient maturity and mental ability to appreciate the benefits of HIV testing, the potential risks of testing and other implications of testing positive or negative for HIV, as being able to give verbal and written consent on their own to be tested (Department of Health, 2016). Given that the majority of undergraduate students in South African universities are in the age range of 20-24 years (Higher Health, 2020), and thus beyond 12 years, the HTS' conditions of informed consent include the University of KwaZulu-Natal students' age group. This, therefore, makes HIV testing services accessible and available to them. A section, which states that clients should be informed of the process and procedures for HIV testing before consent is obtained, their rights to refuse to test, and be given a chance to either accept it, or opt-out without being coerced, is also there (Department of Health, 2016). Clients who choose to opt-out are required to sign a refusal form which should be kept in their files (Department of Health, 2016). This legalisation of the process positions HIV testing as being risky. So those who sign a document saying that they do not want to take the test are protecting themselves from the potential risks of the practice they are encouraged to engage in. This legalisation of the testing process also positions the government as defending itself from being accused of not respecting the client's autonomy and freedom. The HTS policy also has a clause that states that clients who refuse HIV testing should still be provided with HIV care services, such as information on the benefits of testing, be encouraged to test, and be assisted in accessing HIV testing services in future. This assumption positions HIV testing as something which people should do, and so even those who refuse to do it still are encouraged to do it.

Overall, these conditions of consent position the client as an individual who, they assume, is free to decide, is informed sufficiently to decide, and is an autonomous individual to make the decision. The possible 'realities' of the client is that, although they have a right to opt-out, many might feel uncomfortable to decline HIV testing when it is expected and considered a 'favourable decision' by their health care provider (WHO, 2015). Clients who had initially refused HIV testing but were later counselled and encouraged to do it might feel obliged to comply due to the power differences between themselves and their health care service providers. Under these conditions, therefore, the clients' right to give informed consent, and voluntary participation in HIV testing, is significantly compromised. This highlights a contrast between how certain discourses are drawn on in the HIV testing policies, in relation to the experiences or realities of the policy's receiver or the testing subject (client).

In an effort to encourage a client to consent to HIV testing, the emphasis is placed on keeping their HIV test result confidential.

3.2.3.2 Confidentiality

The HTS policy document positions the health care service provider as having the responsibility to keep a client's information related to HIV test results, sexual behaviours, substance abuse, and the use of illegal drugs, confidential. This positions the health care service provider as wanting to intervene by making the client change their behaviours. This also positions the HTS policy as protecting the privacy, interests, and integrity of people who go for HIV testing. Perhaps this is important given that the way an HIV diagnosis is constructed in this policy is as if it is a stigmatising illness. This positioning of the health care service provider also positions the client as lacking knowledge about health risks, and their practices and activities as risky. This assumption seems to be drawing on the biomedical models' understanding of diseases and the risk discourse because the focus here is on increasing an individual's knowledge, with the hope that this would translate into actual change in behaviour.

The HTS policy document also positions the health care service provider as responsible for encouraging and supporting a client who tests positive for HIV to voluntarily reveal their status to their significant other (families or sexual partners), and bring these others in for partner or family testing. The assumption here seems to be that people *must* all know their HIV status, and so informing others of having HIV is for the benefit of all. The actor improves everyone's awareness of HIV, and motivates others to seek the HIV testing service to know their status, and minimises HIV and HIV testing stigma.

HTS policy also gives the health care service providers the option to disclose the client's HIV positive status to a partner(s), family and other people, but only with the client's expressed consent, or if ordered by a court of law. This positions the client as not having a right to do what they want, as not having a right to privacy, as not having a right not to disclose their HIV status to others, and as not having a right not to get tested for HIV.

While notifying other people about having HIV is constructed in the HTS policy document as beneficial for all, in reality, it has been proven to have adverse social and emotional consequences. These can be more challenging to deal with than the physical symptoms of an AIDS illness itself. For example, research by Daftary et al. (2007), which explored HIV testing and TB screening amongst patients at a hospital in Durban, South Africa, found that self-disclosure was done to a network of close confidantes, for example, a spouse or existing sexual partner(s), and sometimes to a family member. In that study, it was established that participants disclosed their HIV positive status to their close confidantes to alleviate the solitary burden of the infection. However, they avoided doing this to the broader community, peers, friends, or workmates due to fears of being ostracised. According to Daftary et al. (2007), participants' fear was not unfounded in the sense that they reported cases of stigma and discrimination. In other studies (Pillay, 2020; Rennie & Frieda, 2006), also conducted in South Africa, self-disclosure to a partner was seen as putting the actor at risk of sexual abuse, secondary victimisation, abandonment, and the disruption of family relations. In Rennie and Frieda's (2006) study, in particular, these threats were disproportionately higher for women compared to their male counterparts.

As studies have demonstrated, notifying others of one's HIV status does not always benefit others by influencing them to know their HIV status, or minimises stigma often levelled against people living with HIV, as stated in the HTS policy. In itself, self-disclosure exposes the actor to the stigma and discrimination of a seropositive status, and potentially violates their liberties and autonomy. These concerns about self-disclosure provide a context for interpreting the government's HIV testing policies as insensitive to the client, or even fostering pre-existing stigma and discrimination. It might be specifically these kinds of issues in the HIV testing interaction that the young people are resisting, rather than opposition to HIV testing *per se*. Thus, it is important to explore how students construct the practice of HIV testing. A question might be, for example, do they construct it as entailing risks such as potential emotional harm, stigmatisation and ostracization, as the reviewed literature suggests? Do they think it is something one should be encouraged to do, as the HTS policy suggests?

In the HTS policy document, counselling is also primarily seen as a mechanism for providing information/education with support.

3.2.3.3 Counselling

The HTS policy comments on the role of pre-test information and post-test counselling services in encouraging and supporting clients to get tested for HIV. In this policy document, the post-test counselling service is emphasised more than pre-test information services, and the reason for this is given in this section.

In the HTS policy, pre-test information is constructed as something which should be offered to all people who seek the HIV testing service on the same day of attending the health facility, irrespective of whether they report higher-risk sexual practices, or show indicators of a possible HIV exposure. The pre-test information service contains the following phrases: the benefits of testing; testing procedures; interpreting test results; management and prevention options; encouraging partner testing; the right to decline to test; and potential risks of testing. These phrases construct the service as something people need to be informed about, and position the health care service provider as mandated to accomplish this (to make this happen). On the other hand, the client is constructed as needing to get tested, but also as lacking knowledge and needing emotional support (counselling). All these works to construct HIV testing as something that people should do, but the process of 'doing' it and diagnosing HIV is somehow 'dangerous', or could 'harm' the client. It has all these problems of potential life disruption, emotional harm, stigmatisation, and ostracization, and it is as if the client is offered information that will 'protect' them from the possible harm of the practice they are encouraged to engage in. Hence, it is important to explore how students construct the practice of HIV testing. A question might be, for example, do they construct it as entailing all, or some discomforts such as those listed above.

In the HTS policy also, there are post-test counselling services for four categories of clients: those who receive positive HIV test result, those who receive negative HIV test result, those who receive HIV-inconclusive result, and those who receive discrepant test results. The post-test counselling services in the context of a client's positive HIV test result contains the following phrases: encouraging and motivating the client to explore significant personal concerns; encouraging and supporting the client to inform their sexual partner of their status and bring them in for partner testing; exploring ways the client can adopt to cope with anxiety and stress which might arise due to the HIV diagnosis, and giving the client information on a lifestyle change. The lifestyle change information contains the following kinds of terms: proper nutrition, clean water, physical exercise, palliative care, adherence to ART, treatment of opportunistic infections, and prevention of re-infection and transmission of HIV through practising sexual abstinence or protected sex. All these works to construct and position the client as needing quite a lot of support (both psychological, medical and practical), and as needing to be guided about proper nutrition, adherence to treatment, and risk-reduction strategies. The health care service provider, on the other hand, is positioned as the agent ensuring that the counselling service is offered to the client.

The post-test counselling service in the context of a client’s negative HIV test result contains the following kinds of terms: encouraging clients to practise sexual abstinence or postpone sexual debut for a designated length of time (perhaps until marriage), and if this is not possible, then to practice monogamy with an uninfected partner (be faithful), and if this is also not practical then practice protected sexual activities (condomise). These terms seem to be drawing on the bio-behavioural discourse, specifically the ABC framework. All these positions the HIV negative person, particularly youth, as still at risk of HIV infection, and the activities they engage in as also risky, and others and the country as at risk from exposure to this subject. These also position the health care service provider as being responsible for intervening by encouraging the young testing subjects (youth) to change their sexual behaviour and activities in order to remain HIV negative.

The post-test counselling service in the context of a client’s negative HIV test result also involves screening a client for STIs, TB, and alcohol use and drug abuse. The screening for STIs appears to be based on the dominant construction of their mode of transmission as being sexual, and same as that of HIV (UNAIDS, 2015; WHO, 2015). Screening for TB, on the other hand, appears to be based on the evidence that approximately 65% of adults with TB disease do have HIV too (Daftary et al., 2007). Hence it seems reasonable to test people with TB for HIV. The alcohol use and drug abuse screening seems to be based on the dominant positivist assumption that substance use and abuse make the person not think rationally, in terms of assessing risk and taking responsibility for their behaviour (Patterson & Keefe, 2008). While the HIV test gives a definitive result, this form of surveillance of an individual and their body (screening for STIs, TB, and alcohol use and drug abuse) construct the HIV negative person, particularly youth, as still at risk of HIV and their practices as also posing a threat, and as needing to be further investigated. These opportunities to engage youth on issues that are highly co-morbid with HIV risk (STIs, TB, and alcohol use and drug abuse) in a public health setting also constructs the post-test counselling service in the context of a client’s negative HIV test result as offering critical opportunities for mediating HIV risk in the society. This also positions the health care service provider as intervening in, or as critical mediators of, HIV risk to protect society from exposure to this subject. Overall, this paragraph highlights the tension between the aims of public health and how it may create a context where people are positioned as high risk, which may cause identity tension and increase their disengagement with health services, for example, HIV testing.

Moreover, while the long-term preventive benefits of post-test counselling for seronegative persons amongst South African youth and the general population is still unknown, CRHCS (2002) argued that such benefits might last up to 12 months. However, research has shown that HIV counselling does not significantly affect sexual behaviour or HIV incidence in individuals who receive negative test results (George et al., 2019; MacPhail et al., 2009; Mohlabane et al., 2016; Paul et al., 2014; Tenkorang, 2016). This highlights a contrast between how certain discourses are drawn on in the HIV testing policies and the realities of the testing subject.

In the HTS policy, an HIV inconclusive test result means that an HIV status could not be immediately determined following an HIV test assay (Department of Health, 2016). This situation is constructed as being caused by a low-quality HIV test assay kit, or errors that might occur at various points along the HIV diagnostic continuum (Department of Health, 2016). The post-test counselling service in the context of a client's HIV-inconclusive result contains the following kinds of phrases: giving the client a clear plan about possible follow-up tests using the high-quality HIV testing technologies, such as the Enzyme-linked immunosorbent assay (ELISA) and asking them to consent to it, and encouraging the client who gets tested to return within seven days for their test result. This assumption constructs the client as potentially at risk of HIV, and as potentially having HIV, unless proven otherwise by scientific technology, such as the ELISA. The post-test counselling service in the context of a client's HIV-inconclusive result also constructs the client as agentive, as being able to see the need through appropriate information and education to consent to the ELISA test, and return within the stipulated seven days for the confirmation of their earlier result.

In the HTS policy, an HIV discrepant test result means that an HIV status of a person comes out positive, and upon re-testing using a different HIV test assay, the same client's test result comes out negative (Department of Health, 2016). This situation is constructed as being caused by a low-quality HIV test assay kit, transcription errors, or seroconversion. Seroconversion is the inability of the test kit to detect the HIV antibodies in a person who has HIV, with this attributed to consistency in using pre-exposure prophylaxis, or ART treatment (Department of Health, 2016). The post-test counselling service in the context of a client's HIV discrepant result contains the following kinds of phrases: screening for pre-exposure prophylaxis or ART use, and encouraging the client to return to the health facility after six weeks to re-test for HIV. This assumption constructs the client as potentially at risk of HIV, and as potentially having HIV, unless proved otherwise upon re-testing after a specified length of time.

Overall, the different kinds of post-test counselling services for the different types of clients, depending on their HIV test result discussed above, seem to construct the service as a risk-reduction plan for all the four categories of the clients regardless of their HIV test result. It is all about the management and containment of HIV, and also the control of the effect of an HIV positive diagnosis on the individual's life. This, therefore, partly explains why the post-test counselling services and information are accentuated more than the pre-test information service in the HTS policy. It is important to explore how students construct the practice of HIV testing. A question might be, for example, do they construct it as involving post-test counselling service? And if they do, do they construct the post-test counselling service as a critical component of a prevention intervention as constructed in the HTS policy?

The national HTS policy also recommended both the pre-test information and the post-test counselling service to be delivered in the language understood by the client, and to consider issues of culture, religion, gender dynamics, sexual orientation, age, and developmental stage. This constructs the HIV testing service as universal in terms of availability and quality, and as unbiased, and these are assumed to create demand for the service.

Moreover, to ensure routine engagement with HIV testing, the SANAC provides a 24-hour hotline as additional support and HIV counselling. On their website, people are encouraged to dial a toll-free AIDS helpline number or send an SMS to find an HIV testing facility near them. These services are available 24 hours / 7 days a week / 365 days a year. The resources put into providing the HIV testing service and its emphasis on primary health care services position HIV testing as being a significant government health priority. This emphasis, and the constant messaging about the service could also exert pressure on the public to get tested and take responsibility for their HIV status.

To provide quality HIV testing service, the government emphasises adherence to the national and international quality assurance standards to ensure that the final HIV test result is correct.

3.2.3.4 Correct test result

The HTS policy recommends the use of widely recognised and accepted HIV testing tools and procedures to ensure correct test result. In this regard, the following terms: the 3rd generation antibody test (the ELISA antibody test), the 4th generation antibody/antigen test (the ELISA combined antigen/antibody test), the rapid diagnostic test, and the HIV self-testing compact kit, are contained in the HTS policy.

3.2.3.4.1 Enzyme-linked immunosorbent assay

As their names suggest, the ELISA antibody test is designed to test the HIV antibodies, while the ELISA combined antigen/antibody test is designed to test the HIV antibodies and antigens (Department of Health, 2016). While no laboratory test provides a definitive HIV test result, these two HIV testing assays are constructed as involving high-quality laboratory work and potentially detects HIV within one month after exposure (Department of Health, 2016). This positions these two HIV testing assays again as highly reliable, making them useful for clinical diagnostic purposes. The major challenge with using them, however, is that, since they involve laboratory work, the service may be costly for some unemployed youth. It could also take a week or so for clients to receive their HIV test results, which may discourage users. This emphasis on the laboratory work, which involves the use of scientific experiments and analyses, and the length of time to receive the HIV test result, is more related to the assumption of the positivist approach. Within this approach, the assumption is that scientific, biomedical accuracy, and objectivity is needed because a false result has significant consequences for people’s behaviour, and for the spread of HIV.

3.2.3.4.2 Rapid diagnostic test

In medical discourse, the rapid diagnostic test is constructed as testing the HIV antibodies within three months after exposure (Department of Health, 2016). The testing activity does not involve drawing much blood, or sending them for laboratory tests, which could take a bit of time. In the HTS policy, the rapid diagnostic test is constructed as convenient, and that the client can receive the test result within 20 minutes. Some research constructs the rapid diagnostic test as reliable in terms of clinical sensitivity and specificity, meaning that there are rare cases of a false-positive result when the test kit is fit for the purpose, and used as prescribed (Figueroa et al., 2015). However, it is as if this emphasis on science and accuracy is drawn on to risk proof the health care service provider’s ability to provide particular information to the client in a more scientific way so that the client can feel safe that their testing process is accurate.

The HTS policy also states that the rapid diagnostic test does not guarantees accurate test results. The users are, therefore, encouraged to do a confirmatory test using the ELISA to rule out multiple errors at various points along the HIV diagnostic continuum. According to the Department of Health (2016), an HIV test result of a person who acquired HIV, but is in the window period may be a false negative. In this policy, the window period is constructed as the time frame between the HIV infection, and before HIV antibodies can be detected by a standardised HIV screening kit (Department of Health, 2016). The window period for a rapid HIV test is 90 days (i.e. 3 months) (Department of Health, 2016). This emphasis on the need for confirmatory tests positions the health care service provider as not being liable for the false test result, which has significant consequences for the client, and for the spread of HIV.

The rapid diagnostic test is used in mobile clinics, free-standing HIV testing sites, on the Pietermaritzburg campus. For example, the mobile testing tents placed on the library lawns, the CHASU offices, and the campus health clinic. Its use in these various testing sites is based on the advantage it provides in terms of lower costs, and quick test results.

3.2.3.4.3 HIV self-testing (HIVST)

In the National HTS policy document, HIV self-testing (HIVST), also called HIV self-screening, is constructed as an alternative that may increase both HIV testing uptake and frequency, and as facilitating early diagnosis and treatment; all of which are associated with decreased HIV-related morbidity, death, and transmission (Department of Health, 2016). The HIVST practice assumes that a subject would collect their specimen (oral fluid or blood), and then screen for HIV using a rapid diagnostic test, and interpret the result, in a private location, either alone, or with assistance from someone they trust (Department of Health, 2016). This constructs the HIVST practice as providing an opportunity for a client to test discretely and conveniently as testing can happen at home, or anywhere the person feels comfortable and safe. It also positions the client as having privacy, thus in control of the testing context, and as agentive. The HIVST practice is also constructed in the HTS policy as removing structural, logistic and social barriers to testing, such as stigma and discrimination and resistance to self-disclosure between sexual partners (Department of Health, 2016).

Previous research in South Africa (Pérez et al., 2016), and elsewhere (Figueroa et al., 2015) has demonstrated the acceptability of the HIVST in the general population. Pérez et al.'s (2016) qualitative study on self-testing in an informal settlement in South Africa reported the acceptability of the HIVST amongst adults. Figueroa et al. s' (2015) meta-analysis of initial trials on attitudes and acceptability of the HIVST amongst key populations globally reported that most people (about 88%) who had refused the healthcare-based approach to HIV testing due to exposure in the testing process, a situation where HIV social stigma could occur, accepted the HIVST option. Figueroa et al. (2015) concluded that there seems to be an overall perception of the HIVST as having the potential to increase people's knowledge of their HIV status, especially in previously untested, hard-to-reach and key affected populations, and as facilitating the early diagnosis of HIV and treatment in these populations. However, there is a paucity of youth-focused research (including amongst university students) on the understanding and acceptance of the HIVST in South Africa. A recent study by Ritchwood et al. (2019) on utilisation of the HIVST amongst rural youth in rural South Africa reported that the HIVST was acceptable to study participants. However, participating youth in Ritchwood et al.'s (2019) study expressed concerns about whether the HIVST could be trusted due to the possibility of getting a false positive and negative result, as well as whether the testing client would be able to emotionally handle a positive result if they tested alone. The participants in Ritchwood et al.'s (2019) study suggested that the HIVST kits need to be used alongside someone who could offer support and counselling.

Govender and Schlebusch's (2013) study on the stress levels of HIV-infected clients in the immediate post-diagnosis period at a South African hospital found that an HIV diagnosis exposes the client to potential harm, such as feeling hopeless, depressed, suicidal ideation, desire to hurt those they think infected them with HIV, and the desire to be vindictive because of their own pain. Drawing on the findings of Govender and Schlebusch's (2013) study, one can argue that the shift in the practice of HIV testing away from the primary health care facility to the individual may expose the client to some, or all of the above potential harms, if they were to test positive for HIV. This is because, unlike the participants in Govender and Schlebusch's (2013) study where those who tested positive for HIV received organised support given by a trained counsellor, there is no adaptive or coping behaviour performed in the form of counselling in the context of self-testing.

Although little is known about how university students in South Africa have responded to the notion of self-screening for HIV, the recent Higher Health 2019-2020 annual report indicated that about 500 university students opted for self-testing in 2019, due to its privacy (Higher Health, 2020). In light of this, it is crucial to explore how youth, particularly educated youth in a tertiary setting in South Africa, construct the practice of self-testing for HIV. A question might be, for example, do they know about the existence of the HIVST compact kit? Have they ever used it? How do they feel about the practice of HIV testing? For example, should an individual do it independently at their home, which is less controlled, or should it be confined to a health care facility, which is controlled and has the immediate pre-test and post-test counselling services? Do they see HIVST practice as being important to diagnose the problem early as it is constructed in the HTS policy? The findings of this study are, therefore, critical, as they shed light on how strategies and interventions aimed at encouraging sexually active educated youth to know their HIV status outside a clinic setting have worked, and compare them with the findings of successful trials in South Africa (Pérez et al., 2016), and elsewhere (Figueroa et al., 2015), presented above.

For a client who has passed through all the above 4Cs and tests positive for HIV, they are linked to ART treatment and other clinical services, which is the last C of the 5C principles of HIV testing.

3.2.3.5 Connecting clients into a continuum of care

A careful review of the HTS policy document shows that HIV testing is constructed as a sound foundation for promoting various forms of biomedical approaches to HIV prevention and management. In what is being constructed as the primary goals of ART in this policy, it contains the following phrases: provides maximal and lasting viral load suppression, restores and preserve immunity, reduces the risk of continued transmission, prolongs life expectancy, improves the quality of life, and reduces opportunistic diseases (Department of Health, 2016). Unlike VCT and HCT policies, which urge the health care service providers to encourage the HIV infected body (client) whose CD4 count is greater than 350 cells and less than, or equal to, 500/mm3 to take up treatment immediately (Department of Health, 2000, 2010), the HTS policy contains the assumption that the sooner people commence ART treatment after being diagnosed with HIV, the more they benefit from it. This positions HIV testing as being the primary step for the person who has HIV to proceed to a continuum of care. This also positions people who have HIV as not having the option to opt-out of the therapy if they do not want to be treated. It also positions the health care service provider as significant in intervening, or ensuring that the client is treated. In light of this, it is important to explore how youth in a tertiary setting in South Africa construct the practice of HIV testing. A question might be, for example, do they construct testing as involving linking those who test positive to a continuum of care? Do they construct ART treatment as being an important intervention in controlling HIV spread, as constructed in the HTS policy?

As part of implementing the HTS policy, a specific category of people is identified as the target for the HIV testing service.

3.2.3.6 Target subjects in the HTS policy

The target subjects (clients) for the HIV testing service in the HTS policy include: pregnant women, clients seeking sexual and reproductive health care services; clients who present with symptoms suggestive of opportunistic infection such as TB and STIs, have experienced domestic violence, gender-based violence, sexual assault or child abuse; a client who is seeking medical admissions to the wards or voluntary medical male circumcision; and clients from areas of high HIV prevalence, or with a history of risky sexual behaviours, for instance, unprotected sex, same-sex relationships, or if using injectable hard drugs (Department of Health, 2016). More generally, this category of people is constructed in an epidemic model (explanatory model) as deviant, and as a vector through which STIs infiltrate wider society, because of the framing of HIV spread as through risky practices (Goldstein et al., 2003). This positions this category of people also as a burden to the larger group, and so they are targeted in health policies and interventions to manage and contain the spread of HIV. The health care service providers are positioned as implementing this government’s initiative (intervening) by creating a demand for HIV testing for these types of people, and trying to get them to change their sexual behaviours. The health care service providers’ role here constructs the HIV testing service as performing the role of risk proofing society, which draws on the medical response to disease and risk models. Similarly, drawing on this positioning of the health care service provider and the construction of the HIV testing service, it is evident that there is no concern about the client’s option to opt-out of the service if they do not want to be tested for HIV. This positions the HTS policy as benefitting the government and burdens the client, who is the receiver of the health care service.

Another category of people identified as the target in the HIV testing service is the couple or partners. In the HTS policy, a client is encouraged to bring in the sexual partner(s) to be tested together (Department of Health, 2016). Here, couple testing is constructed as influencing decisions about HIV management and prevention, and sexual and reproductive health, for example, contraception, conception and making plans for the sake of their children's future (Department of Health, 2016). All these assumptions position the couple as sexually active, and not using condoms, and needing to be concerned about the future, and therefore, there is a need for this surveillance and protection (couple testing). Thus, it is important to explore how educated youth in South Africa construct the practice of HIV testing. A question might be, for example, do they construct it as something which partners should be encouraged to do together? Do they consider, or practice joint testing in their everyday life and in their relationships, and why?

Moreover, the accredited lay counsellors are identified in the HTS policy as being part of the implementors of the policy. They are positioned as easing a shortage of trained nurses, as increasing access to quality services, and as ensuring equitable testing services across the country (Department of Health, 2016). This constructs the HIV testing service as universal in terms of availability, access and quality, which is assumed to facilitate access to the testing service.

3.2.4 Synopsis of the section

This section has presented a brief history of the South African government's engagement with HIV testing as an approach to address HIV as embedded in its policy documents. A description of how the HIV testing health practice has been conceptualised in the past as VCT, then HCT, and presently as HTS, and the discourses being drawn on, and what motivated these shifts in discourse, is given. In analysing the unintentional consequences of particular language used in these policies, one gets a sense that HIV testing is positioned as a service to mitigate HIV incidence and prevalence in South Africa. The government's focus on, or reason for encouraging people to take an HIV test is to lay the basis for HIV management and prevention, and not necessary for people to know their HIV status.

In the review of the HIV testing policies also, there are some assumptions about the testing service. The service is constructed as client-initiated and voluntary in the VCT policy, and as provider-initiated and needed by the client in the HCT and the HTS policy documents. When one analyses these two (HTS and HCT) policy documents further, it is evident that these policies set the framework for delivering wide-scale HIV testing services regarding what, where and how testing should be conducted, who should be targeted, and the service is not entirely voluntary. In terms of the target population, the HTS and HCT policy documents encourage the health care service providers to recommend and offer the testing service to pregnant women, clients who present with TB and STIs, or have experienced gender-based violence or sexual assault, or from areas of high HIV prevalence, or with a history of risky sexual behaviours. According to Goldstein et al. (2003), framing certain practices as risky in the health care system has negative consequences for people who engage in those practices. In line with this argument, the inclusion of these types of people in the HTS and HCT policy documents was primarily in the context of being constructed as a risk to others. The health care service providers are positioned as wanting to intervene to protect others from these types of people by creating a demand for the HIV testing service, and making them change their sexual behaviour. This also implies that most HIV prevention efforts do not focus on sex positivity but rather on risk discourses. Arguably, this construction of the service and positioning of the health care service providers as mediating risk in the society makes it more likely that the client has no option to opt-out of the service if they do not want to be tested for HIV.

Another key lesson learnt from this identification and inclusion of particular categories of people in the health care system is the hidden role of HIV testing services as risk proofing society. This makes HIV testing policies look more attractive at the expense of the clients' emotional state, and seems to be the primary reason for the shift in the discourses. This highlights a potential impediment to implementing the national HIV testing policies and initiatives therein as an approach to address HIV risk. This inadequacy in the government's response to the HIV risk through HIV testing is compounded by a general lack of recognition of the position of the client, who is constructed in these policies as the receiver of the health care service, in the public health debates and policies. It is evident from the review that it is very little (e.g., HIVST) in the HIV testing policies that construct the individual as having a right to do what they want, as having a right to privacy, as having a right not to disclose their HIV status to others, and as having a right never to get tested for HIV. It might be specifically these kinds of issues in the HIV testing interaction that the young people are resisting, rather than opposition to testing *per se*.

Given that youth in South Africa still do not seem to engage actively in, and regularly with HIV testing as discussed in this section, and in the prior chapters, it appears then that there could be a feature of HIV risk and HIV testing practice, which is socially constructed, but has not been addressed in the government's health policies and initiatives. Thus, it will be interesting to find out in a study, such as this one, how students' constructions of the risk of HIV and the practice of HIV testing, is related to this construction of testing evident in HIV testing policies in South Africa, as being the primary intervention for HIV risk management and containment, and people as being agentive. In a study by Schneider and Ingram (1993) on the social construction of target populations in the public health policies in the United States of America, it was concluded that discourses in public health policies on HIV and AIDS tend to influence people's constructions of HIV risk, and attitudes, and positioning in relation to health practices, such as safe sex and HIV testing. Thus, it is crucial to explore how youth, particularly educated youth in a tertiary setting in South Africa, construct the practice of testing for HIV. In this regard, some important questions to explore include, for example, do their constructions relate to what the health policies are trying to do? Are they different from the constructions evident in the policies and, therefore, that any initiatives based on these kinds of policies might not work? Could that be why there is a lack of HIV testing practice amongst youth in South Africa?

In the case of whether and how youth in South Africa engage with HIV testing as a protective strategy, researchers have not sufficiently investigated constructions of, and positioning in relation to HIV risk, which could be crucial in theorising youth's HIV testing practices. The next section reviews the existing research on HIV risk and HIV testing health practice amongst youth in South Africa, to highlight the extent to which the current research problem has been investigated.

3.3 Social construction of HIV risk and implications for HIV testing health practices

According to Goldstein et al. (2003), the problem of HIV may be understood through its social constructions that function to influence individual responses to it. Inspired by this argument, this second section of this chapter investigates how the problem of HIV risk and HIV testing health practice amongst youth, including university students in South Africa and globally, has been explored in research. It focuses upon the social constructions of HIV risk, how youth have been constructed and positioned in relation to HIV risk, how this construction and positioning relates to their HIV testing practices, and the discourses drawn on. But before I engage directly with the review of the relevant literature on the issues mentioned above, one first needs to understand how HIV and AIDS are socially constructed, and the discourses drawn on. This may be crucial in theorising youth's perceptions and understanding of, and positioning, in relation to HIV risk, and their HIV testing practices.

3.3.1 Social constructions of HIV infection

In the biomedical discourse, HIV and AIDS are problematised in terms of transmission, acquisition, infectivity, framing, and characterisation of the key population and risky practices. In the course of socially constructing an HIV diagnosis and AIDS in the field of HIV, two central discourses are being drawn on, the medicalisation of, and the stigmatisation of HIV and AIDS. Goldstein et al. (2003, p.16) noted that in the medicalisation of HIV and AIDS discourse, "the focus is on fatality, and it serves to entrench the power of medicine and science, leaving individuals disempowered to take responsibility for managing the illness themselves." This discourse may be understood as part of the ongoing attempts to raise awareness about the threat of HIV using the fear arousal approach. The stigmatisation of HIV and AIDS discourse is evident in the attention on the visible, fatal, devastating and stigmatising consequences of the condition, which are constructed as inevitably advancing towards death (Goldstein et al., 2003). This discourse may be understood as part of the ongoing efforts to identify, and isolate those who have HIV or AIDS in an effort to control its spread.

In the biomedical discourse, HIV is defined as a virus that infects a human being and weakens their immune system, and by implication, as a sickness. Thus, the focus is on treating the sick individual by prescribing particular drugs, ART. This construction appears to be drawing on the medicalisation of HIV and AIDS discourse argued by Goldstein et al. (2003). This way of constructing an HIV diagnosis as an illness is reported in some studies amongst youth in South African universities. For example, student participants in the HEAIDS (2010) survey constructed HIV infection as having only one outcome, sickness and death, and used that to justify not engaging with HIV testing. This view constructs the activity of HIV testing as only for diagnostic purposes, and not to lay the foundation for HIV prevention and management, as it is being constructed in the HIV testing policies. In another study on barriers to, and facilitators of, HIV testing amongst the first-year university student participants, taking an HIV test was constructed as subjecting the individual, after receiving an HIV diagnosis, to embarrassing questions about what love and sex mean (Buldeo & Gilbert, 2015). In that study, a person who tests positive for HIV was constructed as no longer being able to have intimate relationships, as less able to engage in sexual activity, as less able to produce children, as less able to have a productive life, and as guilty. While all these issues described by Buldeo and Gilbert (2015) are primary desires of youth after they complete their university education, they highlight the possible stigmatisation related to being HIV positive, and the possible reactions that an individual would expect from others if it were known that they tested positive for HIV. This way of constructing an HIV diagnosis might lead to avoidance of HIV testing amongst youth.

3.3.2 Social constructions of AIDS

In the biomedical discourse, AIDS is constructed as epidemiologically linked to clinical symptoms of HIV infection, which can lead to death. This definition taken from the UNAIDS Terminology Guideline released in 2015 appears to be drawing on the descriptive model, which relies on medical science and logical positivism to give meaning to an illness. However, drawing on the work of Goldstein et al. (2003) on the social construction of AIDS, the focus is on the visibility of the sickness, a body severely affected, losing weight, with skin blotches, severely diarrhoeal, and having a persistent cough, and mouth and skin problems. This construction appears to be drawing on the stigmatisation of HIV and AIDS discourse, and has implications for how the AIDS subject is likely to position themselves. Goldstein et al. (2003) argued that the sick AIDS subject is often less able to distinguish between one's sense of self and the virus, and sometimes constructs and positions oneself as being diseased, infected, contaminated, impotent, malfunctioning, helpless, and hopeless. This negative self-talk might lead to depression, guilty feelings, and the fear of death and dying (Goldstein et al., 2003).

The social construction of AIDS in terms of fatality and devastation is also reported in an extensive meta-analysis of Malawian studies investigating conversations around AIDS during a time of evolving access to ART treatment (Conroy et al., 2013). The dominant discourse in this review of the early ART treatment era was fatalism. Conroy et al. (2013) reported that participants in various studies recalled experiences with the hospitalisations of, and death of family and friends from, what was constructed as a deadly virus that causes dire suffering to the human body. However, Conroy et al. (2013) observed a shift in the discourse during the ART expansion era, where AIDS fatalism was slowly replaced with medicalisation and prolonged life after ART treatment. It is evident from Conroy et al.'s (2013) study that the meaning of HIV and AIDS is indeed socially constructed, which is related to individual experience and context.

Another issue of interest in terms of the social construction of AIDS amongst youth in South Africa is documented in Steinberg's (2008) book on the journey of a young man called Sizwe through the HIV and AIDS epidemic in the Eastern Cape Province. Sizwe constructed AIDS as a sickness being caused by witchcraft, or displeasure from the ancestors. According to Steinberg (2008), such ways of constructing AIDS are an attempt to make sense of the existence of an unexplainable disease, to give potential answers to it, and to explain the untimely death of a youth which has been attributed to AIDS. This way of constructing AIDS appears to be drawing on the victim discourse, and has implications. It seems to shift blame and responsibility for creating HIV risk onto others and reduces the need to adapt or engage in HIV testing as a protective strategy. Sizwe only acknowledged AIDS as an STI later when his friend died of it, and even after this, he was hesitant to engage in HIV testing (Steinberg, 2008). In this regard, Sizwe's positioning of other people as being responsible for creating the risk of HIV, and himself as not needing to test for it, may have served as his protective strategy. For example, this framing of HIV might make him feel guilty that he could have HIV or AIDS based on his risky sexual practices, but it could also have alleviated anxiety related to death and dying. Overall, Steinberg's work demonstrates the mystery and fear about HIV and AIDS and the stigma engulfing everyday 'realities' of young people, which play a vital role in shaping their responses to HIV testing health policies.

Research in South Africa has shown that in the absence of HIV testing, some youth draw on the images of a wounded, degraded, attacked body to diagnose themselves and others as having HIV (Steinberg, 2008). Others use these images of a sick AIDS body to identify and isolate those whom they think that they have the disease, in an effort to protect themselves from them, or to identify partners perceived as 'safe' (HEAIDS, 2010), while others use them to make decisions about getting tested for HIV (HEAIDS, 2010; MacPhail et al., 2009). This positions youth as assuming that the HIV infection is a visible sickness, and their protection strategy involves the selection of an asymptomatic (uninfected) partner, and isolating those they construct as being infected based on their physical appearance. This construction diverges from, or contradicts the medical, or scientific knowledge of HIV and AIDS. For example, according to the UNAIDS (2015), HIV has a prolonged incubation period, and people living with it may not necessarily exhibit any physical symptoms. Therefore, in this study, the focus is on analysing participants' meanings, perceptions, and understandings of HIV risk and HIV testing, or their ways of talking about, and constructing HIV and prevention. In doing this, the multiple discourses being drawn on can be identified and defined, for example, whether participants draw on the assumptions of the medicalisation of, and the stigmatisation of, HIV and AIDS discourses, which renders the HIV and AIDS a threat to them.

Moreover, the discourses drawn on by youth to construct an HIV diagnosis and AIDS are significant determinants of their perceptions and understanding of HIV risk and their positioning on HIV testing. In the next section, I will discuss research related to youth’s constructions of HIV risk, their positioning, and the implications of these for their HIV testing health practices.

3.3.3 Social constructions of HIV risk

In the dominant biomedical theories of health promotion, risk perception is constructed as a necessary condition for behaviour change (Ajzen, 1991; Brown, 1995; Glanz & Reimer, 2008; Kenyon et al., 2010). Kenyon et al. (2010) further noted that HIV risk perceptions change depending on the context in which people with risky behaviours live. Several studies provide evidence that managing HIV risk depends fundamentally on personalising it, which allows for its construction as the enemy (and a threat), and increases the need to adapt (Durojaiye, 2011; Kenyon et al., 2010; Tenkorang, 2016; Van der Riet & Nicholson, 2014; Ziki, 2015).

Moreover, research has shown that people who construct themselves as being threatened by HIV, or the risk of contracting it, and as feeling exposed to it, and as believing that HIV testing would decrease their risk of being infected, particularly after engaging in unprotected sexual activity with a new partner of unknown status, would act to test (Mabuto et al., 2019; Okelola, 2019; Peltzer & Matseke, 2013; Tenkorang, 2016). However, different findings are reported in two South African studies conducted with university students (Evans et al., 2018; Maughan-Brown & Venkataramani, 2018). Evans et al.’s (2018) study investigated knowledge about HIV, risk perceptions, and access to HIV health care services across six universities in the Gauteng province. A significant finding in Evans et al.’s (2018) study is that although university students regularly engaged in unsafe sexual practices at university, and knew that they were at risk of contracting HIV, they refused to get tested due to the fear of finding out that they have the disease. This means that for participants in Evans et al.’s (2018) study, the risk of finding out that they have HIV is assessed as worse than the risk of getting HIV in the first place, and therefore, not testing is ‘rational’. On the other hand, Maughan-Brown and Venkataramani’s (2018) longitudinal study amongst female students aged 20-30 years in the Western Cape province found no association between perceived susceptibility to HIV risk and actual change in HIV testing behaviour was reported. This study, therefore, argues that the ways in which students make sense of HIV risk and HIV testing practice are socially determined, and not related to the notion of perception, which draws on the positivist assumption that cognition drives behaviour change.

Most South African studies have used biomedical models such as the health belief model and the theory of planned behaviour to investigate university students' perceptions of HIV risk, and their intentions to engage in preventive practices like HIV testing. Glanz and Reimer (2008) present the health belief model as a value-expectancy theory. For Glanz and Reimer (2008), the value becomes the desire to avoid illness (for example, HIV and AIDS), and expectancy is a belief that a particular health action (or decision) available to an individual (for example, HIV testing), would prevent disease. The primary assumption here that one can critique is that behaviour is driven by cognitive assessment and evaluation of risk, and knowledge of what to expect. Some of the studies using the health belief model in research with students have been, for example, to quantitatively explore first-year students' responses to HIV and AIDS through HIV testing at the University of Witwatersrand (Buldeo & Gilbert, 2015); the uptake of HIV testing services as part of the universal test and treat programme at the University of KwaZulu-Natal (Okelola, 2019); influences on students' use of HIV testing services at the Nelson Mandela Metropolitan University (Musemwa, 2015); and factors influencing adoption of high-risk sexual behaviours amongst undergraduate students at a private university in the Gauteng province (Ziki, 2015).

The theory of planned behaviour is a conceptual model which explains how sensory input, with some cognitive processing (much of which is unconscious), is linked with behaviour (Ajzen, 1991). The primary assumption of this theory is that one can critique is that behaviour is determined by one's attitude towards the effect of one's actions, regardless of whether one puts their intentions into actual actions (Ajzen, 1991). Some of the studies using the theory of planned behaviour in research with students have been, for example, to investigate HIV testing behaviour and intentions to test, or not test amongst university students (Haffejee et al., 2018); and condom use amongst youth in a time of HIV and AIDS (Gwala, 2019; Mbelle et al., 2018). The predominant theme connecting all the studies presented above is that although student participants had engaged in high-risk sexual behaviours, they were still reluctant to self-identify with HIV risk. This positioning deterred them from talking about HIV risk in their relationships, or seeking HIV testing service, or engaging in protected sexual activity.

Overall, the lesson learnt from all the studies presented above is that university students' perception of HIV risk has been investigated in relation to facilitating, or impeding their engagement with HIV testing as a protective health practice. However, very little attention has been given to how university students construct HIV risk in relation to their HIV testing health practices. Maticka-Tyndale (1992, p.239) argued that "for scientific knowledge to influence behaviour, it must become part of common sense knowledge." Inspired by this argument, this study argues that for one to understand the HIV testing practices of sexually active youth potentially at high risk, it is crucial to understand their constructions of risk and their methods of addressing it, specifically through HIV testing.

The HEAIDS (2010) survey investigated the prevalence and trends of crucial HIV-related indicators (knowledge, attitudes, behaviours, practices) amongst staff and students in South African universities. These HIV-related indicators in the HEAIDS survey seem to be drawing on the biomedical perspectives for understanding health, illness, risk and human behaviour. The HEAIDS survey reported that student participants assumed that the university context is least affected by HIV and their potential sexual partners are HIV negative. In that survey also, some students constructed themselves as not being at risk of HIV, and justified this by citing their previous engagement with HIV testing where they tested negative. They also cited their involvement in a long-term partnership, or a monogamous relationship with a peer. Their justifications positioned potential sexual partners as not being a threat in relation to HIV infection. This view appears to be drawing on the dominant constructions of HIV as being a visible sickness. Asymptomatic peers were viewed as being at no, or low risk of HIV infection, which reinforces the sense of trust in sexual relationships with peers as a form of protection. These constructions of immunity to HIV tend to diverge from the biomedical understanding of HIV risk, which focuses on the individual personalising the threat of HIV in sexual activity and prioritising their safety.

Some researchers, such as, Nene (2014) and Van der Riet and Nicholson (2014), have attempted to use the social constructionist perspectives to investigate sexual risk and responsibility for managing risk amongst the University of KwaZulu-Natal students in South Africa. The primary finding of these studies is that some students constructed the risk of pregnancy as their primary concern and dismissed the risk of exposure to HIV, stating that it should be a concern to them, but it was not. The reason given by their participants for this is that pregnancy is a visible outcome of sex, which is stigmatising and directly threatens their future finances and status as students. Nene's (2014) study reported that female students addressed the risk of pregnancy by using hormonal contraceptives, mainly the contraceptive pill, the injection, and the emergency contraceptive. The consequence of this prioritisation of the threat of pregnancy is that condom use, or uptake in the use of oral pre-exposure prophylaxis, which are the effective methods for preventing HIV, is often low and/ or inconsistent, as reported in previous studies in South Africa (Bekker et al., 2020; Coates et al., 2011; Gwala, 2019). In light of this, an alternative practice that sexually active youth need to consider to protect themselves against HIV infection is to test regularly for HIV. Therefore, this study aims to explore how university students position themselves in relation to HIV risk, and how this positioning is related to their practice of HIV testing.

However, drawing on the assumption of social constructionism that individual social practices and actions are socially constructed (Parker, 1992), one's positioning in relation to HIV risk and, therefore, HIV testing, is related to perceived or actual attitudes of peers, partners, family and society towards the HIV infected person.

3.3.4 Social constructions of HIV stigma and discrimination

According to Parker and Aggleton (2003), stigma is a social construction of nonconformity to an ideal or expectation, contributing to a dominant discrediting social label that reduces the way individuals, for example, those living with HIV, construct themselves and are constructed and positioned by others. When stigma is acted upon, the result is discrimination. The UNAIDS (2015) defines discrimination as a social construction of a person based on an inherent peculiar characteristic, for example, confirmed or suspected HIV seropositive status, resulting in forms of exclusion or restrictions regardless of whether, or not there is an explanation for these actions.

According to Goldstein et al. (2003), some people construct HIV infection as divine retribution for the sin of sexuality, and within such perspectives, responsibility and blame are often assigned. Goldstein et al. (2003) pointed out that a person who contracts HIV comes to be regarded as a victim, and is situated on a continuum of 'innocence', or 'guilt', and consequently of 'deserving', or 'non-deserving' of the condition. In these discourses, the innocent subject is constructed as one who lacks a component of personal will in their actions, and as non-deserving of the disease, and is shown sympathy, care, and support (Goldstein et al., 2003). On the other hand, the guilty subject is constructed as deviant, as promiscuous, as inhuman, as at fault, as dangerous, and as deserving of the disease (Goldstein et al., 2003). Goldstein et al. (2003) further argued that such positioning of the subject as innocent, or guilty has led to those who are regarded as guilty/deviant in relation to HIV risk potentially being subjected to continuous stigma, discrimination, social ostracism, and even violence by their family, society, government officials, and medical practitioners.

The social constructions of stigma related to being tested for HIV, and of testing positive, and the discrimination against people living with HIV have been reported in several South African studies amongst youth (MacPhail et al., 2009; Peltzer & Matseke, 2013; Ritchwood et al., 2019), including university students (Buldeo & Gilbert, 2015; Chimbala-Kalenga & Makuwira, 2016; Evans et al., 2018; Haffejee et al., 2018; HEAIDS, 2010; Higher Health, 2020; Musemwa, 2011; Paul et al., 2014), as formidable barriers to HIV testing uptake, and the disclosure of an HIV positive status to others. It was established in the above studies that the fear of taking an HIV test is related to the risk of stigma and discrimination based on an HIV positive status. This fear delayed youth's uptake of HIV testing, or resulted in the decision not to test, or the decision not to approach a facility that offers the HIV testing service.

Higher Health (2020), in particular, noted that most students who took part in the health and wellness programmes in government-owned tertiary institutions from April 2019 to March 2020, commented that they found it easier to test for HIV during the health and wellness days on their campuses. Higher Health (2020) further observed that the decline in these activities in 2019 and 2020 was reflected in a downturn in screening and HIV testing figures, by about 41% compared to the previous year (2018). In the HEAIDS (2010) survey, student participants commented that they did not want to get tested for HIV because a seropositive result would leave them depressed and fearful of how their friends and family would treat them. In Pillay's (2020) qualitative study on students' patterns of disclosure of HIV-positive status to others, participants reported that they were afraid to disclose their HIV positive status to their friends and roommates at the university. In their justification, participating students in Pillay's study focused on the fear of being judged and stigmatised by others, or labelled HIV positive. The findings of all these studies reveal a clear association between an HIV positive status and the risk of being stigmatised, and discriminated against by others. However, the main issue here is that being HIV positive is being constructed as an extremely stigmatised identity, and it is to be avoided at all costs. Thus, not engaging in HIV testing is their way of actively investing in a particular form of social reputation; it is a different kind of prioritisation of self (Van der Riet et al., 2018).

Furthermore, the quality of client-health care service provider interactions matters a lot in HIV testing facilities. Part of young people's avoidance of taking an HIV test relates to the dominant construction of some health care service providers as being judgemental towards unmarried and sexually active youth (De Zoysa et al., 1995; MacPhail et al., 2009). In De Zoysa et al.'s (1995) study, the stigma and acts of discrimination were related to social, religious and cultural practices limiting sex to marriage, which renders HIV as more of a moral issue, almost a punishment for sexual sin, rather than being a health issue. In MacPhail et al.'s (2009) study, the fear of being judged or labelled as HIV positive by a health care service provider was considered a factor that can hinder sexually active youth from volunteering for HIV testing, or disclosing their risky sexual behaviours to the health care providers in order to get the health care services they need. This is an indication that for some youth, HIV testing may also signify the admission of sexual behaviour or judgment for having 'risky sex'. Participating youth in MacPhail et al.'s (2009) study also reported that being infected with HIV is better than the psychological consequences of stigma and discrimination based on the HIV positive status. The health care personnel's attitudes might mean that even if HIV testing resources are available, they are still inaccessible to young people because they fear discrimination or judgment for their sexual behaviour or lifestyle.

Research has shown that the attitudes of the health care personnel in primary health care facilities, especially in South African universities, is changing. For example, the study conducted by Haffejee et al. (2018) found that some student participants (31%) reported less perceived stigma in the university health clinic than in the community health care facilities. Additionally, the student participants who perceived the university health clinic as less stigmatising were more likely to test for HIV at the university clinic. This finding positions the university clinic as potentially creating alternative opportunities for youth to feel safe to know their HIV status if the issue of stigma and discrimination is minimised.

Moreover, it seems the challenges faced by youth around HIV testing cut across contexts. A study in Botswana, which explored psychosocial factors influencing young people's willingness to engage in HIV testing (Fako, 2006), and three Nigerian studies on HIV risk perceptions and implications for HIV testing amongst youth (Durojaiye, 2011; Nwachukwu & Odimegwu, 2011; Obidoa et al., 2012), reported that youth who perceived themselves as being at risk of HIV, and suspected a positive HIV test result were less likely to engage in testing, with this attributed to the fear of being stigmatised by peers. This finding suggests that some youth have internalised stigma, which could hinder them from engaging in HIV testing as a protective practice. Participants in the study by Nwachukwu and Odimegwu (2011) discussed their fear of being discriminated against in the case of a positive HIV test result, with that being an indication of being sexually active, a behaviour proscribed by elders.

Another South African study on HIV testing practices and TB screening amongst patients at a hospital in Durban found that perceived social stigma preceded and surpassed enacted stigma (Daftary et al., 2007). In that study, patients who suspected that they could be HIV positive and at risk of being stigmatised by others were reluctant to visit clinics due to the fear of being seen accessing the HIV testing services. These findings correspond with those reported in another South African research on the HIV testing practices of men (Orr et al., 2017). In Orr et al.'s (2017) study, which explored men's fears about HIV counselling and testing and ART treatment, some participants expressed their concerns about queuing outside an HIV testing facility because of the risk of being suspected by other people of having HIV. They constructed this situation as one in which stigma and discrimination could occur. Another South African study amongst heterosexual men found that participants who suspected themselves as having HIV and decided to test for it were likely to do it without involving their sexual partners (Snow et al., 2010). In that study, participants who believed that they would be stigmatised or abandoned by a sexual partner if they were to have HIV were likely to conceal their status from their partners and knowingly infect them with HIV.

To conclude on the theme, the social constructions of HIV stigma and discrimination, it is worth reiterating the point made earlier that the dominant language in HIV prevention discourses in the health policies tend to focus on making the HIV testing service available by increasing the number of points of service but fail to note that the number of points of service does not translate into access or use because of HIV-related stigma. Thus, it is important to explore how youth in a tertiary setting in South Africa construct the practice of HIV testing. A question might be, for example, do they construct it as being risky, as exposing one to the risk of stigma and discrimination from others (e.g. general public, sexual partner, and the health care service providers)?

Daftary et al. (2007), Orr et al. (2017), and Snow et al.'s (2010) findings related to the HIV testing practices of men and their resistance to self-disclosure, at least in part, reflect the risks to which women in heterosexual relationships may be exposed. In the next section, I will discuss research related to the social positioning of young women in relation to HIV risk and HIV testing practice in South Africa.

3.3.5 Social positioning of women in relation to HIV risk

The unevenness in HIV infection rates for young men and women has existed since the early years of the HIV epidemic in South Africa (Kabiru et al., 2013). The recent HSRC survey reported a high HIV prevalence rate of 3.6% amongst young women aged 20-24 years, which is higher than the prevalence rate of 1.8% amongst their male counterparts (Simbayi et al., 2019). This same survey found that young women aged 15-24 years were four times more vulnerable to HIV risk and being infected at an earlier age compared to young men within the same age range. A recent large-scale survey conducted in the uMgungundlovu district (the locus of this study) also observed that about 25% of all new HIV infections in the KwaZulu-Natal province in 2018, occurred amongst adolescent girls and young women between the ages of 15-24 years (George et al., 2019). The recent Higher Health 2019-2020 annual report also reported that young female students are more burdened by HIV risk compared to their male counterparts. According to Higher Health (2020), a large proportion of new HIV infections (about 28%) occurred amongst adolescent girls and young women between the ages of 15-24 years in South Africa in 2019. Higher Health (2020), the HEAIDS (2010), and the South African Council on Higher Education (2017) noted that university students fall within the age range of 20-24 years and 15-24 years. The age bracket of the subpopulation reported in the Higher Health report and the HSRC survey as being at risk of, and living with HIV, was one of the motivations for focussing on this age range (18-24 years) of young people in the university setting of the University of KwaZulu-Natal.

However, this disparity in the HIV infection rates of young men and women has been a focus of investigation and concern, with the majority of researchers linking it with the intersection of sex-based biological features, the social positioning of women in heterosexual relationships, the demographic fact there are more women than men, and age (less than 24 years old).

3.3.5.1 Sex-based biological features

Women’s anatomical and physiological makeup means that they are at a higher risk of acquiring HIV infection through unprotected sexual intercourse compared to men (Chersich & Rees, 2008; Eastment & McClelland, 2018; Goldstein et al., 2003; Jangu, 2014). Chersich and

Rees (2008) argued that the vaginal tract tissues are very soft and likely to tear during sexual activity, meaning that women have a seven times higher chance of getting HIV compared to their male counterparts. However, not all women are equally vulnerable to HIV risk physically. The vulnerability differs with age, the general health of the vaginal tract, and the presence of *Prevotella bivia* bacteria and STIs (Chersich & Rees, 2008; Eastment & McClelland, 2018). Biology is further compounded by the social positioning of women in heterosexual relationships.

3.3.5.2 Social positioning of women in heterosexual relationships

Hollway (1984) argues that discourses are a terrain of power struggle; they testify to the continuing power struggles over who may define, position, and categorise sex and gender, and from which perspective. Hollway (1984) further notes that gender is a context-specific, time-specific, and changeable social construct which defines what is expected, acceptable and appreciated in a woman, or a man in a given situation. Heterosexuality, according to Hollway (1984, p. 230), is constructed by how "at a specific moment several coexisting and potentially contradictory discourses concerning sexuality make available different positions and different powers for men and women". Hollway (1984) further notes that within the scope of gender, as well as the domain of heterosexuality, men and women do not have the same power (which plays a substantial role in the extent to which a woman can negotiate HIV risk, or engage in health practices like HIV testing).

On researching the discourse of HIV and prevention practices amongst educated and professional women in Tanzania, Jangu (2014) found that although the majority of participants personalised HIV risk, they could not convince or influence their partners to engage in HIV testing, or protected sex. Jangu (2014) also reported that for some participants, when they chose to engage in safe sex, or to take an HIV test, they would be constructed and positioned by their partners as being diseased, and as being HIV infected. Jangu's (2014) study concluded that the way a woman positions herself or is positioned by a male partner as being subordinate in sexual decisions places her in a challenging situation to act in ways that could protect herself from becoming infected with HIV.

Focusing on women in South Africa, MacQueen et al. (2016) similarly reported that men are positioned as largely determining decisions around HIV testing and condom use in sexual relationships. In MacQueen et al.'s (2016) study, women were constructed as giving in to their men's desire for unprotected penetrative sex to maintain the status of being in a relationship. A woman's focus is, therefore, on keeping the relationship, rather than following the biomedical prescription of condom use. Some researchers have argued, based on studies on HIV risk amongst female students in South African universities, that a young woman is more concerned with satisfying a man's sexual desire, or holding on to a relationship to prove to her peers that she can not only attract a man but also keep him (Chebitok, 2017; Chimbala-Kalenga & Makuwira, 2016; Gwala, 2019; Mthembu, 2017; Nene, 2014; Van der Riet & Nicholson, 2014). This positioning reduces a young woman's need to protect herself against the risks in sexual activity. Almost similar findings are reported in an extensive survey on sex grades and power amongst university students in Ghana and Tanzania (Morley, 2011). Morley's (2011) study concluded that young women are less able to make independent decisions on sexual issues in heterosexual relationships. Overall, the findings of the above studies suggest that young women prioritise one investment (keeping a man) over another (personal safety against HIV infection) just to maintain the social reputation of being in a sexual relationship. The positioning of young women as subordinate and passive in sexual health decisions is also strengthened by the demographic fact there are more women than men in South African universities.

3.3.5.3 Low male-to-female sex ratio

Patterson and Keefe (2008) argued that the high population of women in many societies compared to men, encourage men to maintain sexual partnerships with two, or more women. Patterson and Keefe (2008) further contended that as the number of available men becomes scarcer, each sexual relationship becomes more challenging to secure, and women may agree to conditions which they would not accept if they had a higher bargaining power within a sexual relationship. A qualitative study by Ngidi et al. (2016) on social factors that influence sexual risk-taking behaviour amongst students at a South African university sheds further light on Patterson and Keefe's (2008) view of the consequences of the uneven male-to-female sex ratio in increasing a woman's risk of HIV infection. Ngidi et al. (2016) reported that the enrolment of female students in higher institutions for distance and contact mode of learning in South Africa, is higher, with a share of 54.2% compared to male students (45.8%). While the ratio of 54:46 is not that big of a gap, and the findings of the HEAIDS (2010) survey that the pool of potential sex partners in South African universities is not limited to other students, it is still concerning. Ngidi et al.'s (2016) study found that this unevenness between male and female students somehow leads to a smaller pool of potential sexual partners to choose from, which encourages concurrency. Some participating female students in Ngidi et al.’s (2016) study reported that they accommodated unfaithful sexual partners for financial and material gain. Others indicated that they conformed to risky sexual activities and practices in their relationships and attributed these to the notion of love and fear of losing a partner. In such context, Ngidi et al.’s (2016) study observed that sexual activity was constructed as an act that strengthens the relationship between two people, provides a woman with some form of security, and contributes to her positive image. Ngidi et al.’s (2016) study concluded that such constructions of the role of sexual activity in a relationship place women at a higher risk of HIV infection compared to men, and may account for the uneven distribution of HIV risk and infection in South African universities. The conclusions of Ngidi et al.’s (2016) study are in line with the assumptions of the ‘have/hold’ discourse. In this discourse, women are positioned as submissive, and keeping a man is expressed as expecting, and wanting love, and maintaining a relationship (Hollway, 1984). In the context of Ngidi et al.’s (2016) study, for a young woman, sexual activity draws its meaning and significance from this have/hold discourse. Hence, an investment in sexual activity is, therefore, an identity investment. The social positioning of women in relation to HIV risk also differs with age and level of education.

3.3.5.4 Age and level of education

On conducting a quantitative evaluation of female students’ perceived risk of HIV at a South African university, Maughan-Brown and Venkataramani (2018) found that prevalence increases with age, with those aged 18–19 years having a low prevalence rate of 0.7% relative to 8.3% amongst those aged over 25 years. Maughan-Brown and Venkataramani (2018) reported no causal relationship between age and HIV risk perceptions. Although young women aged 18–19 years had a low prevalence rate of HIV, this subpopulation was also reported in Maughan-Brown and Venkataramani’s (2018) study as not engaging in prevention practices, such as condom use at last sexual encounter as well as HIV testing practice, compared to those aged over 25 years. The explanation Maughan-Brown and Venkataramani (2018) gave for this is that young women aged 18-19 years are not well informed about HIV risk and have limited sexual experience compared to older women, and can be taken advantage of by older male students. This constructs all first-year female students as naive and unaccountable for their choices. Moreover, this construction of a young woman at the university as being at risk of HIV is evident in Evans et al.’s (2018) study on knowledge and perceptions about HIV risk and access to HIV health care services amongst students in six South African universities in the Gauteng province. Evans et al.’s (2018) study concluded that young female students have little knowledge and awareness about the risk of HIV, do not get tested for HIV, and tend to position themselves as being less vulnerable to HIV risk, compared to men.

The notion of older male students taking advantage of the naivety of young female students, especially those in their first year of university education, is also evident in Mutinta and Govender's (2012) study on social and environmental determinants of university students' sexual risk behaviours and practices, and HIV prevention at a South African university. Mutinta and Govender's (2012) study brought to light the notion of 'gold rush'. In this situation, a senior male student rushes into a sexual relationship with a young first-year female student who is most likely to be inexperienced about campus life. Here, the 'gold rush' phenomenon is an artefact of the first-year female students not wanting to partner with the first-year male students compared to slightly older male students who are more established, and the fact that third/fourth-year male students not able to attract same-age women. This potentially creates the conditions for young female students' vulnerability to HIV infection as they do not enter the sexual relationship with senior male students on equal terms.

Mutinta and Govender's (2012) study also reported that many students (62%), both male and female, who were still virgins when they joined the university, lost their virginity in their first year of university education due to stigma around virginity. Mutinta and Govender (2012) reported that some participants in their research indicated that they wanted to, or had lost, their virginity, and attributed this to the idea that those who remain virgins remain so because they cannot find a partner. Mutinta and Govender's (2012) study concluded that young women and men are under a lot of pressure to develop a concept of themselves as sexual beings, and to engage in sexual activities to address this shame about remaining a virgin. However, Van der Riet et al. (2018) argued that these actions do not mean that young people are giving in to the expectations of their peers, or being 'dominated by peer pressure' to engage in sexual activities, but rather they are actively investing in a particular form of social reputation. The consequence of this framework is that investment in self is prioritised, and personal safety against HIV infection is constrained (Van der Riet et al., 2018).

Evans et al. (2018), Maughan-Brown and Venkataramani (2018), and Mutinta and Govender's (2012) findings concur with George et al.'s (2019) study, which explored the impact of HIV testing and ART treatment services on risky sexual behaviour in the key population of youth aged 15-24 years in the uMgungundlovu district in South Africa. George et al.'s (2019) study reported that young women between the ages of 15-24 years are infected with HIV by men who are ten years older than them. George et al.'s (2019) study attributed this to the age differences in the relationship, which places a young woman in a position of powerlessness in sexual decision making, particularly the agency to negotiate or demand safer sex or HIV testing. George et al.'s (2019) study also found that young women engage in age-disparate partnerships for personal gain, which is the need for financial and material support, and the attention shown by some older men. In such contexts, a young woman would fear the adverse reactions of her partner if she were to initiate or demand condom use or HIV testing, especially if she is being given monetary support (George et al., 2019). This, therefore, means that for a young woman, an investment in a sexual relationship with material benefit is valuable, a significant finding in Van der Riet et al.'s (2018) study on the interaction of identity development and sexual relationships amongst youth in a rural area in South Africa. For Van der Riet et al. (2018), the consequence of this framework is that an investment in the relationships and the identities that constitute them are prioritised, which overrides the potential costs of engaging in unprotected sex in the context of HIV and AIDS.

Furthermore, a young woman's inability to make rational decisions in situations of sexual risk may be explained biologically. Although youth within the age range of 18-24 years, which is the age range of the participants of this study, are considered adults, it is not known if a substantial brain development has occurred, particularly at the prefrontal cortex. According to Johnson et al. (2009), the prefrontal cortex, a brain section responsible for decision-making, does not mature fully until a person is 25 years old. Johnson et al. (2009) argued that this might influence a young woman's susceptibility, and resilience in relation to HIV risk and HIV testing decisions. However, such an impact may not be that big or significant.

While it is evident in this section that the social positioning of a young woman in a heterosexual relationship creates the possibility for her risk in this context of high HIV prevalence, she is still positioned as being accountable for sexual risk prevention.

3.3.6 Feminising HIV risk prevention

Studies in South Africa (Coates et al., 2011; Kilembe et al., 2015; Mabuto et al., 2019; Orr et al., 2017; Simbayi et al., 2019), and Tanzania (Jangu, 2014) have found that women are positioned as being responsible for initiating discussions around HIV risk and HIV testing, and as engaging in HIV testing, while men are, for the most part, pardoned from this duty. In the study of Coates et al. (2011), in particular, the female partner was, in most instances, expected to play a goalkeeper role in the relationship by initiating discussions around HIV risk and HIV testing, while the male partner was pardoned from this role. In that study also, women were said to be responsible for raising such discussions mainly in the context of their own need to have children, or concerns regarding raising their children. On the other hand, in Jangu's (2014) study, men relied on proxy/surrogate HIV testing as a protective strategy. Jangu (2014) reported that men depended on their female partners to get tested for HIV as a way of ascertaining their own serostatus. Relying on proxy/surrogate HIV testing is problematic and risky in the case of a serodiscordant couple. Serodiscordance is a situation whereby a mother-and-child pair or an adult couple exhibits a mixed HIV status (Ndirangu, 2017, as cited in Simbayi et al., 2019). The HSRC survey reported a significant prevalence rate of 11.3% in the serodiscordant couple (Simbayi et al., 2019), which suggests that a substantial number of men are likely to be diagnosed with HIV at a later stage of the infection. This may explain the higher-long term AIDS-related mortality and morbidity amongst South African men compared to women, even after initiating ART treatment (Kharsany & Abdool-Karim, 2016; Orr et al., 2017; SANAC, 2017; Simbayi et al., 2019).

In sum, then, it seems the dominant construction of a female subject in a heterosexual relationship as powerless, as vulnerable, as the primary sufferer of the consequences of unprotected sexual activity (HIV infection and unplanned pregnancy), and also as responsible for preventing the threat of HIV, may explain why the dominant discourse on HIV risk and prevention in South Africa revolves around a woman, particularly a young female subject (Department of Health, 2016; George et al., 2019; SANAC, 2017), including young women at the university (Blignaut et al., 2015; HEAIDS, 2010; Higher Health, 2020; Maughan-Brown & Venkataramani, 2018; Mbelle et al. 2018; Nene, 2014). The interventions that focus on young women in South African universities address issues of: access to condoms, contraception, safe HIV testing services, and biomedical HIV prevention and management agents (pre-exposure and post-exposure prophylaxis, and ART treatment); ensuring the continuation of school attendance; utilising available social security benefits, and advocacy to end gender-based violence (Higher Health, 2020).

However, getting all young female students in South Africa to adhere to the above preventative efforts is still problematic. Three South African research conducted with university students provides evidence to support this (Blignaut et al., 2015; Chimbala-Kalenga & Makuwira, 2016; Mbelle et al., 2018). Blignaut et al. (2015) focussed on HIV risk behaviours of sexually active first-year students, while Chimbala-Kalenga and Makuwira (2016) explored students' strategies for managing sexual risk in the era of HIV and AIDS. Mbelle et al. (2018), on the other hand, explored students' perceptions and attitudes about male and female condom use in a time of HIV and AIDS. A predominant theme connecting these works is that young women tend to tolerate their abusive partners and ignore negotiating HIV risk, HIV testing, or introducing condom use. Blignaut et al. (2015), Chimbala-Kalenga and Makuwira (2016), and Mbelle et al. (2018) attributed this to young women's desire to maintain the status of being in a relationship. This view is reinforced by evidence suggesting that in the face of the abundance of health initiatives targeting young women, these efforts have not effectively reduced the prevalence of HIV amongst young South African young women aged 15–24 years (George et al., 2019; Johnson et al., 2017). This suggests the need for an integrated understanding of what HIV risk means to a young woman, how she positions herself in relation to it, how she is positioned in heterosexual relationships and how this relates to her risk of HIV, and her ways of responding to this threat in the context of power imbalance in heterosexual relationships. However, this study went beyond these into investigating how sexually active tertiary student participants (both male and female) constructed and positioned themselves and others in relation to HIV risk, or positioned their sexual partners, or are being positioned by others in their socio-cultural and historical contexts, and how this is related to their HIV testing practices, and the discourses drawn on. Identifying their constructions, positioning, and discourses may help us to understand gender issues at play, which has implications for young men and women's agency in protecting themselves against HIV risk through HIV testing.

3.3.7 Synopsis of the section

This section has attempted to explain some of the dominant issues surrounding HIV risk and HIV testing health practices amongst youth, including university students, in South Africa and other African countries. It has elucidated how an HIV diagnosis is constructed as a sickness, which draws on the medicalisation of HIV and AIDS discourse, and AIDS as fearsome, as deadly and as depressing, which draws on the stigmatisation of HIV and AIDS discourse. Given these prominent discourses surrounding HIV and AIDS, it was evident from the literature reviewed that young people would be concerned about being diagnosed with HIV, or dying from AIDS, or being stigmatised and discriminated against by others if they themselves were to test positive for HIV in the future. It also seems that such constructions of HIV and AIDS have implications for how young people position themselves and others in relation to

HIV risk. It was evident from most studies that young people seem to possess a false sense of safety that they will not acquire HIV, irrespective of their sexual practices. This feeling of invulnerability to HIV infection affected their decisions to engage in HIV testing and seek health care services. This positioning diverges from the biomedical understanding of HIV and AIDS, where the focus is on personalising risk and safety. Although it is evident that university students in South Africa still do not seem to personalise HIV risk and safety, specifically by engaging actively in HIV testing, comparatively few studies have directly investigated university students' constructions of, and positioning in relation to HIV risk, and how these relate to their HIV testing health practices in South African universities. Given this, it is perhaps unsurprising to find that alternative voices from subjects they call 'clients' who are the recipients of the health care services (including HIV testing), such as youth, are silenced in the public health policies and intervention strategies. This, therefore, illustrates the need for this study which aimed to utilise a discursive framework to investigate how youth at a South African university draw on discourses to talk about their HIV risk and associated prevention strategies, specifically HIV testing.

This section also highlighted the differences between the sexes in the construction of HIV risk, and in expectations regarding the construction of HIV prevention strategies, particularly negotiating health practices like HIV testing. The literature reviewed tended to construct and position the female subject in a heterosexual relationship as being passive, as needing to maintain the status of being in a relationship, which then affects her agency to prioritise her health. It also seemed that this positioning of women has somehow decreased the likelihood of HIV being seen as a significant risk for men in society.

Therefore, at this stage, it would be pertinent to present the assumptions of social constructionism, which is the conceptual framework underpinning this study.

3.4 Social constructionism

Kenneth Gergen's work in social psychology in 1985 is understood as the foundation from which the emergence of social constructionism in research is dated. Social constructionism proposes that particular practices, patterns of behaviour, actions and sets of beliefs are manifested, produced or identified based on the discourses drawn on by subjects (people) (Gergen, 1999). Edwards (2005) noted that part of the analysis process in social constructionist (discursive) research involves identifying and working with discursive positioning. It is this kind of approach that is used in this study to explore the discourses that participants draw on to construct HIV risk and to position themselves and others in relation to this form of risk. This thesis argues that when youth take up positions within discourses (for example, as at-risk or not at risk within discourses of risk, or as good and responsible health subject or bad health subject within discourses of HIV prevention), these positions afford them possible actions and practices in relation to HIV testing.

In social constructionism, 'knowledge' is the object of social construction (Burr, 2003). According to Burr (2003), knowledge is about how we make meaning about the world; it is not what the world is in the first place. In relating this argument to this study, HIV prevalence is a 'fact' of the world, but how HIV prevalence is made sense of (why it is higher in X group over Y etc.) is the object of social construction. Drawing on Gergen's (1985) work, Burr (2003) outlined four critical assumptions about knowledge in a social constructionist approach. They include a critical stance towards taken-for-granted knowledge, knowledge as an historically and culturally specific phenomenon, knowledge as produced and sustained by social processes, and knowledge as implying social action. These aspects are relevant to this study, and are discussed in detail in this section.

3.4.1 A critical stance towards taken-for-granted knowledge

Social constructionism takes an anti-positivist and anti-essentialist view that disputes objectivity and empiricism in how knowledge is attained. Burr (2003) argued that ideas, feelings, actions, beliefs, attitudes, motivations, perceptions, intentions and norms whose commonality is taken for granted or assumed, rather than specifically addressed, are often shared by people in their interactions in order to create accounts of themselves and events and ideas that are effective for them. This form of knowledge is based on, governed, and maintained by deep structures such as multiple normative rules, interactive processes and interpretative repertoires (Burr, 2003). Burr (2003) noted that these deep structures might only become apparent when exposed through social interactions.

Edwards (2005) defined interpretative repertoires as an identifiable routine of arguments, justifications, descriptions and evaluations found in a subject's conversation, often distinguished by familiar narratives, clichés, anecdotes and tropes. Drawing on Edward's definition, interpretative repertoires are things through which one makes sense of the world. Thus, there could be multiple interpretative repertoires in people's interactions with other people, but they selectively choose particular ones from their stock of knowledge while leaving others under the process of selective appropriation. Burr (2003) defined the phenomenon of selective appropriation as involving continuous questioning and personal reflection based on prior knowledge and experience. In relating this to this study, young people's talk about HIV risk and their HIV testing practices can be analysed for these essential aspects of human knowledge (interpretive repertoires), the recognisable routine of arguments, conventions, and justifications of their actions in response to HIV risk. An analysis of this kind might enable the 'taken-for-granteds' (Alldred & Burman, 2005), including the implicit common sense or assumptions of positivist frameworks that inform the development of public health policies and interventions, to be identified and critiqued. It would also be significant for understanding the lack of HIV testing uptake. For example, whether and how student participants construct HIV as a threat, to themselves or to others, or whether they position themselves as 'not at risk', will form part of their justification for testing, or not testing for HIV; and a pattern to be explored in this study.

3.4.2 Knowledge is an historically and culturally specific phenomenon

According to Gergen (1985, as cited in Burr, 2003), the way people make meaning of an idea and the concepts they use, is historically and culturally specific and, therefore, incomplete, particular, and to some extent, subjective. Alldred and Burman (2005) argued that discursive approaches locate the meaning of a social phenomenon at a cultural (social), rather than individual level. Therefore, discursive approaches reframe the research enterprise as the construction of a culturally located account of cultural meanings and practices, which they call 'discourses', often through the study of how particular people are able to draw on, or are positioned within these discourses (Alldred & Burman, 2005). In relating Alldred and Burman's (2005) argument to this study, the ways HIV risk and the HIV testing social practices may be understood and interpreted by the youth studied depend on the cultural codes available for reasoning about them. It then becomes apparent that a study of youth's constructions and positioning can be understood as an active, subjective process that is being influenced, produced, and interpreted in relation to the discourses drawn on (Alldred & Burman, 2005).

A relevant example to illustrate how knowledge is an historically and culturally specific phenomenon is a context where people construct the agents beyond their control, for instance, a punishment from God or a bewitchment as causing HIV, as argued by Sizwe in Steinberg's (2008) book. According to Goldstein et al. (2003), in a context where other people are constructed as responsible for creating the risk of HIV and AIDS, preventive actions which are emphasised in the explanatory models, such as safe sex and HIV testing and medical interventions such as ART treatment, are also not considered. Goldstein et al. (2003) further argued that the explanatory models and interventions focus on the sick individual and the body, rather than the different ways of responding to health issues in society, such as prayer, faith, repentance, fighting off evil spirits, sacrifices or taking of particular medication. Therefore, it appears as though what is to be responded to is not simply the sick individual but the entire community. This reflects and reveals every aspect of the culture in which HIV and AIDS occurs and plays a significant role in how the perception of HIV risk and, in turn, the meaning is organised, which shapes and influences health practices, such as HIV testing. Thus, health debates, public health interventions, and health policies targeting youth should be understood in the context of ongoing constructions of HIV and AIDS and the different ways of responding to it, where youth potentially draw their knowledge and understanding of HIV risk and HIV testing practices.

Citing Webb (1997), Goldstein et al. (2003, p.17) argued that "community perceptions and individual perceptions of HIV and AIDS incorporate culturally specific beliefs relating to its origins and aetiology, risk perception and attitudes towards those infected." The HIV and AIDS epidemic in South Africa has a history that is influenced by social and cultural context. The first HIV and AIDS cases reported in this country occurred in the early 1980s amongst men who had sex with men (Butler, 2005). This means that the HIV and AIDS discourse was not dominant before then, and perhaps people did not feel that they needed to engage in HIV testing. Pregnancy could have been the prevalent sexual risk, and the discourses revolved around pregnancy risk and testing for it. When the concept of HIV emerged in the 1980s, the discourses shifted and changed to accommodate this, and HIV risk became an additional sexual risk. In this period, up until the end of the 20th century, men in South Africa did not enjoy freedom as to with whom they might have a sexual relationship. Research has shown that men who have sex with men were significantly stigmatised by society, allied to their lifestyles and behaviours (Connelly & Macleod, 2003; Goldstein et al., 2003). This stigmatisation influenced the social construction of HIV and AIDS as a risk and disease of a man who has sex with another man (Connelly & Macleod, 2003; Goldstein et al., 2003). Goldstein et al. (2003) further noted that the media played a significant part in constructing this view, often referring to AIDS as the 'gay disease', or the 'gay plague.' The initial linking of HIV and AIDS with men who had sex with men constructed this category of people as promiscuous, inhuman, as at fault for having HIV, as deserving the disease, and as not deserving health care resources (Goldstein et al., 2003). The subject position available in this construction is that of ‘immoral gay men’, which appears to be drawing on the deviance and scapegoat discourses.

Over time, the incidence of HIV acquired through heterosexual contact has increased in South Africa to the extent that heterosexually transmitted infections are more than the number of cases attributed to people in same-sex relationships (Kharsany & Abdool-Karim, 2016; McNeil, 2019, August 27; Orr et al., 2017; SANAC, 2017; Simbayi et al., 2019). McNeil (2019, August 27) further noted that by July 1991, the number of new HIV infections contracted through heterosexual sex was equivalent to those acquired through same-sex relationships. This contributed to new discourses of heterosexuality and HIV risk and challenged the dominant discourse, which associated the threat of HIV with men who have sex with men and deviance. Patton (1994) described this as a ‘de-gaying’ of AIDS, a process that potentially weakens the original construction of men who had sex with men as the high-risk group. As the HIV epidemic progresses in South Africa, the positioning of the high-risk population keeps shifting and changing. In particular, youth aged 15-24 years are constructed and positioned as at high risk of exposure to HIV, given that they are sexually active, and their sexual practices are deemed ‘unsafe’.

In view of this history of HIV and AIDS, and the people who become infected, it is clear that the structure of the HIV risk discourse and constructions of the risk population has shifted and changed over time. Therefore, it becomes crucial that an investigation of HIV risk and HIV testing practice go beyond perceptions of HIV risk and barriers to, or motivators for HIV testing, into exploring the broader cultural meanings of HIV risk and HIV testing. This is part of this study’s motivation to investigate university students’ constructions of HIV risk, the positions they take in relation to the threat of HIV, how they position others in relation to it, the discourses they draw on to justify their constructions and positioning, and their ways of responding to it, specifically HIV testing. The outcome of this analysis will potentially show the context, which is specific to this group of participants (university students) who are at the University of KwaZulu-Natal in South Africa. Moreover, this context-specific knowledge is understood as drawing on different linguistic ideas (resources) made available through particular cultural practices, which comes from social processes, which is the third assumption about knowledge in a social constructionist approach.

3.4.3 Knowledge is produced and sustained by social processes

The social constructionist stance that grounds this study postulates that the individual, or self, and practices are continually constructed, reconstructed, negotiated and determined through interactions between members of the same society or culture (in this study, the university community), and with their social world (Burr, 2003). In describing how knowledge is produced and sustained by social processes, Hall (1992) argued that all social practices have a discursive aspect or meaning. Applying Hall's (1992) perspectives to this study, it is postulated that it is through identifying and defining discourses that students draw on when talking about their risk of HIV and HIV testing practices that one can understand how discourses facilitate and limit, enable and constrain what can be said by whom, where and when, which will allow us to understand how the practice of testing/not testing for HIV works amongst young people in South Africa.

In elaborating how this common sense knowledge is produced and sustained by social processes, Maticka-Tyndale (1992, p.239) argued that:

> From the perspective of social constructionism, society's members are both authors of and actors in the realities they construct. As authors, they rely on a common stock of knowledge rooted within existing institutions, everyday language, shared meanings and understandings. This knowledge consists of recipes or scripts for action and typifications of people, events, and objects. Variations in reality construction result, in part, from variations in people's lives based on their division into strata (e.g. age, gender, race).

In applying Maticka-Tyndale's (1982) perspectives to this study, the students' constructions of HIV risk and their subjectivities regarding the research problem do not 'come out of the blue', but through their interactions with a myriad of discourses in their social world. According to Brown (1995), such discourses may include: diverse kinds of knowledge or what people have been told, or have learnt, about HIV; personal experiences; ideas about health, illness and risk; socio-cultural, religious, political and moral perspectives; power relations; and how people have been influenced by social networks, such as the health care professionals, peers, family, and intimate partners. This uniqueness in ways of identifying, describing, understanding, and interpreting discourses at work in participants' constructions and positioning may also say something about their engagement with HIV testing practice, particularly some way of understanding why this particular response to testing is maintained and sustained. However, the way students construct and reconstruct HIV risk and their HIV testing practices constitute a form of social action, which is the fourth assumption of knowledge in social constructionist research.

3.4.4 Knowledge as implying social action

Gergen (1985, as cited in Burr, 2003) argued that the meanings people assign to their social practices are understood from their modes of description, negotiations, statements and explanations in a dialogue. Lupton (1992) followed the same line of thought, arguing that people come to know and understand themselves by explicating the discourses they draw on, which has consequences for their health actions. Similarly, Van der Riet and Nicholson (2014) argued that how young people talk about sexual risk and health practices facilitates specific patterns of social action or behaviours while prohibiting others. In relating these arguments to this study, it is postulated that it is through analysing the students' constructions of HIV risk and identifying the positions that they create and use, and discourses that are drawn on in these positionings that one can potentially understand their actions, specifically their practices in relation to HIV risk and HIV testing. By analysing their talk and their account of HIV risk and testing also, one can identify their rationalisations and justifications for their constructions and positionings, and consequently, the discourses at work for these participants.

3.5 Summary of the chapter

This chapter reviewed the related literature for this study. In accomplishing this, the chapter was divided into three sections. In the first section, South Africa's National Health Policies of interest to this study's investigation were reviewed to give the reader a sense of the context and some possible sources from which the study participants could draw their constructions of HIV risk and HIV testing practices. From this aspect of the review, it became apparent that the HIV testing policies set and define the context for HIV prevention through testing and the different types of people targeted in the HIV testing service.

The second section is a review of related studies conducted in South Africa and elsewhere on the topic of HIV risk and HIV testing. From this review, it became apparent that the university students' perception of HIV risk has been investigated in relation to facilitating or impeding their engagement with HIV testing as a protective practice. However, little attention has been given to how university students construct and position themselves in relation to HIV risk, and how these relate to their HIV testing health practices. The trend in the literature reviewed seemed to suggest that it is possible that students are not resistant to undergoing HIV testing *per se* but are reluctant to do so due to the problems associated with accessing the service and the result that arises from their engagement in that practice. For example, the risk of being stigmatised and discriminated against, the risk of being exposed as the testing process is visible in primary health care facilities and mobile testing tents, the risk of being labelled as HIV positive, the risk of being rejected or abandoned by a sexual partner, the risk of finding out that they have a sickness that is chronic and ultimately deadly, etc.

The final part of the chapter was devoted to highlighting the social constructionist framework that constitutes the theoretical grounding for this study. The core of this framework is the view that subjects invest in the discourses they draw on and incorporating them into their talk, particularly those that reinforce, or support their own identity, and could be seen as functioning to create certain practices and actions about them in the conversation. Based on this understanding, this thesis argues that students' constructions of HIV risk and HIV testing are influenced by the society and culture in which they undertake their day to day activities. In other words, such constructions do not arise from a vacuum but are a product of discourses (all interactions and conversations on HIV and AIDS going on around them). Hence, the focus of this study is to identify discourses participants draw on to construct HIV risk in relation to their practice of HIV testing, for it is through understanding such discourses that one can understand their positioning in relation to HIV testing, and whether, or how they engage with it as a protective strategy. This information could potentially inform the development of interventions and policies that better fit the lives of those to whom they are addressed, such as the University of KwaZulu-Natal students. Hence, the discursive approach, being socially constructed, provides an alternative to explanatory models which seemingly reinstate the agentic individual. At this stage, it would be pertinent to provide an overview of the research process adopted to pursue the aims and objectives of this discursive study, and the next chapter highlights this.

CHAPTER FOUR: RESEARCH METHODOLOGY

4.1 Introduction

This chapter discusses the methodology that was followed in implementing this study. The study explored how sexually active university students aged 18-24 years at the University of KwaZulu-Natal, Pietermaritzburg campus, constructed HIV risk; how they constructed and positioned themselves and others in relation to HIV risk; and how their constructions and positioning worked, and what they achieved by using them in this way in relation to their practice of HIV testing, in the sense of whether and how they engaged with it as a protective strategy. The epistemological commitment to social constructionism with an emphasis on discursive analysis shaped the decisions made during the research process. This chapter commences with a description of my own context in connection with the research problem, which informed all my methodological choices. Following this is an explication of the research paradigm; the research design; the research setting; the study sample and sampling methods; the ethical considerations regarding the study; the procedures that I followed in collecting data for the study through the semi-structured individual interview process; the methods of analysing the interview texts using critical discourse analysis; and the methodological challenges I encountered in conducting the research. In this chapter also, I critically discussed my own positioning in the study (reflexivity) as this relates to the research process. Here, I focussed on my feelings, thoughts, contributions to the research problem, and how the data were generated, analysed and interpreted. The chapter concludes by discussing how the rigour of the study was enhanced, and issues, such as credibility, dependability, transferability, and confirmability aspects of the research were addressed.

4.2 Personal context

Although I am a Kenyan citizen, I have been residing in South Africa for the past seven years, pursuing my postgraduate studies. Before I came to South Africa, I did some research to learn more about the country, and amongst the significant and unique information that came up was the prevalence of HIV and AIDS. Upon further search on Google, I found that the KwaZulu-Natal province is disproportionately affected by HIV infection compared to other provinces in South Africa, and that young people and women, in particular, are more burdened. As an outsider, I found this information very troubling, and I became more worried about my own risk of exposure to HIV as a middle-aged woman. My worries increased when I landed in the

KwaZulu-Natal province in the year 2014 to pursue my postgraduate studies at the University of KwaZulu-Natal. I had prior knowledge that HIV is mainly spread through engaging in unprotected sex with an infected person. So, I ‘promised’ myself to be ‘careful’ not to engage in risky sexual practices. Although I had the impression that I can take full control over my sexual life as an educated woman, I wanted to educate myself more on sexual risks, particularly pregnancy and HIV risks, and responsibility for managing them, and how other educated students in this prestigious university perceive these concepts. This created in me a quest to pursue a study related to pregnancy risk and HIV risk at masters and PhD levels, respectively. I aimed to understand how young university students construct safer sex and risky sex in the era of HIV and AIDS, how they position themselves in relation to these risks, and the measures they take to protect themselves, particularly contraceptive use and HIV testing.

In the years 2016-2017, I conducted qualitative research on contraceptive use with 25 students (13 men and 12 women) at the University of KwaZulu-Natal on the Pietermaritzburg campus (see Chebitok, 2017). The key finding of that study was that young women have little say in negotiating safer sex practices and contraceptive use in relationships. The study also revealed that pregnancy prevention was viewed as a woman’s duty. Another significant finding was that male student participants preferred condomless sex, arguing that the use of condoms diminished sexual enjoyment. Yet research has shown that unprotected sex exposes both a man and woman engaged in a sexual act to the risk of HIV (Blignaut et al., 2015; George et al., 2019; Johnson & Dorrington, 2020; Kharsany & Abdool-Karim, 2016; Mbelle et al., 2018; Parker et al., 2014; Shisana et al., 2014; Simbayi et al., 2019). This issue intensified my interest to explore why educated youth pay little attention to the risk of HIV, despite being sexually active, and their sexual practices are unsafe, and are in a country with high HIV prevalence amongst youth.

Consequently, this research was initiated to explore, amongst other things, HIV testing as a protective strategy amongst the University of KwaZulu-Natal students. In the process of developing my research proposal, it became clear that there is a paucity of discourse-analytic research on how university students construct HIV risk, their positioning in relation to it, their prevention practices, specifically HIV testing, and the discourses drawn on. As indicated in the previous chapters, the focus of prior researchers when studying youth and their health behaviours in relation to HIV has primarily been on exploring knowledge or risk perceptions, or facilitators and barriers to HIV testing and condom use. Thus, I chose to address this gap by investigating university students’ constructions of, and positioning in relation to HIV risk, and how these relate to their HIV testing health practices, using a discursive analysis/social constructionist approach.

It is worth noting that being a student on the Pietermaritzburg campus of the University of KwaZulu-Natal for four years at the time of collecting data gave me some advantages in terms of understanding the study setting, accessing it, and smoothly connecting to student participants.

Having provided an account of how my interest in this study evolved and my position within it, the next section discusses the social constructionist stance as the philosophical and methodological paradigm governing my research.

4.3 Research paradigm

This study adopted the philosophical and methodological premise of social constructionism, with a focus on discursive analysis to explore the problem of HIV risk and HIV testing practice amongst youth. According to Edwards (2005), the discursive turn in psychology emphasised language as a leading force in the construction of subjectivity. Burr (1996, p. 4), while explaining the meaning of discursive analysis in qualitative research, noted that:

> It is through the daily interactions between people in the course of social life that our versions of knowledge become fabricated. Therefore, social interactions of all kinds, particularly language, are of great interest to social constructionists.

Burr (1996) further argued that discursive analysis is about paying attention to how meanings of objects, social practices or subjects are constructed, understood and explained in a naturally occurring social exchange. Inspired by Burr’s (1996) epistemological conceptions of discursive analysis, social constructionist research was adopted as the research paradigm for this study to analyse the discursive resources (in the form of phrases, terms, metaphors, representations, images, stories, and statements) that youth talk about or share with others when they construct particular versions of the discursive worlds that they inhabit concerning HIV risk in relation to their HIV testing practices. Moreover, consistent with Burr’s (1996) argument that language prescribes all social actions and practices, analysing and interpreting participants’ spoken texts in relation to HIV risk and HIV testing practice in my interview conversations with them may help to understand all their practices in relation to HIV testing, in the sense of whether they do it, how they do it, and why they do it, or not do it.

According to Gale (2010), the social constructionist perspective contains the assumption that people's constructions of their world are not universal. Burr (1996) argued that different discourses construct different social realities. Given this understanding, I acknowledge that all participants have their own different methods and ways of making sense of their own social practices surrounding HIV risk and HIV testing. Knowing this to be the case, I am not interested in validating my participants' claims, constructions, or positions as true or accurate, but rather examining how their constructions create particular representations of subjects (participants themselves and other people) in terms of the object of HIV risk and HIV testing.

The discursive qualitative research design was considered suitable for this study because it provides insight into the research problem due to its engagement with the particular representations of people's discursive worlds in dialogue. This is elaborated in the section that follows.

4.4 Research design

A qualitative research design was adopted in this study. According to Denzin and Lincoln (2013) and Lincoln and Guba (1994), qualitative research attempts to make sense of, understand, or interpret phenomena in terms of exposing the meanings, discourses, theories or experiences people contribute to social interaction. This process, according to Polit and Beck (2004), is inductive reasoning. Polit and Beck (2004) defined inductive reasoning as a situation whereby a researcher, like me, uses the research itself to learn what the essential questions are and derives all the assumptions from the data. Given this understanding, the qualitative research design was considered relevant for this study. It fits with what I am trying to investigate, which is to make sense of, understand, and interpret the target student participants' social constructions of HIV risk in relation to their HIV testing practices.

Although there are various approaches to qualitative research, this social constructionist research followed a discursive qualitative research design that was exploratory in order to allow for the production of comprehensive data in the form of student participants' constructions and positioning in relation to HIV risk and HIV testing. Silverman (2013) commented that a discursive qualitative exploratory research design seeks to produce broad and context-specific understandings of the social issue under study based on rich, nuanced and detailed data.

Silverman (2013) further argued that in quantitative research, there is a single objective reality that researchers seek to observe, understand, and measure to establish correlations between variables, while in discursive qualitative exploratory research, the assumption is that the world contains multiple social realities or discourses which are subject to numerous interpretations. This position taken by qualitative research makes it a suitable approach to adopt in exploring social practices such as the construction of HIV risk and HIV testing amongst youth.

According to Dowsett (2007), discursive qualitative exploratory research design could be useful to examine a phenomenon in subgroups, which are part of a larger population. Dowsett (2007) further noted that a discursive qualitative research design is suitable for investigating why, and how human beings do what they do and what they need to change. Inspired by this argument, this study uses a discursive qualitative research design to explore how sexually active university students construct HIV risk, how they position themselves and others in relation to it, and whether and how they engage with HIV testing, in the sense of why they do it, or not do it. In this study, HIV risk was considered a discursive object whose implicit meanings can only be obtained by analysing what has been said about it by people in social interaction with one another. Identifying discourses surrounding HIV risk may contribute to an understanding of social aspects and processes that affect young people's ability to initiate and sustain health practices, such as HIV testing. These issues may prove crucial in behaviour change interventions.

The discursive qualitative exploratory research design was also adopted in this study due to its assumption that knowledge is neither inside a person nor outside in the social context but exists in the relationship between persons and their context (Brown, 1995; Burr, 1996, 2003; Gergen, 1999). Denzin and Lincoln (2013) argued that a qualitative exploratory research design contains the assumption that individuals influence a setting, and a setting influences an individual, and an individual influences other individuals, and one setting influences another setting. Gale (2010) argued that in qualitative exploratory research, the relationship between individuals and their social context is multidirectional, jointly constituted, and continually changing. Based on these philosophical conceptions, it is clear that a qualitative exploratory research design recognises that social phenomena like the social construction of HIV risk and HIV testing health practice need to be understood and described within the context in which they are explained, and acknowledges the complexity and unpredictability of the social context.

The next section, therefore, presents a broad overview of the social context in which this research was conducted.

4.5 Research setting

The setting for this study was the University of KwaZulu-Natal. This University was formed in 2004 due to a merger between the University of Natal and the University of Durban-Westville. It has five campuses: the Edgewood campus, the Howard college, the Nelson R Mandela School of Medicine, the Pietermaritzburg campus, and the Westville campus. This University is organised on a College model and has four colleges: the College of Agriculture, Engineering and Science; the College of Health Sciences; the College of Humanities; and the College of Law and Management Studies. All the Colleges offer undergraduate and postgraduate degrees. The University of KwaZulu-Natal's data published recently on the United States News and World Report (2021, May 17) website states that the university has 34,732 students currently registered, and of this figure, the majority are undergraduate students (26732) and women (19366). This imbalance in sexes (men and women) is a clear indication of how gender norms have shifted over the years, which have resulted in more women enrolling in universities.

This study was conducted with sexually active students aged 18-24 years registered on the Pietermaritzburg campus. The Pietermaritzburg campus is located within the Scottsville suburb in the Midlands region of the KwaZulu-Natal Province in the uMgungundlovu district, in the Msunduzi Local Municipality. The Pietermaritzburg campus is approximately 3,3 km from the Pietermaritzburg city centre. The location of this Campus is very significant in relation to the research problem because the uMgungundlovu district has a high prevalence of HIV infections, which then increases risk, and the prevalence rate is high in the Pietermaritzburg area, with youth aged 15-24 years said to be disproportionately affected relative to other age groups (George et al., 2019; IHME, 2019, May 15; KwaZulu-Natal Provincial AIDS Council, 2017). Furthermore, this age range (15-24 years). According to the South African Council on Higher Education (2017) estimates, most of the University of KwaZulu-Natal students at the undergraduate level are aged 18-24 years, and thus falls at the middle to the upper end of the subpopulation (15-24-year-olds) said to be at risk of, and living with HIV at the uMgungundlovu district in South Africa (George et al., 2019; IHME, 2019, May 15; KwaZulu-Natal Provincial AIDS Council, 2017). These characteristics thus made the Pietermaritzburg campus a suitable location for this study.

As discussed earlier, students on the Pietermaritzburg campus engage in patterns of sexual practices such as concurrency, age-disparate sexual relationships, and non-condom usage (see Chapter Two section 2.2 The rationale of the study), and exploring the problem of HIV risk and HIV testing with students on this Campus is crucial for understanding the context in which educated young people's constructions of HIV risk in relation to their HIV testing practices are formulated and expressed. Therefore, in the next section, I will discuss how student participants were sampled into the study.

4.6 Sampling methods

The ethical principle of fair subject selection proposed by Wassenaar (2006) was used to choose a suitable sample to answer the research questions of this study (see Chapter Two, section 2.5 Research questions). Gentles et al. (2015, p.1775) defined sampling in qualitative research as "the selection of specific data sources from which data are collected to address the research objectives." The study adopted three non-probability sampling methods, namely convenience sampling, purposive sampling and snowball sampling, to access student participants within the context of an institution of higher learning (Pietermaritzburg campus).

4.6.1 Convenience sampling

Convenience sampling is a technique of recruiting volunteer participants who are willing and available to participate in the study (Gentles et al., 2015). Gentles et al. (2015) further argued that convenience sampling relies not only on the availability of participants and their willingness to participate but also the cases should mirror the characteristics of the population being studied. In this study, the notion of a suitable sample to participate in the study was extended to all students aged 18-24 years registered on the Pietermaritzburg campus and willing to participate and talk freely about HIV risk and their HIV testing practices.

The recruitment of potential students who were willing and available to participate in the study was through an advert (see Appendix 1) placed on the University's noticeboard calling for volunteers. The advert was non-coercive and gave a brief explanation of the research topic, target participants, my contact details as the researcher, and assurance of confidentiality in the research process. Permission to post the adverts on the Pietermaritzburg campus noticeboard was obtained from the University's Risk Management Services. In the advert, I invited prospective participants to send me an email, WhatsApp message, short message or call me, if they were interested and willing to participate in my study. Upon receiving these messages and calls, I arranged to contact each participant to explain the nature of my research, its purpose, and what their participation would entail. In the call, I asked them some questions related to their age, current registration status, and whether they are sexually active, to determine whether they fulfilled the criteria for being recruited into the study. I also gave them sufficient time to ask questions. To be recruited to participate in this study, one had to be registered at the University of KwaZulu-Natal on the Pietermaritzburg campus, sexually active, and aged between 18-24 years. In total, 12 participants (all female undergraduates) responded to the advert, and 11 met the sampling frame, but only eight were interviewed, while the rest dropped out. Thus, in total, 8 participants (all women) were recruited through the convenience sampling technique.

4.6.2 Purposive sampling

Purposive sampling, also called theoretical sampling, is a non-random sampling method used in in-depth studies, whereby the researcher chooses participants with knowledge of an issue of interest in the study (Gentles et al., 2015; Patton, 2015; Silverman, 2011; Terre Blanche et al., 2006). Purposive sampling was considered appropriate for this study to recruit participants who were knowledgeable and willing to talk openly about the problem of HIV risk, their sexual practices, and their HIV testing practices. Terre Blanche et al. (2006) further noted that demographics of the sample recruited using the purposive sampling technique should represent the characteristics of the study population. In this study, participants were purposefully recruited based on their being registered at the University of KwaZulu-Natal on the Pietermaritzburg campus, between 18 and 24 years of age (which is the age range reported as having a high risk of HIV exposure in South Africa), and sexually active (which is considered a risk factor in terms of HIV amongst youth). Although this university has some students aged below 18 years, this group of youth were not included in this study. This is because including them would require consent from their legal guardian or parent, which could raise practical challenges. In total, 8 participants (3 men and 5 women) were recruited through the purposive sampling technique.

4.6.3 Snowball sampling

However, after the initial analysis of the data, I decided to recruit additional participants to broaden the scope of discourses identified, and also to support my analytical claims and discourses identified. The difficulties encountered in accessing potential participants partly relates to the sensitivity of the research topic. Therefore, a snowball sampling technique was used to broaden the potential range of discourses represented in the initial interviews. Snowball sampling is a method whereby available participants are requested to refer potential participants to the researcher (Babbie & Mouton, 2010). I asked participants who took part in the semi-structured interviews to refer me to other potential students to participate in the study. In adopting this recruitment approach, I recruited new participants continually into the study until I felt that I had the needed saturation of discourses to build and support my analytical claims. Patton (2015) constructed this way of recruiting participants continually into the study as sampling to redundancy. In total, 4 participants (2 men and 2 women) were recruited through the snowball sampling technique.

By combining the three sampling techniques, I recruited 20 participants in total, consisting of 15 female and five male students. The theoretical premise of understanding discourses supports such a small sample size. Willig (2008) noted that the intensive nature of discursive analysis needs a small number of participants to identify discourses, interpret them, and explain how they work. A sample size of 10-30 participants has also been used in other discourse analytic studies (Jangu, 2014; Willig, 2008). Other qualitative methodologists argued that saturation generally occurs between 10-30 interviews (Denzin & Lincoln, 2013; Gentles et al., 2015; Patton, 2015).

4.7 Demographics sheet

Some researchers have argued that the identity characteristics of participants will shift the attention to actual categories that subjects use to take particular positions in relation to the research problem (Burr, 1996; Gale, 2010; Silverman, 2013; Parker, 1992). In line with this, I was conscious that my participants' constructions and positioning might differ depending on their social identifiers, for example, their age, sex, race, nationality, marital status, college, faculty, and the level of study. Thus, I prepared a brief demographics sheet (see Appendix 2) to elicit the above identity characteristics of my participants.

A diversified sample emerged out of the recruitment process. A full description of the sample and sample size is given in the next section.

4.8 Sample description and sample size

This study's sample consisted of male and female students aged 18 to 24 years who were registered on the Pietermaritzburg campus of the University of KwaZulu-Natal in South Africa. All participants self-identified as sexually active heterosexuals and single/unmarried at the time of the interview. In terms of the nationality of the participants, there were 15 South African nationals (RSA) and five international students. The international students came from Zimbabwe (ZIM), the Democratic Republic of Congo (DRC), Uganda (UGA), Kenya (KEN), and Tanzania (TAN). In terms of the racial classification of the sample, only students from three (coloureds, black Africans, and Indian/Asians) of the four racial groups (whites, coloureds, black Africans and Indian/Asians) used to classify people in South Africa, took part in the study. The numerical classification of the sample according to the racial origin of the participants stood as follows: three coloureds (C), 14 Africans (B), and three Indian/Asians (I). These participants self-identified as members of the racial groups named above.

In terms of place of origin (home), seven participants self-identified as coming from an urban area, which is a geographic area region surrounding a city or a town; eight participants self-identified as coming from a rural area, which is a geographic area that is located outside towns and cities; two participants self-identified as coming from the semi-urban area, which is a geographic area partly urban or an area between rural and urban; and three participants self-identified as coming from the township, which is a geographic area that is close to a town, but underdeveloped and racially segregated in South Africa.

In terms of their level of university education, the sample consisted of 12 undergraduates (UGs) and eight postgraduates (PGs). In terms of the College of study, there were 15 participants from Humanities (HUM); four from Law and Management Studies (LMS); and one from Agriculture, Engineering and Sciences (AES).

In terms of HIV testing history, the majority of participants (13) (three males and ten females respectively) reported having been tested (T) in the last 12 months; four participants (one male and three females) reported being tested only once; three participants (all female) reported never been tested (NT). None of the participants was asked to report their HIV serostatus. It is important to note that these HIV testing practices and other demographics of participants are based on self-report.

Table 1 below was created to give a summary of relevant information related to the sample characteristics.

Table 1: Summary of the characteristics of participants

Pseudonym	**Age in years**	**Sex**	**Race**	**Nationality**	**College**	**Level of Study**	**HIV testing history**
Alfred	21	M	C	RSA	LMS	UG	T, Mar 2019
Andrew	24	M	B	KEN	LMS	PG	T, Jul 2018
Bongani	20	M	B	RSA	HUM	UG	T, Jul 2018
Bongi	24	F	B	RSA	HUM	UG	T, Mar 2018
Buhle	24	F	B	RSA	HUM	PG	T, Mar 2017
Carol	20	F	C	RSA	HUM	PG	NT
Esther	23	F	B	RSA	HUM	UG	T, Aug 2015
John	20	M	B	DRC	LMS	UG	T, 2015
Leah	20	F	B	TAN	AES	PG	T, Jan 2018
Liz	23	F	I	RSA	HUM	PG	T, 2014
Londi	24	F	B	RSA	HUM	PG	T, Oct 2017
Nicole	19	F	I	RSA	HUM	UG	NT
Nipho	20	F	B	RSA	HUM	UG	T, May 2017
Phumi	22	F	B	ZIM	LMS	UG	T, May 2018
Purity	20	F	C	RSA	HUM	UG	T, Jun 2017
Sane	22	F	B	RSA	HUM	PG	T, Apr 2019
Sarah	24	F	I	RSA	HUM	PG	T, Apr 2018
Tumi	19	F	B	RSA	HUM	UG	T, Dec 2018
Zama	20	F	B	RSA	HUM	UG	NT
Zazi	22	M	B	RSA	HUM	UG	T, Jan 2019

As seen from the above table, the sample is diverse, as are students on the Pietermaritzburg campus of the University of KwaZulu-Natal.

Ethical considerations were central throughout the research process, and I discuss here how I adhered to Wassenaar's (2006) eight practical elements of conducting proper research.

4.9 Ethical considerations

Wassenaar (2006) drew on Emanuel et al.'s (2004) work in developing these principles. These principles include the need for adherence to: fair subject selection; community and stakeholder engagement or collaborative partnerships; independent ethics review; favourable risk/benefit ratio; informed consent; respect for research subjects; social and scientific value; and scientific validity. In addition to these guidelines, this study was conducted in line with the HPCSA's (n.d.) ethical guidelines for good practice in health research. The fair subject selection element of Wassenaar's (2006) eight principles of ethical research has already been discussed in the recruitment section (see 4.6 Sampling methods). The other seven principles are discussed in their appropriate sections below.

4.9.1 Community and stakeholder engagement or collaborative partnership

According to Emanuel et al. (2004), the primary researcher should involve the community and participants in designing the research and assessing the direct or indirect impact of the research design on the community and stakeholder or partnership. This study did not involve the community of the university of students in its design and implementation. However, the research focus, and the outcome of the study will be communicated to relevant stakeholders in the university setting (e.g., the University of KwaZulu-Natal management, the CHASU, the University's health clinics, the Student support services). This research did not involve any partnership. Consistent with Emanuel et al.'s (2004) argument that consent from leaders may be required before researchers can recruit participants, I obtained gatekeepers' permission from the University of KwaZulu-Natal's Registrar's Office (see Appendix 3). The approval allowed me to approach students on the Pietermaritzburg campus regarding their participation in my study.

4.9.2 Independent ethics review

Emanuel et al. (2004) argued for an independent and competent regulatory approval for some types of research. In line with this recommendation, the University of KwaZulu-Natal's Humanities and Social Sciences Higher Degrees Committee approved the research design and methodology of the study. According to Wassenaar (2006), the review helps to minimise issues related to the researcher's conflict of interest and ensure that the research has potential social value, and the privacy of participants is protected. Wassenaar (2006) further noted that the review process involves ensuring that the researcher protects the public from harm or exploitation. The approved ethics protocol reference number for the study is HSS/0005/019D (see Appendix 4).

4.9.3 Favourable risk/benefit ratio

Wassenaar (2006) argued that the information provided to potential participants before recruitment should indicate the risks and benefits of their participation. In Wassenaar's (2006) view, the risk to benefit ratio of their involvement should be favourable and fair. In line with this recommendation, this research was guided by the ethical principle of "do no harm" to participants recommended by Wassenaar and Mamotte (2012). In particular, although the study did not entail any invasive or medical procedure of any kind, participants were protected from any possible adverse repercussions of their participation. This precaution was considered because HIV is a sensitive issue, and discussions related to it could have triggered negative emotions about HIV testing and receiving the result. I was also mindful that some of my participants might have contracted HIV and other STIs due to their sexual activities or during birth, and interactions related to HIV risk and HIV testing might make them feel embarrassed, guilty, regret, or remind them of the social, emotional, and financial challenges which could have accompanied their misfortunes. For these reasons, the possibility of causing harm was expected, and this was addressed.

In drawing on Wassenaar and Mamotte's (2012) recommendation, measures were put in place to deal with any foreseeable harm. Permission was obtained from the Director of the Child and Family Centre (CFC) in the Discipline of Psychology on the Pietermaritzburg campus to refer participants to the CFC as a result of their engagement with this study (see Appendix 5). Participants were informed that if they experienced any emotional problems resulting from participating in this study, they could contact the Centre should they need counselling. Participants were also informed of the free counselling and support services available at the Student Support Centres on the Pietermaritzburg campus and given directions and contact details. Participants were also informed of the free resources available on the Pietermaritzburg campus health clinic, such as information and materials about HIV and AIDS, pre-exposure prophylaxis, post-exposure prophylaxis, ART, condoms, lubricants, and contraceptives. If these resources or health services were required, they could book an appointment at the health clinic, and contact details were provided. Participants were also made aware of the psychosocial support, HIV testing and HIV and AIDS management services available at the CHASU offices located at the Student Union Building on the Pietermaritzburg campus, and given contact details of the officers.

Most critically, potential participants were fully informed about the nature and scope of the research before they were recruited. I informed all the prospective participants that I was not interested in knowing their HIV status, and that I would not ask them to report this to me in the interview session. I also informed them that in our discussion, we would focus on how they feel and think about HIV risk, whether they feel at risk, whether they have been tested or not, why they were tested, their feeling about the process of HIV testing, the decisions they make in their sexual relationships to protect themselves against HIV risk, challenges that confronted them, and how these were resolved. This precaution was taken to ensure that only participants who were willing to participate and could openly talk about HIV related issues were recruited. The next section discusses the data collection process used in this study.

4.10 Data collection tool

A discursive qualitative and exploratory study uses data collection methods which are open-ended, semi-structured, in-depth and non-standardised (Jamshed, 2014). A discursive approach to research positions interviewing as a production site of knowledge in terms of its linguistic and interactional features, including the differences between oral discourse and written text (transcript), and emphasises the narratives constructed in the interview (Gergen, 1999). The semi-structured interview activity enabled this study to produce knowledge about participants' constructions of, and positioning in relation to HIV risk, and how these relate to their HIV testing practices.

4.10.1 Semi-structured open-ended interviews

Semi-structured, in-depth interviews with a pre-planned set of questions related to participants' lives, experiences and circumstances were used to collect knowledge (data) for the study. Jamshed (2014) argued that unlike traditional means of investigating health behaviour, such as asking participants to perform an experimental task, or to respond to a survey and structured interviews, semi-structured interviews are interactive and provide well-founded knowledge about people's conversational reality. Gale (2010) argued that interviewing in qualitative research is a process of knowledge construction. To elaborate on this, Gale (2010) contended that semi-structured interviews provide access to the dominant discourses, social practices and social processes that people have internalised and continue to enhance through dialogue. Given this understanding, the semi-structured interviews fit well with this study's argument from a social constructionist perspective that knowledge about HIV risk and HIV testing is constructed in the interactive process.

Gale (2010) further argued that exploring people's subjectivity allows for a process of dual reflexivity. Gale (2010) defined the process of dual reflexivity as a situation where both the researcher, like myself, and the participant, like the 20 students interviewed for this study, have the opportunity to reflect on their life experiences, circumstances, and positions in relation to the research problem. Lupton (1992, p.146) follows a similar position, stating, "interview knowledge is not merely found, mined, or given, but is actively created through questions and answers, and the product is co-authored by interviewer and interviewee.” Inspired by the philosophical conceptions portrayed above, the semi-structured, in-depth and open-ended interview activities were used in this study to obtain knowledge about participants’ meanings of HIV risk and their HIV testing practices. The discussion between myself as the researcher and the 20 participants, particularly the talk generated in that discussion, facilitated the generation of data for the study, which could be analysed discursively.

Individual interviews are confidential and flexible, which permits the researcher to probe participants’ responses with ease, to gain an understanding of their meanings of words, statements, and change the course of the research as it progresses (Jamshed, 2014; Noaks & Wincup, 2004). This study involved asking participants sensitive and personal questions related to their understanding and construction of HIV risk, sexual behaviour, including the number and type of sexual partnerships and individual experiences of HIV testing. Thus, individual interviews were deemed suitable. By interviewing participants individually, I was able to gain and maintain trust when asking these questions. Noaks and Wincup (2004) constructed this process of building a relationship of trust with participants as the researcher’s attempt to ‘see’ the world from the interviewee’s perspective. Doing an HIV test is also a personal event, although it could be undertaken by a couple (Kilembe et al., 2015). Thus, the freedom to talk in a confidential space afforded by the individual interview situation potentially provided participants of this study an appropriate and safe space to say what they wanted to say about their HIV testing practices.

There is, however, an ethical concern in discursive research in the sense that power is at play, particularly between the researcher and participants, and their multiple positions and identities, during the data collection process. How these issues were addressed in this study is explored in the next section.

4.10.2 Power difference in interviewing practice

Emanuel et al. (2004) argued that the primary ethical concern in conducting social research is the existence of social inequality or unequal power relation between the researcher and the participant. In the context of social constructionist research, Parker (2005) and Lupton (1992) contended that power relations between the researcher and the participant emanate from the social positions and identities, such as skin colour, social class, sex, level of education and sexuality. Parker (2005) further noted that all these demographics inform what is said and how it is said by participants and the meanings we make of their accounts as researchers. I was curious about how the multiple social positions I occupied as the researcher might influence my interaction with the participants and the research outcomes. I was older than all the participants (31 years of age at the time of the interviews), a black woman, heterosexual, able-bodied, Christian, an international student/foreigner, and at the doctoral level of study. On the other hand, my participants were young male and female students, between 18-24 years of age, from different nationalities, and most were undergraduates. Although I introduced myself as a fellow student on the Pietermaritzburg campus, I was also the 'researcher' collecting data for my doctoral research. My positioning here implied that I am the one directing our interview discussions, and I felt that this could potentially make me appear more 'powerful' than my participants. To minimise this anticipated power difference, I informed all my participants about the sensitivity of the topic, which involved asking them personal questions. I made it clear to them that they would be in control of what to say and what not to say, and that they should not feel forced to respond to all my questions.

I also followed Shenton's (2004) suggestion on relational ethics by creating interpersonal ties and initiating and maintaining conversations. I tried to establish rapport in the opening moments of each session. In doing this, I encouraged my participants to be frank in telling their own stories of their understanding of HIV risk and their HIV testing practices. I emphasised that there was no right or wrong answer to any of my questions since they are the bearers of their own experiences in relation to the research problem, which is consistent with the philosophical and methodological approaches employed to answer the research questions of this study as they all challenge the notion of 'objectivity/truth/reality'. Alldred and Burman (2005) argued that within the discursive framework, the assumption is that an individual's account relates to perceptions or subject positions, rather than to their (unified) identity. I also reassured my participants that I had an ethical obligation as the researcher to preserve their privacy, identities, and the information they shared with me.

While I tried to create this 'equal power relation' during the interview sessions, Parker (2005) argued that complete equality is not possible in an interactive process. Given this understanding, I am cognizant that there is a possibility that the power difference between the participants and me as the researcher, could have had some influence on the way they responded to me. For example, most participants (13) presented themselves as responsible health acting subjects in terms of HIV testing and positioned their sexual activities as ‘not that bad’ (or risky). Also, five male participants who reported engaging in unprotected sexual activities with partners of unknown HIV status positioned themselves as ‘not in control of the process’, and not as risking themselves ‘deliberately’.

Parker (2005) highlighted the assumptions about gender-appropriate and inappropriate actions embedded in every social interaction. I found it a bit challenging discussing HIV as a sexual risk with male students due to social and cultural barriers. Being a woman from the Kalenjin tribe in Kenya, I was brought up in a cultural context where sex-related discussions with men are forbidden. In my tribe, men are encouraged during the circumcision phase (13-18 years) not to have one-on-one conversations with women on issues related to sex or masculinity. I, therefore, entered the data collection with some firmly developed expectations that young men are reluctant to talk about sex-related topics, particularly those related to their sexual behaviours and HIV risk. Contrary to my expectations, the male student participants I interviewed were very open in talking about their sexual behaviours, their risks of HIV, and their HIV testing practices.

Although Parker (2005) argued that there is an unequal power dynamic in a research engagement and that the researcher is the more powerful party, I felt that in some ways, the participants were ‘more’ powerful than me. They were experts in their own lives and in accounting for their own experiences, which is something I had previously taken-for-granted; it is something I had not thought about when conceptualising this research. This revelation supports the argument made by Alldred and Burman (2005), Gale (2010) and Willig (2008) that in research, participants should not only be taken as providers of information but also as partners in the creation of knowledge. Therefore, as researchers, we research with participants, rather than investigating their lives from the outside (Alldred & Burman, 2005; Gale, 2010; Willig, 2008). Consequently, as researchers, we do not see the research interviews as providing us with a clear ‘window’ through which participants’ experiences can be seen (Alldred & Burman, 2005).

How the insider versus the outsider positions was addressed in this study is explored in the next section.

4.10.3 Negotiating insider versus outsider positions interviewing practice

Merriam et al. (2001) argued that a researcher is likely to be either an insider or an outsider during the interview process. Merriam et al. (2001) further noted that often, there is a fluid interaction between these two positions. I was curious about how my own position based on the social identities mentioned in the previous section would intersect with my participants' social identities in the interview sessions. In many aspects, I considered myself as different from my participants in terms of nationality, home language and level of education. I was curious about whether these identities and my role in this study might influence my participants to position me as an 'outsider' in relation to themselves. For example, I used English throughout the interview sessions and asked participants to translate the words they said in *isiZulu* into English. *IsiZulu* is a language that the majority of the black South Africans speak. I considered this also as an aspect that was likely to influence my participants positioning of me as being an 'outsider.' As it turned out, my positioning as an outsider compared to my participants (as insiders) did not seem to have an effect; at least, judging from their readiness to respond to all my questions without hesitancy or any attempt at holding back. Indeed, it actually worked to my advantage because, as Merriam et al. (2001) observed, the issue with being an outsider, in such a study as this one, is that one can position oneself as 'not knowing' and invite participants to 'educate' one or inform one on the issue under discussion. This was exactly what happened as, in most cases, during my interviews with the study participants, I took the position of a 'learner' of their constructions of HIV risk and their HIV testing practices.

In some instances, I found myself included in female participants' talk, where I was positioned as an 'insider', and particular shared identifications were assumed. For example, some used gender-specific terms like 'you as a woman', 'we as women', suggesting that they felt that I would understand what they were talking about. In such instances, I found it challenging to detach myself from their experiences. To minimise my participants' assumptions that I was an expert or had prior knowledge of women's experiences, I explained to them my position as a researcher and the purpose of our conversation; namely, that it is not just social interaction but a special form of conversational practice (interaction) to generate some data for research purposes. Therefore, I wanted to hear their views, particularly how they construct and position themselves in relation to HIV risk and whether and how they engage with the practice of HIV testing. Even so, the 'insider' position I was given seemed to have made it easy for female participants to talk freely about their sexual behaviours and HIV testing, and share their views with confidence. For example, some female participants began their response with the words 'to be honest with you', to position themselves as sharing something personal with me and implying that they were going to be direct and truthful.

What now follows is a description of the content of the interview guide used in this study.

4.10.4 Semi-structured interview guide

Noaks and Wincup (2004) argued that a semi-structured interview guide makes the questions clear and allows for an interrogation of the influence of the researcher in the research process. In this study, the semi-structured set of general questions (see appendix 6) were developed to generate a discussion about HIV risk and HIV testing amongst youth. The questions were formulated based on the research questions of the study (see Chapter Two, section 2.5 Research questions), and previous studies on this topic. The words used in asking these questions were simple, direct and familiar to all participants. The questions did not involve asking participants to report their HIV status but focused on how they think and feel about HIV risk, whether they are concerned about it, whether they have been tested, how they negotiated HIV risk in their sexual relationships, and the challenges that confronted them and how these were resolved. The questions were open-ended, giving room for interaction. Often, in the interview sessions, there were rich interactions generating 'talk' that could be analysed discursively. This flexibility also permitted me to change the direction of the interview in relation to the research questions, as the interview progressed. The flexibility of the questions in the interview guide also encouraged active listening, a pattern of listening that keeps participants engaged with the researcher in a positive manner (Noaks & Wincup, 2004). Thus, using this interview guide to direct the interview session was useful. The questions prioritised participants' interests and gave them the freedom to generate their own questions and ideas using their own phrases, terms, metaphors, representations, stories, and statements to construct, change, explain, elaborate on their meanings, or simply defend their stance in relation to HIV risk and HIV testing.

The interview guide was piloted with two undergraduate female students aged 18-24 years registered on the Pietermaritzburg campus. These participants mirrored the targeted study sample's social and cultural context and characteristics. Their input, comments and reaction to the questions in the interview guide helped me to refine the interview schedule in terms of wording, length of time in each session, and the flow of questions. Pilot testing also enabled me to identify some data for analysis to identify discourses at work and any other necessary issue in relation to the research problem.

The interview data were obtained within a time period of 4 months (between February and May (2019).

4.10.5 Semi-structured interview process

Prospective participants who met the sampling criteria (registered on the Pietermaritzburg campus, aged 18-24 years and sexually active) and expressed their willingness to participate in the study were asked to make time to complete the demographics sheet (see Appendix 2) by ticking the option(s), which applies to them before the interview date and time agreed on. I took this action because I had anticipated that completing it during the actual interview session would set the tone of the questionnaire, rather than a conversation. Participants were given the option to receive the document via their email or collect the hard copy from me. All participants preferred to pick up the hard copy from me, perhaps because receiving it through email would require them to print it, a process that could be inconvenient in terms of time and cost. Throughout the process, from contacting them to issuing the demographic sheet, I reassured all my participants that I would keep their identities and information they shared with me confidential.

All the interview sessions took place at the Research Psychology Laboratory in the Discipline of Psychology on the Pietermaritzburg campus. This venue was convenient for students and private, given the sensitivity of the topic. It was only the participant, and myself at each interview session, and I locked the room to ensure that other people had no access. Moreover, one has to have a password to access the venue, and a sign on the door indicated that an interview was taking place. All interviews were conducted during the day, and at times convenient for participants.

Considering that I am not proficient in any of the local (South African) languages, all the interviews were, out of necessity, conducted in English. Fortunately, in my interactions with all participants, I found that all were fluent in English. This relates to the fact that my participants were youth at the university. However, some students said some words in their mother tongue (*IsiZulu*), but I asked them to explain the words in English.

The interview sessions were recorded using two audio recorders for data backup in case one gadget failed. As argued by Gale (2010), Jamshed (2014), and Seale and Silverman (1997), there are several advantages of recording the interactions in the interview sessions. Amongst these advantages is that recording the interactions makes it easier for the researcher to focus, stay focussed on the interview process and its contents, and record verbal prompts. Seale and Silverman (1997) further observed that unlike field notes of observational data, recorded files could offer a highly credible record to which researchers can return as they develop new assumptions from the data.

According to Jamshed (2014), semi-structured interviews generally last for 30 to 60 minutes. While planning this study, I anticipated that the interviews would last approximately 60 minutes, but the typical duration was 23–46 minutes, and one extended up to 57 minutes. Some participants were not keen to stay in the session for a long time due to other commitments they had. This was expected given that they were university students and had academic work to attend to. Despite this, the length of the interview sessions accommodated paraphrasing of the questions and probing their responses for an insightful discussion.

4.11 Additional ethical considerations in the research process

This section foregrounds additional ethical considerations that were taken into account in the research process. In doing this, I will comment on Emanuel et al. (2004) and Wassenaar's (2006) practical elements of conducting ethical research not discussed in the preceding sections.

4.11.1 Information sheet

When I met with each potential participant at the interview, I greeted and acknowledged them for agreeing to participate in my study. I then introduced myself briefly. Emanuel et al. (2004) noted that all potential participants should be well informed about the research in order for them to make fair judgements and decisions to participate in it, or not. In line with this, I gave each participant a detailed information sheet (see Appendix 7), and read through its content with them. The document contains information about the purpose of the study; the nature of their involvement; their rights; potential risks and benefits of their participation; what is going to happen to the data and the measures that have been taken to ensure their confidentiality; dissemination of the findings; storage and destruction of the data; and contact details of the psychological and psychosocial support services arranged for them. The information sheet also contains a statement that a brief synopsis of the findings will be made available to them upon request. I also included my contact details, that of my research supervisor, and the Humanities and Social Sciences Research Ethics Committee in case any of my participants had any questions or complaints regarding my study. I explained all these issues verbally and asked them to keep the document for future use should they require any information or contact details. I also gave them a chance to ask questions.

4.11.2 Informed consent

Taking the ethical principle of the need for informed consent in research stressed in Emanuel et al. (2004), Wassenaar (2006), and Wassenaar and Mamotte's (2012) work into account, the purpose of this study was made clear to all participants before recruitment. Those who agreed to the conditions of the study were asked to carefully read the consent form (see Appendix 8), and provide their consent by writing their name and signing the form. By doing this, they were acknowledging that they had understood the nature of their participation and had been given contact details of the psychological and psychosocial support services arranged for them. While doing this, I assured them that their names would not be disclosed to anyone or linked to the information they would provide during the interview session.

A separate consent document was prepared for recording the interview sessions. Participants were asked to consent to this recording by signing the consent to audio record the interview (see Appendix 9). All participants agreed to the sessions being recorded. Once all of the permissions were obtained, participants were asked to hand in their demographics sheet (see Appendix 2). I then reassured them that their identity would be kept confidential throughout the research process. How this was achieved is documented in the next section.

4.11.3 Ensuring ongoing respect, privacy and freedom of each participant

According to Emanuel et al. (2004) and Wassenaar (2006), researchers should ensure ongoing respect for, the privacy, and freedom of each participant. Emanuel et al. (2004) further underscored the need for researchers to ensure that their participants are made aware that they can refuse to participate in, or withdraw from, the study at any time. In line with this, I made all participants aware of their right to participation, that it is voluntary, and that their refusal to answer any questions or terminate the interview would not result in any negative consequences. Emanuel et al. (2004) further accentuated that researchers should ensure the integrity of the research as well as keeping the identity of their participants confidential and non-traceable. In line with this principle, in my data transcripts, the identifying details of participating students and the names of their friends, family members and intimate partners were protected by having their personal identifiers deleted. In presenting my findings, I have not included any information that could reveal my participants' identities or those of their friends, family members, and sexual partners. I have also used pseudonyms instead of the study participants' real names, and I plan to keep to this measure in any other public document, such as journal articles and conference presentations that might arise from this study. To ensure their identity was kept confidential, I assigned all participants different code names from the ones they chose during the interview sessions to decrease the possibility of self-identification. In addition to these measures, I have made it a duty to give no data from the study to a third party. I have also prepared a brief synopsis of the findings, and I will make it available to any of the participating students upon request. The synopsis is generalised, anonymised and de-linked from the data to minimise the chances of any participant identifying oneself or other participants.

4.11.4 Storage and dissemination of the data

I made all my participants aware of how the data from my interviews with them will be stored and destroyed. The data from this study in written and digital form has since been kept safeguarded in a locked cabinet in my supervisor's office and will remain there for five years, after which they will be incinerated. The data from this study might also be presented at conferences and used in journal articles. I assured my participants of their rights to anonymity in this thesis and any presentation or publication that might arise from the study.

4.11.5 Establishing the social and scientific value of the research

Emanuel et al. (2004) and Wassenaar and Mamotte (2012) maintained that any research with human subjects should be acceptable, relevant, and of potential value to the target population. Although this study is conducted for academic purposes, I am aware that it should offer participating students a favourable social value in their context. Exploring the problem of HIV risk amongst students is of great social and scientific importance for three reasons. Firstly, although there was no direct benefit to the participants, there was an indirect benefit. All participating students received materials related to HIV testing services, pre-exposure prophylaxis, post-exposure prophylaxis, sexual health, and mental health sourced from the Pietermaritzburg campus health clinic, the CHASU offices, and the Student Support Services. Secondly, there was an indirect benefit to participating students regarding what my findings might lead to. Emanuel et al. (2004) and Wassenaar (2006) argued that the research should show how its findings will contribute to new knowledge and insight into the research problem. I am convinced that this discursive study will contribute towards extending the existing knowledge on youth constructions of health about HIV risk and implications for their health practices, specifically HIV testing.

Emanuel et al. (2004), while making comments related to the interaction between participants and researcher in a study such as this one, argued that the social exchange is not only a tactical strategy but also potentially part of the intervention paradigm itself. In line with this argument, the participating students seemed to have benefited from being involved in an interview process, which allowed for reflection, which is the third social value of this study. Before I adjourned the interview session, I asked each participant if there were anything they would like to take out, or add to our discussion. Our discussions seemed to have empowered them from their responses, and I have selected a few extracts to exemplify this.

Extract 1 below is taken from a coloured South African female participant who reported never been tested for HIV.

Extract 1

320 Betty: So, is there anything you would like to add or remove from what we talked about?
321 Carol: I just want to say, I felt like when you approached me, I needed this personal interaction,
322 uh talk, because I needed something just to push me to do it because I have been holding myself
323 back for many years, but I just want to get it over and done with it because I don't like
324 something sitting at the back of my mind, what if? What if? What if? So, I am just thankful for
325 this whole interview because it just confirmed my belief of going to get tested. I need to, so
326 jah.

(20, F, C, SA, UG, Not tested)

In this talk, Carol voiced her tendency to procrastinate coming to a decision to take the HIV test and justified this by citing fear of finding out that she has HIV, 'what if?', as part of the reason for this (line 324). In her use of the words 'needed something just to push me' (line 322), 'I want to get it over' (line 323), 'confirmed my belief of going to get tested', and 'I need to' (line 325), she positions my interactions with her as having had a positive influence on her urgency to take an HIV test.

Extract 2 below is taken from a black South African male participant.

Extract 2

130 Betty: Is there anything you want to add with regards to what we have been discussing?
131 Bongani: Well, I just want to say us as students because there is a lot of people here, there is a
132 lot of potential partners. So, what I should emphasise is regular testing with my partners as you

133 have said because sex is not the only way of obtaining HIV. I have learnt a lot, and I hope to
134 work on my testing. Jah. Thank you.

(20, M, A, SA, UG, Tested)

In this talk, Bongani highlighted the significance of our session. He described students' risks of HIV within the context of expanded sexual networks. He says that the university environment, because of the size of the student population, provides students with access to 'a lot of potential partners' (lines 131-132). He expressed the intention to insist on regular HIV testing in his relationships as his risk management strategy and to 'work on [his] testing' (line 134).

Extract 3 below is taken from a black South African female participant who was pregnant at the time of the interview. In response to a similar question, she says:

Extract 3

159 Tumi: uh (.3) think this interview has made me realise the things I assume in my relationship.
160 Even if I have been tested, I need to push him to test, I don't know, but he has to do it for us to
161 be safe and for our baby.

(19, F, A, SA, UG, Tested)

This short account positions Tumi as someone who benefited from our discussion, especially with regard to encouraging her partner to get tested, which is something she positioned herself as having been ignoring. She constructs the possibility of her partner engaging in HIV testing positively, and seeing the idea of getting such knowledge in good time as being for their well-being and also that of their unborn baby (lines 160-161).

While the account of the three participants is all largely at the level of intentions, they suggest that Emanuel et al.'s (2004) stance that the interaction between the researcher and the participant is a part of the intervention paradigm itself is something achievable, and seemed to have been achieved partly in this study.

4.11.6 Compensation

There were no financial incentives given to participating students in the study. A voucher for the Hexagon Coffee Shop worth R35 was issued to each participant as a way of compensating them for their time and effort given in participating. To avoid this voucher being a form of inducement, they were not informed about it before recruitment, and the voucher was only issued once they had participated.

Having provided an account of how this study followed several ethical considerations, drawing on the work of Emanuel et al. (2004), Wassenaar (2006), and Wassenaar and Mamotte (2012), the next section discusses how the data arising from the interviews I had with the 20 participants were processed and analysed to identify useful information that answered the research questions of the study (see Chapter Two, section 2.5 Research questions).

4.12 Data processing

Gale (2010) defined data transcription as a process by which an audio-recorded file is put into written form. For Parker (1992), turning the 'text' into a written form is not only a preliminary step to doing discourse analysis but also a significant and necessary step of analysis and practice that helps in the development of a critical and non-judgmental attitude in a social constructionist qualitative study (such as this study of HIV risk and HIV testing). Gale (2010), Parker (1992), and Silverman (2005) recommended doing verbatim transcription of the audio-recorded data to ensure that everything to be analysed by the researcher is textual. In this study, all the 20 audio recorded files were transcribed verbatim, as heard, and not edited or corrected for grammar. These were done in order to retain an accurate representation of the social interactions that took place in the interview sessions.

The verbatim transcription process was guided by the notations of the Jefferson (2004) system of transcriptions (see Appendix 10 for Simplified Jeffersonian Transcription Conventions). These notations are aligned with critical discourse analysis informed by postmodern and post-structural Foucauldian thinking. This was the method of analysis employed in this study. Gale (2010), Seale and Silverman (1997) and Silverman (2005) contended that verbatim transcripts based on standardised conventions provide an excellent record of naturally occurring interactions, and provide detailed information related to the conversation being transcribed, such as length of pauses, emphasis, the loudness of speech, intonation and overlapping talk. By using Jefferson's (2004) notations in this study, I was able to provide detailed information of my interactions with the participants in my data transcripts. All these helped me identify how HIV risk was co-constructed in the session, which has implications for initiating, negotiating and maintaining health practices like HIV testing.

Gale (2010) further argued that a new aspect of what was said, and how it was said are often noticed through listening to the audio recordings multiple times. Inspired by this argument, following each transcription, I ensured the accuracy of my data transcripts by repeatedly listening to the audio recordings to hear “each word, rhythm, and emphasis, pauses, interruptions, overlap, repetitions, and breath intakes/exhales” (Gale, 2010, p.17) as I compared them with the transcripts. While doing all of these checks and reading my transcripts multiple times, I was able to fully immerse myself in, and engage actively with all segments of the data corpus, and I noted down my thoughts about the data. After that, I numbered each line of the transcript to ease the analysis process so that I could refer to specific parts of the transcribed data when analysis commences. I then printed all the transcripts, jotted down my initial impressions, and commented about my understanding of participants’ constructions and positioning and resonating discourses. This data processing technique, according to Parker (2002), is called free association.

4.12.1 Challenges encountered in transcribing the data

Although I had planned carefully in terms of the effort and time needed to transcribe my audio-recorded files, this process did not come easy. It was very strenuous, tedious and time-consuming. It took me up to six or more hours to put 30 minutes of my interactions with participants into written form. Having to listen to my voice repeatedly while transcribing the data was also very monotonous. Despite these challenges, I was able to transcribe the data into a text form which captured the richness of my interview interactions with the participants. Transcribing the data on my own also helped me familiarise myself with the data, and I could jot down emerging issues. It also enhanced my awareness of the data, a considerate advantage for this discursive study.

Another challenge I encountered during the transcription process was that some participants used slang, such as ‘check for HIV’, ‘that thing’, ‘look for HIV’, and others used metaphors in their local language, such as ‘*unyathele icable’, ‘ukucheka, ukuhlola igazi.*’ I often wondered how to translate their statements without losing their voice. Considering that I am not proficient in *IsiZulu,* I asked participants who made those statements to translate them. They said that ‘*unyathele icable*’ means to ‘step on a live wire’, and this phrase is used to describe a person who has contracted HIV. They said that ‘*ukucheka*’ means to check/test for HIV, while ‘*ukuhlola igazi’* means to test for HIV. Despite the language barrier, however, this had a minimal effect on my transcription process.

Having provided an account of how the data were processed and the challenges encountered, the next section discusses my approach to analysing the data.

4.13 Approach to data analysis

Gale (2010) defined discourse analysis as a well-demarcated, independent, and critical method of analysing patterns in naturally occurring instances of language-in-use to construct, and accomplish social interaction and subjectivities in any context. Gale (2010) further noted that this form of analysis has emerged in social psychology only reasonably recently as an alternative approach to analysis to those in the mainstream, such as traditional content analysis, semiotics, ethnomethodology, thematic analysis, and phenomenological analysis. Alldred and Burman (2005) argued that there are several approaches to discourse analysis depending on the field the researcher chooses to draw on. However, common to all many varieties of analysing discourse are three ideas:

> First, that language is structured so as to produce and constrain sets of meanings; second, that the social world can only be accessed and interpreted via language; and third, that this, therefore, means that it can only be studied via an approach that explores the work done by language. (Alldred & Burman, 2005, p. 178).

In this study, the analysis of critical discourse was taken as an appropriate tool to clearly and systematically illustrate youth constructions of health about HIV risk and implications for their HIV testing health practices. According to Stubbs (1997), critical discourse analysis is the analysis of public discourse to identify constructions, assumptions, and beliefs coded implicitly behind explicit propositions generated in social interactions. I considered critical discourse analysis as useful in my study in the sense that it helped me to undertake a close inspection and reading of the transcribed interviews with the 20 participants, which encompasses words, sentences, phrases, statements, metaphors, representations, and participants' stories on the subject of HIV risk and HIV testing. In this way, the benefits of critical discourse analysis match the assumptions of qualitative research design undergirding this study. According to Lincoln and Guba (1994), a qualitative research design involves the analysis of naturally occurring language used in structuring everyday realities in any social context. In this regard, one significant advantage of critical discourse analysis that was undertaken in this study is that, unlike thematic analysis that focuses on the identification of central themes and trends in a given textual data, or more general approaches to discourse analysis, a critical discourse analysis from Foucault's perspective goes beyond this to enable the researcher, like me, to undertake a close reading of the textual data arising from the study to decipher the deeper layers of language and voices (in the form of participants' opinions and propositions), representation, (claims to) knowledge, and their implied meanings embedded in the spoken text (transcripts).

In the process of doing critical discourse analysis in this study, I followed the seven guidelines/steps for identifying discourses at work proposed by Parker (1992, 2002), and partly supported by several discursive researchers (Alldred & Burman, 2005; Burr, 2003; Gale, 2010; Lupton, 1992; Stubbs, 1997; Terre Blanche et al., 2006). According to Parker (1992), these guidelines or "steps" are not necessarily linear or sequential but should be employed iteratively to identify discourses at work in the data. Similarly, in this study, the data collection and analysis occurred concurrently in an iterative cycle that uses comparative methods. Initially, six interviews were conducted with female students who responded to the advert. This was followed by recruiting new participants continually into the study until data saturation was achieved. In this way, the data collection and analysis processes ended once there were no more emergent discourses to build and support my analytical claims. Silverman (2011) argued that analysing data as they are collected, as I did in this study, has some advantages. Amongst these advantages are that it provides a basis for understanding the phenomenon under study, makes the process of analysis faster, allows documentation of emerging issues (discourses), and helps identify perspectives that would have otherwise been overlooked. All these were applicable to this study.

In the next sections, a brief sketch of Parker's (1992, 2002) guidelines and how they were used in this study are presented and discussed.

4.13.1 A discourse is a coherent system of statements that constructs an object

Drawing on the work of Foucault, Parker (1992) argues that discourses operate independently of the intentions of speakers (participants) or writers, as ideas or conceptual resources that cohere and not only reflect the social world but also serve to construct it. In taking this first step of doing discourse analysis as Parker (1992) stipulated, I took a Foucauldian stance and continuously inspected all the data fragments to check for points of coherence and incoherence, and contradiction and tension in how participants constructed HIV risk; how they constructed and positioned themselves and others in relation to it; how their constructions and positioning worked, and what they achieved by using them in this way, in relation to their own practice of HIV testing, in the sense of whether and how they engaged with it as a protective strategy. Tensions and contradictions within each participant's positioning were identified. They include the responsible health acting subject, but with gaps in protective practices (condom use and HIV testing); the invulnerable to HIV risk subject, but this positioning is a clear reflection of false bravado; the subject with more than one sexual partner and position other partners as responsible for creating their (subject's) risk of HIV while ignoring of their own multiple partnering; the concern for partner's risk and not for oneself subject; a young woman's versus a man's expectation in a dating relationship; the 'comfortable' and 'safe' HIV testing process versus the 'bad' and 'risky' HIV testing condition, to mention a few. According to Parker (1992), all forms of contradictions, like those identified in this study, express profound features of the culture and indicate the diversity of discourses at work in participants' accounts, rather than seeing this as the individual's logical inconsistency as the positivist approach assumes. Hence, the identified discourses were explored in terms of how they function in participants accounts.

4.13.2 A discourse is realised in texts

The second step in the discourse analysis of my interview data is anchored on the assumption proposed by Parker (1992) that the discourses people draw on when referring to a particular issue naturally exist in the text, and it is the onus of the researcher to identify and interpret them in order to make sense. In the context of this study, the texts analysed were all the data transcripts generated from the semi-structured interviews with 20 participants. The way I located discourses at work in the participants' constructions and positioning was not limited to the textual level to determine what is accomplished in interaction but included contextual and social dimensions of texts. In this second step, I analysed the transcripts bearing in mind seven questions proposed by Hall (1992). They included: what are the actions going on here? What activities are being carried out? What are the things that are happening here? What is the participant doing with their words/language? Why is this being said in this way? What effect does it have? What is the broader conversational context?

To locate themes that together make a discourse in my interview data, I applied an open coding approach suggested by Hsieh and Shannon (2005). Coding is creating labels that are useful for identifying participants' positions and the different discourses drawn on. In open coding, as used in this study, there are no pre-set codes, but they are developed and modified, being guided by the data (Hsieh & Shannon, 2005). Silverman (2011) argued that the data analysis process should retain participants' voices. In this step, I looked for a range of discursive techniques/rhetorical strategies which participants used to make their arguments about HIV risk, or to justify and rationalise their position, and used these to create codes. NVIVO 11, a qualitative analysis software programme used for data management and coding, was used to identify recurrent codes and extract segments of the data that contain some kind of interaction to support the stated codes. Similar codes were grouped and placed under a theme that fits them.

For example, much of the discussion in the interviews centred on the description of HIV as being ‘widespread’, ‘very high’, ‘very serious’, ‘odd amongst students’, and ‘a lot of people have it’. These descriptions were grouped and placed under the theme ‘constructions of HIV as a huge threat’, and under a discourse of seriousness of HIV risk. All the comments centred on HIV as something ‘you cannot see, or tell who has it’, ‘people are on the ARV’s, and you cannot know who has it’, ‘people who have it do not say that they have it’, for example, were grouped and placed under the theme ‘constructions of HIV a huge threat due to its invisibility’, and under a discourse HIV risk as being invisible. All the comments centred on students as engaging in ‘unsafe sexual activities, yet there are condoms’, and disregarding the threat of HIV in ‘campus parties’ were grouped and placed under the theme ‘constructions of HIV a huge threat due to people’s tendency to ignore it’, and under the framework of particular kinds of social activities and sex as being very risky. All the comments centred on HIV as ‘not as serious as it used to be’, ‘not a stigma anymore’, ‘people are educated about it’, ‘those who have it are protecting those who do not have it’, ‘people are have learned to live with it’, ‘people are adhering to the ARV’s’, ‘people can live with it for decades’, were grouped and placed under the theme ‘constructions of HIV as a minimal threat’, and under a discourse of information, education and communication health framework. All the discussions centred on HIV testing as something they engaged in because they saw a mobile testing tent on campus, or because they were required to do it at the antenatal clinic, or because they participated in the activation and health and wellness day at the University of KwaZulu-Natal, for example, were grouped and placed under the theme ‘experience of involvement in incidental HIV testing practices’, and under a discourse of avoidance of HIV testing.

If the identified themes and discourses became too broad, some of the codes and extracts were moved into an existing theme or discourse where they seemed to fit better. At this stage of my analysis, the identified themes and discourses informed the future data collection sessions (interviews) specifically in trying to identify new themes or assess whether the identified discourses had reached saturation. Throughout the analysis, I returned to my initial codes, themes and discourses and adjusted my descriptions and understanding to accommodate the newly identified data.

4.13.3 A discourse reflects its own way of speaking

The notion that a discourse reflects its own way of speaking is one of Parker's (2002) principal assumptions. Influenced by that assumption, I took the third step in the analysis of my data to see if I could highlight the distinguishing features of discourses at work in participants' constructions of, and positioning in relation to HIV risk, and how these relate to their practice of HIV testing. HIV risk has, for a long time, been constructed and theorised exclusively in sexual terms as the dangers of exposure to HIV infection through vaginal and anal intercourse (Maticka-Tyndale, 1992; UNAIDS, 2015). This means that behaviours such as having an HIV test, sexual abstinence, having correct and consistent condom use, and the practice of sexual monogamy, are discursive practices (practices arising from certain discursive representations) that together reproduce the behaviour change discourse. In doing the analysis, in this third step, I identified the discourses which are supported or resisted in participants' constructions and positioning, and described the discursive practices that are used to do so.

For example, some participants constructed HIV as being a threat to them and attributed this to their activities of unsafe sex, which appears to be drawing on a discourse of the at-risk subject. Other participants constructed HIV as being a threat to them and attributed this to other people's destructive behaviours, such as at risk of a violent rapist; an unknown male figure and a cheating partner, and non-sexual transmission routes such as blood contamination or health policies that treat HIV with ART, which renders its presence as HIV in everyday life invisible. This positioning appears to be drawing on a victim discourse. Other participants distanced themselves from it and justified this by positioning themselves as being sexually responsible subjects even though they did not report any protective practice in their sexual activities, or as sure of their HIV negative status, or as not engaging in high-risk practices such as alcohol abuse and sexual activity with people of unknown HIV status. These are discursive practices and appear to be drawing on two discourses, namely, a 'no, or low-risk' subject discourse, and a 'rational, reasonable and responsible' health subject discourse.

4.13.4 A discourse refers to other discourses

Under the fourth step in Parker's (2002) guideline for analysis, discourses are understood as intertwined. This means that you are to draw on other existing discourses when you are referring to a particular discourse. In analysing the interview data at this stage, I focused on identifying multiple discourses at work in a specific discourse or different ways of talking about HIV risk and implications for HIV testing health practice. In accomplishing this, I tried to answer three critical questions suggested by Parker (2002) as being salient at this stage, namely, what discourses are drawn on by participants to explain, rationalise, or justify their position; how and why they position themselves in these discourses; and what purpose this positioning serves for them. For example, some female participants drew on the sexually responsible health subject discourse to position themselves as being sensible and accountable for themselves, but positioned themselves again as not being able to control the sexual behaviours of their male partners. To justify their positioning in this regard, they drew on the assumptions of both the ‘have/hold’, and the ‘male sex drive’ discourse (Hollway, 1984) to discuss the differences in the expectations of men and women engaged in casual dating relationships. In the have/hold discourse, women are positioned as submissive, and keeping a man is expressed as expecting, and wanting love, and maintaining a relationship (Hollway, 1984). Hollway (1984) argues that for women, sex draws its meaning and significance from this have/hold discourse. In the male sex drive discourse, men are constructed as wanting their physical needs for gratification met. Hollway (1984) asserts that for women, keeping a man means continuing to be attractive to him (e.g. by ensuring that his physical aspects of sex (satisfaction, release) are met). By drawing on the assumptions of these two discourses, these participants are also aligning themselves with them. Moreover, as Parker (1992) suggested, I considered whether there are alternative versions of the discourses identified in the text, and mapped out those.

4.13.5 A discourse is about objects

In Parker’s (1992) fifth step of doing discourse analysis, which I undertook at this stage in analysing my interview data, discourses are positioned as consisting of socially constructed objects. Parker (1992) noted that discourses do not merely describe the social world but also the mode through which the world of social ‘reality’ is created. To elaborate further, Parker (2002) identified two types of objectification: the reality to which a discourse refers, and the objectification of the discourse itself. The former deals with the objects brought into existence through the discourse, which is separate from the people who create them. The latter is a situation in which the talk in itself is identified and described as an object. The objects of discourse analysis in this study are HIV risk and HIV testing. Following Parker’s (1992) arguments that the researcher in this fifth step of analysing data should engage in the process of objectification, my analysis in the fifth stage involved identifying and describing phrases, terms, metaphors, representations, and statements through which the participants expressed or verbalised their constructions of HIV risk and HIV testing, and meanings and values implied. In doing this, I identified words that frequently co-occurred with, or related to the objects of this study (HIV risk and HIV testing) in my data transcripts. Examples of these objects include the HIV treatment drugs, which participants called 'ARV's, 'virus', 'thing', 'symptoms', 'death', 'window period', 'clinics', 'tents', 'condoms', 'HIV testing', 'risk', 'student', 'chronic', 'check', 'status', to mention a few. These objects may or may not exist separate from the discourses that constitute or hold them together. Hence identifying and examining the relations between them not only permitted extensive analytic processes but also said something about participants' knowledge of HIV risk and HIV testing health practice. Parker (1992) argued that the process of analysing discourses should focus on how objects of discourse analysis in the research were constructed, rather than the frequency with which they were raised. In line with this view, I concentrated on how the identified objects were broadly expressed and discussed by participants, followed by understanding the discourses at work in the text.

Parker (1992) further contended that discourses allow certain things to be said and limit other expressions depending on the amount of knowledge held by the subject. In line with this, I was aware that participants' constructions of HIV risk and HIV testing objects do not arise from the vacuum, but as a product of discourses (all interactions and conversations on HIV and AIDS going on around them). For example, they will be drawing on discourses in advertisements, the mass media, educational awareness programmes, health research, interactions with health care service providers and peers, and their experiences of health care on, and off campus.

4.13.6 A discourse contains subjects

The assumption that goes with Parker's (2002) sixth step of analysis adopted in this study is that a discourse contains a subject, where the term subject is taken to refer to a person who speaks, writes, hears or reads texts where discourses are at work. In this step of the analysis, I paid particular attention to interpretive repertoires used by participants to construct and position themselves and others as subjects in relation to HIV risk, what kinds of people were constructed, described and positioned in the text, what multiple subject positions they hold, what relationships reside between them, what functions these subjects served, and what power exists in the different subject positions identified. In conducting such an analysis, I considered what my participants can say from each position and how this might function to position them in a particular way in relation to the research problem.

For example, if a participant constructed HIV as being a problem for themselves, they might engage in discursive practices that support a subject position of 'the protective subject' or 'the health-abiding subject.' This subject positioning might be reflected in their construction of HIV testing as a protective practice or other self-protective strategies like condom use and sexual monogamy. If they avoid relating the problem of HIV to themselves and their specific practices, they might engage in discursive practices that support a subject position of a 'low risk subject', or an 'invulnerable to HIV risk subject'. This subject positioning might negatively affect their decision to go for HIV testing. Alternatively, they could construct HIV as a problem for others, partly due to the stereotypes about this disease. In some participants' accounts, the othering of the HIV risk generally intersected with social identities of gender and age (a young female subject), race (a black African subject), other students, and socioeconomic status (uneducated, rustic, traditional subject). In that way, a young woman, particularly in her first year of university education, a black African subject, and an uneducated, rural subject was constructed and positioned as not able to protect themselves from the threat of HIV, and as not engaging actively in HIV testing as a protective strategy. The rustic subject, in particular, was constructed as not having sufficient resources to support HIV testing practice. In analysing my data in this way, I was able to unpack sets of cultural meanings embedded in the text.

Parker (2002) further noted that contradictions and multiple subject positions and constructions are ordinary features of everyday life and not something marking out the irrational or pathological subject as the positivist approach might assume. To better understand these subject positions and how they are constructed, Parker (1992) urged researchers to identify ways in which speakers (or participants) in their studies create different identities, and to what end. In line with this, my analysis at this sixth step also took into consideration the participants' social identities of age, sex, race, nationality, level of university education, and whether they have tested for HIV or not. Some researchers argue that these positions and identities could shape and influence participants' understanding and reasoning in relation to the research problem (Burr, 1996; Gale, 2010; Silverman, 2013; Parker, 1992).

4.13.7 A discourse is located in a historical context

The assumption behind Parker's (2002) seventh step of analysing discourses, which I followed in this study, is that discourse is located in a historical context. According to Parker (2002), discourses shift and change over time, and so the processes of identifying and describing them should consider their socio-historical formation. In doing such analysis, according to Parker (2002), the discourses that were dominant in the past and those that are existing currently might emerge in the data. Based on this understanding, having identified the various constructions of HIV risk, positioning, and broader discourses at work, I then tried to establish their socio-cultural and historical meanings, signification, attributions and definitions, and how these were related to the context of this study's participants. For example, some participants compared the current state of the problem of HIV and AIDS with the early decades of this epidemic, 'in the eighties and early nineties'.

With the formulation of the discourses through following the discursive analytic 'guidelines/steps' highlighted above, the identified themes were synthesised, interpreted and are reported in the next chapter (Chapter Five) in line with the three research questions of the study (see Chapter Two, section 2.5 Research questions). On the other hand, the significance of the discourses drawn on by participants to construct, change, explain, elaborate on their understandings of HIV risk and positioning in relation to it, or simply defend their stance, and implications of these (discourses) for their HIV testing practices are presented in Chapter Six, which is the discussion of findings chapter.

The fact that analysing discourses is an active, subjective process of interpretation, as indicated in this section, has received a fair share of criticism about epistemology, including who is recognised as a 'knower'.

4.13.8 Limitations of discursive approaches

Some criticisms against the discursive approaches to research have been around for a long time, but most have been answered. A criticism often levelled against Foucault's approach to textual interpretations relates to the nature and quantity of the data for analysis. Stubbs (1997) argued that this approach is suitable for analysing a relatively small amount of selected data to exemplify its categories and cannot be applied to analyse a large body of texts; for example, when exploring the discourses that people draw on when the issue of interest requires millions of words running in texts. Stubbs (1997) further noted that observing repeated linguistic patterns positioning people in particular ways requires an extensive collection of texts. Although this study does not take on Stubbs' (1997) view, it acknowledges the argument as valid against discursive analysis. The analysis of a large body of texts in relation to participants' constructions of HIV is undoubtedly more reliable in identifying patterns and critical dimensions that shape and sustain human behaviour, particularly HIV testing. In response to such criticism, Lupton (1992, p.148) stated that:

> The extensive use of the actual textual material used in the analysis is vital, for it allows others to assess the researcher's interpretations and follow the reasoning process from data to conclusions. In discourse analysis the text is not a dependent variable, or an illustration of another point, but an example of the data itself.

In line with Lupton's argument, the data for this study were collected and analysed until redundancy was reached. Verbatim quotations from the transcripts were systematically selected to illustrate issues emerging across the data (see the next chapter, Chapter Five). The extracts are comprehensive enough to promote the visibility of participants' voices and demonstrate their constructions of, and positioning in relation to HIV risk, and how these relate to their practice of HIV testing, and the discourses drawn on. This gives me some confidence that the identified trend in participants' accounts may serve as exemplifiers of youth constructions of HIV risk and HIV testing practices in a similar context (Pietermaritzburg campus).

While discursive researchers take credit for the fact that "they inevitably bring into the practice of research political, conceptual and ethical resources that any technical approach cannot in itself specify or provide" (Alldred & Burman, 2005, p. 176), this is considered by positivist researchers as a limitation to the discursive approaches to research. A repeated criticism levelled at discursive approaches is that they provide little guidance in defining specific interpretive matters. Instead, the analysis is dependent on the analysts' own interpretations and political judgements, hence inviting the possibility of them finding what they are set out to look for or expect to find, whether absences or presences (Alldred & Burman, 2005; Stubb, 1997). In response to such criticism, Burr (1996, p.60) argued that:

> Given that there are numerous and conflicting discourses surrounding any 'object', we are left with no notion of 'truth' (i.e. the discourse that can be said to describe the object

> correctly, all the others being false). All we have is a variety of different discourses or perspectives, each apparently equally valid.

Here, Burr (1996) claimed that it is impossible to validate a discourse, construction or position as objective/truth/factual or as false when compared to ‘reality’, and insists on the discursive formations. Guided by these assumptions of discursive approaches to research, I was aware that could be multiple constructions of HIV risk and positioning from the participants’ perspective and discourses drawn on. My focus thus was not to validate my participants’ viewpoints, practices and actions as either real/correct or false/unauthentic because the discursive approach adopted in this study refuses to provide this. Instead, I analysed and established patterns in participants’ accounts and what they achieved by this in relation to their practice of HIV testing and justified my interpretations of the discourses identified.

Another criticism levelled at discursive analysis is the possibility of under-analysis by taking sides or over-analysis when conducting discourse analysis. To elaborate on this, Lupton (1992) noted that discursive analysis is constructed as too dependent on the researcher’s partial and subjective account of participants, and their own positioning in the talk at that particular point in time, rendering it unscientific. In response to such criticism, Lupton (1992, p.148) asserted that:

> The coherence of a set of analytic claims will stand itself as testimony to the effectiveness of the analysis, if both the broad pattern and micro aspects of a discourse have been explained thoroughly and with insight.

Alldred and Burman (2005) also take almost a similar position as Lupton (1992). Alldred and Burman (2005) argued that from the outset of doing discourse analysis, analysts should be cautious against either over-attributing political potential to structures of discursive approaches or, on the other hand, ignoring them. Given this understanding, I tried to analyse the data in the context in which they were produced and examined in the form and the way they were collected. I am confident that I did not over-report participants’ constructions and positioning or ignored things that did not fit into my ‘theory’. The interpretations and novel explanations I have given to understand my participants’ constructions, positioning and discourses at work in their accounts represent my discursive world (context) concerning the research problem. By doing this, I enhanced my ability to describe the data, and more thoroughly convince the readers of this work of the credibility of the resulting claims and conclusions.

In concluding this section, I can say that although critical discourse analysis from a constructionist perspective has its limitations, it is still the preferred analytical approach for this study. By adopting it, I was able to summarise the massive amounts of data and produced reasonably minimal data that answered all my research questions. However, given these limitations of the discursive analysis, reflexivity is suggested as a way forward to defend the analyst's position (Alldred & Burman, 2005; Gale, 2010; Lupton, 1992; Silverman, 2006; Stubbs, 1997). In the next section, I have discussed my own thoughts, feelings and assumptions about the data and the decisions I have taken on the process of analysis.

4.13.9 Reflexivity

Reflexivity is the most salient concern in discourse-analytic research like this one. Gale (2010) and Silverman (2006) defined reflexivity as the researcher's ability to identify and understand participants' meanings, situations, and events at the same time evaluating their own assumptions about the data, implicit meanings, unspoken practices, and how all these influences the research process. Like many different methods of inquiry, according to Alldred and Burman (2005), Gale (2010), Silverman (2006), Stubbs (1997), discursive analysis, like the type undertaken in this study, requires the researcher's participation through a talk-in-interaction (in the interview), in producing the transcription, conducting the analysis, interpreting the data and beyond this into how their interpretations are represented within research reports, like this thesis. This contrasts with the positivist explanation of data collection as a neutral and unbiased process of gathering pre-existing truths, facts or realities that are unmediated by the researcher's perceptions and unchanged by their practices of description and representation (Alldred & Burman, 2005). Alldred and Burman (2005) further argued that the direct involvement of the researcher in hearing, interpreting and representing participants' voices invites the possibility of finding what they are set out to look for or expect to find, whether absences or presences.

Inspired by the above positions that knowledge is perspectival, is reliant on the viewpoint and values of the researcher, like me, I reflected upon what conceptions of knowledge I bring as a researcher to the interview inquiry, the assumptions I make about this study, subjective processes that enter into my interpretative decisions about my representation of participants' constructions and positioning, and the kind of knowledge produced. Given that the problem of HIV risk and HIV testing amongst youth is a product of my own research interest to generate a report for academic purpose, as a researcher, I am the one who defined and delimited these research objects and identified and interpreted their cultural meanings, with all these being influenced by my own political (and academically situated) judgements. Hence, I was aware that my own preconceived notions of the study, experiences, thoughts, beliefs, and expectations about the participant characteristics and the research problem and how I ask participants questions might impact the interviews. I was also conscious that the way participants might respond to my questions might have been about who I was to them and how they were trying to present themselves to me in relation to the research problem (HIV risk and HIV testing). To overcome these, I tried to be as non-judgmental as possible in the way I approached the interviews and the way I used the data emerging from these interviews. The interview schedule (see Appendix 6 for an interview schedule) that was formulated to guide the study was flexible, not biased and did not ask questions in a way that led participants to answer in a particular manner. The interview schedule also facilitated the rapport essential for a focus on the sensitive issue of HIV risk and HIV testing amongst youth.

According to Gale (2010), any word, utterance, statement or interaction a researcher hears in doing the transcription can trigger their own emotional and storied significance based on past experiences, theories, convictions, and individual and cultural norms. Alldred and Burman (2005) argued that when the researcher transcribes the voice note, they use their own understanding of the meanings intended, and is thus already engaged in an interpretative process in the data production, before what is conventionally considered as the analysis stage. To facilitate and document a reflexive approach during the transcription process, I focussed on my visceral responses, thoughts and stories that arose and let them pass without being judgmental. I also paid much attention to the sounds and metaphors of the recordings and attempted to capture what each word meant to the participants in their context, rather than what it meant to me in my context. These strategies possibly helped to reduce the impact that my beliefs and assumptions could have had on my reporting of participants' views about HIV risk and their HIV testing practices.

Gale (2010) contended that one's biases would sum up the knowledge one has as a person, and as a group, and one becomes aware of them by talking about them. In line with this, I had frequent debriefing/supervision sessions with my supervisor. In those discussions, I highlighted emerging issues in the data and interpretations of the data. I also sent the data transcripts and my interpretations of the data to my supervisor. My supervisor's insightful comments helped me to draw attention to flaws in my proposed course of action, generate a broader range of discourses that I had not considered on my own, notice the particularities of my own perspectives and overall, extended my interpretations of the data.

Additionally, being a trained educational psychologist and having practised as an intern psychologist before helped me to remain critical, impartial, and objective in the way I looked at the research problem in relation to my participants. Thus, I am confident that my interpretations of how participants' constructions of, and positioning in relation to HIV risk, and how these relate to their practice of HIV testing, and the discourses drawn on, represent the social realities in which each participant was embedded.

Furthermore, my investment in this study was to ensure that proper methodological procedures were followed to intensify the richness of my findings. To achieve this, I used several strategies explored in the next section.

4.14 Enhancing the rigour of the data

The scientific validity of any study, this one inclusive, involves an ethical requirement proposed by Emanuel et al. (2004), and supported by Wassenaar (2006). Concurring with Emanuel et al. (2004) and Wassenaar (2006) in this regard, Babbie and Mouton (2010) argued that validating scientific rigour throughout a research, like this one, will allow conclusions of the study to be more trustworthy. However, as earlier indicated, the social constructionist framework, adopted in this study, does not claim to provide the traditional notions of objectivity, authentic understanding, or universal truth about the social issue (e.g., young people's constructions of HIV risk and HIV testing) studied. Knowing this to be the case, to enhance the quality of my research process, and the reliability of my findings, I adhered to the four strategies of enhancing rigour in qualitative research proposed by Guba and Lincoln (1989). These four strategies are credibility, dependability, transferability and confirmability. A brief clarification of what they mean and how each was ensured in this study is presented below.

4.14.1 Credibility

According to Babbie and Mouton (2010), credibility in research refers to the researcher's effort to ensure that the views, thoughts and experiences of the research subjects are accurately identified and described by them (researcher) without attempting to predict anything further. This study, being social constructionist research, my focus was to make claims that represent how my participants' constructions of HIV risk and positioning worked, and what they achieved by using them in this way in relation to their practice of HIV testing. To ensure this, I adopted qualitative methods embedded in the social constructionist approach in my processes of sampling, data collection and data analysis.

For example, the non-probability sampling techniques (convenience, purposive and snowballing) were used to recruit study participants from a more diverse background in terms of age, sex, race, nationality, and level of study. This diversity in the kind of people who responded to this study helped to intensify the richness of my findings and reduced the potential of having a biased sample. Shenton (2004) emphasised that the data from a diversity of participants is useful in conducting comparative analysis. By using a wide range of student participants, I identified tensions, contradictions, consistencies, and differences within each participant's account and compared these with that of other participants. Shenton (2004) further noted that if similar issues (discourses) are identified in a study, then the findings may have greater credibility in the eyes of the reader. For example, in this study, similar patterns in participants' positioning in relation to HIV risk as not responsible for their HIV risk but as 'victims' were identified. This positioning makes other people responsible for their HIV risk, which reduces their need to adapt or engage in HIV testing as a protective strategy. Such commonality is an indication of greater credibility recorded by this study.

Although a discursive qualitative research design and its methods were the most significant methodology for this study, this design has received a reasonable share of criticism from quantitative researchers regarding the validity and reliability of its findings. A repeated criticism is the problem of anecdotalism. Anecdotalism is a situation where readers are provided with brief, interesting and persuasive extracts as evidence of a particular claim (Silverman, 2005). To minimise potential bias in data selection, Lupton (1992) and Silverman (2005) suggest extensive use of direct extracts from the data transcripts to provide evidence of a particular discourse or contention. In Lupton's (1992) work, the text in discourse analysis is not a dependent variable or an exemplar of another argument but an example of the data itself. In this study, verbatim quotations from the transcripts were systematically selected to illustrate issues emerging across the data (see the next chapter, Chapter Five). The extracts are comprehensive enough to promote the visibility of participants' voices and demonstrate their constructions of, and positioning in relation to HIV risk, and how these relate to their practice of HIV testing and discourses drawn on. The interpretations and novel explanations I have given to understand my participants' constructions, positioning and discourses at work in their account represent my discursive world concerning the research problem. By doing this, I intensified my ability to describe the data, and more thoroughly convince the readers of this work of the credibility of the resulting claims and conclusions.

Another critique related to the credibility of qualitative research design is that the interpretations of data transcripts may be weakened when significant pauses and overlaps are not recorded (Silverman, 2005). To minimise this, all the data collection sessions were recorded using two audio recorders. These procedures helped to ensure the credibility of my findings as the recordings were always available to me as the researcher at any time. I could refer to them at any time to retrieve and gain proper access to the words or pauses of the participants. I also took responsibility to transcribe all the 20 audio recorded files verbatim, which gave me some confidence about the data. This might also provide the future readers of this work some assurance that all transcripts used were true to their original sources. In transcribing the data, I used notations drawn from the Jefferson (2004) System of Transcriptions (see Appendix 10 for simplified Jeffersonian Transcription Conventions). The notations in verbatim transcripts help to retain the tone and pace of participants' responses, and so their use in this study is expected to give future readers of this work some degree of contact with how the 20 youth on the Pietermaritzburg campus of the University of KwaZulu-Natal constructed HIV risk in relation to their practice of HIV testing in individual conversations.

Quantitative researchers also doubt the validity of the explanations provided by qualitative researchers. Commenting on this, Silverman (2005) noted that quantitative researchers tend to position qualitative researchers as not attempting to analyse less clear data. Critical discourse analysis that was adopted to identify participants' constructions, positioning and discourses around HIV risk and HIV testing helped to overcome this. In response to this criticism, Alldred and Burman (2005, p.188) argued that:

> Discursive approaches encourage analyses that connect the microlevel (including within the particular interview dynamic and local cultures of meaning), with the macrolevel of broader social conditions and meanings (including what could not have been said from the subject position of child interviewee).

In line with Alldred and Burman’s (2005) argument, the use of a critical discourse analysis approach in this study helped me to identify deviant cases and outliers in participants’ accounts, and I incorporated these into my analysis.

Seale and Silverman (1997) suggest the use of computer data analysis programmes to assist in analysing qualitative data, including deviant case analysis. The use of the NVIVO 11, a qualitative analysis software designed for this purpose, in this study, helped to ensure systematic investigation and analysis of representative instances of the data that captured relevant issues of the study, including deviant cases. Thus, this software helped to provide a solid complement to evidence-based qualitative research.

4.14.2 Dependability

Dependability refers to the extent to which the findings of the research are consistent if the study methodology was to be replicated (Babbie & Mouton, 2010; Guba & Lincoln, 1989). According to Shenton (2004), in-depth coverage of how the research was conducted allows the reader to assess the extent to which proper research practices have been followed, which impacts the trustworthiness of its findings. Based on the above arguments, all methodological procedures adopted in this study, for instance, the discursive qualitative study design and its methods, processes involved in sampling, sample characteristics, data collection methods, and data processing and data analysis methods, have been documented and explained in this chapter. In addition to this is a thick contextual description of the research setting, reasons for favouring one approach, theory or method when others could have been taken, and how the conclusions of the findings were reached. Consequently, it is expected that if others independently inspect the evidence of my recordings, the status of the accounts generated (interview transcripts) and analytic processes, and literature reviewed, they might draw similar conclusions as this study. I am also confident that if such research will be repeated using similar participant characteristics like those of this study, and in a similar context (the Pietermaritzburg campus) and applying similar methodologies and approaches as used in this study, similar findings might emerge.

Citing Lincoln and Guba (1984), Babbie and Mouton (2010) emphasised the close ties between credibility and dependability in research. They argued that there is no credibility without dependability, and it is presumed that the attention given to achieving both trustworthiness and saturation in this study served to promote its dependability.

4.14.3 Transferability

Transferability is the degree to which the findings of the study can be applied to similar participants in similar contexts (Babbie & Mouton, 2010; Guba & Lincoln, 1989). Shenton (2004) argued that it is impossible to demonstrate that the findings and conclusions of qualitative research apply to other situations and populations. Saunders et al. (2009, p.127) take a similar position, arguing that:

> Qualitative researchers are keen on gaining an understanding of people's behaviour and experience in a rich and complex setting that is specific for the particular group of people or setting that are being studied, and not in obtaining information which can be generalised to other larger groups.

With inspiration from the philosophical arguments depicted above, this study utilised qualitative exploratory research design to investigate the problem of HIV risk in-depth in a rich and complex setting (university) that is specific for a particular group of people (sexually active youth aged 18-24 years). Therefore, knowledge produced within this study is not automatically generalised, transferable to, nor commensurable with, knowledge within other larger groups. This research also did not aim to generate a theory or develop consensus amongst researchers regarding young people's constructions of HIV risk and implications for their HIV testing practice as in the case of grounded theory and consensual qualitative research, respectively. Instead, my focus was to give a comprehensive explanation and interpretation of how discourses work to enable sexually active youth on the Pietermaritzburg campus to construct HIV risk in relation to their HIV testing practices.

Lincoln and Guba (1994) argued for the selection of cases according to theoretical criteria as another way of enhancing the transferability of research findings. In line with this, the purposive sampling technique was used to identify and recruit student participants to ensure a measure of diversity, particularly in terms of age, sex, race, nationality, and the level of study. The less clear data were also considered for analysis. By doing this, I was able to move beyond specific cases of the research and make a broader generalisation of youth constructions of health about HIV risk and implications for their HIV testing health practice informed by the data. Seale and Silverman (1997) also argued that although each case may be unique, it is also an example within a broader group, and so the issue of transferability should not be immediately rejected. The discursive framework employed in this study also supports this position that human beings are social agents and their shared subjective experiences and understandings of the world become their social reality (Gergen, 1999). In this view, the repetitive issues, discourses and practices identified in this study may apply to youth in other South African universities. However, it is worth noting that before any transferences are made, the readers of this work should scrutinise the context in which this study was undertaken. They should carefully note the type of student participants, restrictions in the students contributing to the data, the number of people involved in the study, the data collection methods, and the number and length of the data collection sessions. This information has been provided in detail in the earlier part of this chapter.

The discursive approaches adopted in this study also emphasise the contextualisation of both the accounts participants give researchers and the accounts researchers give or make sense of these accounts (Alldred & Burman, 2005). Hence, while it is possible to transfer the findings of this study as applicable to the student participants, the extent to which they can be applied to other student population on the Pietermaritzburg campus is uncertain. This is because participants differ in their experience and understanding of social reality. To assess the extent to which this study's findings may be transferred, parallel projects employing similar methodologies are recommended in Chapter Seven, the conclusion chapter. Lincoln and Guba (1994) argued that understanding a phenomenon is gained gradually through several studies, rather than one major project conducted in isolation. This study, therefore, provides baseline information within which the findings of subsequent work could be compared.

4.14.4 Confirmability

Confirmability refers to the extent to which the outcome of the study reflects its aims and objectives, and not the biases of the researcher (Babbie & Mouton, 2010; Guba & Lincoln, 1989). The interview transcripts of this study were analysed in ways that contributed to answering the study's research questions and the overall discursive exploratory approach of the research. Patton (2015) commented on the difficulty of ensuring objectivity in qualitative studies as the researchers design the data collection tools and intrusion of their biases are inevitable. Alldred and Burman (2005) argued that analysing the transcribed data discursively is not about producing an accurate representation of the data, as assumed by the positivist approaches, but rather to represent social reality or, at least, reality as interpreted by the participant. To minimise the possibility of intrusion of my biases in handling the data, I followed the position advocated by Silverman (2011), who argued for the use of the principle of refutability. Here, I define the notion of refutability as referring to my ability to negate initial assumptions about the data from transcription to analysis in order to ensure that these processes are credible and rigorous. I have used the refutability principle throughout this thesis to negate my initial assumptions about the data. In addition to this is the use of reflective commentary (see section 4.13.9 Reflexivity) to self-critique and admit my own assumptions about the data and participants to maintain objectivity.

Moreover, several methodological issues have been acknowledged within this study as a whole, and in this chapter in particular. Typical examples are the seven steps of identifying discourses at work suggested by Parker (1992) and how they were used to identify discourses at work in participants' constructions and positioning, and how conclusions were gathered and processed during the study. All these descriptions are provided to guide the readers of this work to determine the trustworthiness of the interview knowledge produced in this study, and how far the discourses and issues emerging from it may be accepted. Again, the recruitment of a range of participants from different faculties on the Pietermaritzburg campus reduces the effect of my biases as the researcher, and this may also enhance the confirmability of my findings.

4.15 Synopsis of the chapter

This chapter has presented an overview of the research methodology used to explore youth constructions of HIV risk and implications for their health practice, specifically HIV testing, using a discursive analysis approach. In doing this, I have given a detailed description of how this study was conceptualised, the social constructionist research paradigm, a qualitative exploratory research design that was used, the research setting, and the research processes that were followed. I have examined critically, noted, and described how every research decision was made and my motivations for these decisions. The chapter also touched on ethical considerations that guided the recruitment of participants and data management. Convenience, purposive and snowball sampling methods were used to access 20 student participants from diverse backgrounds and registered on the Pietermaritzburg campus of the University of KwaZulu-Natal to intensify the richness of my findings. Special consideration was given to the sensitivity of the research topic when planning this study, and the ethics of participation were adhered to. A detailed description of the data processing methods and analytical steps on how discourses were identified and interpreted were also given. I also presented and discussed some criticisms levelled at discursive analysis, how some researchers have answered these, and how I tried to address these criticisms in my study. In addition to this is my reflections on the process of analysis. Here, I emphasised that while this study was on students' constructions of HIV risk in social interaction, my understanding of this issue also played a part. Hence, I acknowledged that I played a role in producing not only the analysis and interpretation of participants' accounts but also the text and described how I managed my assumptions about the study and the kind of knowledge produced. I concluded this chapter by discussing how the rigour of the study was enhanced by exploring the credibility, dependability, transferability, and confirmability aspects of the research. The use of these several strategies to ensure the trustworthiness of the data may convince the readers of this work of the resulting claims and conclusions.

In the next chapter, the findings of discourse analysis of this study's data transcripts are presented and analysed along the lines of the three research questions of this study.

CHAPTER FIVE: ANALYSIS OF FINDINGS

5.1 Introduction

In this chapter, the findings of this study are presented and analysed. The study was designed to investigate three questions: (1) How do sexually active university students draw on different discourses to construct HIV risk? What discourses do they draw on to construct HIV risk?; (2) How do sexually active university students construct and position themselves and others in relation to HIV risk? What rationalisations or justifications do they give for their position?; and (3) How do sexually active university students' constructions of, and positioning in relation to HIV risk, relate to their practice of HIV testing? The findings are presented along the lines of the above three questions. In presenting these findings, an effort has been made to organise them into themes that demonstrate the pattern of participants' responses to the research question addressed.

But before presenting these findings, it is worth noting how the extracts used to illustrate each theme are presented throughout the chapter. In all the extracts, participants' pseudonyms are used, and I have used my name (Betty) as the researcher in extracts where I am involved in the talk, for example, in asking questions, seeking clarity, or contributing to the discussion. The line numbers are included to show how they appear in the full data transcripts. Additional information is also given at the end of each excerpt in brackets to illustrate a participant's age in years; sex (M) for male or (F) for female; race (B) for black African, (I) for Indian or (C) for coloured; nationality (abbreviation of their country) for an international student or (SA) for South African citizen; the level of study (UG) for undergraduate or (PG) for postgraduate; and whether they have ever been tested for HIV or not. Following this approach, the findings in relation to the first research question will now be presented and analysed.

5.2 Research question one: How do sexually active university students draw on different discourses to construct HIV risk? What discourses do they draw on to construct HIV risk?

The findings in relation to this research question revealed that the students studied have a way of constructing HIV risk, which demonstrates that they are drawing on existing discourses in advertisements, the mass media, educational awareness programmes, health research, interactions with health care service providers and peers on, and off campus, and their experiences of health care on, and off campus. This is because, in most of the participants' (16) accounts, HIV is constructed as a huge risk, which reflects the messages contained in the above sources of knowledge on HIV available in their everyday life. Even the few participants (4) who constructed HIV as a minimal risk can still be seen as being influenced by their understanding of the messages in the above-mentioned sources of knowledge on HIV risk. The study’s findings under the first research question can be classified under two themes: Theme One and Theme Two. Theme One presents participants’ constructions of HIV as a huge risk, while Theme Two presents participants’ constructions of HIV as minimal risk. Details of participants’ constructions concerning these themes are presented below, beginning with Theme One.

5.2.1 Theme One: Constructions of HIV as a huge threat

The majority of participants (16) generated various justifications to substantiate their constructions of HIV risk in South Africa in general and on the Pietermaritzburg campus in particular. The reasons include: a high HIV prevalence in South Africa, the presence of high-risk sexual activities on campus, the presence of intensified HIV testing activities on campus, heightened awareness on campus, the invisibility of the threat, the silence surrounding it amongst students, and the tendency of the people to ignore this form of risk. Findings in relation to participants’ constructions of HIV as prevalent in South Africa will now be presented and analysed.

5.2.1.1 Constructions of HIV as prevalent in South Africa

Throughout the interviews, there were often references to HIV in South Africa as being a ‘very serious’, ‘quite big’, and ‘very widespread’, risk. Extracts from interviews with six participants are used to illustrate this sub-theme.

Extract 1 below is taken from a black South African female participant.

Extract 1

Betty: How serious do you think HIV is in South Africa?

Sane: HIV and AIDS is basically very widespread. It is very serious, it is a common issue. And uh (.2) I think it is one of the major problems that South Africa is facing, and it needs to be really addressed because it is really spreading out quickly. Many people have it out there.

Betty: So, are some people who are more at risk than other people in South Africa?

Sane: Uh (.2), definitely someone who has unprotected sex is more at risk than somebody who has protected sex. But I feel like every person has that equal chance of contracting it because none of us has an immunity against the virus. So, at any point, anyone can get it, whether you are black, white, coloured, or Indian, or man or woman, or young or old. But if you are going to have unprotected sex, you are more likely to contract HIV.

(22, F, A, SA, PG, Tested)

In her use of the emphasising phrases ‘very widespread’, ‘very serious’, ‘a common issue’ (line 5), ‘one of the major problems’ (line 6), and ‘really spreading out quickly’ (line 7), Sane constructs the risk of HIV in South Africa as omnipresent. With the use of the words ‘many people have it out there’ (line 7), she constructs HIV as prevalent. By using the word ‘people’ here, she constructs HIV as being other people’s problem, and by implication, not for herself. She ascribes the responsibility for addressing HIV as that of other people. She does this through her use of the words ‘it needs to be really addressed’ (lines 6-7). Furthermore, she constructs the risk of HIV as exclusively dependent on a person’s behaviour in the form of unsafe sexual practice rather than demographics of race, sex or age. She does this by using the words ‘definitely someone who has unprotected sex’ (line 9), and ‘at any point, anyone can get it, whether you are black, white, coloured, or Indian, or man or woman, or young or old’ (lines 11-12). In her use of the words ‘none of us has immunity against the virus’ (line 11), she positions herself as being vulnerable to HIV risk. This perspective contrasts with her earlier construction of others rather than herself as being vulnerable to HIV risk.

In Extract 2 below, taken from an Indian South African female participant, the seriousness of HIV was discussed acontextually.

<u>Extract 2</u>
5 Betty: How serious do you think HIV is in South Africa?
6 Sarah: I think it is very serious. It is actually a worldwide endemic [sic]. Um, I worked for a
7 research organisation, so we got stats from that it is mainly in KwaZulu-Natal province
8 specifically. I think we are one of the highest populations with the disease. So, I think it is very
9 serious. I know outside South Africa, I think India also has a very large population that has the
10 disease.

(24, F, I, SA, PG, Tested)

In her use of the words ‘worldwide endemic [sic]’ (line 6), Sarah constructs the problem of HIV in South Africa as prevalent. With the words ‘mainly in KwaZulu-Natal province’ (line 7), and ‘we are one of the highest populations with the disease’ (line 8), she positions the KwaZulu-Natal province as having a higher infection rate, and the pronoun ‘we’ here serves to position her as linked to this context. In her use of the words ‘India also has a very large population that has the disease’ (lines 9-10), she makes the situation comparable with another country, India (also a developing country). In doing this, she is perhaps reaffirming the above construction of HIV as being a global threat (line 6). She uses the words ‘I worked for a research organisation, so we got stats’ (lines 6-7) to position her claim as factual, as having authority (perhaps scientific and research authority). Yet again, in her use of the words ‘I think’ four times (lines 6, 8, 9), she positions herself as unsure, uncertain, as not really knowing the extent of the problem of HIV in South Africa.

Extract 3 below is taken from a coloured South African female participant.

Extract 3

5 Betty: So, tell me, how serious do you think HIV is in South Africa?
6 Carol: It is very serious and spreading because it is not only destroying lives, it is taking the
7 lives of youth at a young age, and it has become a serious epidemic in South Africa, and worst
8 we don't have like particularly in rural areas, there are no adequate facilities to see to people,
9 and people are not educated enough.
(20, F, C, SA, UG, Not tested)

In her use of the words 'very serious', 'spreading' (line 6), and 'serious epidemic' (line 7), Carol constructs the problem of HIV in South Africa as prevalent. Her use of the words 'destroying lives' (line 6), and 'it is taking the lives of youth at a young age' (line 7) positions HIV again as a dreadful and catastrophic condition and threatening youth. With the use of the words 'in rural areas, there are no adequate facilities to see to people' (line 8), and 'people are not educated enough' (line 9), she constructs HIV as a threat to rural people. With these words also, she positions the rural people as ignorant, as uninformed, and as not knowing enough to manage the risk of HIV for themselves, thereby vulnerable to it, and by implication, she is contrasting them with herself being an educated university student, and thereby invulnerable. With these words, Carol also positions rural people as victims of structural vulnerabilities in contrast to people in urban areas. This construction appears to be drawing on a distinction between the educated urban group versus the uneducated vulnerable rural group. This positioning thus draws not only on the education distinction, but also an issue of location.

Extract 4 below is taken from a coloured South African male participant.

Extract 4

10 Betty: Okay, and are there people who are more affected by HIV than other people.
11 Alfred: Yes, there are people infected.
12 Betty: So which group of people are you referring to then as at risk of HIV than others?
13 Alfred: Uh, I would say it is more black people, the South African black people are more
14 infected, maybe because they are the majority, but many have HIV. I looked at the stats of the
15 people who have HIV, jah it is very serious.
(21, M, C, SA, UG, Tested)

In his use of the words 'black people', 'South African black people' (line 13), 'many have HIV' (line 14), and 'very serious' (line 15), Alfred constructs the problem of HIV in South Africa as immense and almost overwhelming in terms of its prevalence in the black African population. To justify his position, he used the words 'maybe because they are the majority' (line 14), with the word 'maybe' here positioning him as being uncertain of the merit of his argument. He uses the words 'I looked at the stats' (line 14) to position his knowledge as based on scientific research (statistics) and, therefore, as credible, and so he can be justified in saying this, and that helps him to defend himself against accusations of being stereotypical. However, this stereotype of HIV as a risk of the black people is interesting because it contrasts with Sane's claim presented earlier (see Extract 1), where she constructed the risk of HIV as mainly associated with behaviour in the form of unsafe sex rather than demographics of race, sex or age. Overall, Alfred's construction and positioning work to show that for him, HIV is a problem in South Africa quite alright, but he distances himself and, perhaps by implication, his race (coloured) from it.

Extract 5 below is taken from a black international male student participant.

<u>Extract 5</u>

6 Betty: How serious do you think HIV is in South Africa?
7 Andrew: It is quite serious, as I have heard on the news.
8 Betty: What have you heard on the news?
9 Andrew: I have heard on the news that South Africa has the highest number of new infections
10 of HIV in Africa.
(24, M, B, KEN, PG, Tested)

In his use of the words 'quite serious' (line 7), and 'has the highest number of new infections of HIV in Africa' (lines 9-10), Andrew constructs HIV in South Africa as immense and almost overwhelming in terms of prevalence. He positions his knowledge as based on an authoritative source, 'the news', and, therefore, as credible. He does this by using the words 'I have heard on the news' (lines 7, 9).

Extract 6 below is taken from a black South African female participant.

<u>Extract 6</u>

14 Tumi: I think more people are infected in South Africa, looking at the people who are at the
15 clinics going to fetch the ARVs, jah, it is quite big and serious.
16 Betty: Which clinics are these?
17 Tumi: In most of the local clinics, they are being called in some other clinics like those who
18 are on ARVs this way, and I think they shouldn't do that uh, jah.
(19, F, A, SA, UG, Tested)

In her use of the words 'more people', 'looking at the people who are at the clinics going to fetch the ARVs', and 'quite big and serious' (lines 14-15), Tumi constructs the problem of HIV in South Africa as prevalent. Through her use of the words 'they are being called in some other clinics like those who are on ARVs this way', and 'I think they shouldn't do that' (lines 17-18), she constructs the process of receiving the HIV treatment in 'the local clinics' (line 17) as public and very exposing and herself as being critical of that exposure. However, she positions her knowledge as based on her experience of what she has seen happening in primary health care facilities, and therefore, as credible. She does this by using the words ‘looking at the people’ (line 14), and ‘they are being called’ (line 17).

The general pattern of participants’ constructions of HIV in South Africa as immense and almost overwhelming in terms of its prevalence seems to be drawing on a discourse of the seriousness of HIV infection. Again, participants’ positioning of their knowledge as being based on scientific research (statistics) or authoritative sources (news) seems to be drawing on a discourse of knowledgeable health subjects.

5.2.1.2 Constructions of HIV as prevalent on campus due to high-risk sexual activities

In the account of most participants (16), there were often references to HIV on the Pietermaritzburg campus as being a ‘very serious’, ‘so high’, and ‘very high’ risk. In their justifications, most participants focussed on the sexual activities of students on campus. However, their account also revealed that HIV does not equally threaten students on account of their sexual activities. Some participants (5) positioned young students, particularly women and other students on campus, as more vulnerable to HIV risk, rather than themselves. Extracts from interviews with six of the 16 participants are used to illustrate this sub-theme.

Extract 7 below is taken from a black South African female participant.

Extract 7

30 Betty: How serious do you think HIV risk is on the Pietermaritzburg campus?
31 Londi: Um (.1) I think it is serious because of how we engage ourselves in sexual activities.
32 Betty: For example, in ten students, how many would be possibly infected?
33 Londi: Uh, it is like six.
(24, F, A, SA, PG, Tested)

In her use of the words ‘serious’ (line 31), Londi constructs the problem of HIV on campus as significant. The emphasis she has given to HIV as being a threat to students is evident in her estimates of the scale of the problem amongst students as being at level six using a scale of one to ten people ‘it is like six’ (line 33). In doing this, she constructs the majority of students as being infected with HIV, with a prevalence of 6/10 infected students. To justify her construction in this regard, she uses the words ‘we engage ourselves in sexual activities’ (line 31), and in using the word ‘we’, she positions herself also as being involved in this practice of unsafe sex.

Extract 8 below is taken from a black international female student participant.

Extract 8

10 Betty: How serious do you think HIV risk is on the Pietermaritzburg campus?
11 Esther: Uh (.1), not sure, but I think HIV amongst students is so high and serious. We tend to
12 trust fellow students a lot, and we end up engaging in unsafe sexual activities, you see. You
13 find that people just date, and they don't even test. Actually, students don't test at all. That is
14 what is making HIV go up on campus because we engage in unsafe sexual activities, yet there
15 are condoms.
16 Betty: So, you said here on campus students do not test, so why is that the case?
17 Esther: The issue which is making us young adults not even think of HIV is this stereotype or
18 what do we call this, you know they normally say people who have got HIV are sick; they have
19 wounds in their bodies or dark marks or spots, and stuff like that. Other people lose weight all
20 of a sudden or (.4) have this running stomach all the time or diarrhoea. So, if you are staying
21 with the person or you have your boyfriend or partner, and you don't see this stuff; obviously,
22 you know that the person is healthy. I am not saying that is how I do, but I know most youths
23 do that; even my sister and friends use these signs to see a person who has HIV. Now, if you
24 don't have this stuff, so you relax because you are not having HIV, and nothing is going to
25 push you to go and test that is the main issue.
26 Betty: Can you estimate for me maybe in ten students how many would be infected?
27 Esther: Uh, um (.3) maybe or rather four students.
(23, F, A, UGA, UG, Tested)

Esther begins her response with the words 'not sure, but I think' (line 11) to position herself as unsure, uncertain, as not really knowing the extent of the problem of HIV on campus. She proceeds to give the account, which justifies why some youth do not consider HIV a risk and HIV testing as their protective practice. In her use of the words 'so high and serious' (line 11), she constructs HIV risk as prevalent on campus. The emphasis she has given to HIV as being prevalent on campus is also evident in her response to the question about the extent of HIV risk amongst students using a scale of one to ten people, and she uses the words 'Uh, um three maybe or rather four students' (line 27). Her use of the number four out of ten people here serves to construct HIV as being a proximal threat to students. To justify her position in this regard, she uses the words 'We tend to trust fellow students a lot' (lines 11-12), and 'we engage in unsafe sexual activities' (lines 12, 14) to position students as vulnerable to HIV risk on account of their activities of sex and believing that their peers are HIV free. With the use of the pronoun 'we' twice here, she positions HIV risk as being in her context and herself as being exposed to it. In her use of the words 'yet there are condoms' (lines 14-15), she positions students' unsafe sexual practices as unexpected, and implying that this should not be the case for students (including herself). Her use of the words 'people just date, and they don't even test', and 'Actually, students don't test at all' (line 13) positions students again as not engaging actively in HIV testing as a protective practice in their relationships, and in her use of the word 'just' here, she positions herself as dismissing this behaviour. However, in her use of the phrase 'That is what is making HIV go up' (lines 13-14), Esther links her construction of students as vulnerable to HIV risk and not engaging in HIV testing with the increase in HIV infections on campus.

In response to why students do not engage in HIV testing, Esther draws on a ‘stereotype’ (line 17) about the HIV sick body. She does this through her use of the phrases ‘wounds in their bodies or dark marks or spots’, ‘lose weight all of a sudden’, and ‘running stomach all the time or diarrhoea’ (lines 19-20), and with all of these words, she seems to be conflating HIV with AIDS. By making reference to the above symptoms of the sick AIDS body, Esther appears to be drawing on the dominant constructions of HIV as being a visible sickness, a body severely affected, wounded, degraded, and attacked, which renders its presence as HIV in the ‘everyday’ life as visible. With the use of the words ‘obviously, you know that person is healthy’ (lines 21-22), she positions herself as being certain that your relationship is safe if your partner does not exhibit the above symptoms of the sick AIDS body. In her use of the words ‘even my sister and friends use these signs’ (line 23), Esther positions youth who are close to her as believing that only people with obvious, distinct and dreadful symptoms are HIV positive. She goes on to give a disclaimer, ‘I am not saying that is how I do’ (line 22) to position herself as outside of this group of youth who use those terrible symptoms to make judgments of their partners’ HIV status. Although the two phrases ‘us young adults’ (line 17) links her to the position she says is that of her ‘sister and friends’, the fact that she is not talking directly about ‘me’ or ‘I’, by implication, positions her as disassociating herself from them. Again, the pronoun ‘you’ used severally in her account (lines 12, 18, 20, 21, 22, 24, 25) is ambiguous because it could be her identification with the problem of HIV, despite saying that she does not. If she really did not, then why does she not use definite othered pronouns like ‘they relax’, ‘they do not have HIV’, ‘they are not pushed to do a test’, or ‘they are staying with their partners’. Perhaps, this could be a case of someone positioning herself to me as the researcher as the ‘proper’, ‘good’ health subject who knows about HIV testing and attends to it and is responsible for all the HIV risk and health messaging.

Extract 9 below is taken from a black South African female participant.

<u>Extract 9</u>

31 Betty: How serious do you think HIV risk is on the Pietermaritzburg campus?
32 Zama: Um, I feel like it is actually very high. It is just that we don’t know because, um, I have
33 a friend that I live with, and they have this other organisation, and then they were distributing
34 condoms and then she was like the number of used condoms that she saw outside the residence
35 was too much, and so I am like, okay, you can use the condoms for the first rounds, but then
36 what if the guy ((man)) is like I am running out of condoms, and can we, please, have sex

37 without using a condom? Most girls would actually agree, so I feel like the fact that there is a
38 lot of sexual intercourse that is actually happening, it leads to so many things like HIV.
39 Betty: Tell me, Zama, why do you think a woman would easily agree to sex without a condom?
40 Zama: Um, to make the guy happy or actually you also want the thing ((unprotected sex)) and
41 you don't want to disappoint the two of you guys. You just feel like maybe this is the right time
42 to do it. I mean, this guy has been with me for the longest time, so I owe it to him too.
(20, F, A, SA, UG, Not tested)

In her use of the words 'very high' (line 32), Zama constructs HIV as an immense risk on campus. With the use of the words 'she said the number of used condoms that she saw outside the residence was too much' (lines 34-35), she positions students as sexually active and their sexual activities as occurring on campus. She positions her knowledge about the state of things on campus as from an anecdotal source, 'friend' (line 34), and did some discursive work to position her claim as still reliable. She does this by using the words 'they have this other organisation, and then they were distributing condoms' (lines 33-34). In doing this, Zama positions her claim as from a trustworthy source and her friend's organisation as serious about the problem of HIV on campus. She also constructs this proliferation in sexual affairs on campus as increasing students' risk of HIV. She does this by using the words 'the fact that there is a lot of sexual intercourse', and 'it leads to so many things like HIV' (lines 37-38). She also highlights the complexity of the sexual decisions students are called to make under highly emotional conditions. She does this by using the words 'what if the guy ((man)) is like I am running out of condoms, and [says] can we, please, have sex without using a condom? Most girls would actually agree' (lines 36-37). In doing this, Zama positions female students as being submissive and vulnerable to HIV risk. In response to why a woman would swiftly agree to sex without a condom, she constructs unprotected sex in the context of heterosexual relationships as being used by young women for various reasons. Firstly, in her use of the words 'to make the guy happy' (line 40), she constructs it as being used as a means of pleasing the boyfriend. Secondly, in her use of the words 'this guy has been with me for the longest time, so I owe it to him too' (line 42), she constructs it as being used as a reward to the boyfriend for his commitment to maintaining the relationship for an extended period. Thirdly, with the use of the words 'you also want the thing ((unprotected sex))' (line 40), she constructs it as a mutual desire for both partners in a sexual relationship. Fourthly, she highlights the extent of pressure that a woman faces to ensure satisfactory intimacy and sexual pleasure in their relationship. She does this by using the words 'you don't want to disappoint the two of you guys' (line 41).

Extract 10 below, taken from a black international female student participant, presents a similar construction of HIV as prevalent on campus on account of students' sexual activities. However, in this account, the focus is on young female students as victims of manipulative traps made by older, wealthier men.

Extract 10

13 Betty: How serious do you think HIV risk is on the Pietermaritzburg campus?
14 Leah: It's really high, jah, high. Uh, I have seen that on Fridays, there by the gate ((university
15 entrance)) there are these older guys who are after young ladies, uh, they can get lured. Most
16 of these older men are probably HIV infected, and therefore you expect them ((young ladies))
17 to be highly affected too because they don't have ability to ask these older men to use a condom.
18 Betty: So, are you saying that it is only young girls affected?
19 Leah: No, mostly. I am not negating others it is just these young ladies and even normal
20 students, uh male, because they are probably dating these younger girls. It is high in that way.
21 Betty: On a scale of one to ten students, how many can you say could be infected?
22 Leah: Yes, there will be around four or five.

(23, F, A, TAN, PG, Tested)

In her use of the words 'It's really high, jah, high' (line 14), Leah constructs the problem of HIV on campus as prevalent. The emphasis she has given to HIV as being a proximal threat to students is evident in her estimates of the scale of the problem amongst students, which she says is 'around four or five' (line 22) out of ten. In her justification, she uses the words 'there are these older guys who are after young ladies', 'they can get lured' (line 15), 'Most of these older men are probably HIV infected' (lines 15-16), 'you expect them ((young ladies)) to be highly affected too' (lines 16-17), and 'they don't have ability to ask these older men to use a condom' (line 17), to position older men who are not students as being responsible for creating young female subjects 'risk of HIV infection'. These words also position the young female subject in such a relationship as lacking the power to negotiate sexual health, and by implication, position such a woman as not responsible for her risks. In her use of the words 'have seen that on Fridays there by the gate ((university entrance))' (lines 14-15), Leah positions her knowledge of a young female subject's sexual behaviour as based on her experience of what she has seen taking place on campus, and therefore, as credible. In response to whether young women are the only group faced with the threat of HIV on campus, she uses the words 'No, mostly. I am not negating others it is just young ladies' (line 19), and 'even normal students, uh male' (lines 19-20). With these words, she maintains her construction of HIV as being a threat to a young female subject, and in her construction in this regard, if there is any need to add another subject, then she concedes that 'even' a man is equally vulnerable to HIV risk. In her use of the words 'because they are probably dating these younger girls' (line

20), she positions a young woman on campus as being responsible for creating a male subject's risk of HIV, and positions the young male student as a victim, as not liable or at fault. In her use of the words 'It is high in that way' (line 20), she is almost blaming young female students for the high HIV infections on campus. Overall, Leah's construction and positioning of a young female subject work to position herself as critical of their sexual behaviour, and she is perhaps contrasting this with herself as not 'like them' as an old student (24 years of age) and at a postgraduate level of university education. By implication, she positions herself as an invulnerable to HIV risk subject.

These constructions of HIV as prevalent on campus on account of young female students' risky sexual practices is also evident in Extract 11 below, taken from a black South African female participant.

<u>Extract 11</u>

23 Betty: How do you think, uh, the HIV risk is on this campus?
24 Bongi: I would say that so many students are gullible, especially the first-year girls. Varsity is
25 a different place as to what they are used to. Girls are used to going to school, coming back
26 home, being protected by their parents and whatnot. And then, when you come to varsity it is
27 like you are given that freedom to now make your choices. You are living away from home so
28 you don't have your parents' protection. And sometimes you would find that guys ((men))
29 would tell you they love you and now you think, okay fine; now I can do whatever, I can go to
30 my boyfriend's place. Nobody can see me. Then you find people sleepover at their boyfriend's
31 houses or their boyfriends goes to their house, and obviously, they gonna have sex. Alcohol
32 consumption amongst students is very high. It is part of life here, you know. If they were not
33 drinking in their high school stage, they are definitely going to start drinking in the varsity
34 stage. With alcohol consumption, then I guess, uh, your guts get let down you know, you stop
35 focusing on, okay, I have to protect myself and whatnot, and you just do anything you want to
36 with alcohol people get like they call it loose in a way, which means that a person could do
37 whatever without thinking about the questions or whatever comes after. You are just living in
38 the moment, and guys will take advantage of you.

(24, F, A, SA, UG, Tested)

Bongi positions 'many students', 'especially the first-year girls', as 'gullible' (line 24), as at the mercy of something or someone else, and as easily persuaded, perhaps naïve and unprepared. She then engaged in a lot of discursive work to demonstrate how the young female subject is vulnerable to HIV risk. In doing this, she constructed two contrasting contexts in relation to young female students' risk of HIV. Firstly, the safe haven of the home under benign parental oversight, as seen in her phrase 'being protected by the parents' (line 26), and secondly, the university context, which is a place and space of unique experiences and independence, as seen in her statement 'you are given that freedom to now make your choices' (line 27). Bongi also constructs the university context as unsafe. She does this by using the words ‘You are living away from home so you don’t have your parents’ protection’ (lines 27-28). However, she also positioned the young female subject as ignorant and unprepared to deal with the unsafe university. She does this by using the words ‘guys ((men)) would tell you they love you’ (lines 28-29), and ‘you find people sleepover at their boyfriend’s houses or their boyfriends goes to their house, and obviously, they gonna have sex’ (lines 30-31). With these words, she positions the young female subject as not in control, as sexually inexperienced, and ignorant of the demands and expectations of sexual relationships in the campus context. The other danger in the context of the university is being influenced by alcohol, and with the words ‘It is part of life here’ (line 32), she constructs this behaviour as being normalised within the university. Again, she uses the words ‘With alcohol consumption, … your guts get let down, you stop focusing, …. (lines 34-35), and ‘guys will take advantage of you’ (line 38) to construct a rather desperate image of a young female subject unable to think for herself, unable to know and understand the dangers of her actions, and as being preyed on by male students. In her use of the words, ‘you just do anything you want to’ (lines 34-35), Bongi constructs an active role for a woman, empowered to do what she wants – this may imply some level of judgement about women who drink and who may lower their inhibitions. She seems to be implying that women who are living in the moment cannot make rational decisions because men will ‘take advantage’ of them– but again, the words ‘take advantage’ implies that Bongi is laying some blame on the women – that is if they did not drink, they would not be taken advantage of by men.

All these categories of other youth Bongi created and positioned as being at risk of HIV (the young new student and the student who drink) are being contrasted with herself, an older student (24 years of age), even though she is at the undergraduate level of university education. By implication, she positions herself as an invulnerable to HIV risk subject.

Although Bongi’s construction and positioning of the young new student is understandable and relevant, it is very generalising. It positions all the first-year female students as experiencing the same dangers in the context of the university and as responding in the same way in their management of the enormous freedom at their disposal. Perhaps her construction is based on her own experience when she was a first-year student.

The constructions of HIV as prevalent on campus on account of young female students’ risky sexual practices reflected in extracts 9, 10 and 11 is also evident in Extract 12 below, taken from a black South African male participant. In his justification for a young female subject’s vulnerability to HIV risk on campus, he referred to how the concept of love in intimate relationships can produce a situation in which HIV risk can be ignored.

<u>Extract 12</u>

19 Betty: On our campus, then, are there some students who are at risk of HIV?
20 Zazi: Yes, there are students who are at risk, especially those who are younger and not
21 experienced. If, for example, we just started dating and they are younger than me, let us take,
22 for example, the first-year students when they get here ((campus)) they are confused and think
23 that maybe I am the one they will get married to. So, automatically if we are having sexual
24 intercourse, they can't tell me anything or to use a condom, but whatever I want to do is what
25 happens, so if I am infected, then I will infect her as well. Most guys ((men)) don't like
26 protection, so guys might infect girls with HIV.
27 Betty: What do you think makes these young women not say that we need to use a condom?
28 Zazi: There is this thing you do believe in love. For example, if you love someone, you think
29 that they are loyal to you, they will only be sleeping with you. Also, as men, we can try to have
30 another girlfriend as well; or in some cases, people just enjoy unprotected and actually, a lot of
31 people enjoy unprotected sex even if they do not know the other person's HIV status, even if
32 it is the first day they are meeting that person they won't mind.
(22, M, A, SA, UG, Tested)

Zazi uses the words 'yes, … especially those who are younger and not experienced' (lines 20-21) to position a young new university student as ignorant and unprepared to deal with campus life. He then engaged in a lot of discursive work to demonstrate how the young female subject is vulnerable to HIV risk. By demonstrating how a male student like him has power over a woman who is 'younger' (line 21) than he is, and he references 'the first-year students' (line 22). His justifications can be seen in his use of the words 'they are confused' (line 22), 'think that maybe I am the one they will get married to' (lines 22-23), 'if we are having sexual intercourse, they can't tell me anything or to use a condom' (lines 23-24), 'whatever I want to do is what happens' (lines 24-25), and 'if I am infected, then I will infect her as well' (line 25). Taken together, these words position a first-year female subject as not in control, as powerless, as sexually inexperienced, as unaware of the dangers of her action, as ignorant of the demands and expectations of sexual relationship, as far less able to exercise agency over HIV risk, and as easily taken advantage of by an older male student subject. This positions the male subject as being responsible for creating the risk of HIV for the young female subject.

In response to the question of why young women do not initiate and demand condom use, Zazi uses the words 'there is this thing you do believe in love' (line 28), 'you think that they are loyal to you' (lines 28-29), and 'as men, we can try to have another girlfriend as well' (lines 29-30) to position a young female subject as to be blamed for assuming that male the partner is faithful and ignoring her own safety, and by implication, as responsible for their own risks of HIV. Interestingly, in his use of the words 'a lot of people enjoy unprotected sex even if they do not know the other person's HIV status' (lines 30-31), he seems to be blaming both men and women rather than just the women in this regard as highlighted in the previous point. He constructs people ignoring the threat of HIV in their sexual escapades. In doing this, what Zazi appears to be implying here is that people tend to privilege unprotected sexual pleasure (a particular kind of sex) above HIV prevention. While his use of the words 'people' (line 30), 'a lot of people' (lines 30-31), and 'they' (line 32) direct the focus away from himself, he seems to be using this as a justification for what he does, as seen in his statements, 'they can't tell me anything or to use a condom' (line 24), and 'as men, we can try to' (line 29). Overall, what is interesting to note in Zazi's account is that it corroborates the view posited by Bongi in Extract 11 on the inability, or lack of agency, of the new young female student in making sexual health decisions in the context of a relationship with a man who is older than her. The same perspective of a male subject tending to take undue advantage of a young female subject on campus and exposing her to the risk of HIV is brought out in both extracts in bold relief. However, a lesson to be learned from Zazi's construction and positioning is that the decision to engage in HIV risk management through condom use depends on a man, and so if he does not want it to be used, it will not be used.

The participants' constructions of HIV as an immense risk on the Pietermaritzburg campus seem to be drawing on two significant discourses. Firstly, constructions of university students as being sexually active and their practice as unsafe, thereby setting up the risk of HIV, seem to draw on a discourse of youth as the main group at risk of HIV infection. They seem to position themselves in this discourse, as seen in their constant use of the shared pronoun 'we'. Secondly, constructions of a first-year female subject as one who is inexperienced, ignorant of the demands and expectations of a sexual relationship, easily taken advantage of by an older man, naïve, and unprepared to deal with campus life, seems to be drawing on a discourse of ignorant and naive health subject. They seem to position themselves against this discourse, as seen in their constant use of the word 'they'.

5.2.1.3 Constructions of HIV as a huge threat due to intensified testing activities on campus

This construction of HIV as a massive threat on account of intensified HIV testing activities on campus was identified in the accounts of six participants. Extracts from interviews with four of the six participants are used to illustrate this sub-theme.

Extract 13 below is taken from a black South African male participant.

<u>Extract 13</u>

37 Betty: How serious do you think HIV risk is on the Pietermaritzburg campus?
38 Zazi: Uh, it is a serious issue because, in most cases, I normally see tents where people go and
39 test, and a lot of people are participating in testing. So, I think it is treated as a serious matter
40 it not being ignored. So, the more people test, the more people know their status, and that is
41 how serious it is.
42 Betty: So, are you saying that students on campus seem to test for HIV?
43 Zazi: Yes, a lot from what I have seen in those tents, many are visiting to go get tested.
(22, M, A, SA, UG, Tested)

In his use of the words 'serious issue' (line 38), Zazi constructs HIV as a considerable risk on campus. His use of the words 'a lot of people are participating in testing' (line 39) positions students as engaging actively in HIV testing. This positioning clearly contrasts with the account of two female participants (Esther and Sane) who constructed students as not engaging in HIV testing (see Extract 8 and Extract 27, respectively). He also constructs HIV as being treated as 'a serious matter' (line 39), as 'not being ignored' (line 40) by someone, perhaps someone with the authority to set up an HIV testing tent on campus. With the use of the words 'the more people test, the more people know their status, and that is how serious it is' (lines 40-41), he positions himself as someone who is aware of the scale problem of HIV on campus and knows that HIV testing is the appropriate health-related behaviour to manage it. Furthermore, he positioned his knowledge about the state of the problem of HIV on campus as based on his experience of what he has seen happening in mobile testing tents on campus, and therefore, as credible. He does this by using the words 'from what I have seen' (line 43).

Extract 14 below is taken from a black South African female participant.

Extract 14
25 Betty: How serious do you think HIV risk is on the Pietermaritzburg campus?
26 Tumi: I think it is serious because, uh, sometimes we see people from other organisations
27 coming to our campus and put tents for students to get tested, they do regular tests during the
28 year.
(19, F, A, SA, UG, Tested)

Extract 15 below is taken from a coloured South African female participant.

Extract 15
21 Betty: How serious do you think HIV risk is on the Pietermaritzburg campus?
22 Carol: I feel like it is a serious situation because I see a lot of marquees at school ((university))
23 where they do HIV testing and constantly campaigning for HIV testing.
(20, F, C, SA, UG, Not tested)

Extract 16 below is taken from a black male international student participant.

Extract 16
14 Betty: How serious do you think HIV risk is on the Pietermaritzburg campus?

15 Andrew: … according to how I see the initiatives taken by the school ((university)), like, um,
16 they usually have some tents and something like that so I would say it is quite serious because
17 they cannot take their time to come and test students in the school if HIV is not a problem.
(24, M, B, KEN, PG, Tested)

The general theme in all the above extracts is that HIV is a huge threat to students. The above three participants (Tumi, Carol and Andrew) rationalised their construction by positioning HIV risk as something that someone has identified (as serious) and putting up ‘tents’ (Extract 14 line 27; Extract 16 line 16), ‘lot of marquees’ (Extract 15 line 22), and ‘constantly campaigning’ (Extract 15 line 23) on campus urging students to ‘do regular tests’ (Extract 14 line 27). All these participants position their knowledge about the state of the problem of HIV on campus as based on their experience of what they have has seen happening in mobile testing tents on campus, and therefore, as factual. This can be seen in their use of the word ‘see’ (Extract 14 line 26; Extract 15 line 22; Extract 16 line 15).

The general pattern in the participants’ constructions of HIV as a huge risk on the Pietermaritzburg campus on account of intensified HIV testing activities on campus seems to be drawing on two major discourses. Firstly, a prevailing health messaging (campaign) discourse, which constructs HIV as a risk and HIV testing as the appropriate health practice in response to it. Secondly, participants’ narration of their close contact with the HIV testing activities in their context seems to be drawing on a discourse of experience and health care.

5.2.1.4 Constructions of HIV as a huge threat due to heightened awareness on campus

Extract 17 and Extract 18 below, taken from two Indian South African female participants, illustrate this sub-theme. The extracts are worth highlighting as the issue reflected in them was identified in the accounts of two participants in the study.

Extract 17
11 Betty: And how serious do you think HIV is on this campus?
12 Liz: I think it is quite serious because there is a lot of awareness brought towards HIV like even
13 within a lot of courses. HIV is something that is being taught all the time.
(23, F, I, SA, UG, Tested)

In her use of the words ‘quite serious’ (line 12), Liz constructs HIV as a considerable risk. In lines 12-13, she justifies this by referring to the increasing ‘awareness’ on HIV, to the extent that it is ‘even’ entrenched in the University’s curriculum. In doing this, she positions herself as being aware of the scale of the problem of HIV on campus.

Extract 18
10 Betty: How serious do you think HIV is on this campus?

11 Nicole: It is very serious, I am doing anthropology, and we just did a whole section on HIV
12 and AIDS in South Africa, and black woman experiences it more than men, and I think that is
13 the sad part because black women feel like they have to offer men something that they deserve,
14 that men deserve their bodies. So, I feel like women like that aren't educated enough about
15 their sexual rights, and that is what makes it so serious because we have students from rural
16 areas, and they don't know much about it.

(19, F, I, SA, UG, Not tested)

In her use of the words 'very serious,' (line 11), Nicole constructs HIV as a huge threat on campus. To justify her construction in this regard, she uses the words 'I am doing anthropology, and we just did a whole section on HIV and AIDS in South Africa' (lines 11-12) to position her knowledge as credible and based on the content of an academic module at the university. In her use of the words 'black woman experiences it more than men' (line 12), she positions a black female subject as more vulnerable and threatened by HIV, and by implication, herself as not like them (she is an Indian, and they are black). She expands on, and reaffirms this positioning by using the words 'black women feel like they have to offer men something that they deserve' (line 13), and 'men deserve their bodies' (line 14) to position a black female subject again as being responsible for making their bodies available to be used by a man, and as objectifying themselves, and she seems to be blaming them for this. Yet, she also appears to construct this group of women as deserving pity for their inability to keep their bodies safe from men, and by implication, from the threat of HIV. This can be seen in her use of the words 'I think that is the sad part' (lines 12-13). She also positions a black female subject as not knowing how to control her own body, and in that way, quite patronising in her positioning of them as being poor, as uneducated, as ignorant and as used by men. She does this by using the words 'women like that aren't educated enough about their sexual rights' (lines 14-15). In her use of the word 'that is what makes it so serious' (lines 14-15), Liz seems to think that if a female subject does not know enough about it, then she is vulnerable to HIV risk. In the last two lines, she positions university 'students from rural areas' as not 'know[ing] much about it' (lines 15-16), and by implication, as being vulnerable to HIV risk, and in doing this again, she distances herself from HIV risk as a university student from an urban area.

In general, Liz and Carol's narration of their close contact with the problem of HIV in their context (campus) seems to be drawing on a discourse of experience and credibility related to formal knowledge. They both positioned themselves as experienced, as knowledgeable, and in contrast to the naïve young black rural women. They rationalised their constructions by claiming expert and authoritative knowledge drawn from the university curriculum.

5.2.1.5 Constructions of HIV as a huge threat due to its invisibility

The construction of HIV as a greater risk on account of its invisibility in everyday life was identified in the account of ten participants. Extracts from interviews with six of the ten participants are used to illustrate this sub-theme.

Extract 19 below is taken from a black international female student participant.

<u>Extract 19</u>

5 Betty: How serious do you think HIV risk is in South Africa?
6 Esther: HIV risk is really very high in South Africa, many people are HIV positive, they are on
7 ARVs, and you cannot even tell or see if they are infected or not because of these ARVs and
8 better health care, that is a big issue. People also know about HIV, we all know about HIV, we
9 see on TV, we read about HIV a lot. So, HIV is very, very serious in South Africa.
(23, F, A, UGA, UG, Tested)

In her use of the words ‘really very high’, and ‘many people’ (line 6), Esther constructs the scale of the problem of HIV in South Africa as immense and almost overwhelming in terms of prevalence. With the use of the words ‘they are on ARVs’ (lines 6-7), and ‘better health care’ (line 8), she constructs people living with HIV as being under treatment and receiving good health care. She constructs this treatment approach again as invisibilising the threat of HIV. She does this by using the words ‘you cannot even tell or see if they are infected or not because of these ARVs’ (line 7). In doing this, she almost seems to resent the ARV’s, and the consequence for her is that she has to defend herself (by implication, if she could see it, then she could protect herself), but she cannot, and for her, this ‘is a big issue’ (line 8). In her use of the words ‘we all know about HIV’, and ‘we see on TV, we read’ (lines 8-9), Esther constructs people as being well-informed and as being exposed to health messages. She seems to align herself with this construction, as seen in her use of the pronoun ‘we’ repeatedly in her account.

Extract 20 below is taken from a Black South African female participant.

<u>Extract 20</u>

10 Betty: So, when you speak about serious, if I would ask you how many people do you think
11 are HIV positive in the country using a scale of one to ten people?
12 Londi: Oh (.3) okay (.) Uh (.3), it is very serious, but it is very hard to know who is positive or
13 even to imagine because it is not something that you can actually see like you can actually see
14 from people’s faces because nowadays people they take ARVs, so they look alike. So, uh(.)
15 that is why I was asking if it is how they say because on TV they tell us maybe it is one-third
16 of the country, but when I am here at school ((campus)), um(.) I know it is said to be serious,
17 but, and it is serious, but it is very hard to say how much because people will just look the

18 same. So that is why I am a bit, I am uh (.), I am a bit stuck with that question. Jah. With the
19 fact that you wouldn't know, you can't see the person if he is HIV positive or not, so it is
20 serious that way.

(24, F, A, SA, PG, Tested)

In her use of the words 'very serious' (line 12), Londi constructs the problem of HIV in South Africa as a considerable risk. With her use of the words 'very hard to know who is positive or even to imagine' (lines 12-13), 'not something that you can actually see' (line 13), 'see from people's faces' (lines 13-14), 'they take ARVs, so they look alike' (line 14), she constructs HIV as invisible and the ARV treatment as an invisibilising (masking) agent in this matter. With these words, she also positions herself as uncertain, as unsure, as not an expert, as not really knowing, and thereby as almost disadvantaged in managing the threat of HIV for herself. Londi's uncertainty in describing the relative danger of HIV for herself is evident in her use of the following phrases 'that is why I was asking if it is how they say', 'Maybe' (line 15), 'I am a bit stuck' (line 18), 'you wouldn't know, you can't see' (line 19) as well as these prefaces to her argument 'Oh (.3) okay (.) Uh (.3)' (line 12). In her use of the words 'so it is serious that way' (lines 19-20), she seems to think that it is not evident, but invisible, and therefore possibly a significant threat, as it is unseen. She also positions herself as aware of how HIV is being portrayed in South Africa, and on the Pietermaritzburg campus as 'very serious', and as being aware of the media, 'TV' (line 15), which talks of its seriousness as 'one-third of the country' (lines 15-16). Overall, the repetition and vacillation in describing the relative threat of HIV show her uncertainty. She is almost positioning herself as under threat from this invisible risk that she cannot defend herself, and therefore constructs herself as a victim. In positioning herself this way, she appears to absolve herself from the responsibility for managing HIV risk and shifts it to the health care system, which treats HIV with the ARV's, rendering its presence as HIV in everyday life as invisible.

Extract 21 below is also taken from a Black South African female participant.

Extract 21

43 Betty: How serious do you think HIV risk is on campus?
44 Zama: Um, I feel like it is very high. I feel like you cannot really tell if a person is HIV or not.
45 There is a lot of sexual intercourse that happens on campus, many people have multiple
46 partners, and some people didn't really get HIV from their sexual partners but from their
47 parents. So, you wouldn't know if that person is healthy like you, you cannot even tell, so we
48 are just at a very high risk on campus if you are active in sex.

(20, F, A, SA, UG, Not tested)

In her use of the words 'very high' (line 44), Zama constructs HIV as being an immense risk to students. To justify her construction, she uses the words 'you cannot really tell' (line 44), and 'you wouldn't know if that person is healthy' (line 47) to construct HIV as being invisible in those who have it, and herself as being vulnerable to HIV risk in that way. She uses the words 'There is a lot of sexual intercourse that happens on campus' (line 45), and 'many people have multiple partners' (lines 45-46) to position herself as a concerned subject who finds herself in a context where the majority of people are not taking responsibility for themselves, and the consequences for her is that she is uncertain of how to avoid getting involved with any of the sexually active men who do not have HIV. In her use of the words 'some people didn't really get HIV from their sexual partners but from their parents' (lines 46-47), Zama constructs students' difficulty in protecting themselves from the threat of HIV again as being more complicated by the fact that she cannot use people's history of their sexual practices as the only way to identify a risky partner as some students might carry HIV from birth. With the use of the words 'we are just at a very high risk on campus if you are active in sex' (lines 47-48), she positions herself and other students who are sexually active as being in a dilemma and as being threatened by HIV, but they cannot defend themselves.

Extract 22 below is taken from a coloured South African female participant.

Extract 22

22 Betty: How do you see this issue of HIV risk on campus?
23 Purity: … there are a lot of people on this campus, and you never know who might be infected;
24 nobody will tell you if they have it.
(20, F, C, SA, UG, CH, Urban, Tested)

In her use of the words 'there are a lot of people' (line 23), Purity constructs the Pietermaritzburg campus as having a high student population. In her use of the phrases 'you never know' (line 23), and 'nobody will tell you' (line 24), she constructs the threat of HIV as high because there are so many potential contacts with HIV infected people since it is invisible, and no one openly discloses being infected. All these works to position HIV as an invisible threat, and herself as almost disadvantaged and vulnerable to HIV risk.

Extract 23 below is taken from a black male international student participant.

Extract 23

12 Betty: On this campus, that is Pietermaritzburg campus, how serious do you think HIV is?
13 Andrew: You know you cannot tell someone who has HIV just in the way they look.
(24, M, A, TAN, PG, Tested)

In his use of the words 'you cannot tell', and 'just in the way they look' (line 13), Andrew constructs HIV as something that is not visible, and therefore he cannot comment on how serious it is.

Extract 24 below is taken from a black South African male participant.

Extract 24

28 Betty: How serious do you think HIV risk is on campus?
29 Bongani: …. You know these days people can disguise he he there are ways. You can fail to
30 know if your partner is, in fact, infected if she is sticking onto medicine, but if you take regular
31 tests, maybe with your partner, then you are assured of your safety somehow.
(20, M, A, SA, UG, Tested)

With the use of the words 'these days people can disguise he he there are ways' (line 29), Bongani positions HIV as not visible in the infected body. His soft laugh 'he he' here is difficult to interpret, but it does serve the function of positioning people who have HIV as having the means to mask their status. The emphasis he has given to the invisibility of the threat of HIV can also be seen in his use of the words 'You can fail to know if your partner is, in fact, infected' (lines 29-30) to position himself as being vulnerable to HIV risk in this situation. He constructs the use of, and adherence to 'medicine' (which means HIV drugs or ART) as 'disguising' the threat of HIV in people who have it. He does this by using the words 'if she is sticking onto medicine' (line 30). With these words, he also seems to resent ART, and the consequence for him is that he has to defend himself (by implication, if he could identify a risky partner by looking at one's face, then he could protect himself), but he cannot. Again, he positions himself as aware of joint testing for HIV as being a required protective behaviour. He does this through his use of the words 'if you take regular tests, maybe with your partner, then you are assured of your safety somehow' (lines 30-31). With these words also, he clearly identifies a mechanism for knowing about HIV status – this is both a means to detect it (if it is hidden) and a protective strategy, you can 'assure your safety' (line 31).

Overall, the above constructions of HIV as a considerable threat because of the way that ARV treatment (ART) invisibilises the presence of HIV in people, or that the sickness is not visible in the infected body, or that those who have it do not disclose their status seems to be drawing on a discourse of HIV visibility. This places those who do not have HIV in a position of uncertainty and potential victims as they cannot identify a risky partner by simply looking at their physical appearance. In effect, these constructions of the threat of HIV position these participants as potential victims of health policies that treat HIV with ART's. They also position themselves as potential victims of people who have HIV but do not disclose their status as it means they cannot plan how to avoid the risk. This positioning, therefore, appears to be drawing on a victim discourse, and has implications in the sense that it seems to make other people responsible for their risk of HIV and HIV status.

5.2.1.6 Constructions of HIV as a huge threat due to the silence surrounding it

Extract 25 and Extract 26 below, taken from South African female participants, a coloured student and an Indian student, illustrate this sub-theme. The extracts are worth highlighting as the issue reflected in them was identified only in the accounts of these two participants, beginning with the coloured participant.

<u>Extract 25</u>

17 Betty: So, tell on this campus how serious do you think HIV is?
18 Purity: I am not sure because people don't really discuss it, a lot of people don't like to discuss
19 it. So, I don't think that they take it that serious, or maybe it is just a sensitive topic.
20 Betty: Are there some students infected?
21 Purity: Yes, I think there might be some students that are infected that is why it is a sensitive
22 topic, and we don't discuss stuff like that. So, it is scary.
(20, F, C, SA, UG, Tested)

Purity begins her response with the words 'I am not sure' (line 18) to position herself as uncertain about the scale of the problem of HIV on campus. This uncertainty is also evident in her use of the words 'maybe' (line 19), and 'I think there might be' (line 21). To justify her positioning in this regard, she constructs HIV as something that people are silent about, as a 'taboo' topic. This can be seen in her phrases 'people don't really discuss' (lines 18-19, 22-23), 'sensitive topic' (lines 19, 21-22), and 'we don't discuss' (line 22). In her use of the word 'we' here, Purity seems to align herself with this construction. Again, in her use of the words 'I don't think that they take it that serious' (line 19), she seems to think that if it is not discussed, or people are quiet about it, then it shows that they are ignoring the threat. However, she constructs this silence as 'scary' (line 22), and in doing this, she positions herself as being threatened by this risk, even when nobody is talking about it.

<u>Extract 26</u>

16 Betty: How serious do you think HIV risk is on our campus?
17 Sarah: Well, I haven't really encountered any student who has HIV or spoken to me about it or
18 a friend even while being here ((campus)). Um, but I think it is very important to have some
19 sort of support or institution in place or something in place where students can go and confide
20 if they have HIV. So, it would be very serious because people don't speak about it like a friend
21 or anyone for the years that I have been here; ever came to me and said they have HIV, even a
22 friend. So, it is important, I think to have a place where people can go and speak about it in
23 order to get help and support from campus.
(24, F, I, SA, PG, Tested)

In her use of the words 'I haven't really encountered any student who has HIV or spoken to me about it or a friend' (lines 17-18), and 'nobody ever came to me' (line 21), Sarah gives a disclaimer that she has not had close contact with HIV risk, she seems to construct it is as not in her social network ‘any student’ or ‘friends’. With the use of the words ‘I think it would be very serious because people don’t speak about it’ (line 20), she seems to also allow for the possibility that people around her might have it, but just that they do not talk about it. However, Sarah appears to call for an action that requires the establishment of an HIV help desk on campus where students can have an opportunity to freely talk about it under confidential conditions. She does this by using the words ‘is important I think to have a place where people can go and speak about it in order to get help and support’ (lines 22-23).

Interestingly, Sarah’s construction of HIV risk as something not being spoken about is not being constructed as a risk, unlike in Purity’s account in Extract 25 above. It is as if Purity’s construction of HIV risk is related to a direct threat to oneself; it is invisible to the eye and the ear, but for Sarah in Extract 26, HIV risk is just not spoken about, and people who experience HIV should talk about it, and an indication that she is drawing on the talking cure discourse. Here, talk is constructed as supportive, as helping, rather than as a warning, as identifying HIV and revealing it (as in Purity’s account).

The general pattern in the participants’ constructions of HIV as an immense risk on account of the silence surrounding it amongst students on campus seems to be drawing on a discourse of stigmatisation of HIV and AIDS. This is because the primary aspect in their constructions revolved around the difficulty and sensitivity of contracting HIV and the problem of not talking about it.

5.2.1.7 Constructions of HIV as a huge threat due to people’s tendency to ignore it

This construction of HIV as an overwhelming threat on account of the people’s tendency to ignore it was identified in the account of 14 participants. Extracts from interviews with six of the 14 participants are used to illustrate this sub-theme.

Extract 27 below is taken from a black South African female participant.

Extract 27

Betty: How serious do you think HIV is on this campus?

Sane: Yooh↑, it is really, really↑ serious because we take it for granted, you know, like, um, I did this HIV and AIDS certificate, and I was also volunteering at CHASU ((the University’s HIV and AIDS unit)) and then I realised from the statistics they had about HIV positive students, those who test and many students are actually not even testing at all. Yooh↑, those who have HIV are a lot. So, it is really a serious issue.

(22, F, A, SA, PG, Tested)

In her use of the words ‘Yooh↑, it is really, really↑ serious’ (line 15), ‘it is really a serious issue’ (line 19), and ‘Yooh↑, those who have HIV are a lot’ (lines 18-19), Sane constructs the scale of the problem of HIV on campus as immense and overwhelming in terms of prevalence. She uses the words ‘because we take it for granted’ (line 15) to position students as ignoring the risk of HIV. The pronoun ‘we’ here serves to position Sane as aligning herself with this construction, while the word ‘because’ serves to construct the problem of HIV as serious in that way (since it is being ignored). With the use of the words ‘many students are actually not even testing at all’ (line 17), she positions students as not only ignoring the risk of HIV but also not engaging actively in HIV testing. In her use of the word ‘not even’, she constructs this fact (ignoring HIV risk) as unexpected, and implies that this should not be the case for students. This positioning of students as not engaging in HIV testing is similar to Esther’s construction (see Extract 8), and contrasts with Zazi’s construction presented earlier (see Extract 13). She uses the words ‘I did this HIV and AIDS certificate’ (lines 15-16), ‘I was also volunteering at CHASU’ (line 16), and ‘I realised from the statistics they had’ (line 17) to position her knowledge of the state of the problem of HIV on campus as based on scientific research (statistics), her education ‘HIV and AIDS certificate’, and her work experience in the University’s HIV and AIDS unit, and therefore, factual and accurate. With these words also, Sane positions herself as an expert and as serious about the issue. By implication, she is different from the category of university students who ignore the threat of HIV and do not engage actively in HIV testing.

Extract 28 below is taken from a black international female student participant.

<u>Extract 28</u>

17 Betty: How serious do you think HIV is on this campus?
18 Phumi: It is very high, but people don’t really take it to be serious like people know about it,
19 but they don’t put their knowing about it into practice, like protecting themselves.
(22, F, A, ZIM, UG, Tested)

In her use of the words ‘very high’ (line 18), Phumi constructs HIV on campus as an immense risk. She uses the words ‘people don’t really take it to be serious’ (line 18), and ‘don’t put their knowing about it into practice’ (line 19) to position students as ignoring the threat of HIV. She constructs the appropriate ‘acting on this knowledge’ as the act of prevention, ‘protecting themselves’ (line 19), and it is almost as if she is positioning herself as acting on her knowledge and awareness.

Extract 29 below is taken from an Indian South African female participant.

<u>Extract 29</u>

29 Betty: Now, let us talk about our campus, how serious do you think HIV is?
30 Nicole: I would say on campus it is serious because although you have been educated, you do
31 forget that this person could be with someone else. I think people always really think it won’t
32 happen to me. So that is why they just ignore it.

(19, F, I, SA, UG, Not tested)

In her use of the words ‘it is serious’ (line 30), Nicole constructs the problem of HIV on campus as huge. She uses the words ‘although you have been educated, you tend to forget’ (lines 30-31) to position students as being educated and aware of the threat of HIV but also absent-minded. With the use of the words ‘people always really think it won’t happen to me’ (lines 31-32), she positions students as believing they are invulnerable to HIV. In her use of the words ‘So that is why they just ignore it’ (line 32), Nicole positions students as ignoring the risk of HIV since they ‘forget’ to assess the risk of HIV and tend to construct it as other people’s problem. With the use of the words ‘you’ (line 30), ‘people’ (line 31), and ‘they’ (line 32), she positions herself as being critical of other students who think that HIV is a risk but not to themselves. She, by implication, positions herself as being serious about the issue.

Extract 30 below is taken from a coloured South African female participant.

Extract 30

7 Betty: How serious do you think HIV is in South Africa?
8 Purity: I think it is a very serious thing because it has become more known, but people don’t
9 understand that if you do have it, you need to take the precaution to keep well.
10 Betty: Okay, so are there people who are at risk of HIV than other people in the country?
11 Purity: I think some people are at more risk, people that don’t really take an interest in knowing
12 about the consequences of having it and knowing about the fact that you can get it from sexual
13 intercourse or by just sleeping around and stuff like that. I think people who are not interested
14 in that, not that they don’t know about this disease, they ignore it and are more at risk because
15 I feel like they wouldn’t take caution ((precautions)), for instance, having safe sex, uh, he he.
16 they wouldn’t do something like that, and they could be infected for not taking precaution.

(20, F, C, SA, UG, Tested)

In her use of the words ‘it is a very serious thing’ (line 8), Purity constructs HIV as a great risk in South Africa. She constructs the knowledge about HIV as developing or increasing. She does this by using the words ‘it has become more known’ (line 8). However, in her use of the words ‘people don’t understand that if you do have it, you need to take the precaution’ (lines 8-9), she positions people generally as not knowing enough about HIV, particularly in living with it. Again, in her use of the words ‘knowing about the fact that you can get it from sexual intercourse’ (lines 12-13), and ‘not that they don’t know about this disease, they ignore it’ (line 14), she constructs people at risk of HIV as those who are not ignorant about it, particularly in how one can get it, and ‘the consequences of having it’ (line 12), but just disregarding the threat of HIV. Moreover, she uses the words ‘they wouldn’t take caution’ (meaning precautions)’ (line 15) to position other people as lacking care and not being safe, ‘for instance, having safe sex’ (line 15), and by implication positioning herself as a knowing health subject who is proactive and responsible about safety. In this regard, the soft laugh ‘he he’ (line 15) functions to position Purity as chuckling at students’ high level of irresponsibility in managing HIV risk on the campus. It might also be her expression of dismay at the ‘state’ of the problem of HIV on campus, particularly the unsafe sexual behaviours of students.

Extract 31 below is also taken from a coloured South African female participant.

<u>Extract 31</u>

30 Betty: Okay. So, tell me, how do you define HIV risk?
31 Carol: Um, I think it is easy to get HIV because nowadays people are just sleeping around, like
32 for example, on campus when we have campus parties and stuff like that, it is just about getting
33 drunk and finding just a guy to hook up with, and I think that is very dangerous for us girls. So,
34 it has become very risky.

(20, F, C, SA, UG, Not Tested)

In her use of the words ‘easy to get HIV because nowadays people are just sleeping around’ (line 31), Carol constructs the risk of exposure to HIV as tied to behaviour in the form of risky sexual practices. With the word ‘nowadays’ and ‘just’ here, she positions people as having no regard for this form of risk. She proceeds to construct the social activities of students on campus as creating danger and risk of HIV. She does this by using the words ‘it is just about getting drunk and finding just a guy to hook up with’ (lines 32-33), and the word ‘just’ here serves to position her as dismissing these priorities. With the words ‘that is very dangerous for us girls’ (line 33), she positions young women as vulnerable to the dangers this context enables and thereby vulnerable to HIV risk. However, she seems to align herself with this positioning, but the fact that she is not talking directly about ‘me’ means that she is trying to take the focus off herself.

Extract 32 below is a continuation of Esther’s response to why students do not engage actively in HIV testing. In expanding that response, she says:

<u>Extract 32</u>

40 Esther: … Also, here on campus, we tend to think that HIV is not really too high here, and we
41 engage in sex without using a condom a lot. You will find most girls just using contraceptives
42 to avoid getting pregnant, so when they have sex, of course, they cannot use protection.

(23, F, A, UGA, UG, Tested)

In her use of the words ‘we tend to think that HIV is not really too high’ (line 40), and ‘we engage in sex without using a condom a lot’ (lines 40-41), Esther constructs students as minimising the threat of HIV in their context and as carefree in their sexual activities. The words ‘tend’ and ‘think’ here suggests that she is dismissing this level of disregard for the threat of HIV on campus, while the pronoun ‘we’ shows that she is aligning herself with this positioning. Moreover, she uses the words ‘You will find most girls just using contraceptives’ (lines 41-42) to position students as prioritising the risk of pregnancy and managing it. In doing this, she constructs contraceptives as facilitating change in their sexual practices, and by implication, positions them as vulnerable to HIV risk. By using the word ‘just’ (line 42), she constructs this fact as unexpected, implying that this should not be the case for female students. She, by implication, positions herself as being critical of students’ priorities in sexual activity.

It is important to note that the practice which most female participants tried to emphasise all through the study is that students engage in unprotected sexual activities, and take responsibility only for managing the risk of pregnancy by means of contraceptive use. This appears to imply that educated youth tend to prioritise the risk of pregnancy in sexual activity, and in so doing, they disregard the threat of HIV.

Extract 33 below is taken from a black South African male participant.

Extract 33

Betty: Tell me, how serious do you think HIV is in South Africa?
Zazi: Uh, it is very serious, but it depends on the location as well in some places it is not very serious while in other places it is very serious but uh, not spoken about, some people aren’t educated about it, so I don’t think it is taken very seriously by many people and our government.
Betty: You said some places it is serious while in other places it is not. Which are these places?
Zazi: Yes, for example, in rural areas. In some rural areas like where I come from, there are hardly any clinics, uh, hardly any schools. Also, in schools uh, the learners are not educated about how to prevent HIV or taught about sexual intercourse because, in some areas, it is believed that sexual intercourse is only for married people, so they just ignore HIV. I think they are just ignorant about HIV because youth who are not married also engage in sexual activities with exposed youth, and they can get HIV. The elders are ignorant and don’t want to tell you about HIV because they think they are telling you to go and have sex anyhow.
(22, M, A, SA, UG, Tested)

In his use of the words ‘it is very serious’ (line 8, 9), and ‘but it depends on the location’ (line 8), Zazi constructs the problem of HIV in South Africa as prevalent in some places and not in others. He uses the words ‘not spoken about’ (line 9) to construct HIV risk again as shrouded in silence. In his use of the words ‘aren’t educated about it’ (lines 9-10), he positions ‘some people’ as ignorant about it, therefore, not protecting themselves from it. He positions ‘many people’ (line 10) and the South African ‘government’ (line 11) as ignoring the problem of HIV, and in doing this, he positions himself as being concerned about the issue and as not ignoring it. He then locates the risk of HIV within ‘some rural areas’ (line 13). He uses the words ‘there are hardly any clinics, uh, hardly any schools’ (line 14), and ‘learners are not educated about how to prevent HIV or taught about sexual intercourse’ (lines 14-15) to position the rural area where he ‘comes from’ (line 13). In doing this, he is constructing these areas as under-resourced, undeveloped, almost backward (in their beliefs that young people do not engage in sex). With these words also, Zazi positions youth as ignorant, uninformed, rustic and traditional health subjects who do not know how to weigh the consequences of their actions and reduce risks to their health. He positions himself as out of this group or as different from this ‘other’ as he is a university student. The emphasis he has given to HIV risk as being a problem for rural youth is quite evident in his use of the words ‘it is believed that sexual intercourse is only for married people’ (lines 15-16), and ‘youth who are not married also engage in sexual activities with exposed youth, and they can get HIV’ (lines 17-18), all of which work to position the rural context as maintaining old fashioned and traditional expectations about youth and sexuality. With the word ‘believed’ (line 16), he positions himself as showing some resistance to this expectation placed on youth. In his use of the words ‘they just ignore HIV’, and ‘elders are ignorant’ (line 18), he positions the elders as not only not knowing about HIV but also as not wanting to know. With the words ‘don’t want to tell you about HIV’ (lines 18-19), Zazi positions the elders as the gatekeepers of knowledge but as not wanting to impart HIV information because of the taboos and expectations related to sex and marriage. Overall, Zazi’s account positions the elders as not only ill-educated about HIV and ignorant for thinking that discussions will lead to sex but also as denying youth information about the thing which is a danger to them, sex and HIV; and it seems for him, the elders are the only option available to youth for this role of passing health messages in the absence of ‘clinics’ and ‘schools’.

In sum, then, the general pattern in the participants’ constructions of HIV as something of a considerable threat due to the tendency of people to disregard its potential risks seems to be drawing on three major discourses. Firstly, the positioning of people in South Africa and students in particular, as knowing about HIV risk but not changing their sexual behaviours, and engage actively in HIV testing, seems to be drawing on the irresponsible health subject discourse. Secondly, the positioning of students as believing that HIV is non-existent in their context appears to be drawing on the ‘invulnerable’ and ‘not-worried-about’ HIV risk subject discourse. Thirdly, the positioning of rural youth as ‘not educated’ enough about how to protect themselves from the threat of HIV seems to be drawing on the discourse of the ignorant, uneducated, uninformed, rural and traditional health subjects.

In contrast to the above constructions of HIV under Theme One, all of which position the problem of HIV as immense and almost overwhelming in terms of its prevalence in South Africa and on the Pietermaritzburg campus, there are a few important outliers, which portrayed HIV as a threat but not a great one. The extracts that speak to this deviational trend are highlighted below under Theme Two.

5.2.2 Theme Two: Constructions of HIV as a minimal threat

In this study, a few participants (4) constructed HIV as being a minimal threat in South Africa and on the Pietermaritzburg campus. In their justifications for this, two significant sub-themes were identified: increasing awareness and interventions on HIV, and the assumption that people are taking full responsibility for themselves and for others. Findings in relation to participants' constructions of HIV as a minimal threat due to increasing awareness and interventions around it will now be presented and analysed.

5.2.2.1 Constructions of HIV as a minimal threat due to increasing awareness and interventions on it

Out of the four participants who constructed HIV as a minimal threat, three of them rationalised this by constructing ARVs as able to minimise the threat of HIV in the infected body. They also justified this by emphasising that increased knowledge and awareness of the disease is responsible for reducing the rates of HIV infection. Extracts from interviews with all these four participants are used to illustrate this sub-theme.

Extract 34 below is taken from a black international female student participant.

Extract 34
5 Betty: Tell me, how serious do you think the HIV epidemic is in South Africa?
6 Leah: The epidemic currently is not as serious as it used to be, probably in the early eighties
7 and nineties when it just started, I think more people are aware of HIV, and more people are
8 aware about the interventions that have been put in place to fight the epidemic. And uh, I
9 believe that although the number of infected and affected is still at a high rate, but because of
10 these interventions, the rates have reduced.
(23, F, A, TAN, PG, Tested)

Leah uses the words 'currently is not as serious' (line 6) to construct HIV as being a minimal threat. In her use of the words 'as it used to be, probably in the early eighties and nineties when it just started' (lines 6-7), she makes the situation comparable with the early decades of the epidemic, and in doing this, she positions herself as knowledgeable about HIV research, patterns and trends. With the use of the words 'more people are aware' (line 7), and 'more people are aware about the interventions' (lines 7-8), she positions people as being well-informed of it, and this change in knowledge or awareness has happened through interventions. Her use of the words 'because of these interventions the rates have reduced' (lines 9-10) positions these interventions again as being responsible for reducing the rates of HIV infection.

Extract 35 below is taken from a South African female participant.

<u>Extract 35</u>
16 Betty: How serious do you think HIV risk is on this campus?
17 Buhle: I think here in this institution, I think it is serious but not much as compared to
18 prevalence across the country. I think is highly affecting people in the country than students.
19 Betty: If you can estimate like in 10 students, how many would be infected?
20 Buhle: Maybe here is one or two.
21 Betty: What about in the general population.
22 Buhle: Maybe in South Africa, I can say five.
23 Betty: So, you seem to be suggesting that HIV prevalence amongst students is not as rampant
24 as in the general population?
25 Buhle: It could be that it is not that serious that much here because even though our youth
26 fellows are engaging in unsafe sex, but they have been educated about the negative effects of
27 HIV, and they know how to prevent HIV and AIDS, they have been educated. Maybe for that
28 target group of students, it could be much less than the countrywide like the country in general
29 because they know how to protect HIV.
(24, F, A, SA, PG, Tested)

In her use of the words 'in this institution, I think it is serious but not much' (line 17), Buhle constructs the threat of HIV amongst students on the Pietermaritzburg campus as minimal. She compares the state of the problem on campus with the people outside the university (the general population). She does this by using the words 'as compared to prevalence across the country', 'I think is highly affecting people in the country than students' (lines 17-18), and 'much less than the countrywide' (line 28). The emphasis she has given to HIV being a minimal risk to students 'as compared to' the general population is quite evident in the estimates she provides to illustrate the scale of the problem on campus as being 'one or two' students in ten students (line 20), and as being 'five' people in ten people in the general population (line 22). This construction of HIV as a minimal threat to students can also be seen in her use of the words 'It could be that it is not that serious that much here' (line 25). She justifies her positioning of students in this regard by using the words 'they have been educated' (lines 26, 27), and 'they know how to prevent' (line 27). In doing this, she positions students as being educated and aware about HIV and how to manage it, and she aligns herself with this. In her use of the words 'because they know how to protect HIV' (line 29), she states that this knowledge and awareness are protective. By implication, she positions the general population as not knowing enough about HIV and how to protect themselves from it, and that helps her to continue with her justification that they are at a greater risk of HIV. Buhle seems to position herself as uncertain of the merit of her argument, as seen in her use of the words 'I think' (lines 17, 18), 'Maybe' (lines 20, 22), and 'it could be' (lines 25, 28). However, Buhle's construction of HIV as being a limited risk and her positioning of students as not being affected much by HIV is interesting in the sense that it differs from the views of other participants discussed earlier, where students were positioned as not acting on their knowledge and awareness on HIV to protect themselves from it (see section 5.2.1.7 Constructions of HIV a huge threat due to people's tendency to ignore it).

Extract 36 below is a continuation of Buhle's account above, but this time in response to how she understands the meaning of HIV risk, to which she says:

<u>Extract 36</u>

33 Buhle: Okay. Um, as far as I know, HIV and as far as we all know about HIV is mortal and
34 frightening, but the thing is now manageable. Okay, I do have people who have told me that
35 they have been living with this condition of HIV for over a decade. The thing is, nowadays,
36 people are adhering to treatment to this virus, so the risk has now decreased in a way because
37 of the ARVs that are being given to people who are positive, so even the virus cannot be
38 detected in the body yet they are infected, so now the risk has become less.
(24, F, A, SA, PG, Tested)

In her use of the words 'as far as I know', and 'HIV is mortal and frightening' (line 33), Buhle constructs HIV infection as a devastating illness. She follows this up with a switch 'but' and then the words 'the thing is now manageable' (line 34) to construct HIV as now being a minimal threat, showing that for Buhle, people have learnt to live with the disease. Her use of the word 'thing' here, in reference to HIV, positions her as not wanting to be specific in naming the condition, and this could mean that she is threatened by it even though she says it is now controllable. She reaffirms her positioning of HIV as being a minimal threat by drawing on her awareness of people who have lived with it 'for over a decade' (line 35). With the use of the words 'the risk has now decreased in a way because of the ARVs' (lines 36-37), 'people are adhering to treatment' (line 36), and 'virus cannot be detected' (lines 37-38), she constructs the ARV's as responsible for minimising the threat of HIV in people who have it, and people who have it and know their status as being responsible for managing the condition for themselves.

This way of constructing the ARV's is different from the account of other participants (Esther, Londi and Bongani), who constructed the ARV's as being a problematic intervention, as invisibilising the threat of HIV in those who have it and, in that way, indirectly making people victims of HIV infection (see Extract 19; Extract 20; Extract 24, respectively). Overall, it is important to highlight that Buhle's account is quite sophisticated – the idea of viral suppression is not in other participants' references to ARV's. It suggests that Buhle might have had direct experience of this, or know people who live with HIV.

Extract 37 below is taken from a black international male student participant.

<u>Extract 37</u>

17 Betty: How serious do you think HIV is on the Pietermaritzburg campus?
18 John: I think it is not really serious as it is in other people who are not students because students
19 are educated, and they are aware that you can get HIV by having unprotected sex, you see. Yes,
20 maybe a few students have HIV, but I don't think they are many like in the country.
21 Betty: Can you estimate, for example, in ten students, how many would be infected?
22 John: I would say one in twenty students, not ten.
23 Betty: Okay, that is quite low. So, what of other people who are not students can you estimate
24 for me, like how many in ten people?
25 John: Uh, I think I would say probably five or maybe let us say six.
(20, M, A, DRC, UG, Tested)

In his use of the words 'it is not really serious' (line 18), and 'maybe a few students have HIV' (line 20), John constructs the threat of HIV amongst students on the Pietermaritzburg campus as minimal. He compares the state of the problem on campus with the people outside the university (the general population). He does this by using the words 'as it is in other people who are not students' (line 18), and 'but I don't think they are many like in the country' (line 20). With the words 'I think' (line 18), and 'Maybe' (line 20), he positions himself as uncertain of the merit of his argument. The emphasis he has given to HIV as being a minimal risk to students as compared to the general population is quite evident in the estimates he provides to illustrate the scale of the problem on campus as being 'one' student in twenty students (line 22), and as being 'five or six' people in ten people in the general population (line 25). He justifies his positioning of students in this regard by using the words 'educated', and 'aware that you can get HIV by having unprotected sex' (line 19). In doing this, John positions students as acting on their education and awareness on HIV to protect themselves.

5.2.2.2 Constructions of HIV as a minimal threat because people are taking full responsibility for themselves and for others

Extract 38 below, taken from a black South African female participant, is used to illustrate this sub-theme. The extract is worth highlighting as the issue reflected in it was identified in the account of only this one participant.

Extract 38

5 Betty: So, tell me, how serious do you think HIV is in South Africa?
6 Bongi: Um, it was very serious, now it is no that longer that serious an issue for people have
7 learned to live with it, and people who don't have HIV have learned how to coexist with people
8 who have HIV, and they have learned how to, uh, people have learned how to protect
9 themselves as well as people with HIV have learned to protect others who don't have HIV from
10 HIV. So, people have now normalised the world with HIV. So, it is not a big thing anymore. It
11 is not like a stigma anymore. It is not serious as it was when it first came, you know, now we
12 know how to protect ourselves. We know how to, um, protect other people as well. So now,
13 yes, it was serious, but now it is not that, that serious because we have learned to live with it.
14 Betty: You spoke about protecting. What does that mean?
15 Bongi: Luckily, the government has made these nice, um, sort of acronyms, the ABC, how to
16 abstain, be faithful, condomise. So now people have like options as to how they want to protect
17 themselves, and in that way, HIV is no longer that serious.

(24, F, A, SA, UG, Tested)

In her use of the words 'no longer serious' (lines 6, 18), 'not serious' (line 11), 'not that, that serious' (line 13), 'not a big thing anymore', 'not like a stigma anymore' (lines 10-11), and 'we have learned to live with it' (lines 13-14), Bongi constructs HIV as being a minimal threat in South Africa and as being normalised. In her use of the word 'not' repeatedly here, she is showing that adaptation has happened. Again, in her use of the word 'learned' seven times (lines 6, 7, 8, 9, 10, 13), she constructs HIV as a lesson to be 'learned', in terms of how to 'live with it' (lines 7, 13), how to live with those 'who don't have' it, and how to 'coexist with people who have' it (lines 7-8). Indeed, this whole theme of learning to live with HIV, and with people who have it, constructs HIV risk as being part of our world, as something to be accepted, which is an interesting shift for some of the participants (like Bongi). It appears to reflect their gradual acceptance of the world with HIV.

Furthermore, Bongi constructs people who do not have HIV as taking responsibility for themselves. She does this by using the words 'people have learned how to protect themselves' (line 8). In her use of the words 'people with HIV have learned to protect others who don't have HIV from HIV' (lines 9-10), she positions people who have HIV and know their status as taking responsibility, and by implication, position those without HIV as 'at the mercy' of those who have it. Again, in her use of these contrasting terms, ‘now we know how to protect ourselves’, ‘We know how to protect other people’ (lines 12-13), and ‘we have learned to live with it’ (lines 13-14), she constructs the problem of HIV as a lesson to be learned and to be conquered by knowledge, by information, or knowing. With her use of the pronoun three times ‘we’ here, she positions herself as acknowledging that HIV affects her, and she is taking full responsibility for herself and others. In response to how people protect themselves from the HIV infection, she uses the words ‘the government has made these nice, um, sort of acronyms, the ABC’ (line 16) to position people as being exposed to the self-protective technologies, ‘abstain, be faithful, condomise’ (line 17), and the South African government as being serious about the issue. She uses the words ‘in that way, HIV is no longer that serious’ (line 18) to position these predominant fundamentals of the ABC framework as being responsible for reducing the severity of HIV, and by implication, position people (herself included) as good health acting subject.

The general pattern in the participants’ constructions of HIV as being a minimal threat in South Africa, and on the Pietermaritzburg campus, seems to be drawing on the information, education, and communication health framework. This is because their justifications focus on students being educated, being aware of HIV risk, and acting on these to protect themselves and the fundamentals of the ABC framework as adopted by people as their primary protective strategy. In addition to this is the positioning of people who have HIV and know their status as adhering to the ARV treatment and using a condom to protect those who do not have HIV from being exposed it, the construction of the ARV’s as helping people who have HIV to live long as well as the positioning of people who have HIV as no longer being stigmatised by those who do not have it. All these serve to position the problem of HIV again as being normalised, and by implication, suggesting that an adaptation has happened.

5.2.3 Trends and conclusions arising from findings on research question one

Ten key findings and discourses were identified from a close study of the transcripts in response to research question one, which relates to constructions of the scale of the problem of HIV in South Africa in general, and on the Pietermaritzburg campus in particular. The first and most prominent of the participants’ constructions were of HIV as immense and almost overwhelming in terms of its prevalence, and this draws on a discourse of HIV severity.

The second key finding is the positioning of their knowledge about the seriousness of the threat of HIV as being based on scientific research (statistics) or authoritative sources (news), which draws on a discourse of the knowledgeable health subject.

The third key finding is the construction of campus life as dangerous, as a context of irresponsibility, disregard for potential risks, and inevitably creating conditions that encourage HIV transmission. This construction appears to be drawing on the framework of sex as a risky practice related to particular forms of social activities.

The fourth key finding is the position taken by some participants, which draws attention to the existence of an assumed HIV transmission chain (pattern). This is made palpable by the leading role which older, and wealthier men play in this regard because, from them, their young consorts (partners) get infected, and they (young women) in turn transfer the HIV infection to their young male partners. This construction appears to be drawing on the dominant framework of the HIV transmission route.

The fifth key finding is the position taken by two participants (Sarah and Nipho), which emphasises that it is no longer a taboo for young women to engage in multiple sexual relationships. This phenomenon puts those practising multiple sexual relationships at a greater risk of HIV compared to their counterparts who practice sexual monogamy. Both these points draw on new forms of femininity and expectations of women discourse.

The sixth key finding is the dominant positioning of young women as fighting on two fronts: to prevent the risk of HIV, and to prevent pregnancy, with a prioritisation of avoiding pregnancy. This draws on the feminisation of responsibility for pregnancy discourse.

The seventh key finding is the position taken by some participants, which constructs the rural areas as a context of deprivation, which is resource-poor, which then affects youth's knowledge and awareness. This is made palpable by the absence of institutions (like schools and clinics) for passing the health information and messages to the youth in the rural areas. This constructs the rural youth as ignorant, rustic, deprived subjects, drawing on a discourse of being informed/uninformed.

But, perhaps, most importantly, is the eighth key finding that the availability and use of ARVs is not seen as only positive. ART is constructed as facilitating the concealment of the risk of HIV. The participants constructed ARV's as suppressing the usual signs of the manifestation of AIDS in the body and therefore invisibilising HIV. This construction draws on a discourse of HIV as being a silent and obscured risk. The participants also constructed ‘undisclosed’ HIV positive people as a threat, and as contributing to their own risk exposure. The consequence for these participants is that they have to defend themselves, but they cannot. If they could distinguish those who have it from those who do not, then they could protect themselves. They are therefore at the mercy of silent HIV, and silent people, and this construction appears to be drawing on a victim discourse. In these constructions, participants are positioned as passive, and desiring that HIV be made visible so that they can face a known risk.

Interestingly, only one participant (Buhle) constructed ART positively, which is the ninth key finding. Buhle positioned ART as life-extending, a relief to those living with HIV, and as a mechanism to enable adaptation. This draws on a discourse of medicalisation of HIV.

The tenth finding is the position taken by four participants, which construct HIV as being no longer as huge a threat as it used to be in the early decades of the epidemic. The construction here is that of minimisation of HIV, which draws on the normalisation of HIV discourse.

The eleventh and final key finding is the participants’ tendency to position people who have HIV and know their status as being responsible for their own health and for the safety of others who do not have it. Here, risk proofing oneself against HIV, and those whom one might infect with HIV is seen to occur through an increase in knowledge, awareness, and engaging in responsible management of sexual practices. This positioning of people who have HIV draws on the information, education and communication health framework.

In sum, the general pattern in the findings in relation to research question one reveals that HIV is constructed as an immense and overwhelming threat in South Africa and on the Pietermaritzburg campus. In the next section, I explore how participants locate themselves and others in relation to the threat of HIV. The findings in relation to the second research question will now be presented and analysed.

5.3 Research question two: How do sexually active university students construct and position themselves and others in relation to HIV risk? What rationalisations or justifications do they give for their position?

Two subject positions were identified in relation to this research question, the at risk subject and the no, or low risk, subject. These two subject positions are presented in themes, with the numbering of the themes continuing from those in research question one. In terms of thematization, therefore, Theme Three presents the at risk subject position, while Theme Four presents the no, or low risk, subject position. Analysis of findings under Theme Three will now follow.

5.3.1 Theme Three: The at risk subject position

Out of the twenty participants interviewed for this study, the majority of them (13) positioned themselves as being at risk of HIV. Two subject positions were identified in their justifications and rationalisations. Firstly, the subject 'at risk' due to their own activities of unsafe sex. Secondly, the subject 'at risk' due to other people's destructive behaviours, such as rape, and at risk from non-sexual transmission routes, such as exposure to contaminated blood or 'touching others'. Participants' account in relation to these two subject positions will now be presented and analysed.

5.3.1.1 The subject at risk due to their own activities of unsafe sex

Out of the 13 participants who positioned themselves as being at risk of HIV, 11 of these participants considered themselves as at risk due to their own activities. Extracts from interviews with six of the 13 participants are used to illustrate this sub-theme.

Extract 39 below, is taken from a black South African female participant.

Extract 39

Betty: So, tell me, Sane, now that you are a student on this campus, and you said that HIV is a problem. How does this uh make you feel about your risk of HIV?

Sane: Um, I am a bit cautious. I do try by all means to protect myself because I have seen it, and I have done my research as well since I have mentioned that this is my area of interest, so by that, I try like almost all the time to be cautious. I use a condom with my partner because he is also from here on campus, I use condoms almost all the time. I try even when helping injured people like I use gloves, you know like I try to be cautious at all given times because I understand how you can contract it and how many people have it.

(22, F, A, SA, PG, Tested)

In her use of the words 'I have seen it' (lines 36-37), 'I understand how you can contract it', and 'how many people have it' (lines 40-41), Sane positions herself as being aware of the problem of HIV on campus, and as being knowledgeable about it in terms of the prevalence rate and modes of transmission. Her use of the words 'I have done my research', and 'this is my area of interest' (line 37) positions herself again as diligent, as academic, as rational, and as serious about the issue. In her repeated use of the words 'I try' (lines 36, 38, 39, 40), 'cautious' (lines 36, 38, 40), 'almost all the time' (lines 38, 39), and 'all given times' (line 40), she positions herself also as a sensible, rational, reasonable and responsible health subject. However, in her use of the adverb ‘almost’ (lines 38, 39), she also positions herself as one who is not able to comply fully. It is as if, despite her positioning, she is not entirely in control of the situation, and I explore this further in Extract 40 below. Here, she produces the account, which suggests inconsistent condom use, but still presents herself as responsible for her own safety.

<u>Extract 40</u>

42 Betty: You said to me that you try to use condoms almost all the time. And how do you feel
43 about your risk in such a situation?
44 Sane: To be honest with you, like, during the intercourse, I don’t feel bad at all, just that after
45 the intercourse, you know like when you have like a guilty conscience, I mean you start
46 panicking, you want to go test, you thinking what if I contracted HIV and AIDS, but usually
47 like the day after or immediately after having sex, I do get those chicken feelings like OH my
48 goodness, what if have contracted it, what am I going to do? What was I doing? What is this?
49 What if this guy has cheated me again? Because he once cheated, as I told. But I do try by all
50 means to use condoms almost all the time.

(22, F, A, SA, PG, Tested)

Sane begins her response with the words ‘To be honest with you’ (line 44) to position herself as sharing something personal with me and that she is going to be direct and truthful. Her account contrasts two positions, not feeling bad and potentially feeling bad after engaging in unprotected sexual activity. In her use of the words ‘I don’t feel bad at all’ (line 44), she positions herself as free of the worry of HIV risk during the sexual act itself. Her use of the words ‘just that after’ (line 44), ‘you start panicking’ (lines 45-46), and ‘you thinking what if I contracted HIV and AIDS’ (line 46) positions her as being aware that engaging in unsafe sex is risky. With the words ‘you have like a guilty conscience’ (line 45), she positions herself as knowing that she has acted incorrectly. She constructs this situation of having risked herself as making her anxious, and as trying to resolve the tension by checking her HIV status. She does this through her use of the words ‘you start panicking’ (lines 45-46), and ‘you want to go test’ (line 46). In her use of the words ‘the day after or immediately after having sex, I do get those chicken feelings’ (line 47), she constructs the earlier good feelings during unprotected sexual intercourse as short-lived only to be followed with a guilty conscience in the end, and this positions her as anxious and afraid. This positioning of herself as doing wrong, as being bad, or as being irresponsible, can be seen through this series of interrogations, ‘what if I have contracted it, what am I going to do? What was I doing? What is this?’ (line 48), all of which work to position her as terrified, as regretful and even questioning the wisdom of her behaviour. In her use of the words ‘What if this guy has cheated me again? Because he once cheated’ (line 49), she positions herself as doubting his fidelity, and as a victim of his irresponsible behaviour.

Sane ends this particular response with the words ‘I do try by all means to use condoms almost all the time’ (lines 49-50) to position herself as being a good health subject, but also as one who ‘lapses’, forgets, and then is drawn sharply back to the reality that she has been a bad subject.

Extract 41 below is taken from a black South African female participant, Tumi. Before this particular extract, Tumi constructed HIV as being an immense risk on campus (see Extract 14).

<u>Extract 41</u>

33 Betty: And how does that make you feel about your personal risk of HIV?
34 Tumi: .hhhh, it makes me feel at risk because we as students are like okay, we are very young,
35 and we might not be infected, so we can do anything at school ((campus)). So that is the thing,
36 we think that young people here ((campus)) do not get infected. And so, we just date.
(19, F, A, SA, UG, Tested)

In her use of the words ‘it makes me feel at risk’ (line 34), Tumi positions herself as vulnerable to HIV risk. In her use of the words ‘we as students are like okay, we are very young, and we might not be infected’ (lines 33-34), she positions young students as vulnerable and uninfected. Her use of the pronoun ‘we’ severally here aligns herself with this position of being uninfected (‘okay’). In her use of the words ‘we think that young people here do not get infected’, and ‘we just date’ (line 36), she constructs young people as carefree, and as assuming they are invulnerable to risk. With the words ‘just date’ (line 36), she positions young people as dating without thinking, without consideration of risks, as ‘carrying on as normal’, ‘as if HIV is not present’, as assuming young people, and the university context are not at risk (do not get infected). She constructs this fact as unexpected, implying that this should not be the case for students.

Extract 42 below is taken from a coloured South African female participant.

<u>Extract 42</u>

35 Betty: Okay. And how do you see yourself in relation to risk?
36 Purity: For me, I feel that sex is actually the main way that I can get it, and I think that it is
37 easier to get it that way than blood transfusion or going to a clinic because clinics are clean you
38 can’t get contaminated with other people’s blood. So, I think whatever is transferred during sex
39 or blood transfusion is the imbalances, it is something that just creates this virus in your body.
40 So, I think the fact that I am sexually active is actually how I feel at risk.
41 Betty: So, what is the nature of your sexual activity?
42 Purity: I wanted us to have protected sex because he hasn’t been tested, but we did try ((to have
43 protected sex)), but then I ended up using contraceptives, but I know we are safe since I have
44 been tested.
(20, F, C, SA, UG, Tested)

In her use of the words ‘sex is actually the main way that I can get it’, ‘easier to get it that way’ (lines 36-37), and ‘the fact that I am sexually active is actually how I feel at risk’ (lines 38-39), Purity positions herself as understanding HIV transmission, and as being aware that she is vulnerable to HIV risk based on her sexual activity. She justifies this positioning by comparing the risk of contracting HIV through sex with other non-sexual routes. She does this by using the words ‘it is easier to get it that way than blood transfusion or going to a clinic because clinics are clean you can’t get contaminated with other people’s blood’ (lines 37-38). With these words, she positions her risk of contracting HIV through non-sexual means as extremely low. In her use of the words ‘whatever is transferred during sex or blood transfusion is the imbalances, it is something that just creates this virus in your body’ (lines 38-39), Purity creates a clear image of a foreign object unsettling and unbalancing you, with the power to ‘create’ a virus, and in doing this, she positions herself as being threatened by this virus, and as being exposed to it. With the use of the words ‘I wanted us to have protected sex because he hasn’t been tested’ (lines 42), she positions herself as being agentive in managing the risk of HIV for herself, and her protective practice is condom use. The emphasis on the word ‘I’ here suggests that it is not a ‘we’ decision that she is making reference to.

Moreover, in her use of the words ‘we did try ((to have protected sex)), but then I ended up using contraceptive’ (lines 42-43), Purity positions herself and her partner as focussing on condom use to prevent HIV, implying that there was a joint responsibility, but then there is the construction of ‘failure’ in ‘we’, and she, herself, alone, resorts to use of contraceptive (sic). Hence what she was saying here appears to be that there was an initial intention to be safe, but then this did not happen. So, portraying herself and her partner as ‘attempting it’ not only undermines her position as a responsible and knowledgeable health subject, but also perhaps hides what happens in moments of sex, and or in the process of negotiating about sex. She follows this up with a switch, ‘but I know we are safe since I have been tested’ (lines 43-44) to position herself as confident that she is still free of HIV, and by implication, position her sexual activities as ‘not that bad’. In her use of the words ‘I know we are safe’ (line 43), and ‘he hasn’t been tested’ (line 42), she seems to be using her own HIV negative status to determine her partner’s safety. By using the words ‘using contraceptive’ (line 43), she positions herself as still a responsible health subject in managing the risk of pregnancy for herself. Interestingly, it seems Purity fits into the group of students constructed earlier by Esther as prioritising the risk of pregnancy in sexual activity and disregarding the threat of HIV (Extract 32). Overall, Purity’s account is riddled with contradictions, from the idea that the virus creates imbalances, to the notion that contraception prevents HIV transmission, to positioning herself as being safe because she has tested for HIV.

Extract 43 below is taken from a black international male student participant who indicated in the demographic sheet that he was in a sexual relationship with three women, two of whom are in his home country, and one is in South Africa.

Extract 43

131 Betty: How do you see yourself in relation to HIV risk?
132 Andrew: I am worried about HIV risk since I am here ((in South Africa)).
133 Betty: What are your worries about?
134 Andrew: Contracting HIV, you see now if I have the audacity to date another lady here ((in
135 South Africa)), what about them ((his two girlfriends in his country)? Are they dating other
136 men or whom I know? So that is my biggest worry, and I feel at risk of HIV.
137 Betty: So, how do you deal with that?
138 Andrew: Hmm(.6). I don't know. I will just accept and move on, but hey, it is really an eye-
139 opening question hey, he he. I have never like really thought about it because I just want one
140 thing with those ladies. It is not about marriage, it is about sexual fulfilment, and that is it.
(24, M, B, KEN, PG, Tested)

In his use of the words 'I am worried about HIV risk' (line132), Andrew positions himself as being vulnerable to HIV risk. He justifies his worry by highlighting the long-distance nature of his relationships ('since I am here ((in South Africa))' (line 132). He positions his partners as potentially putting him at risk. He does this by using the words 'if I have the audacity to date another lady here ((in South Africa)), what about them ((his two girlfriends in his country)? Are they dating other men or whom I know?', 'that is my biggest worry', and 'I feel at risk of HIV' (lines 134-136). Taken together, these words position Andrew as being aware that engaging in multiple sexual relationships makes one vulnerable to HIV risk, and so the fact that he is doing it and is concerned about his two female partners' fidelity in his absence makes him feel threatened by something he is not responsible for, or at fault. In this way, he constructs himself as almost at the mercy of his partners' fidelity. In response to how he deals with his worry that someone might expose him to HIV, he begins his response with a short pause lasting for about six seconds 'Hmm(.6)', followed by the words 'I don't know' (line 138) to position himself as being helpless in this situation. This hesitancy might be about how he wants to perform in the interview, like considering what position he wants to assume. It is possible, too, that he is aware of the contradictions in his positioning. As indicated earlier, he positions himself as vulnerable because of the behaviour of others, and yet he is also made vulnerable by his own actions, as well as making other people vulnerable (causing risk for others). It is interesting, for example, that he does not say 'I know that I am engaging in risky sexual activities' but I do this, 'I test', or 'I use a condom all the time', etc. He takes no responsibility for his actions. In his use of the words 'it is really an eye-opening question' (lines 138-139), he comments about the context of the interview, and he congratulates me on the good questions I posed to him, which made him think. He then goes back to his position of focussing on himself as at risk of HIV because of others. He does this using the words ‘I just want one thing with those ladies’, ‘It is not about marriage, it is about sexual fulfilment, and that is it’ (lines 139-140). These words position him as being a callous and insensitive subject, one who focuses on his physical gratification. The soft laugh ‘he he’ (line 139) in his interaction with me shows that he is chuckling at himself as he tries to make light of his position that he has been a bad health subject.

However, here, it is possible, given that Andrew is Kenyan, that he is engaging with me as a Kenyan. The possible dynamic that is happening is, therefore, difficult to decipher because, as I mentioned in the method chapter, the issue of talking to men about sex is sensitive in the Kenyan context, but then here he is quite open and direct, and almost too open.

Moreover, the position adopted by Andrew points to another dimension of understanding the threat of HIV for a male student who has concurrent sexual partners. This is because, with him, the concern is not only about his risk of HIV infection in South Africa (or campus) but also, perhaps, more importantly, being a potential victim of HIV due to the possibility of his female partners cheating on him in his absence. However, this is not unique to Andrew as an international student since many South African students come from areas out of Pietermaritzburg – they might have two lives – one here and one there. Hence, the issue with Andrew here is not really about his internationalness as a student.

Extract 44 below is also taken from a black international male student participant who indicated in the demographic sheet that he was in a sexual relationship with two women who are both in South Africa.

<u>Extract 44</u>

122 Betty: So now that you have these partners, how do you prevent yourself from HIV?
123 John: I know myself, so definitely, if I get HIV, it will be her who infected me with HIV.
124 Betty: But you have two women, so how will you know it came from which one?
125 John: The thing is, one woman I use protection, another one I don’t ((use a condom)) because
126 I trust her. Now obviously, it will be this other one with whom I use protection with but you
127 know, sometimes there are those moments you just find yourself in the act without thinking,
128 but then I try always to use protection. So, I can say my risk of HIV is not that high.
(20, M, A, DRC, UG, Tested)

In his use of the words ‘I know myself’ (line 123), John positions himself as a responsible health subject. The emphasis he has given to this positioning is quite evident in his use of the words ‘definitely, if I get HIV, it will be her who infected me’ (line 123), ‘one woman I use protection, another one I don’t because I trust her’, and ‘now obviously, it will be this other one with whom I use protection' (lines 125-126), all of which work to attribute his risk of HIV to one of his female partners. With his use of the word 'trust' here, he positions her as trustworthy, as not a threat and himself as being able to rely on that judgement of her in making a decision of whether to protect himself from HIV or not. In his use of the words 'sometimes there are those moments you just find yourself in the act without thinking' (line 127), he positions himself as at the mercy of sexual drives, sexual spontaneity. This positioning is a contradiction; it suggests that he is not in compliance with the health acting subject he created (see line 123). He ends his response to this particular question with the words 'I try always to use protection' (line 128) to position himself as still a responsible health subject despite his inconsistency in managing the threat of HIV for himself through condom use, and this helps him to continue with his justification 'I can say my risk of HIV is not that high' (line 128). This minimises his risk, and by implication, position his sexual practices as not that bad.

It is important to mention that in many of the accounts presented by the participants who positioned themselves as not being at risk of HIV, there are contradictions – people adopting different positions that are in tension with each other. For example, 'I am safe, I use try condoms mostly'; 'I am safe and not safe'; 'I know I am safe and yet I still am unsafe'; 'I have more than one partner, I distrust my other partners, they will cause my HIV, silence about their own multiple partnering'. John, in the above extract, is a classic case. He acknowledges that he has multiple partners, but at the same time, blames his partner for HIV.

Extract 45 below taken is from a black South African female participant who gave an account of her experiences in serial monogamous relationships and positioned herself as a victim of HIV risk in these relationships. Serial monogamy is a practice of engaging in multiple sexual partnerships without any overlapping.

<u>Extract 45</u>

Betty: Okay, and how do you see yourself in relation to this risk?

Bongi: I think at first year when I also started out, I was at risk ((of HIV)) a lot because not that I had multiple partners at one time, but (.) but I would be in this relationship, and it wouldn't work out, then I go to another one, and the same thing happens, then I go to another. Then you find that in the space of a year, I have had almost seven or eight sexual partners in a year, not because you wanted to have multiple partners it is because at that stage you are younger, you just came to varsity, you can't tell who is genuine and who is not. When I start dating, there is that trust, that love that we have as women, we tend to date and see the future, and the guy ((man)) is not really there yet. He will tell you things that you want to hear, of course, you are happy, now you start trusting him, and now you give yourself to him in the form of having sexual activities with them. Then after that, the relationship sort of fades away, and he starts cheating on you because he does not care about you anymore, and now you are

thinking of HIV because he has cheated. Now that I am older, I can tell that this guy is genuine or not. I now know that a man can tell you what you want to hear.
Betty: And before moving to these relationships, did you ever think of knowing their status?
Bong: No, I didn't, to be honest with you. I didn't, and I regret it, but now I test for HIV a lot.
(24, F, A, SA, UG, Tested)

Bongi traced her risk of HIV to her 'first year' of university education (line 56), and engaged in a lot of discursive work to justify her positioning in this regard. In her use of the words 'not that I had multiple partners at one time' (lines 56-57), and 'I would be in this relationship, and it wouldn't work out, then I go to another one, and the same thing happens, then I go to another' (lines 57-58), she positions her former sexual relationships as not overlapping, which fits into the construction of serial monogamous relationships. In her use of the words 'not because you wanted to have multiple partners', and 'at that stage you are younger', 'you just came to varsity', 'you can't tell who is genuine and who is not' (lines 60-61), she positions these multiple relationships as not a deliberate choice. She positions herself at that phase of her life (in the first year) as young, as naïve and not aware enough of how to assess how a man is truthful/genuine. By implication, she positions herself as not responsible for her risk of HIV in this situation. To justify this positioning further, she uses the words 'there is that trust', 'that love that we have as women', 'we tend to date and see the future, and the guy ((man)) is not really there yet', 'He will tell you things that you want to hear', 'now you start trusting him', 'now you give yourself to him', to construct men as people who use nice words to 'tune up' their female partners only to manipulate them into engaging in unprotected penetrative sex with their male partners. She uses the words 'Then after that, the relationship sort of fades away', 'he starts cheating on you', and 'now you thinking of HIV because he has cheated' (lines 61-67) to position women as people who become wiser only after their men have deceived and exploited them and misappropriated their trust. Taken together, these phrases (see lines 61-67) serve to position Bongi as showing love and commitment and expects the same from her partners, but on finding these not reciprocated, she positions herself as hugely disappointed and emotionally disempowered and constructs her partner as one setting up a risk for her. She uses the words, 'Now that I am older, I can tell that this guy is genuine or not', and 'I now know that a man can tell you what you want to hear', (lines 67-68) to construct a naïve young first-year student who is a victim, and exploited, and preyed up, as one to blame for not being able to assess/evaluate/judge the character of a man; and contrast her with an older, wiser person, who 'can tell', who is aware that a man can manipulate 'can tell you what you want to hear' (line 68). In response to whether she considered knowing the HIV status of her former sexual partners, Bongi uses the words ‘No, I didn’t’ and ‘I regret it’ (line 70) to position herself as guilty and as knowing that she risked her life. In her use of the phrase ‘to be honest with you’ (line 70), she positions herself as being truthful.

Overall, Bongi’s justifications and rationalisations work to construct her former self as young and innocent, as not knowing enough (naïve), as not being able to assess that she is being taken advantage of in the relationship, and as less able to recognise her risks. She implicitly contrasts this with her current self as ‘older’ (line 67) and as ‘know[ing]’ (line 68) of men’s callous and manipulative behaviour in sexual relationships. With the words ‘but now I test for HIV a lot’ (line 70), she positions herself as agentive. With all of these, she constructs her current self as a health abiding subject and almost invulnerable to HIV risk.

In sum, the subject position constructed under this theme (5.3.1.1 The subject at risk due to their own activities of unsafe sex) appears to be drawing on the at risk subject discourse.

In contrast to the above subject positionings, all of which suggest that they are more vulnerable to HIV risk based on their activities of sex, a few participants (as evident in the accounts above as well – John blames women, Bongi blames men) position other people as being responsible for their risk and themselves as victims in this regard. The extracts that speak to this deviational trend are highlighted below.

5.3.1.2 A victim subject

Two Indian South African female participants (Nicole and Liz) adopted this subject positioning. Extracts from interviews with those two participants are presented below, beginning with Nicole.

Extract 46

50 Betty: So, when do you think you might be at risk of HIV?
51 Nicole: I feel like for females, it could be anywhere. Personally, I like to stay at home. So,
52 campus is where I mostly go, but I think as females, there is always a possibility of rape. So,
53 there is always that fear that the person who might rape you is HIV positive. So, for me, I would
54 say I have more fear on campus because I am here ((campus)) mostly I don’t go out much. So,
55 my fear is mostly on campus that something could happen, someone could rape me, someone
56 could get cut, and my blood will get mixed. All these things are what I fear most of the time
57 because it is not safe here, you know. I feel that way.

(19, F, I, SA, UG, Not tested)

In her use of the words ‘for females, it could be anywhere’ (line 51), Nicole positions a female subject’s risk of HIV as being omnipresent, and she aligns herself with this as a woman. To justify her position, she uses the words ‘as females, there is always a possibility of rape’ (line

52), and 'there is always that fear that the person who might rape you is HIV positive' (line 53) to position herself as at risk of a violent rapist; an unknown male figure who is positive. Also, she positions herself as 'at home' mostly, and safe, and women as vulnerable out there in the world. She also positions HIV here as being outside her home, her life, her family. In her constructions, it will be a stranger who rapes, which will cause her to contract HIV. The emphasis she has given to herself as a potential victim of HIV risk is quite evident in her use of the words 'I like to stay at home' (line 51), 'I don't go out much' (line 54), and 'I have more fear on campus' (lines 54, 55) to contrast the safe haven of the home and the great danger of the university context. She constructs the threat in the context of the university as related to the possibility of something ominous happening to her, such as being 'raped' (line 55). With her use of the words 'I am here ((campus)) mostly' (line 54), she positions herself as constantly facing the threat of HIV in her context, but she cannot resolve it. The other danger she referred to in the context of the university is being made vulnerable to HIV risk through non-sexual transmission routes. In doing this, she uses the words 'someone could get cut, and my blood will get mixed' (lines 55-56). In her use of the phrases 'All these things are what I fear most of the time' (line 56), 'not safe here', and 'I feel that way' (lines 57), Nicole positions herself as being concerned and worried about other people creating the risk for her.

It is interesting to note that this position she adopted as someone constantly faced with an enormous threat of HIV on campus contrasts with what she said she could do in a consensual sexual relationship. This is illustrated in Extract 47 below.

Extract 47

228 Betty: So, thank you so much for your time. Is there anything you want to add or say?
229 Nicole: Um, I think guys ((men)) are becoming more interested in using a condom because
230 guys are nowadays like this girl is not safe because there is a lot of HIV in South Africa. I can't
231 trust her with my life; I am going to use a condom. Because in my relationship, there was no
232 doubt about it. If we are having sex, then it has to be safe sex, we don't want kids, and we don't
233 want anything. We didn't have to sit and discuss it, but we knew condoms for sure. So, in a lot
234 of relationships now, it is barely a discussion; I have to use a condom. In the past, it was more
235 of; you have to discuss for a condom; otherwise, it was not going to be used. So, discussions
236 now have become easy, and sometimes there is no discussion at all because for sure you are
237 using a condom, you can't say, I don't want to use it because then we won't have sex. I think
238 times are changing, more people are enlightened and are like we must use a condom.

(19, F, I, SA, UG, Not tested)

In response to the question about whether she has any other thing to add or say in the context of our discussion, Nicole positions men in South Africa currently as being aware of the threat of HIV posed by female partners, and as taking responsibility for managing this threat. She does this by using the words 'guys nowadays are like this girl is not safe', 'there is a lot of HIV in South Africa', 'I can't trust her with my life', 'I am going to use a condom' (lines 230-231). To justify her position further, Nicole draws on her relationship experience to construct safer sex as something not negotiated but normalised. In doing this, she uses the words 'there was no doubt about it', 'If we are having sex, then it has to be safe sex', 'we don't want kids, and we don't want anything', 'We didn't have to sit and discuss it', and 'we knew condom for sure' (lines 231-233). With these words, Nicole positions herself and her partner as 'good', 'responsible' health practising subjects who are in control of their health. In her use of the words 'in a lot of relationships now it is barely a discussion' (lines 233-234), 'In the past, it was more of; you have to discuss for a condom; otherwise, it was not going to be used', (lines 234-235), and 'times are changing, more people are enlightened' (line 238), she positions condom use as being normalised and young people as rational, as prioritising their own safety. This particular positioning sets Nicole apart compared to the majority of participants who tended to paint a bleak impression of youth as being unduly resistant to the use of a condom as a means of managing the threat of HIV for themselves. What is also interesting in her positioning is that although she is a young woman aged 19 years old (at the time of this interview), she did not have to negotiate condom use with her partner, who was 18 years old then, as she indicated in the demographic sheet. This position is in contrast with the overall discursive pattern in this study which tended to portray young women as giving in to a man's desire for unprotected penetrative sex to avoid threatening the relationship. This pattern is shown in Extract 48 below, taken from Liz, an Indian South African female participant.

<u>Extract 48</u>

17 Betty: How do you view yourself in relation to this risk of HIV as a student?
18 Liz: It is scary because campus is not safe all the time. So, anything can happen, you know.
19 And we are living in a country where it is not safe for you as a woman, and I think that is the
20 sad part. So, I don't know at any moment I could just get raped or just touching somebody I
21 don't know because people are not going to disclose their status to anybody. And it is a personal
22 thing.

(23, F, I, SA, UG, Tested)

In her use of the words 'It is scary' (line 18), Liz positions herself as being vulnerable to HIV risk. She uses the words 'campus is not safe all the time' (line 18) to construct the context of the university as being risky. Her use of the words 'we are living in a country where it is not safe' (line 19) constructs the risk of HIV as going beyond the university context, as being omnipresent. This positions her as constructing HIV risk as a generalised threat, a position that is not mentioned in other participants' accounts. Similarly, the emphasis she has given to herself as being a vulnerable female subject is evident in her use of the words 'at any moment I could just get raped' (line 20). With these words, she positions herself as at risk of a violent rapist, an unknown male figure who is positive and herself as not liable or at fault. In her use of the words ‘I think that is the sad part’ (lines 19-20), she positions herself as being disappointed, sad at something lost, in this situation, as someone who finds herself in a risky context, but cannot defend herself. Through her use of the words ‘people are not going to disclose their status’, and ‘it is a personal thing’ (lines 21-21), she constructs HIV as something which is concealed, and there is a threat to her. Although her use of the words ‘just touching somebody I don’t know’ (lines 20-21) is not very logical and also not a common way of contracting HIV, the direct reference to ‘I’ as a victim is perhaps expected in the sense of acquiring HIV in this manner would be viewed as someone else’s fault, and not related to the fact that she is a sexually active subject.

Overall, this subject position of the at risk subject due to other people’s destructive behaviours and non-sexual transmission routes appears to be drawing on a victim discourse.

In contrast to the above subject positioning of being vulnerable to HIV risk, there were a few important outliers framing HIV as not a personal threat. The extracts illustrating this position are presented under Theme Four.

5.3.2 Theme Four: The no or low risk subject

Out of the 20 participants interviewed for this study, seven participants (6 female and 1 male) positioned themselves as no or low risk subjects. Following a careful analysis of their transcripts, three subject positions were identified in their accounts. These include a monogamous healthy subject, a subject who is currently sexually abstinent, and a subject who is not engaging in high-risk practices such as alcohol abuse or sexual activity with people of unknown HIV status. Participants’ account in relation to these three subject positions will now be presented and analysed.

5.3.2.1 A monogamous healthy subject

Out of the six female participants who positioned themselves as not being at risk of HIV, the practice of self-identifying as a monogamous healthy subject was evident in the accounts of three participants highlighted in Extracts 49, 50, and 51.

Extract 49 below, is taken from an Indian South African female participant, Sarah. Before this particular extract, Sarah had positioned the KwaZulu-Natal province as having a higher HIV infection rate as compared to other provinces in South Africa (see Extract 2).

Extract 49

24 Betty: You being a South African and living in the KwaZulu-Natal province, how do you see
25 yourself in relation to this risk of HIV?
26 Sarah: I have one partner, and we are not HIV positive now. We don't have the disease yet, not
27 that we wouldn't get it because we are both faithful to each other. It is just both of us. I only
28 have one partner, who is him, and he only has one partner, who is me.
29 Betty: How long have you been together with your partner?
30 Sarah: We are now together for ten years, so we are in a long-term relationship, and that is why
31 I was telling you I am not worried about HIV. I don't feel at risk for now, and obviously, he
32 doesn't have another partner; he has not been with someone else I have not been either. The
33 more people engage in risky and unsafe sexual practices with many people, that is where the
34 disease can be spread easily or increase the risk of spreading it, but I don't feel at risk for now.
(24, F, I, SA, PG, Tested)

In her use of the words 'we are not HIV positive now', and 'We don't have the disease yet' (line 26), Sarah positions herself as confident that she is not in close contact with the threat of HIV. In her use of these emphasising phrases 'I have one partner' (lines 26, 27-28), 'we are both faithful to each other', 'It is just both of us' (line 27), and 'he only has one partner, who is me' (line 28), 'We are now together for ten years', (line 30), 'obviously, he doesn't have another partner', and 'he has not been with someone else I have not been either' (lines 31-32), she positions herself and her partner again as being responsible health acting subjects, and she positions herself as having absolute confidence, not a trace of doubt in her relationship, all of which work to position her as being confident in her justification of their HIV negative status and as not exposed to the risk of HIV. Moreover, with her use of the word 'obviously' (line 31), she positions herself as certain about her partner's relationship history. This way of constructing a dating relationship as not involving cheating is different from the positioning adopted by other participants (Sane, Andrew, John, Nipho, Zazi, Londi, Bongi and Carol), where they raised suspicions of their partners cheating and creating the risk of HIV for them. However, in her use of the word 'now' three times (lines 26, 30, 31, 34), 'yet' (line 26), and 'not that we wouldn't get it' (lines 26-27), she positions herself and her partner as ordinary humans who are not immune to the frailties and fragilities of human experience, and hence she is cautious not to position herself as entirely invincible in the war against HIV prevention. In her use of the words 'The more people engage in risky and unsafe sexual practices with many people, that is where the disease can be spread easily (lines 32-34), she shifts the risk of HIV to the general other. This can also be seen in her use of the words 'but I don't feel at risk for now' (line 34), which positions her as distancing herself from the risk of HIV.

Extract 50 below is taken from a female international student participant, Esther. She discusses her own sexual practices with reference to, and in deference to other students. Before this particular extract, Esther had constructed HIV risk as prevalent on campus (see Extract 8).

Extract 50

28 Betty: How does that make you feel about your personal risk of HIV?
29 Esther: He he, for me, I think I am different because I only date one man at a time, and before
30 we engage in sex, I would have known his past relationships. I have dated one person for the
31 past five years, and before that, I had tested for HIV, and I tested again in 2016 after we met,
32 and I was fine, and so I even trusted him more. So really, I know students can be at risk of HIV,
33 but I think for me, it is a different case, jah.
34 Betty: Okay, and to what extent do you trust your boyfriend?
35 Esther: Hey, I think I can trust him. I am not sure if he has tested, but I know he is not HIV
36 positive because I have tested as I told you.

(23, F, A, UGA, UG, Tested)

In her use of the words ‘I think I am different’ (line 29), Esther positions herself as being different from other students. She uses the words ‘I only date one man at a time’ (line 29) to position herself as being monogamous. Her use of the words ‘known his past relationships’ (line 30) positions her again as knowing her partner’s sexual history. With the use of the words ‘I had tested’, ‘I tested again in 2016 after we met’ (line 31), and ‘I was fine’ (line 32), she positions herself as confident that she is not at risk of HIV infection, and as unequivocal about her HIV negative status. In her use of the words, ‘Hey, I think I can trust him’, and ‘I am not sure if he has tested’ (line 35), she positions herself as tentative and uncertain about her partner’s HIV testing practices and, by implication, his HIV status. Yet again, in her use of the words ‘I know he is not HIV positive because I have tested’ (lines 35-36), she positions herself as confident that her partner is also out of the danger of HIV, and she is basing this on her own HIV negative status. Overall, this account positions Esther as a good health subject, and her protective strategies are sexual monogamy, knowledge of her partner’s former relationships, and personal testing for HIV. She seems to position these strategies as making her ‘different’ from other students but again leave a gap in her protective practices. This subject position contains contradictions, which she ignores. This is because knowing his past partners is not proof, nor is her own negative test; there is a suspension here of scientific thought – one can be in a relationship and still be involved with others. If she has not tested for HIV right at this moment, how does she know that she is not at risk of HIV? One can raise this question here because she does not really know his HIV status or whether he is faithful, and all the HIV tests are hers, not joint/couple testing. So, the soft laugh ‘he he’ (line 29) could imply that she is chuckling at herself as she tries to make light of her own position as being ‘different’, and as not being at risk of HIV. The soft laugh could also imply that she is aware that as a researcher I would disagree with her choice to accept the risks for the sake of her relationships and felt uncomfortable in having to defend this.

Extract 51 below is taken from a black international female student participant, Phumi. Before this particular extract, Phumi had constructed HIV as being a threat to students, and in her justification, she positioned students as knowing about it but not acting on this knowledge (see Extract 28).

Extract 51

23 Betty: How does this uh make you feel about your risk of HIV?
24 Phumi: No, at the moment. I don't feel like I am at risk of HIV because the person that I have
25 been with is not infected. I have only been with him. Of course, you talk about these things,
26 although not so much, but if you ask them if they are HIV positive, they say no, I am fine, I
27 have been tested. So, I just sort of believed him, although it is a bit stupid to believe it, but I(.5),
28 it wasn't really an issue for me because I thought I believed that person and I said jah maybe,
29 and the person seems trustable, so I just believed him. And we have had sex anyway, so nothing
30 will even change even if we go get tested together, whatever the result, you know. So, you
31 don't see that need to even talk about it and make him feel bad for nothing. You actually don't
32 want to sort of offend him; it is just about caring for his feelings.

(22, F, A, ZIM, UG, Tested)

In her use of the words 'I don't feel like I am at risk' (line 24), and 'the person that I have been with is not infected' (lines 24-25), Phumi positions herself as someone who is not in close contact with the risk of HIV. Her use of the words 'I have only been with him' (line 25) positions her again as being monogamous. With the use of the words 'if you ask them if they are HIV positive, they say no, I am fine I have been tested' (line 26), she seems to allow for the possibility that her partner does not know his HIV status as he says. She appears to be doubting his claim, and by implication, position herself as concerned about her safety. In her use of the words 'although it is a bit stupid to believe it' (line 27), she positions herself as irrational, as knowing that what she is doing is not correct (she is submitting herself to HIV risk). This can also be seen in her use of the words 'we have had sex anyway, so nothing will even change' (lines 29-30), which serves to construct sexual activity as something inevitable in her relationship. It is as if it is through the activity of sex that she is invested with value in her relationship.

Moreover, she positions herself as not wanting to raise suspicion that her partner has HIV and as not wanting to threaten him and the relationship. She does this by using the words 'you don't see that need to even talk about it and make him feel bad for nothing' (lines 29-31), and 'You actually don't want to sort of offend him' (lines 31-32). With these words also, she positions herself as more concerned about her risk in relating with him than about ‘caring for his feelings’ (line 32), as she says. Overall, her tendency to rely on hearsay and trust to absolve her partner from the risk of HIV weakens how she positioned him earlier as ‘not infected’ (line 25), and herself as ‘not feeling at risk’ (line 24).

5.3.2.2 A subject who is currently sexually abstinent and confident of being HIV negative

Out of the six female participants who positioned themselves as not being at risk of HIV, two participants self-identified as being currently sexually abstinent subject and not valuing sex as others. Extracts from the interviews with those two participants are used to illustrate this sub-theme.

Extract 52 below, is taken from a black South African female participant, Londi. This extract is a continuation of her account in Extract 7, where she positioned students on campus as sexually active and their sexual activities as unsafe.

Extract 52

36 Betty: How does that make you feel about your risk of HIV infection?
37 Londi: (.4) since uh, at the moment I am not engaging in sexual activities um, I feel safe, but ::
38 if I were, even if I would trust the person that I have, I would be in hundred percent risk because
39 of how our relationships are in this context.
40 Betty: But you told me earlier that you have been in a relationship in the past.
41 Londi: Um, because I tested after the relationship, but it wasn’t really an easy thing to do
42 because I knew how much risk I was in as I am saying that (.4). I knew that this guy cheated,
43 and not once but several times. So, in fact, I came to know later, after all that happened, how
44 much risk I was in. So now, since I have tested, I don’t feel that I am at risk because I know
45 that I am safe at the moment.

(24, F, A, SA, PG, Tested)

In her use of the words ‘at the moment I am not engaging in sexual activities (line 37), and ‘I feel safe’ (line 37), Londi positions herself as practising secondary sexual abstinence and as being at no risk of HIV. She uses the words ‘even if I would trust the person that I have, I would be in hundred percent risk’ (line 38) to position herself as being aware that trusting a partner is not protective, which is different from the account of other participants (Esther, John, Bongi, Phumi) who relied on the verbal judgement of their partners to rule out the threat of HIV in their sexual partners and fellow students campus (see Extracts 8 & 51; Extract 44; Extracts 45; Extracts 40; Extracts 50; Extracts 51, respectively). In her use of the words ‘I knew how much risk I was in’ repeatedly (lines 42, 43-44), and ‘I knew that this guy cheated and not once but several times’ (lines 42-43), she positions her former sexual partner as being responsible for her risk and herself as a victim. She uses the words ‘it wasn’t really an easy thing to do' (line 41) to construct her HIV testing experience as tense and risky, and she relates this to the fact that she knew that she had risked herself. She uses the words 'since I have tested, I don't feel that I am at risk', and 'I know that I am safe at the moment' (lines 44-45) to position herself as unequivocal about her HIV negative status. In her use of the words 'I knew how much risk I was in' severally, she positions herself as complacent in managing the risk of HIV. However, in Extract 53 below, Londi's positioning changes.

<u>Extract 53</u>

430 Betty: You spoke earlier about going for an HIV test with your partner in future, and how is
431 that possible because you also talked about your fear of losing the person?
432 Londi: Now it is different because I was saying that you might lose a person if, let us say I
433 found out in the relationship that I am HIV positive, but now I will do it at the earlier stage
434 when we haven't even thought about sex because I understand that we can have sex anytime,
435 but if I am saying that we want to be in a relationship, that would be like a prerequisite ((couple
436 HIV testing)). If you are not doing it, then there is no future for us, I am not scared to lose you
437 because at the beginning of a relationship, usually for women, it is the man that wants you. So,
438 you are not really sure whether you really love this person. So, if he doesn't want, let him go.
439 If they don't want, then you have escaped because you don't know really this person. So that
440 is like it is now a prerequisite to get me. So now it is like a standard thing that I have to consider
441 in going forward.

(24, F, A, SA, PG, Tested)

Londi uses the words 'that would be like a prerequisite' (line 435) to position herself as having a condition on which having a relationship is based on couple testing. This positioning is quite evident in her use of the words 'If you are not doing it, then there is no future for us' (line 436), and 'If they don't want, then you have escaped' (line 439). With these words, she is acknowledging and prioritising her safety in the relationship, positions herself and to me as the researcher as being determined, as valuing herself and her future, as structured, and as able to set terms and conditions for managing her exposure to the risk of HIV. She uses the words 'because I understand that we can have sex anytime' (line 434) to position herself as being aware that sexual activity is something one cannot plan for, but as something spontaneous. So, by initiating and insisting on joint testing before committing to a relationship, she seems to be preparing herself for it. This positions her as being a responsible health subject, and her protective practice is joint testing. I say this because, in her account, the important construction is the notion of couple testing as critical to starting a relationship, which is a new and different approach to the risk of HIV (compared to the other participants).

Extract 54 is taken from a black international female student participant, Leah. Before this particular extract, Leah had constructed HIV as being prevalent on campus (Extract 10).

<u>Extract 54</u>

30 Betty: Okay, and so how does that make you feel about your personal risk of HIV?
31 Leah: I think I would be worried only if I were engaging in sexual activity, but since I am here
32 particularly for studies, I do not think I want to be worried about HIV.
33 Betty: If you were to be in your home country, would you be worried about HIV?
34 Leah: Yes, I will be, of course, because that is where I can say I am sexually active, and my
35 partner is there.
36 Betty: Okay, have you guys talked about this issue of HIV risk?
37 Leah: NO. It is not really easy to even talk about HIV when you trust somebody, HIV should
38 not even be a concern, but it depends on the type of relationship since you have a future
39 together, then you are fine.

(23, F, A, TAN, PG, Tested)

In her use of the words 'I would be worried only if I were engaging in sexual activity' (line 30), Leah positions herself as not being vulnerable to HIV risk. She uses the words 'since I am here particularly for studies, I do not think I want to be worried about HIV' (lines 31-32) to position herself as a focussed student at university, and in South Africa for a particular reason, and HIV as something outside of herself and her life. In response to whether she talks about HIV risk with her partner, Leah uses the words 'NO. It is not really easy even to talk about HIV when you trust somebody, HIV should not even be a concern' (lines 37-38). These words serve to position her construction of broaching the topic with someone she trusts as important. With the words 'since you have a future together, then you are fine' (lines 38-39), she constructs her focus as being on keeping the relationship with him. Overall, Leah's account positions her relationship as low risk, and long-lasting, which justifies her passivity regarding HIV testing, and allows her to maintain the status quo even though she previously mentioned her concerns as an individual in a relationship.

It is also worth noting that Leah's positioning in this extract contrasts with the view of Andrew, another international student, but this time a male participant (see Extract 43). This is because Andrew, unlike Leah, had a concern not only about his risk of HIV in South Africa (or campus) but also, perhaps, more importantly, his female partners setting up a risk for him by cheating in his absence. Leah's concern is not with the HIV threat in South Africa and on campus at all because she is not sexually active, but in her country when she returns because that is where her activities of sex occur (lines 34-35).

5.3.2.3 A subject who is not engaging in high-risk practices

Two participants (a male and a female) self-identified as not engaging in high-risk practices. Extracts from interviews with those two participants are used to illustrate this sub-theme, beginning with the female participant.

Extract 55

40 Betty: How do you see yourself in relation to this risk?
41 Buhle: I am not susceptible to getting this virus at this stage unless if someone rapes me. I have
42 always had protected sex; I only became sexually active in Feb this year. I have not been in a
43 car accident either.

(24, F, A, SA, PG, Tested)

In her use of the words ‘not susceptible’ (line 41), and ‘always had protected sex’ (line 42), Buhle positions herself as a safe and responsible health subject in relation to HIV risk. She also positions herself as someone who is not in close contact with the threat of HIV. This is quite evident in her use of the words ‘I have not been in a car accident either’ (lines 42-43). Furthermore, in her use of the words ‘unless if someone rapes me’ (line 41), she positions someone else as being responsible for her risk and herself as not liable or at fault (victim). This particular way of constructing the possibility of contracting HIV as someone else’s fault, or destructive/bad behaviour (rape), is similar in content and emphasis to the positioning adopted by Nicole and Liz in Extract 46 and Extract 48, respectively.

The male participant positioned himself as managing his risk by making behavioural changes. Extract 56 below illustrates views.

Extract 56

22 Betty: Now, tell me, Alfred, how do you see yourself in relation to this risk?
23 Alfred: People get HIV when they are irresponsible. Here on campus, when they have
24 unprotected sex, they get HIV or, like the majority of students on campus, drink a lot, and so
25 they can just engage in sex without knowing their status.
26 Betty: Okay, so how does that put you at risk of HIV?
27 Alfred: I don’t feel at risk because I don’t drink to get drunk. I just take one or two, then I go.
28 I drink on occasion, and most of the time, I use protection if I don’t know the status of that
29 person.

(21, M, C, SA, UG, Tested)

Alfred uses the words ‘People get HIV when they are irresponsible’ (line 23) to position himself as knowing how one can become vulnerable to the threat of HIV, and with the word ‘people’ he distances himself from this risk. In his use of the words ‘the majority of students on campus drink a lot’ (line 24), and ‘they can just engage in sex without knowing their status’ (line 25), he positions students as being vulnerable to HIV risk in their context, and he seems to contrast this with himself, as not like them. In his use of the word ‘just’ (line 25), he positions himself as being critical of students for ignoring the threat of HIV. He constructs HIV risk as outside his life, unlike other students. This is evident in his use of the words ‘I don’t feel at risk’, ‘I don’t drink to get drunk’ (line 27), and ‘most of the time, I use protection’ (lines 28-9). With all of these words, Alfred positions himself as rational and able to weigh the consequences of his action, fitting into the construction of a responsible health subject.

However, he also uses the words ‘most’, and ‘if’ (line 28), which position him as a not completely compliant health subject. It is as if, despite his positioning as a responsible health subject, he is not entirely in control of the situation. Perhaps this could be a case of a participant positioning himself to me as the researcher as the ‘good’ health subject who knows and attends to health messaging and is responsible for his health.

Overall, the above positioning of a no, or low risk subject show awareness of HIV risk and its management. It also reflects an investment in self, which appears to be drawing on a discourse of the responsible health subject.

5.3.3 Trends and conclusions arising from findings on research question two

Some significant findings were identified in this analysis in relation to research question two. The first of these is Sane’s construction of engagement in unprotected sexual behaviour in the era of HIV and AIDS as an action that comes with a good and a bad outcome; namely, enjoyment of the act and the regrets that come after that.

The second key finding is the positioning adopted by some participants (Sane, purity, Andrew and Alfred) as a ‘good’ ‘responsible’ health subject, but also as one who ‘lapses’, forgets, and then is drawn sharply back to the reality that s/he has been a bad subject.

The third key finding is Tumi’s construction of students as assuming that the context of the university is free of HIV threat and students as being invulnerable subjects. She positions these students as having a false sense of bravado about the risk of HIV.

The fourth key finding is the tendency of some male participants (Zazi, John, Alfred, and Andrew) to boldly act and claim that they are no or low-risk subjects, yet they did not report protective practices in their sexual activities.

The fifth key finding is the tendency of some female participants (Purity, Tumi and Sane) to use their own HIV status as a condition for determining the safety of a sexual partner. This positions each of them as assuming that once their own HIV status is negative, then there is no need to worry about their partners’ HIV status.

The sixth key finding is Leah’s (international female student) positioning which contrasts with the view of Andrew, another international student but this time a male participant. This is because Andrew’s concern is not only about his risk of HIV infection in South Africa (or campus) but also, perhaps, more importantly, his female partners setting up a risk for him by cheating in his absence. While for Leah, the opposite is the case; her concern is not with the HIV threat in South Africa and on campus at all because she is not sexually active, but in her country when she returns because that is where her activities of sex happen.

The seventh key finding is the positioning adopted by some participants (Nicole, Liz and Buhle) in which other people were constructed as being responsible for creating the risk of HIV for them. In this way, they position themselves as not at fault; the threats of HIV have nothing to do with them, despite being sexually active. This positioning appears to be drawing on the victim discourse.

In contrast to the above subject positionings, in which HIV is constructed as a threat to people's health and safety, which reflects a discourse of the at risk subject, is the position as not being at risk adopted by seven participants. To justify their positioning, three of the seven participants positioned themselves as practising sexual monogamy; two of them positioned themselves as certain of their HIV negative status; while the other two positioned themselves as not engaging in high-risk practices, such as alcohol abuse and sexual activity with people of unknown HIV status. This positioning of a no or low risk subject appears to be drawing on a discourse of the responsible health subject.

Finally, the construction of the sexual relationship by some participants in this study influenced how young people positioned their risk of HIV, and their need to engage in HIV prevention services. For instance, in some of their accounts, it seemed less about the positioning of the female or male as only victims of their partner's behaviours, but the construction of love/trust/the relationships was used to justify why they did not position themselves as at-risk.

Participants' constructions of HIV risk as demonstrated in the findings relating to research question one, and their positioning in relation to this form of risk as shown in the findings relating to research question two, shapes and influences their HIV testing practices. In the next section, the findings in relation to the third research question are presented and analysed. In presenting these findings, the theme numbering will be a continuation from those used for research question one and research question two.

5.4 Research question three: How do sexually active university students' constructions of, and positioning in relation to HIV risk, relate to their practice of HIV testing?

The analysis of participants' transcripts in relation to this research question revealed interesting contradictory trends in relation to participants' understanding of the importance of the practice of HIV testing. For instance, in most of their accounts, HIV testing was constructed as being a required protective health behaviour, as facilitating a change in identity and status, as of great significance, and as providing linkages to HIV treatment and support. Yet, of the 20 students who took part in the study, three of them, all female, positioned themselves as never been tested at the time of the interview. Even though most participants (17) reported having been tested, inconsistencies and contradictions in their accounts were identified. The accounts of the majority of participants revealed that HIV testing is not something they engage actively in. It became apparent in their justifications that their HIV testing practices were largely incidental and often responses to their engagement in risky sexual encounters, or their experiences of their cheating, or their own infidelity, or in reaction to having visible symptoms suggestive of AIDS. In the attempts to justify their hesitancy to take an HIV test, most participants constructed the process of testing as visible and public, a situation that exposes people to the risk of stigma and discrimination.

Overall, the findings of this study under this research question can be classified into four themes. These themes are analysed below under themes five, six, seven, and eight. Theme Five presents the account of three female participants who reported never been tested for HIV. Theme Six presents the HIV testing practices of participants who reported having been tested for HIV. Theme Seven presents participants' constructions of the risks related to the visibility of the HIV testing process. Finally, theme Eight presents participants' constructions of the HIV testing process as needing to be accompanied by trained counselling support. Analysis of findings under Theme Five now follows.

5.4.1 Theme Five: Accounts of three female participants who reported never been tested for HIV

Three female participants (Nicole, Carol and Zama) positioned themselves as having never been tested for HIV. Their rationalisations and justifications and their plans concerning this health practice are presented below.

Extract 57 below is taken from Nicole, an Indian South African female participant. Before this particular extract, Nicole had constructed HIV as a considerable risk amongst students on the Pietermaritzburg campus. In her justification, she positioned students as not acting on their knowledge to protect themselves from HIV risk (see Extract 18). She had also positioned herself as a potential victim of HIV due to the possibility of something ominous happening to her on campus, such as being 'raped by someone who has HIV' or being exposed to contaminated blood (see Extract 46). In response to what HIV testing means to her, she says:

Extract 57

58 Nicole: For me, it is something crucial. It means that you are just checking to see if you are
59 okay. I mean, anything could have happened; as I said, you could have been cut, and you are
60 exposed to someone's blood who has HIV or raped, or your boyfriend could have lied to you
61 that he is negative. So, for me, it is just making sure that you are on the okay side, and if you
62 are not okay, then you start taking the medication that you need to stay healthy.

(19, F, I, SA, UG, Not tested)

In the extract above, Nicole uses the words 'exposed to someone's blood who has HIV', 'raped', and 'your boyfriend could have lied to you' (line 60) to position her risk of HIV as being brought about by someone else, and herself as not responsible or at fault. In her use of the phrase 'it is something crucial' (line 58), she constructs HIV testing as being a required health behaviour. The emphasis Nicole has given to HIV testing as being an appropriate health practice is quite evident in her statement, 'it is just making sure that you are on the okay side and if you are not okay, then start taking the medication' (lines 61-62). The irony in Nicole's account, however, is that despite her positive constructions of HIV testing as a crucial risk control strategy, she still positioned herself as 'have never been tested'. In Extract 58 below, she did a lot of discursive work to rationalise her positioning in this regard.

Extract 58

63 Betty: So, tell me, have you tested for HIV?
64 Nicole: I have not.
65 Betty: So, why have you not tested?
66 Nicole: I have not gone for the check-up yet because I haven't put it in my schedule, I guess
67 because I have always been busy with my studies on campus, but also because I have only had
68 sex with one sexual partner and he has only ever had one sexual partner who is me. I know he
69 has not slept with anyone before, and myself, I know I haven't, so the risk has never been there.
70 Um, but we did speak about it at some point. We were like, are you clean, and am I clean, but
71 I have never been tested, and he hasn't tested. So, I feel like there is no need for us to go yet. I
72 mean, I will go but not at the moment.
73 Betty: Okay, and how do you think he may respond if you were to ask him you guys for testing?
74 Nicole: I think he will ask why you are asking why you want to get tested? We have only been
75 at each other. And that I think he has nothing to hide.

(19, F, I, SA, UG, Not tested)

In her use of the words ‘I have not gone for the check-up yet because I haven’t put it in my schedule’ (line 66), Nicole constructs HIV testing practice within a ‘check-up’ routine as something which should be scheduled and organised (almost like a lecture). She uses the words ‘I guess because I have always been busy with my studies on campus’ (lines 66-67) to position herself as a focused student who appears to place her academic needs above her health needs. Her use of the words ‘I guess’ here indicates her lack of certainty in her position, or an admittance that this prioritisation might not be the best one. To justify her lack of engagement with HIV testing further, she uses the words ‘I know he has not slept with anyone before and myself I know I haven’t, so the risk has never been there’ (lines 68-69) to position herself and her partner as being in a first-love sexual relationship, and thereby as being invulnerable subjects in relation to HIV risk. Her use of the words ‘I know’ and ‘never’ here serves to position her as certain and very confident about her own and her partner’s relationship history.

Moreover, in her use of the words ‘We were like, are you clean, and I am clean’, and ‘but I have never been tested, and he hasn’t tested’ (lines 70-71), she seems to allow for the possibility that her partner does not know his HIV status and that she is only using the authority of hearsay to determine their (her and partner’s) safety from HIV risk. By using this as a justification, she does not feel the need for them (her and her partner) to get tested. This particular positioning is evident in her use of the words ‘So, I feel like there is no need for us to go yet’ (line 70). In her use of the words ‘he will ask why you are asking’, ‘why you want to get tested?’, and ‘We have only been at each other’ (lines 74-75), she constructs the broaching of the topic of HIV testing with her partner as something sensitive and dangerous, and as potentially threatening him. With the use of the words ‘I think he has nothing to hide’ (line 75), she rationalises her belief in her partner’s trustworthiness, setting up a distinction between him and someone else who would have something to conceal, perhaps an HIV diagnosis

It is also evident that Nicole’s hesitancy to take an HIV test relates to how she positions people as stigmatising people who go for testing. This is evident in Extract 59 below.

Extract 59

76 Betty: So, you are saying you have never been to an HIV testing centre?
77 Nicole: Yes. I have never been to a testing centre, but I think those places scare me. I feel like
78 if you go there one, you are going to be judged by the person who sees you there. Two, people
79 testing you are not as sensitive about the topic as they should be. They will be like do you think
80 you have HIV? Are you having sex? Why would you have HIV? I mean, I would be
81 embarrassed, there is always the stigma, and I feel like if you go there, you just have the stigma.
82 Betty: So, will you consider testing at all?
83 Nicole: I am not sure yet. I do not see the reason why I should do it since I am sure I have not
84 been raped, and I have not cut myself in public, but I will do it if, by chance, I get raped.

(19, F, I, SA, UG, Not tested)

In the above extract, Nicole's use of the words 'those places scare me' (line 77) constructs HIV testing as an intimidating and risky process. In her use of the words 'you are going to be judged by the person who sees you there' (line 78), she constructs the process as potentially stigmatising. Furthermore, she uses the words 'people testing you are not as sensitive about the topic' (lines 78-79), and 'they will be like do you think you have HIV? Are you having sex? Why would you have HIV?' (lines 79-80) to position health care service providers as generally insensitive in asking direct questions about sexual practices and risk. With the use of the words 'I would be embarrassed, there is always the stigma' (lines 80-81), Nicole positions herself as being vulnerable to the risk of stigma and being judged negatively by the health care service providers and people around who see her going for testing. In her use of the words 'I am not sure yet' (line 83) in response to whether she will consider getting tested, Nicole seems to resist taking an HIV test to avoid this perceived stigma. She uses the words 'I have not been raped', and 'I have not cut myself in public' (lines 83-84) to rationalise her stance of not testing. She constructs the people who need to go for HIV testing as those who know that they have put themselves in situations of HIV risk. With her words 'I do not see the reason' (line 83), she positions herself as aware of the risk, and of the need for a particular health behaviour in response to the risk, but convinced that she is not at risk. Overall, given that HIV testing is not something Nicole has been engaging actively in, she seems to be drawing on constructions of HIV testing as being a required protective behaviour, as seen in Extract 57.

Extract 60 below, is taken from Carol, a coloured South African female participant. Before this particular extract, Carol had constructed HIV as an immense risk to students on the Pietermaritzburg campus. In her justification, she positioned HIV testing as being actively promoted on campus (see Extract 15). She positioned herself as being at risk of HIV, and in her justification, she raised her suspicions about her partner cheating and putting her in situations of risk. In response to what HIV testing means to her, she says:

<u>Extract 60</u>

54 Carol: As I told you, I haven't tested, but for me, it means having the courage to face reality.
55 HIV is something that is there, we all know about HIV, but testing is not something that just
56 comes easily. It is for people who have courage and are ready to get either positive or negative
57 result, depending on how they have been carrying themselves.

(20, F, C, SA, UG, Not tested)

In the above extract, Carol uses the words 'having the courage to face reality' (line 54) to construct HIV testing as something that demands 'courage' and one being ready to accept with equanimity whatever result that emerges from it; and in positioning it in this way, she constructs it as something that is difficult to face and threatening generally. She uses the words ‘we all know about HIV’ (line 55) to position herself as aware of the risk of HIV. In her use of the phrase ‘but testing is not something that just comes easily’ and ‘for people who have courage and are ready’ (lines 55-56), she links HIV testing with confronting the problem of HIV and positions herself as being terrified to engage in it. This positioning is quite evident in Extract 61 below, where she expresses her desire to know her HIV status through testing, but she is scared to do it.

<u>Extract 61</u>

58 Betty: Okay, and so why have you not tested?
59 Carol: There was this day I wanted to get tested; it was after matric. I told my boyfriend Um,
60 randomly, babes let us go and get tested because the people testing were in school, and he was
61 like, what? Why do you want us to get tested? No, no, no, no ↑. Me, I know my status. He
62 doesn’t want to. So that made me hesitant to test.
63 Betty: And why do you think he refused for you guys to test?
64 Carol: I mean, he just says he knows himself even though he hasn’t been tested. He was just
65 ranting about it as if there is something wrong, you know. And uh, it feels like me asking that
66 of him is like me doubting him and our relationship and our trust. But, meanwhile, for me, it is
67 something like a box to tick. I want to make sure I check this and that, and I just wanted to
68 make sure that my HIV status is checked so that it should be something that is done and not at
69 the back of my mind always.
70 Betty: Okay. So, will you consider testing for HIV?
71 Carol: I will. I will go to my doctor this weekend; I have a check-up to check if my IUD is in
72 place. I will just ask her, can you just do a test for me and sign off? I feel like it has been on
73 my mind for years. I want to get it done, but I have this fear in me.

(20, F, C, SA, UG, Not tested)

In the extract, Carol justifies her lack of engagement with HIV testing with an account of a conversation, which took place in her secondary where she asked her partner to get tested with her. In describing his response, she uses the words ‘what? Why do you want us to get tested? No, no, no, no ↑’ (line 61) to construct him as being shocked and surprised and suspicious of the idea of being tested. With the use of the words ‘Me, I know my status’ (line 61), she positions her partner as dismissive of HIV risk. In her use of the words ‘me asking that of him is like me doubting him and our relationship and our trust’ (lines 65-66), she constructs the conversation as difficult with a problematic outcome. In response to why she thinks her partner refused to test, she uses the words ‘he just says he knows himself even though he hasn’t been tested’ (line 64) to position his claim of not needing to get tested as unjustified and herself as sceptical about his HIV negative status. This positioning can also be seen in her statement, ‘He was just ranting about it as if there is something wrong’ (lines 64-65) which positions her as allowing for the possibility that he might have HIV and as allowing for some emotion, perhaps fear that he has set up a risk for her. She uses the words ‘He doesn’t want to’ and ‘So that made me hesitant to test' (lines 61-62) to position herself as one who feels discouraged to engage in HIV testing since her partner was not supportive of it; a situation which positions her as someone who is resigned to the situation, and without agency in her relationship, and it is as if she is at his mercy.

Carol positions herself as wanting and needing certainty about her HIV status. She does this by using the words 'I just wanted to make sure that my HIV status is checked so that it should be something that is done' (lines 67-68). In this phrasing, she constructs HIV testing as a task to be ticked off as completed and as something she wants to normalise. In her use of the phrases 'it has been on my mind for years', and 'I want to get it done' (lines 72-73), Carol positions herself again as one who is aware of the importance of HIV testing in controlling the risk of HIV, and as one who feels potentially vulnerable to HIV risk and wanting to live in the truth of knowing her HIV status. She also positions herself as agentive in managing the risk of pregnancy. She does this by using the words 'I have a check-up to check if my IUD is in place' (lines 71-72). However, in response to how she will deal with her 'fear' (line 73) of taking an HIV test, she says:

Extract 62

74 Carol: I will just pray about it ((HIV testing)) and just do it. I feel like if I spend too much time
75 talking about it to someone, as much as I might sound open, but slowly, psychologically, I am
76 building up a wall against it. So, I rather just be in the moment, just pray and do it quickly
77 without thinking. So, I rather be there at the doctor's office when she does a check-up. I will
78 tell her; can you please check my HIV status. I don't want to talk about it.
79 Betty: Okay, but normally HIV testing involves some counselling.
80 Carol: Honestly, to be very honest, I feel like I wouldn't seek counselling because I feel like
81 there would be that shame of getting counselling. If I did find out, I am positive; it would be
82 very heartbreaking and shameful. I just don't even want to think of it. I feel I need to first find
83 strength in myself before finding strength in someone else. I need to be able to stand and be
84 like, that is it. It is not the end of my life. I will move on from it.

(20, F, C, SA, UG, Not tested)

In her use of the words 'I will just pray about it ((HIV testing)) and just do it' (line 74), and 'just pray and do it quickly without thinking' (lines 76-77), Carol positions herself as religious and HIV testing as something she wants to 'just' engage in without thinking decisions. The emphasis she has given to impulsivity in the activity of testing is quite evident in her use of the words 'I rather just be in the moment' (line 76), and 'I don't want to talk about it' (line 78). In so doing, she seems to position herself as avoidant and procrastinating because of fear. She uses the words 'I might sound open, but slowly, psychologically, I am building up a wall against it' (lines 75-76) to construct pre-test counselling in the process of HIV testing as increasing her resistance to taking the test. In response to whether she will consider pre-test counselling, she uses the words ‘Honestly, to be very honest, I feel like I wouldn’t seek’ (line 80) to position herself as sincere in her statement about not considering the counselling services. To justify her position in this regard, she uses the words ‘I feel like there would be that shame’ (lines 80-81), and ‘If I did find out, I am positive; it would be very heartbreaking and shameful’ (lines 81-82) to position herself as potentially positive, and fearing of the same and heartbreak that would follow. She constructs the process of finding out about her status as potentially deeply distressing and shameful, and rationalises that this would best be done in private, not in public, in front of a counsellor. The emphasis she has given to the fear that she might have HIV is evident in her use of the words ‘I just don’t even want to think of it’ (line 82) which positions her as apprehensive, avoidant and in denial about her HIV status. Hence the idea of ‘not thinking about it’ is her coping mechanism. Moreover, in the last two lines (lines 83-84), she positions herself as being strong enough to accept her HIV status if she ever tests positive and as being ready to embrace a positive living. Towards the end of the interview, she positioned herself as ultimately agentive in the sense that affirmed the importance of HIV testing, an activity she had earlier constructed as for people who have ‘the courage and ready to face reality’ (see Extract 60); a positioning that implies a shift in perspective on her part from her earlier construction on the matter.

Extract 63 below, is taken from Zama, a black South African female participant. Before this particular extract, Zama had constructed HIV as a huge risk amongst students on the Pietermaritzburg campus. In her justification, she positioned students as sexually active and their activities as unsafe (see Extract 8). She also positioned herself as being at risk of HIV, and in her justification, she focussed on the uncertainty of not knowing who has it due to it being an invisible threat (see Extract 41). In response to what testing means to her, she says:

Extract 63

61 Zama: I feel like from the beginning, like when you find out that you are HIV positive and the
62 fact that obviously, you have a deadly disease that is going to be there forever in your life. It is
63 not only going to make you sick, but you are going to lose confidence in who you are, and there
64 are just a lot of things like you can no longer enjoy having direct sex, you have to use a condom
65 almost all the time. And I feel like you are just even at a higher risk of wanting actually to
66 infect others because someone has also infected you.

(20, F, A, SA, UG, Not tested)

In her use of the words ‘deadly disease’ (line 62), in relation to her construction of HIV, Zama links HIV with death. She uses the words ‘going to be there forever in your life’ (line 62) to construct HIV again as something permanent and ultimately terminal, and with the words ‘not only’ (line 63), she constructs the state of being positive as severely constrained. Her construction of HIV as being appalling is evident in her use of the phrases ‘there are a lot of things’, ‘make you sick’, ‘lose confidence’, ‘you can no longer enjoy having direct sex’, and ‘you have to use a condom almost all the time’ (lines 63-65) to construct her notion of the state of being HIV positive, of acquiring HIV, as being dire. In Zama’s account, there is no positive construction in relation to living with HIV or being on ARVs. Moreover, in her use of the words ‘wanting actually to infect others because someone has also infected you’ (lines 65-66), Zama positioned people living with HIV as vindictive, and as desiring to infect others because of their anger at being infected. All of these seem to create and exacerbate Zama’s fear of being tested. In Extract 64 below, Zama constructed HIV as something to avoid, even to be known about.

Extract 64

67 Betty: Okay, so have you tested?
68 Zama: Um, hhhh, l will speak from my own perspective. I have never been tested. I feel like
69 for me, uh, it will be a big thing in my life if I test because the reason I do not want to get tested
70 is the fact that what if I discover that I am HIV positive, is my life going to be the same? Am I
71 going to get healthy kids? And stuff like that. Am I going to have the same thoughts about
72 marriage like I have right now? I want to be married and get children, you know. So, at the
73 moment, HIV testing is a scary thing to me.
74 Betty: So, you are telling me that your concerns are about your future as in what will happen
75 following testing, and I see marriage and kids seems to be your big concern. I wonder why?
76 Zama: If there is a man who is serious into me to the point that he asks me to marry him, which
77 means we are going to have unprotected sex. Now, if I am HIV positive, I don’t feel like I can
78 actually be at that point of telling that guy that I am HIV positive, um, revealing my status to
79 him, yet I should tell him to protect him from getting HIV from me, you know. So that is why
80 I try by all means to avoid testing for HIV he he because if I tell a guy ((man)), I have HIV, or
81 when you become too open, he will leave you and be like, nope, I am not dating a sick person.
82 But I feel like I just believe that since my parents don’t have it, I do not have it.
83 Betty: You seem to be knowing your parents’ HIV status?
84 Zama: Yes, because they have tested for HIV before.
85 Betty: Will you consider testing for HIV at all?
86 Zama: Not at the moment.

(20, F, A, SA, UG, Not tested)

In the above extract, Zama did a lot of discursive work to justify how difficult it is for her to do an HIV test. She constructs herself as ‘never been tested’ (line 68) and constructs the idea of going for testing as a ‘big thing’ (serious) in her ‘life’ (line 69). She positions herself as avoidant and in denial. To rationalise her position, she uses the words ‘what if I discover that I am HIV positive, is my life going to be the same?’, ‘Am I going to get healthy kids?’, ‘Am I going to have the same thoughts about marriage like I have right now?’ (lines 70-72), all of which position the infected HIV body as being affected in the core aspects of life (marriage and having healthy children). She repeatedly comments on the fear she has of the outcome, as seen in her statement, ‘HIV testing is a scary thing to me’ (line 73). It is possible that she constructs HIV testing in this way because her life and aspirations are defined by marriage, family and children. She constructs the HIV test as a potential threat to that. She justifies her fear by saying that men will reject her, and that she will not be able to have unprotected sex, which creates the impression that, for her, there is no alternative or provision for safe sex. In her use the words ‘Now, if I am HIV positive, I don’t feel like I can actually be at that point of telling that guy that I am HIV positive’ (lines 77-78), ‘yet I should tell him to protect him from getting HIV from me’ (line 79), she positions herself as one who would be unable and ashamed to disclose her status to her partner if she were to have HIV. In other words, she could not actually reveal her status because of the stigma. However, she positions herself as in a dilemma; if she does not disclose, she will put him at risk. She is thus positioning herself as knowing how to be a responsible health subject but unable to be one, because of the fear of the consequences to her own life and future. With the use of the words ‘because if I tell a guy ((man)), I have HIV, or when you become too open, he will leave you’ (lines 80-81), she positions herself as being placed in a dilemma of having to choose between the relationship of health protection and the loss of the partner.

Furthermore, Zama seems to construct HIV infection as a sickness. She does this by using the words ‘I am not dating a sick person’ (line 81), which constitutes a form of stigmatisation. In response to whether she will ever consider taking an HIV test at all, she uses the words ‘I try by all means to avoid’ (line 80), and ‘Not at the moment’ (line 86); all of which show that in her construction of HIV, it is such a fearful outcome, that she cannot bear to engage with it to position herself as one who chooses to live in a state of ignorance about her HIV status by not testing so that she does not have to live with not only the dilemma but also the fear of the loss of a future life – marriage, children. She is very frightened of putting her partner at risk if she tests positive, and yet she wants to keep the relationship with him. She uses the words ‘I just believe that since my parents don’t have it, I do not have it’ (line 82) to position herself as not at risk of HIV. Her use of these words reveals her assumption that she is ‘only’ at risk through mother to child transmission, and making this claim might be a form of denial to manage the fear. However, it appears that such positioning is adaptive for her since it is her way out to overcome the need to go for HIV testing and being declared having HIV, which for her is a deadly disease that can change her life forever (see Extract 63). The disquieting dilemma that

Zama faces in trying to keep the relationship with her boyfriend, and at the same time being uncomfortable to talk about HIV testing, is clearly reflected in Extract 65 below.

Extract 65

136 Betty: Have you ever had a conversation with your boyfriend about HIV risk?
137 Zama: No, I feel like we are just a boyfriend and girlfriend; it is not yet serious.
138 Betty: What are the risks or consequences if you start asking your boyfriend about HIV risk?
139 Zama: It is because I don't want the person to feel bad about himself, or I don't want the person
140 to actually feel like I think he is HIV positive, or you think he actually inherited it from his
141 parents or other women. I feel like that is what is actually making me not to ask the guys if
142 they are HIV positive. Also, sometimes you feel like he will think that you have HIV, and then
143 maybe the relationship will end (.3); you don't want to lose the person because you love him
144 and stuff like that. But, also, you feel like you have him, you have his trust, you know him
145 already. So I think that is what actually prevents me from talking about HIV with the guys.
(20, F, A, SA, UG, Not tested)

In her use of the words 'I don't want the person to feel bad about himself' (line 139), and 'feel like I think he is HIV positive' (line 140), Zama positions herself as caring for her boyfriend and not wanting to offend him, or question him, or challenge him. She uses the words 'you think he actually inherited it from his parents or other women' (lines 140-141) to position herself again as not wanting to confront him with matters concerning his parents or his sexual histories as that will threaten him and the relationship. Her use of the word 'inherited' positions her as worried that her partner could be HIV positive, and it is not his 'fault'. In her use of the words 'he will think that you have HIV, and then maybe the relationship will end' (lines 142-143), she constructs her instigation of the idea of HIV testing to a partner as almost like raising the suspicion that he has HIV, a process that may, at best, lead to getting a name as 'HIV positive' (line 141), and this may result in being stigmatised and weakening the relationship, and that is something she fears so much. However, in her use of contrasting statements 'you feel like you have him', 'you love him', 'you have his trust', and 'you know him already' (lines 145-146), she positions herself as trying to hold on to a man, which is a different positioning from that of Londi and Buhle who tended to prioritise themselves and their health and insisted on being protected (see Extract 53 and Extract 55, respectively).

Overall, Zama's construction suggests that she is trying to convince herself, and me, of the view that it is extremely risky and dangerous and scary to raise the issue of testing to her partner; that it is something to really not to do. Her whole construction of HIV testing revolves around the fragility of the relationship and protecting it, and protecting him in it. She constructs each attempt to question him as a potential for undermining his status and his history (asking him would make him think that she doubted him and his family history and his relationship history). She constructs the act of questioning him, or broaching the issue of testing, as a fundamental challenge to his identity and security, and also the stability of the relationship (see lines 142-143). She, therefore, chooses not to challenge him (because this is more of a larger risk, or a more long-term risk), and in doing this, she does not prioritise herself and her health (and his health). This issue of having and holding onto the man she has, draws on the have/hold discourse, which contains the assumptions that women expect and want love and affection in a relationship (Hollway, 1984).

5.4.2 Theme Six: HIV testing practices of participants who reported being tested

The accounts of the majority of participants (16) who had taken an HIV test revealed that their practices are unplanned, incidental, and often responses to the threat of HIV posed by their knowledge that their partner is cheating or the suspicion that their partner is cheating, or their own activities of unprotected sex with people of unknown HIV status, or their having visible symptoms suggestive of AIDS. However, one participant in this study positioned herself as a health abiding subject in terms of HIV testing. Before presenting some of these participants' practices in relation to HIV testing, it is worth noting that the interviews I had with them took place in 2019, between March and May, and so their most recent HIV testing practices are assessed based on that.

5.4.2.1 Experience of involvement in incidental HIV testing practices

Discussions related to this sub-theme came from 12 female participants and two male participants (John and Alfred). Extracts from interviews with five of the 12 female participants and John are used to illustrate this sub-theme.

Extract 66 below, is taken from Liz, an Indian South African female participant. Before this particular extract, Liz had constructed HIV as being an overwhelming risk to students on campus, and in her justification, she focussed on the heightened awareness of HIV on campus (see Extract 17). However, she positioned her risk of HIV as being caused by someone else's actions, and she focussed on her fears of being raped or her blood being contaminated (see Extract 48). In Extract 66 below, she positions herself as having tested but only once and locates her practice in a hospital.

Extract 66

Betty: Have you tested for HIV?
Liz: Uh, not directly speaking, but I have had blood tests before and like everything has been tested. So, I have not specifically gone for an HIV test.

34 Betty: So, when were these blood tests done?
35 Liz: I was seriously sick, and then they had to do all the tests at the hospital; it was a few years
36 ago, maybe like five or six years ago.
37 Betty: So since then, you have not been tested?
38 Liz: Yes.
39 Betty: Okay, so why have you not decided or initiated the issue of going to get tested?
40 Liz: Uh, I have only been with one guy, and he has only been with me, so I didn't think that it
41 was necessary for me to get tested he he.
42 Betty: Well, do you talk about HIV testing with your boyfriend?
43 Liz: Never ↑, it has never come up because we are both safe. It's just us.
44 Betty: Okay, and will you consider testing for HIV soon?
45 Liz: It is not a priority in my list right now but like hypothetically speaking, I don't know if I
46 am raped, God forbid or something like that or touch somebody's blood or something for
47 whatever odd reason, then I would definitely go get tested because I can't run that risk.
(23, F, I, SA, UG, Tested)

In response to whether she has been tested for HIV, Liz uses the words 'not directly speaking, but I have had blood tests before' (line 32), and 'have not specifically gone for an HIV test' (line 33) to position HIV testing as not something she deliberately engaged in but did it once and the activity was unintended and unplanned. The emphasis she has given to her testing activity as being incidental is quite evident in her use of the words 'I was seriously sick, and then they had to do all the tests at the hospital' (line 35). This positions that particular testing activity for a pragmatic reason related to her sickness and herself as the patient, thereby not being involved in the testing process. To justify her HIV testing practices further, she uses the words 'Uh, I have only been with one guy, and he has only been with me' (line 40) to position herself and her partner as having no prior sexual partners and therefore as invulnerable subjects in relation to HIV risk. She justifies this positioning by using the words 'I didn't think that it was necessary for me to get tested' (lines 40-41). Although her soft laugh 'he he' (line 41) is difficult to interpret, it does serve to justify the position she takes as not exposed to HIV risk, and so her avoidance of HIV testing is rationalised as acceptable. This positioning of herself and her partner as invulnerable subjects is also evident in her use of the words 'Never ↑, it has never come up because we are both safe. It's just us' (line 43). In response to whether she will consider taking an HIV test soon, she uses the words 'It is not a priority in my list right now' (line 45) to position HIV testing as something optional for her rather than being a necessity. She positions HIV testing as something she would 'definitely' (line 47) engage in, under two conditions, 'if [she ever gets] raped' or 'touch somebody's blood' (lines 45-46). With these words, she positions herself as a potential victim of HIV but only through someone else's actions, which is an overall position she took in the interview session when talking about her own risk of HIV. With the use of the words 'I would definitely go get tested, because I can't run that risk' (line 47), she positions HIV testing as her risk management strategy under such uncontrollable situations, and that helps her to continue with her justification, 'It is not a priority in my list right now' (line 45), 'I didn't think that it was necessary for me to get tested' (lines 40-41) (by implication, she has not been raped and exposed to situations of risk, and so her avoidance of HIV testing is justified).

Extract 67 below, is taken from Sarah, also an Indian South African female participant. Before this particular extract, Sarah had constructed the scale of HIV threat in South Africa as high (see Extract 2). She had also positioned herself as not being at risk, and in her justification, she focussed on the length of time of, and the nature of her relationship (long-term, monogamous and first love) (see Extract 49). In Extract 67 below, Sarah reported having tested for HIV once and locates her practice in a health campaign on campus.

Extract 67

Betty: So, Sarah, have you tested for HIV?
Sarah: Yes, I have. It was last year, around April or May.
Betty: What were your reasons for testing?
Sarah: Well, I was at the medical school campus of UKZN in Durban, and they were having a walk, and it was an AIDS walk and then afterwards they had like all these things where you could go and test your general health, weight, your cholesterol, and they also had HIV testing. So, it was the first time ever actually I tested. So, I said, why not? The opportunity is here; let me take it. I knew I have nothing to hide; I just wanted to confirm. So, I went in and tested.
Betty: I wonder why you did not do it the other years?
Sarah: I think uh(.7) because the opportunity didn't come up as easily and it is not something we do in our home or even talk about it, and I trusted my partner, and we always said what is the need for HIV testing yet it has only been you and I. Because that opportunity was so easily available, I said, why not use it.
(24, F, I, SA, PG, Tested)

In the above extract, Sarah made reference to her participation in the activation and health and wellness day (AIDS Walk) at the University of KwaZulu-Natal and positioned herself as having used that 'opportunity' (lines 57, 60) to do an HIV test. She uses the words 'it was the first time ever actually I tested', 'I said, why not?', and 'the opportunity is here' (line 57) to position HIV testing as something she does not engage actively in but as something incidental (she did it as a result of participating in the activation and health and wellness day). In her use of the words 'they had like all these things where you could go and test your general health, weight, your cholesterol, and they also had HIV testing' (lines 55-56), she constructs that particular campus opportunity as enabling the normalisation of HIV testing, where it is 'just' a part of all other kinds of health checks. This position reflects the health messaging that HIV has to be 'normalised' for people to personalise risk and act to know their serostatus through

HIV testing. In her use of the words ‘I knew I have nothing to hide’ (line 58), she positions herself as open, and unconcerned, contrasting herself with others who might have something to conceal. With these words also, she seems to be trying to position herself as not a bad person to be suspicious of someone who is possibly HIV positive. Her use of the phrase, ‘I just wanted to confirm’ (line 58), suggests that she wanted to prove herself right (she wanted verification, justification perhaps for continuing her practices in the same way because she was not at risk).

In response to why she had not considered taking an HIV test before that particular ‘opportunity’ she made reference to (see lines 57-58), Sarah began her response with the words ‘I think’ followed by a short pause lasting for about seven seconds ‘uh(.7)’ (line 60) which position her as uncertain in what she was about to say. Her account then constructs the activity of testing for HIV as difficult. She does this by using the words ‘because the opportunity didn’t come up as easily’ (line 60). Her use of the words ‘it is not something we do in our home or even talk about it’ (lines 60-61) positions HIV testing again as not normalised in her home and as something sensitive, and herself as not having close contact with someone who has done it. In the use of the words ‘we always said what is the need for HIV testing yet it has only been you and I’ (lines 61-62), she positions herself and her partner as monogamous in their relationship and HIV risk as not within their context; with this (that they are monogamous) serving as her justification for not needing to engage actively in HIV testing.

Extract 68 below is taken from Leah, a female international student participant. Before this particular extract, Leah had constructed HIV as being a minimal threat to students on campus, and in her justification, she focussed on the interventions around HIV prevention on campus and positioned these interventions as being responsible for reducing the rates of HIV infection amongst students (see Extract 34). She had also positioned herself as not being at risk, and in her justification, she constructed herself as currently sexually inactive and certain of her HIV negative status (see Extract 54). In Extract 68 below, she positions herself as having tested for HIV twice and locates her practice in an antenatal clinic.

<u>Extract 68</u>

54 Betty: We are going to discuss your most recent activity of testing. When was that?
55 Leah: It was in 2015↓
56 Betty: What were your reasons for testing?
57 Leah: The reason for testing was because I was pregnant with my son, which is why I got
58 tested. You know, if you are pregnant here in South Africa, even back at home ((Tanzania))
59 you are expected to test for HIV in the clinic.
60 Betty: It has been a long time. We are in 2019, uh, April. What are your plans for testing?

61 Leah: I will do it even anytime he he, but he he I don't think I will do it because of my past
62 experiences. My history already says that I rarely go for tests voluntarily, so maybe I would
63 not do it again in future, but I think it is important to keep on doing testing.

(23, F, A, TAN, PG, Tested)

In response to when her most recent HIV testing activity was, Leah uses the words 'It was in 2015↓' (line 55) to position HIV testing as not something she engages actively in. In her use of the words 'I was pregnant with my son, which is why I got tested' (lines 57-58), she constructs that particular testing practice as not coming out of her initiative to know her status but as something that is strongly enforced, almost required at ante-natal clinics (although one should not force anyone to test). So what Leah is trying to say here is that it was not on her initiative; it was something expected in the context (it is not her choice or her desire to engage in it). Her construction of HIV testing along this line can also be seen in her statement in lines 58-59, which positions it as being required for health reasons for the baby. Similarly, the emphasis she has given to HIV testing as not something she actively participates in, is evident in her use of the words 'My history already says that I rarely go for tests voluntarily, so maybe I would not do it again in future' (lines 62-63). She uses these words to position herself as uncertain of her plans concerning this health practice. She justifies this positioning by showing that it is not something she engages in regularly and voluntarily. At the same time, in her statement, 'I think it is important to keep on doing testing' (line 63), she positions herself as someone who knows that regular testing is the correct health-related behaviour. The words 'I think' here position her as unsure and uncertain and as not seeing HIV testing as being 'important'. The soft laugh 'he he' (line 61) shows that she is laughing and chuckling in the response she gives, which shows that she is aware that she is coming across as a bad health subject, and she is trying to moderate it by making light of it. Similarly, the low tone '↓' (line 55) when referring to her most recent HIV testing practice serves to position her as kind of ashamed of saying so, and perhaps she is thinking that I am judging her.

Extract 69 below, is taken from Tumi, a black South African female participant who was three months pregnant at the time of the interview. Before this particular extract, she had constructed HIV as being a considerable threat to students, and in her justification, she cited the presence of intensified HIV testing activities on campus (see Extract 14). She had also positioned herself as being at risk, and in her justification, she focussed on her unsafe sexual activities (see Extract 41). In Extract 69 below, she positions herself as having taken an HIV test several times recently, and similar to Leah's construction, she locates her most recent practice in the antenatal clinic.

Extract 69

79 Betty: When did you test last for HIV?
80 Tumi: I tested in December ((2018)). Okay, uh, I test a lot lately because I am pregnant.
(19, F, A, SA, UG, Tested)

In response to when her most recent HIV activity was, Tumi uses the words ‘I tested in December ((2018)), ‘I test a lot lately’ (line 80) to position HIV testing as something she engages actively at the time of the interview. In her use of the words ‘because I am pregnant’ (line 80), she positions her practices as incidental (testing happening as a result of pregnancy).

Extract 70 below is taken from a black South African female participant.

Extract 70

33 Betty: When was the last time you tested?
34 Phumi: Last year ((2018)), around May or June.
35 Betty: Where did you go to?
36 Phumi: there was a tent here in varsity ((campus)).
37 Betty: Why did you choose that tent and not any other place, for example, like the clinic?
38 Phumi: MMM, I had never really thought about going to test for HIV if it was not for that
39 particular day, even if I had thoughts about testing, but I don’t feel like pushed to go and test
40 even on campus, I think I just saw the opportunity, and then I decided to go and test for it, but
41 otherwise I don’t feel under pressure to go get tested.
(22, F, A, I, UG, Tested)

In response to when her most recent activity of testing was, Phumi uses the words ‘Last year ((2018)), around May or June’ (line 34) to position HIV testing as not something she engages actively in, but as something that came but once. She positions her most recent testing activity as having taken place in a mobile testing tent on campus (line 36). Her use of the words ‘I just saw the opportunity, and then I decided to go and test for it’ (line 40) positions that particular practice as incidental (she said she did it because she saw a tent offering the service on campus). In response to why she chose the mobile testing tent and not another testing site like the Campus health clinic, she uses the words ‘I had never really thought about going to test for HIV’ (line 38), ‘I don’t feel like pushed and to test’ (line 39), and ‘I don’t feel under pressure’ (line 41), all of which serve to position her as lacking a sense of urgency to engage in HIV testing.

Extract 71 below, is taken from a male international student participant. Before this particular extract, John had constructed HIV as being a minimal risk to students on campus, and in his justification, he positioned students as aware and educated, and this knowledge and awareness as protective (see Extract 37). However, this construction notwithstanding, he positioned himself as being at risk and attributes this to one of his female partners (see Extract 44). In response to when his most recent activity of HIV testing was, he says:

Extract 71

57 John: It was in 2013. I was like a kid, you know, I was just tested. There was kind of a
58 government thing testing people, so I just got tested.
59 Betty: So since then, you have not tested for HIV?
60 John: Mmm, yes, I have not.
61 Betty: What is the reason then for not testing again? It has been like six years down the line.
62 John: For me, I have been using protection, and also my girlfriend got tested in 2016, and she
63 was HIV negative. But then the thing is, me I hate hospitals, I hate going there, queues and you
64 meet many women with children, a lot of things, you see. As I said to you earlier, one day, you
65 will get what you are looking for going there to test. What are you testing for? If you believe
66 in yourself and you trust the person you are having sex with so, you are safe.
(20, M, A, DRC, UG, Tested)

In his use of the words ‘in 2013’, ‘I was just tested’ (lines 57, 58), and ‘There was kind of a government thing testing people’ (line 58), John positions HIV testing as not something he actively and regularly engages in but as something he had once undertaken in response to a government’s directive on it, thereby incidental. In his use of the words ‘I was like a kid’ (line 57), he positions himself in agreeing to be tested at that time as someone who just followed the government’s directive on the matter, unthinkingly, and therefore, non-agentically (without agency). In response to why he has not been engaging actively in HIV testing, he uses the words ‘For me, I have been using protection’ (line 62) to position himself as a safe health acting subject. With these words also, he indirectly constructs HIV testing as a practice that people should engage in when they indulge in unsafe sex practices or after risking themselves. Again, his positioning as an invulnerable subject is evident in his use of the words ‘my girlfriend got tested in 2016, and she was HIV negative’ (lines 62-63) to position his female partner as being HIV negative and himself as also being negative by proxy.

What is interesting in his account is the diversion he makes in his use of the words ‘but then the thing is me I hate hospitals, I hate going there, queues …, a lot of things’ (lines 63-64). In using these words, he constructs the process of testing for HIV as being conducted within a non-confidential environment, that is, in public, thus exposing people who go for testing to the full view of others (men, women and children); all of which he detests as this possibly exposes him to the social stigma of seeking help, and he worries about this. In his use of the words ‘you meet many women with children’ (lines 63-64), he is not only positioning hospitals as spaces where stigma may be a concern but also, he is positioning clinic spaces as female spaces. He proceeds to highlight the statement he made earlier in the interview that ‘one day, you will get what you are looking for … What are you testing for?’ (lines 64-65). With these phrases, he constructs the testing process as confirmatory of HIV positive status, and the act of testing as something one engages in because one suspects that one is positive, a pattern that helps him to continue with his justification, ‘If you believe in yourself and you trust the person you are having sex with so you are safe’ (lines 65-66). In doing this, he is convincing himself that he does not have HIV and positions his safety practices as based on condom use, believing in himself as being safe, and trusting in hearsay evidence that his partner is safe.

5.4.2.2 Engaging in HIV testing practice in response to the risk posed by a cheating partner

The accounts of three female participants (Phumi, Londi and Sane) revealed that they engaged in HIV testing in response to their perceived risk of HIV posed by the actions of a cheating partner or their suspicions that a partner was cheating. Londi and Sane’s account in this regard were discussed earlier (see Extract 52 and Extract 40, respectively). Thus, Phumi’s (black international female student) account below is used to illustrate this sub-theme. Before this particular extract, Phumi had constructed HIV as being an enormous risk to students on campus, and in her justification, she positioned students as ignoring the threat (see Extract 28). She had also positioned herself as not being at risk, and in her rationalisation, she positioned herself as being in a committed relationship with one partner (see Extract 51). She had also constructed her most recent HIV testing practice as having taken place in a mobile testing tent on campus in May or June of 2018 (see Extract 70). In response to the question of why she engaged in that particular testing activity, she says:

<u>Extract 72</u>

43 Phumi: Uh, he once cheated on me last year, and then we had to talk about that. I was like,
44 dude, do you realise that you have put me at risk since you have cheated on me? I don’t know
45 uh (.2) what you did with this girl. That is actually what made me to test; I had this fear that I
46 got that disease. So now I am fine.
(22, F, A, SA, PG, Tested)

In her use of the words ‘he once cheated on me last year’ (line 43), ‘That is actually what made me to test’, and ‘I had this fear that I got that disease’ (lines 45-46), Phumi positions her partner as being unfaithful and herself as being threatened by the risk of HIV infection. Thus, she considers her engagement in HIV testing as her response to this threat. This situation is evident in her use of the words ‘dude, do you realise that you have put me at risk since you have cheated on me’ (line 44) to position herself as empowered, as assertive, and as a responsible subject who is at the same time a victim of HIV. Although she constructs her partner as ‘cheating’, which is highly risky, earlier, she gave an account which positions her as relying on the verbal judgment of her partner to position him as not having HIV and used that to exonerate him from taking an HIV test (see Extract 51). This undermines the position of a responsible health subject, which she has adopted in this account (Extract 72).

5.4.2.3 Engaging in HIV testing practice in response to the risk posed by own activities of unprotected sex with people of unknown HIV status

Discussions related to this sub-theme came from all five male participants and one female participant (Londi). Extracts 73-78 are taken from interviews with four male participants (Bongani, Zazi, Alfred and Andrew) and Londi. John's account was earlier discussed (see Extract 44).

Extract 73 below, is taken from Bongani, a black male South African participant. Before this particular extract, Bongani had constructed the scale of HIV threat on campus as high. In his justification, he focussed on how ARV's invisibilised the risk of HIV and indirectly making people victims, and he aligned himself with this construction (see Extract 24).

<u>Extract 73</u>

32 Betty: Have you tested for HIV?
33 Bongani: Yes, I tested six or seven months ago ((2018, July)).
34 Betty: What were your reasons for testing for HIV?
35 Bongani: Because of this thing of having different partners, and uh, I was afraid I got HIV at
36 that time, and so I went to test to be sure.
37 Betty: Having done the HIV test, how did it make you feel?
38 Bongani: After knowing my status, I felt proud that I was a man enough to go into the testing
39 room.
40 Betty: Does that mean some men are reluctant to take in this idea of testing?
41 Bongani: Some men just do not like going to the clinic.
42 Betty: Why is that the case?
43 Bongani: They ((men)) are scared to test because they know what they are doing is making
44 them to easily get HIV like this thing of having many women, men like dating many women.
(20, M, A, SA, UG, Tested)

In the above extract, in response to whether he had tested for HIV, Bongani uses the words 'I tested six or seven months ago ((2018, July))' (line 33) to position HIV testing as not something he engages in regularly. In his use of the words 'Because of this thing of having different partners', and 'I was afraid I got HIV' (line 35), he positions himself as knowing that his sexual practices are risky and HIV testing as something he does in response to the threat of HIV. In his use of the words 'I felt proud that I was a man enough to go into the testing room' (lines 38-39), he draws on the concept of masculinity. He positions himself as courageous and brave to perform the act of testing. In this construction, he positions some men as potentially not being 'man enough' to 'risk' doing the test. In response to why some men are reluctant to engage in HIV testing, he positions them as engaging knowingly in sexually risky practices. He uses the words 'they know what they are doing is making them to easily get HIV like this thing of having many women' (lines 43-44) to position men as knowing that their activities of sex with multiple women is increasing their risks of HIV. He positions them as afraid (line 43) to confront the problem by going for testing, contrasting their behaviour with his ‘man enough’ stance. He seems to position himself as not like this group of men who are ‘scared to test’ (line 43). With the words ‘men like dating many women’ (line 44), he seems to normalise men’s sexual practices, and in doing this, he is allying himself with this practice. This is also evident in his use of the words ‘this thing of having different partners’ (line 35).

Extract 74 below, is taken from Zazi, also a black male South African participant. Before this particular extract, Zazi had constructed HIV as being a massive threat to students on campus, and in his justification, he focused on intensified HIV testing activities on campus (see Extract 13). He also positioned himself as being at risk of HIV and attributed the threat to the possibility of his partner cheating.

<u>Extract 74</u>

71 Betty: Have you tested for HIV before?
72 Zazi: Yes, I would say I test at least six times in a year because there is this thing called the
73 window period or something, so that window period the last time I checked was every three
74 months or something.
75 Betty: Given that you told me you have been using protection, what motivates you to get tested
76 quite often?
77 Zazi: Because as I said, there are those instances where we sometimes do it (sexual activity), I
78 just find myself in the act, but then in most cases, let us say out of ten times; there will be only
79 that one incident where I did not use protection maybe I could not control myself. So, I go get
80 tested just to make sure.

(22, M, A, SA, UG, Tested)

In response to the same question of whether he had tested for HIV, Zazi uses the words ‘I test at least six times in a year’ (line 72) to position it as something he engages actively in. He uses the words ‘there is this thing called the window period …. the last time I checked was every three months or something’ (lines 73-74) to position himself as someone who knows about HIV and the ‘window period’ which is a term commonly used in HIV messaging to imply the time frame between the HIV infection, and before HIV antibodies can be detected by a standardised HIV screening kit (Department of Health, 2016). With these words also, Zazi positioned himself as one who is in touch with, concerned about, and up to date in his knowledge about the complexities of HIV testing. In his use of the words ‘there are those instances where we sometimes do it (sexual activity)’, ‘I just find myself in the act’ (line 77), and ‘maybe I could not control myself’ (line 79), he constructs sex as something not under rational control. He positions himself as sometimes unthinking in his activities of sex, as not always conscious of what he does, or of how he decides to engage in things concerning sex, but as not risking himself deliberately. He also did some discursive work to counter this positioning of a reckless self in sexual activity. He does this by using the words ‘in most cases, let us say out of ten times; there will be only that one incident where I did not use protection’ (lines 78-79) to construct his risk of HIV as being minimal and his actions as many times ‘not that bad’. He counters the lapse in being a responsible health acting subject, with the action of testing, ‘I go get tested just to make sure’ (lines 79-80). With these words, he positions himself wanting to take action to ascertain his HIV status, and by implication, as still responsible, despite the gaps in his protective practices (condom use); he presents a self that does not entirely ignore HIV risk. Overall, it appears that there is nothing new or unique in Zazi’s positioning in that he seems to be giving the ‘right’ responses that echoes public health messaging, which urges people ‘to be protective subject’, and to ‘test regularly’. Hence, he is presenting himself to me as a good and knowledgeable health subject; however, he was inaccurate in part of his account when he mentioned the issue of the window period as lasting for three months, instead of three weeks.

In Extract 75 below, Zazi constructs HIV testing as something he does in response to the threat of HIV. He noted that conversations about risks in sexual activity in his relationship focus exclusively on pregnancy. In his rationalisation, he refers to the impact of unplanned pregnancy as a more dominant threat, more of immediate concern for him as a university student.

Extract 75

129 Betty: In your relationship, do you discuss issues to do with HIV?
130 Zazi: In my relationship, no, what we normally discuss is about pregnancy; I don’t want her to
131 fall pregnant. We cannot support the kid because we are students; we discuss that.
132 Betty: So, HIV has not really been a concern to you?
133 Zazi: It is not something I always discuss; it is just something I just test. What we do is, when
134 we discuss, maybe about a sexual relationship, it is normally pregnancy if, and uh, if we do by
135 any means I have unprotected sex, then we test.
136 Betty: So, you would only test following unprotected sex?
137 Zazi: I am not saying it is the right thing to do, but that is the case.
138 Betty: So, testing here means what?
139 Zazi: Just to confirm any chance of HIV, maybe.
(22, M, A, SA, UG, Tested)

In response to whether he has ever discussed the topic of HIV risk with his partner (line 129), Zazi uses the words ‘no what we normally discuss is about pregnancy’ (line 130) to construct pregnancy as a more important threat in his relationship. In his use of the words ‘We cannot support the kid because we are students’ (line 131), he positions the risk of pregnancy as having a direct outcome on their future potential to ‘support the kid’ (perhaps financially and emotionally) as university students. In his use of the words ‘I don’t want her to fall pregnant’ (lines 130-131), he positions himself as being concerned about ensuring that this sexual risk is consistently prevented. His use of the pronoun ‘we’ (lines 130, 131, 133, 134, 135) in reference to responsibility for managing pregnancy risk serves to position him as accountable, and responsible for sharing the burden of parenting with his partner, constructing himself as a caring partner. In response to the question of whether HIV risk is a concern for him, he uses the words ‘It is not something I always discuss; it is just something I just test’ (line 133), and ‘if we do by any means I have unprotected sex, then we test’ (lines 134-135) to position HIV testing as something he does in response to the threat of HIV, and as not something he regularly engages in. This positioning contradicts his earlier position as actively engaging in HIV testing (see Extract 74 line 72). In response to what his testing practices mean to him, he uses the words ‘I am not saying it is the right thing to do’ (line 137), which serve to position him as knowing that testing is a good health practice and that the fact that he only tests after engaging in unprotected sex might be wrong. This subject position can also be seen in his use of the words ‘Just to confirm any chance of HIV, maybe’ (line 139), which serve to position him knowing that he is risking himself, and his HIV testing practices relate to proving to himself that he is still negative. Overall, Zazi’s account positions the risk of getting her partner pregnant (see lines 130-131) as a considerable threat to him, unlike HIV. Though the danger of HIV is there, he does not always consciously try to ensure that it does not happen by engaging in protective sex.

Zazi’s positioning in Extract 74, as not entirely in control of his sexual activities, is the same as that of John discussed earlier (see Extract 44), and is also evident in Extract 76 below, taken from a coloured South African male participant, Alfred. Before this particular extract, Alfred had constructed HIV as being a huge threat to students on campus, and in his justification, he positioned students as engaging in risky practices, such as alcohol abuse and unprotected sex. He also contrasted students’ behaviour with his, positioning himself as a responsible alcohol drinker and a good health subject who complies actively with the principle of condom use (see Extract 56).

Extract 76

Betty: Okay, when was the last time you tested for HIV?
Alfred: It was uh (.5) 20th March 2019.
Betty: What were your reasons for getting testing?
Alfred: Just to be on the safe side, uh, I go like almost every four months.
Betty: You said to me you test four times in a year, and you tested in March, and you said you test because you want to be aware of your status. Do you sometimes put yourself at risk perhaps having unprotected sex with women you don’t know their HIV status?

60 Alfred: Yes, I do, sometimes. Like I remember this one time last year when I had this girl I met
61 here at school ((campus)). I visited her at her res ((residence)), and things got out of control,
62 but I have been tested after that, and I know I am okay. So, I am just testing so that I get to
63 know if I am HIV positive, I will know where it came from, and I can confront the person
64 because it is definitely from her.

(21, M, C, SA, UG, Tested)

In response to when his most recent testing activity was, Alfred uses the words ‘20th March 2019’ (line 54), and ‘I go like almost every four months’ (line 56) to position HIV testing as something he engages actively in. In response to whether he sometimes puts himself in situations of risk in relation to HIV, for example, having unprotected sex with women he does not know their HIV status, he agrees, ‘Yes, I do, sometimes’ (line 60), which serves to position him as risking himself occasionally. He justifies his position with an account of his encounter with a female student at the university residence. He uses the words ‘things got out of control’ (line 61) to justify his actions in sexual relationships as, at times, being driven by desire, rather than by logic and control, but as one who often ‘lapses’. In other words, his construction is of sex as something which ‘gets out of control’; it is not his fault. In his use of the phrase ‘but I have been tested after that, and I know I am okay’ (line 62), he positions himself as still not having HIV despite this lapse of responsibility. His account of HIV testing as something he engages actively in is evident in his use of the words ‘I am just testing so that I get to know if I am HIV positive I will know where it came from’ (lines 62-63). With these words, he positions himself as in control of his HIV status and his motivation for testing as not being about taking responsibility really, but to be able to find a person to blame in case of HIV infection. It is as if he is saying that he is clean, and it will be someone else who infects him (it is not his actions, in other words). What is, however, clear from Alfred’s construction of HIV testing is that the testing practices he described in line 56 are reflective of his responses to the threat of HIV posed by his risky sexual practices, and not necessarily because he is a responsible health acting subject he earlier claimed to be (see Extract 56). Also, his difficulty in giving this response, as evident in the short pause, lasting for about five seconds ‘(.5)’ in line 54, could mean that he is perhaps trying to consider carefully what he is going to say to me as the researcher, and that helps him to continue with his justification, I test ‘almost every four months’ (line 56). This short pause could also mean that perhaps he was calculating this frequency based on his most recent few tests.

The HIV testing practices of the above two male participants (Zazi and Alfred), which position them as engaging in it as a strategic response to their risk of HIV, is also evident in Extract 77 below, taken from a black international male student participant, Andrew. Before this particular extract, Andrew had constructed HIV as being an enormous threat to students on campus. In his justification, he focused on the intensified HIV testing activities on campus (see Extract 16). He also positioned himself as being at risk of HIV and attributed his threats to the possibility of his partner cheating (see Extract 43).

Extract 77

Betty: Okay. So, tell me, Andrew, what does HIV testing mean to you?
Andrew: HIV testing is important to me because it gives you an opportunity to know whether you are on the safe side, or the wrong side because you wouldn't know if you have it. So any time, it is a good time to get tested so that if you have it, they can tell you what steps to take.
Betty: When was the last time you tested?
Andrew: The last time I tested for HIV was in July last year ((2018)).
Betty: Okay, so what were your reasons for testing?
Andrew: My reasons for testing, uh(.5), I had an encounter with another lady that is not my girlfriend, and we didn't use protection, so I had to go and test for HIV.
Betty: So, you went to do the test immediately?
Andrew: Not immediately, uh we had sex on Sunday night, and I went and tested on Monday morning.

(24, M, B, KEN, PG, Tested)

In response to what HIV testing means to him, Andrew uses the words 'important' (line 36), 'gives you an opportunity to know whether you are on the safe side, or the wrong side' (lines 36-37), and 'you wouldn't know if you have it' (line 37) to position himself as being aware of the threat of HIV as invisible, and HIV testing as a way to ascertain your HIV status and live in the relief that comes from the test result particularly when the outcome of the test is negative. In response to when his most recent activity of testing was, he uses the words 'July last year ((2018))' (line 43) to position it as not something he regularly engages in but as something often incidental, and a once-off activity at certain times in his life. This can be seen in his use of the words 'I had an encounter with another lady' (line 42), and 'we didn't use protection, so I had to go and test' (lines 42-43). With these words, he positions HIV testing as something he does in response to the threat of HIV posed by his unsafe sexual practices.

Moreover, he positioned his most recent HIV testing activity as being spontaneous, as something he did a few hours after risking himself. He did this by using the words 'we had sex on Sunday night, and I went and tested on Monday morning' (lines 48-49). These words, in particular, position him as having limited knowledge of the window period, which is the timeframe between the HIV infection and when the test can reliably detect the HIV in one's body. His limited knowledge is also evident in his construction of HIV testing as something which could happen at any time, as seen in his statement, 'any time, it is a good time to get tested so that if you have it, they can tell you what steps to take' (lines 37-38). His positioning in this regard is, therefore, in complete contrast to that of Zazi in Extract 74, who positioned himself as fairly knowledgeable and up to date in his HIV testing practices.

In sum then, the positioning adopted by the four male participants (Bongani, Zazi, Andrew, and Alfred) and even by John discussed earlier in Extract 44 as people who are sometimes unable to 'control' their sexual urges in the presence of a woman, draws on the male sex drive discourse. In this discourse, a man's sexual urge is constructed as being controlled by an outside force, as being biologically instigated and therefore as something which men are often unable to control (Hollway, 1984).

Extract 78 is taken from Londi, a black South African female student. Before this particular extract, Londi had constructed HIV as a huge risk to students on campus, and in her justification, she positioned students as engaging in high-risk sexual activities (see Extract 7). However, she distanced herself from the threat of HIV, and in her justification, she constructed herself as currently sexually inactive and as confident about her HIV negative status (see Extract 52).

Extract 78

60 Betty: When was the last time you tested?
61 Londi: Um(.) let me just tell you briefly about uh, um, this is what happened, when I engaged
62 in sex um, from my teenage years until I broke up with my recent boyfriend, I didn't test. It is
63 very scary because when we have those tents that do testing her at school ((campus)), I would
64 watch my friends stay there, but I do not want to be tested. I would have pimples, and I know
65 that it might be HIV. For instance, you can see that I have sensitive skin now I am comfortable;
66 I was not comfortable then because I don't know whether it is HIV or not, and I don't even
67 want to know. It is very uncomfortable, and it is not easy. I only tested after I broke up with
68 my ex-boyfriend, and I didn't do it immediately. Because I remember, I think we broke up in
69 November in 2016 and then I tested later on the following year ((2017)) around October. I
70 didn't test on purpose because I know he cheated, he did all of that, and I know I haven't been
71 using condoms, and I didn't test because I knew that I might be HIV positive, and I was not
72 ready. So, I then decided to take the risk to test, and then after that, it has been easy, and I can
73 test any time because I know that I am not positive.

(24, F, A, SA, PG, Tested)

In her use of the words 'when I engaged in sex from my teenage years until I broke up with my recent boyfriend, I didn't test' (lines 61-62), and 'I tested later on the following year ((2017)) around October' (line 69), Londi positions herself as knowing that she has been risking herself, and HIV testing as something which she has not been engaging actively in. She uses the words 'It is very scary' (lines 62-63), and 'I would watch my friends stay there, but I do not want to be tested' (lines 63-64) to show how difficult and terrifying it was for her to take an HIV test after risking herself. An account of her difficulty in taking an HIV test is evident in her statements, ‘I would have pimples, and I know that it might be HIV’ (lines 64-65), ‘I don’t even want to know’ (line 66-67). Similarly, her discomfort and avoidance in taking the test are evident in her statements, ‘It is very uncomfortable, and it is not easy’ (line 67), ‘I only tested after I broke up with my ex-boyfriend, and I didn’t do it immediately’ (lines 67-68). In addition to the above is her fear of a positive diagnosis which is evident in her statements ‘I didn’t test on purpose because I know he cheated’ (lines 69-70, ‘I know I haven’t been using condoms’ (lines 70-71), and ‘I knew that I might be HIV positive and I was not ready’ (lines 71-71). With all of these words, Londi positions herself as being aware that she was at a high risk of HIV but very scared to confront the problem by testing for HIV. Indeed, her use of the words ‘I then decided to take the risk to test’ (lines 72) is an interesting phrase in this thesis as a whole. This is because while in this thesis, I construct the problem as HIV being the risk. The participants construct testing for HIV as the risk, as scary, as risky, as worth avoiding and delaying. Through these constructions, she positions herself as one who is prepared to bear the outcome of HIV testing after putting herself in risk situations. But she becomes ready to do this (test) only after a lot of delay and denial first. In her use of the words ‘and then after that, it has been easy, and I can test any time because I know that I am not positive’ (lines 72-73), she positions herself as one who enjoys the benefit of getting her HIV status determined by means of testing, particularly after the test turns out to be negative since in that case, she is already in a safe position – it is no longer a risk.

Overall, Londi’s account demonstrates the difficulties youth go through when making decisions about taking an HIV test when they know that they have been risking themselves and suspecting that they might be infected. Londi’s account also reflects a general pattern that was identified in this study, that most participants tended to construct HIV testing as a one-off affair, thereby portraying a lack of knowledge of the fact that the result that comes from the first HIV test may not be entirely accurate without the benefit of the confirmation (second) test.

5.4.2.4 HIV testing practices instigated by visible symptoms suggestive of AIDS

Extract 79 below, taken from a male international student participant, John, is used to illustrate this sub-theme. The extract is a continuation of John’s statement in Extract 71. In that extract, he positioned HIV testing as not something he actively and regularly engages in but as something he had once undertaken in response to a government’s directive on HIV testing. In response to whether he will consider taking an HIV test soon, he says:

Extract 79

68 John: Um (.3), uh, maybe if I will start really seeing myself having these symptoms like getting
69 sores, or thin, falling hair and stuff like that or get sick. Also, maybe, if in future my girlfriend
70 insists that we test before we get married, we can test, but really testing is not something easy
71 he he. Not that I suspect myself or something. It is just those fears, but myself, I believe that I
72 am HIV negative.

(20, M, A, DRC, UG, Tested)

In this extract, John gives an account which positions HIV testing as something he would engage in under two conditions: having visible symptoms suggestive of AIDS and a transitional life event (before marriage). In his use of the words ‘maybe if I will start really seeing myself having these symptoms like getting sores, or thin, falling hair’, ‘get sick’ (lines 68-69), he constructs the evidence of an HIV positive status as something tangible and visible. For him, anyone without these visible symptoms is to be positioned as ‘healthy’, and thereby as not needing to engage in HIV testing. In doing this, he aligns himself with the people who are healthy, and implying that his avoidance of HIV testing is ‘justified’. In constructing HIV risk as manifesting itself largely physically and visibly, he portrays his possible ignorance of the fact that people have HIV without manifestation of symptoms. In his use of the words ‘maybe, if in future my girlfriend insists that we test before we get married we can test’ (lines 69-70), he constructs HIV testing as something that is called for in a transitional moment, namely, ‘before marriage’. With the words ‘if in future my girlfriend insists’, it becomes clear that throughout this account, he takes no responsibility at all for the need to test, and seems to shift responsibility for HIV prevention through testing to his future wife and partner. In his use of the word ‘maybe’ twice (lines 68, 69), he positions himself as uncertain whether he will really take an HIV test under these two conditions. This uncertainty is also evident in his use of the words ‘really testing is not something easy he he’, ‘Not that I suspect myself or something’, and ‘it is just those fears’ (lines 70-71) to position himself as one who is generally terrified to know his HIV status through testing. It is as if the apprehension he feels and his hesitancy to take an HIV test relate to his belief that knowing his HIV status through testing may come with a devastating consequence of knowing that he has it, which is a dreadful disease he fears and wants to avoid by all means if possible. The soft laugh ‘he he’ (line 71) serves to position him as chuckling at himself as he tries to make light of his position as invulnerable to HIV risk, as seen in his words ‘but myself I believe that I am HIV negative’ (lines 71-72). He is banking on being HIV negative because his 2013 testing had declared him so (see Extract 71), yet he knows that he has exposed himself in situations of risk based on his activities of unprotected sex with multiple women (see Extract 44). In this way, there is nothing in his account to show that he is aware that undergoing just one test for HIV is not enough to make one confident that you are HIV free. This again means that the same element of ignorance identified in the account of the previous participants, particularly on the dynamics of the window period of HIV infection, and the need for one to undergo a second (confirmatory) test is reflected in John’s account.

5.4.2.5 Engagement in regular HIV testing practices

Extract 80 below, taken from a black South African female participant, is used to illustrate this theme. The extract is worth highlighting because before this extract, Sane had constructed the scale of the problem of HIV on campus as being high, and in her justification, she positioned students as ignoring the risk, and as engaging less in HIV testing (see Extract 27). Sane had also positioned herself as being at risk of HIV, and in her justification, she focussed on her unsafe sexual activities (see Extract 40).

Extract 80
53 Betty: What does HIV testing mean to you?
54 Sane: To me, it means you know yourself and your status. I feel it is very important to know
55 yourself and to know where you stand. You never really know unless you have been tested
56 regularly. So, it just gives me that relief, that dignity and that pride when I know my status.
57 Betty: When last did you test for HIV?
58 Sane: I usually test almost all the time, and the last time I checked, it was in April this year
59 ((2019)).
60 Betty: What are your reasons for testing?
61 Sane: When I first started testing, it was because, at home, my mom usually takes us for testing
62 like my mom usually goes and tests us, like almost all the time we had to be tested. When I got
63 to varsity, she stopped that. But I took it upon myself to continue testing. I guess it was
64 something that had become a tradition or norm to me, and so I continued with it. What even
65 encouraged me more was the fact that we got incentives here at school ((university)) when you
66 get tested. So, I usually go there, and I know that I am going to get incentives, but most
67 importantly, I understand more about HIV testing. It gives me a sense of knowing who I am
68 when I have tested. I don’t know, it helps me when I know my status; I feel like I can walk up
69 with my shoulders up. Not that I am saying people who haven’t tested they shouldn’t do that,
70 but when I know my status, it makes me happy; I can feel proud.
71 Betty: And what do you do with the test result?
72 Sane: I kept them. I have a file; as I said, it has been something that has been going on for a
73 very long time. So, I try and keep those slips almost all the time.
74 Betty: Why do you do that?
75 Sane: I just keep a record, uh, and I feel more proud, and I can track my history.
(22, F, A, SA, PG, Tested)

In response to what HIV testing means to her, Sane uses the words ‘know yourself and your status’ (line 54), ‘it is very important’, ‘know where you stand (lines 54-55), and ‘You never really know unless you have been tested regularly’ (lines 55-56) to position herself as aware of the act of testing as a good health practice in response to the threat of HIV. In her use of the words ‘it just gives me that relief, that dignity and that pride when I know my status’ (line 56), she constructs an HIV negative result as a liberating experience for her as it offers enormous freedom from the fear of HIV risk (perhaps after risking herself, as she said earlier in Extract 40). The confidence she places in knowing her HIV negative status is evident in her use of the words ‘it helps me when I know my status’, ‘I feel like I can walk up with my shoulders up’, ‘it makes me happy’, and ‘I can feel proud’ (lines 68-70). With these words, she positions herself as doing something which gives her self-assurance (she is happy, has a sense of knowing) and somehow elevates her above those ‘who haven’t tested’ (line 69), and she is satisfied being this way. Moreover, in her use of the words ‘I just keep a record’, ‘I can track my history’ (line 75), she positions herself as accountable and up to date in her protective practices (HIV testing practice, condom use and fidelity of her partner), fitting into the construction of a good/responsible and ideal health subject.

In response to when her most recent activity of testing was, she uses the words ‘April this year ((2019))’ (lines 58-59) to position HIV testing as something she engages actively in. In the attempt to rationalise her HIV testing practices, she uses the words ‘When I first started testing, it was because, at home, my mom usually goes and tests us’, ‘almost all the time’ (lines 61-62), ‘I took it upon myself to continue testing’ (line 63), ‘had become a tradition or norm to me’, ‘I continued with it’ (line 64), and ‘something that has been going on for a very long time’ (lines 72-73). With all these words, she attributes the original initiative of her HIV testing practices to her mother’s actions, and positions herself as a responsible health subject in terms of HIV testing. In her use of the words ‘usually goes and tests us, like almost all the time’ (line 62) with reference to her mother, Sane positions her mother as serious about HIV risk. It is as if Sane’s mother takes an object (her children) and enforces regular tests on them, and there seemed to be no agency or power ascribed to her children in this regard. However, it is worth noting that Sane’s positioning of her mother as responsible for initiating the HIV testing and normalising this health practice at home is unique to her compared to the experiences of other participants in this study. Perhaps her mother was a health practitioner, or she was trying to educate her children, or prepare them for the future, or allay her suspicious about their behaviour, or engage in an extreme form of surveillance of her children.

Furthermore, the position she adopts as one who engages actively in HIV testing is evident in her use of the words ‘What even encouraged me more was the fact that we got incentives here at school ((university)) when you get tested’ (lines 64-65) to position herself as one who appreciates the incentives in the form of material reward given to people who go for testing, and above all, the health reward that results from it, for example, the security in knowing that she is HIV negative. Also, at the end of line 66, she makes a diversion to justify her HIV testing practices. She does this through her use of the words, ‘but most importantly, I understand more about HIV testing’ (lines 66-67) to position herself as minimising incentives as an inducement for her engagement in HIV testing but as someone aware of how serious the problem of HIV is, and knows that she might be at risk, and that testing is the appropriate health practice in that regard. In relating this position to her account in Extract 40, where she positioned herself as being aware that she is risking herself by not using a condom and this is bad behaviour, it is reasonable to position Sane as one who has internalised a particular good/ideal health subject and how one should behave in the light of that ideal. The position she adopts is also in contrast to most of the other participants who constructed HIV testing as a one-off process in the sense that for her, HIV testing is something that one needs to engage in regularly and keep a record of their test result. Overall, Sane’s position suggests that she is glorifying the activity of testing for HIV rather than staying HIV negative.

In general, participants’ accounts in response to what HIV testing means to them reveals that they all construct it as being the correct health practice in response to the threat of HIV. The avoidance of HIV testing presented in the accounts of three participants under Theme Five and the hesitancy to engage in it presented in the account of the majority of participants (except Sane) in Theme Six, shows that taking an HIV test is not a straightforward process but a complex one. This study found that the complexity relates to HIV testing facilities being public and visible, exposing the testing subject to the risk of stigma and discrimination. The extracts that speak to this finding are highlighted below.

5.4.3 Theme Seven: Constructions of risk of visibility of HIV testing process

Most participants (15) who had been tested for HIV constructed the testing process as too public as visible, and as not conducted in a protected, confidential environment. They constructed this situation as exposing those who had taken an HIV test to the prying eyes of the observing community, uncomfortable, unsafe, and stigmatised. Extracts (81-85) from interviews with five participants are used to illustrate this theme.

Extract 81 below, is taken from a black South African female participant, Buhle. She constructs two HIV testing scenarios, hers, which was ‘comfortable’ and ‘safe’, and another one with heightened risk compromised by the visibility of the testing process.

Extract 81

123 Betty: Um, how do you wish the HIV testing process would have happened differently? Is there
124 anything you feel like should have changed in that setting?
125 Buhle: No, nothing at all. I was comfortable with everything, Oh↑ but I think for someone who
126 is positive, there is one thing uh that should be changed there because the tent was just outside
127 various buildings, there were shops there, a driving school, you know, there were these guys
128 selling braai meat so when I stepped out of the tent, they could look at my facial expression,
129 they could see that I was relaxed and they congratulated me. So, imagine for someone who
130 found out that she was positive, then the guys out there will know that okay, now this one is
131 positive, and they can say bad things to her. Now even the person who got tested at that time,
132 she was going to feel disrespected or ashamed. So, I think for the sake of the people who are
133 going to be tested positive, the tent should be isolated from people. It should be in places where
134 there are not many people going around, you know, maybe a place like a mall but I don't know
135 which side or corner of the mall that is much quiet.

(24, F, A, SA, PG, Tested)

In response to whether there is a way she wishes the HIV testing process to be conducted differently than it is at the moment, she uses the words 'I was comfortable with everything' (line 125) to position herself as being contented and comfortable with her experience and the HIV testing process in a mobile testing facility in a tent. She, however, follows this up with an intake of breath 'Oh↑' (line 125) and proceeds to explain the potential risks of taking an HIV test, particularly for those who will test 'positive' (lines 125-126). In her use of the words 'the tent was just outside various buildings' (lines 126-127), 'shops', 'driving school' (line 127), and 'guys selling braai meat' (lines 127-128), she constructs the ad hoc mobile testing tent as very public, as visible and exposing. The emphasis she has given to the HIV testing process as being noticeable and exposing is evident in her use of the words 'when I stepped out of the tent, they could look at my facial expression, they could see that I was relaxed, and they congratulated me' (lines 128-129) to construct her experience of the testing process as exposing her to the scrutiny of the public. She constructs an alternative experience of a hypothetical woman who tests 'positive, then the guys out there will know that, okay now this one is positive, and they can say bad things to her' (lines 130-131). In her use of these words, Buhle positions those who test positive (under the current practice of the testing process in a publicly accessible testing venue) as very vulnerable and exposed to the scrutiny and commentary of others. This constructs HIV testing (in the visibilising environment under which it is done) as a risky activity, although she felt safe (since she tested negative), and was not affected by this risk of the visibility of the HIV testing process.

She positions herself as an advocate for better testing conditions. She does this through her use of the words 'I think for the sake of the people who are going to be tested positive, the tent should be isolated from people' (lines 132-133) to position the HIV testing site as needing to be as isolated from the public eye to minimise the risk of exposure of the testees in the testing process. She then makes references to ‘a mall’ (line 134) as an example, and she follows this up with words ‘I don’t know which side or corner of the mall that is much quiet’ (lines 134-135), which serves to position her as expressing doubt in her proposal. This hesitancy perhaps relates to the busyness of the mall in general, in which the issue of exposure to public scrutiny in the process of testing might become unavoidable.

In Extract 82 below, taken from a black South African female participant, Phumi presents her HIV testing experience at a mobile testing facility in a tent in a slightly different way. She constructs two HIV testing contexts, hers at a mobile testing tent on campus which was ‘comfortable’ and safe, and another one at the clinic, as tense and exposing. This extract is a continuation of Phumi’s account in Extract 70, where she constructed herself as not feeling ‘pushed’ or ‘pressurised’ to engage in HIV testing. In response to the question of why that is the case, she says:

<u>Extract 82</u>

48 Phumi: It is just fear, you know, testing is not really a walk in the park he he what if you have.
49 It is just the fear about uh (.4), you know, at the clinic there are usually older people ((health
50 care providers). So when you go and test they think there is something that must have happened
51 maybe engaged yourself in sex, something that you shouldn’t be doing at your age, you know,
52 but at the tent, it was more friendly because there were other younger people around although
53 the people they were doing the testing were old I mean nurses I don’t know where they were
54 coming from, but the environment was sort of welcoming, it didn’t look scary unlike going to
55 a clinic.

(22, F, A, I, UG, Tested)

Phumi, in her use of the words ‘it is just fear’ (lines 48, 49), and ‘testing is not really a walk in the park’ (line 48) constructs the testing process as something terrifying, tense and risky. In her use of the words ‘what if you have’ (line 48), she relates her fears of taking an HIV test to the risk of confronting the problem (of the possibility of taking the test and knowing that you have HIV). In referring to the health care service providers in general, she uses the words ‘they think there is something that must have happened maybe engaged yourself in sex, something that you shouldn’t be doing at your age’ (lines 50-51) to position them as critical of youth sexuality. However, in referring to the HIV testing setting on the Pietermaritzburg campus, she uses the words ‘more friendly’, ‘there were other younger people around’ (line 52), ‘environment was sort of welcoming’ (line 54), and ‘it didn’t look scary, unlike going to a clinic’ (lines 54-55) to position the HIV testing conditions at a mobile testing facility in a tent on campus as comfortable and safe. She contrasts this with the testing process at the ‘clinic’. In her account, to be judged by older nurses in a public clinic is different from the more accepting context of a university testing facility with young people, who might be more similar to her, and where there is no judgement of her life and sexual activity.

The positive assessment of the Pietermaritzburg campus health clinic in relation to the testing process constructed by Phumi in extract 82 above is directly contradicted by Sane in Extract 83 below. Sane constructs the campus health clinic context as public, and as a place she finds embarrassing to go for testing. Yet, the two clinic contexts created by Phumi and Sane are comparable; both entail a specific room and surveillance by others.

Extract 83

122 Betty: Is there a way you wish HIV testing should have happened differently?
123 Sane: No, I am satisfied except for the fact that I don’t like it when you go to the clinic here at
124 school, and then they say, um, people who are here to get tested, they should go to that room.
125 Why do they have to separate us from the other patients? I don’t like that because I feel they
126 are embarrassing us. They are exposing us. There are people who are going to stigmatise us;
127 they are going to have assumptions now that, oh, this one is going for an HIV test, oh she
128 doesn’t know her status, oh she is not using protection. Or maybe when you come back from
129 the consultation room, if you are smiling or if you choose not to smile, they are going to be
130 like, oh, she is grumpy, so she has HIV. You know, they are labelling us, and I feel like they
131 shouldn’t do that. They should just put us together with all the other patients because we know
132 where we are going. We know that, for instance, at the campus clinic, we know that there are
133 only two people who test people, and we know their consultation room. So, if you get there
134 and then the nurse calls your name, you know where to go to, that people who are testing rather
135 than them having to separate us.

(22, F, A, SA, PG, Tested)

In response to whether there is a way she wishes the HIV testing process would have happened differently, Sane uses the words ‘No, I am satisfied’ to position herself as contented with her experience and the testing process in a clinic facility on campus. In her use of the words ‘except for the fact that I don’t like it’ (line 123), she makes a diversion which justifies why her HIV testing experience was not that comfortable. She does this through her use of the words ‘they say, um, people who are here to get tested, they should go to that room’ (line 124) to construct the HIV testing activity in the campus health clinic as visible and risky, and herself as very vulnerable and exposed to this risk. She uses the words ‘Why do they have to separate us from the other patients? I don’t like that’ (line 125) to position herself as being dissatisfied with the design and implementation of the process of testing and implying that this should not be the case. Her concern with the exposure to which students who go for HIV testing are subjected in the process of testing at the campus health clinic is evident in her use of the phrases ‘embarrassing us’, ‘exposing us’, ‘stigmatise us’ (line 126), ‘this one is going for an HIV test’ (line 127), ‘oh, she doesn’t know her status’, (line 128), ‘oh, she is not using protection’ (line 128), and ‘oh she is grumpy, so she has HIV’ (line 130), and ‘they are labelling us’ (line 130).

In doing this, Sane constructs this situation as one in which stigma and discrimination from other students would occur, and she sees herself in this situation of being exposed. Similar to Buhle's position (see Extract 81), Sane proceeds to give an account, which positions the testing process as needing confidentiality and students who go for testing at the campus health clinic as needing to be anonymised. She does this by using the words 'They should just put us together with all the other patients because we know where we are going' (lines 131-132).

In Extract 84 below, taken from a coloured South African female participant, Purity constructs her testing experience at the Pietermaritzburg campus library lawn as exposing and thus risky and unacceptable.

<u>Extract 84</u>

93 Betty: Okay, and is there a way you wish testing would have happened differently?
94 Purity: I didn't like the library lawns, to be honest. Um, I think they should do it in a building
95 or private spaces instead of on the main campus like on the lawns because I feel like it is an
96 open area and a lot of people feel embarrassed to be tested for HIV, so they wouldn't want to
97 sit there when everybody is walking passed them. So even though you go into a section in that
98 little tent to do your test with this person testing you, I think the fact that people can still see
99 you is embarrassing for some of us because you imagine these people are going to judge me,
100 they are going to treat me differently, you know, or think that I have this disease. So actually,
101 that is why we won't go and test.

(20, F, C, SA, UG, Tested)

In response to the same question of whether there is a way she wishes the HIV testing process would have happened differently, Purity uses the words 'I didn't like the library lawns, to be honest' (line 94) to position herself as unsatisfied with her experience and the HIV testing process in a library lawn on campus, and as one who is honest with her view of things in this regard. Her use of the words 'it is an open area' (lines 95-96) constructs the library lawns as public and renders the process of testing visible and exposing. The emphasis she has given to the exposure in the process of testing at the campus library lawn is evident in her use of the words 'I think the fact that people can still see you is embarrassing for some of us', 'you imagine these people are going to judge me', 'they are going to treat me differently', 'think that I have this disease', and 'Actually, that is why we won't go and test' (lines 98-101). With all these words, she positions the ad hoc mobile testing tents on the campus library lawn as inappropriate for testing. She justifies this by constructing university students as discriminatory. The act of testing is therefore potentially stigmatising, and many students fear this. In using these words also, she positions herself as being vulnerable to, and fearing the risk it could involve as a result of engaging in HIV testing. In her account, this scenario of exposing people who go for testing to the view of others, tends to discourage students from opting for taking the test. Like Buhle and Sane's positioning discussed earlier (see Extract 81 and Extract 83, respectively), Purity proceeds to position herself as an advocate for confidentiality and promoting the need for the concealment of the process of HIV testing by isolating testing facilities. She does this by using the words 'I think they should do it in a building or private spaces' (lines 94-95).

The same construction of the visibility of the HIV testing process is also evident in Extract 85 below, taken from a black male international student participant who discussed his HIV testing experience at a tent which was located in a primary health care facility in his home country.

<u>Extract 85</u>

94 Betty: Based on your experience in that tent you went to, is there a way you wish testing should
95 have happened differently?
96 Andrew: Doing it in an enclosed place would have been better. I didn't like the idea of people
97 seeing me going into that tent. It is shameful. I wish it were somewhere else like an office
98 which is completely out of the picture so that nobody knows what goes in there because other
99 people who have come to the hospital would see you going there, and they all know in this tent
100 people go to for HIV tests and they will start imagining why you are in there. Because you see,
101 some people can think you have HIV, but you only went there to test, so it is not a good picture
102 to be seen walking in there. When you get tested, and maybe you are positive, people would
103 see you are positive because of your sad face.

(24, M, B, KEN, PG, Tested)

In response to the same question of whether there is a way he wishes the HIV testing process would have happened differently, Andrew uses the words 'I didn't like the idea of people seeing me going into that tent', 'It is shameful' (lines 96-97), and 'it is not a good picture to be seen walking in there' (lines 101-102) to position himself as discontented with his HIV testing experience at the mobile testing tent which was public, and thereby too exposing. The emphasis he has given to the exposure in the process of testing is quite evident in his use of the words 'they will start imagining why you are in there' (line 100), 'some people can think you have HIV' (lines 100-101), and 'people would see you are positive because of your sad face' (lines 102-103) to position the HIV testing facility he visited as exposing testees to the view of others, and other people (onlookers) as suspicious of a person who goes for testing and himself (Andrew) as being vulnerable to this risk of being suspected of having HIV, which brings the fear of exposure because of stigmatisation. Similar to the position taken by other participants mentioned above (Buhle, Sane, and Purity), Andrew uses the words 'enclosed place would have been better' (line 96), and 'office which is completely out of the picture' (lines 97-98) to construct HIV testing as a risky and exposing activity which needs to be conducted in a safe and confidential, private context.

Overall, from the accounts of the above participants, the concern is that although some youth position themselves as being threatened by the risk of HIV and HIV testing as being the correct response to it, they construct HIV testing as something that needs to be conducted in a confidential context where the fear of exposure in the process of testing could not arise. They take the position that the health clinic, mobile testing tents, and services on the library lawns could expose them to the risk of being stigmatised and discriminated against by other people and even the health care service providers. They construct this lack of confidentiality in the venues for HIV testing as a critical disincentive for their engagement in HIV testing as their primary protective strategy, especially for those who know that they have risked themselves. These barriers to HIV testing uptake could potentially be addressed by HIV self-testing, a new modality of HIV testing that shifts the focus away from the traditional HIV testing facility to an individual. This health initiative was explored in the present study, and participants' views about it are highlighted below under Theme Eight.

5.4.4 Theme Eight: Constructions of HIV testing process as needing to be accompanied by trained counselling support

In the interview I had with all the 20 participants, I asked them whether they are aware of the presence of the HIV self-testing kit, and specific situations, circumstances or experiences of using it. The majority of participants (18) positioned themselves as unaware of it, and no participant reported having tested for HIV on their own in private. In response to whether youth should be encouraged to test for HIV on their own, all of the participants stated that self-testing is inadvisable. In their justifications, three forms of risks were identified. Firstly, the possibility of the self-testing client being vindictive by spreading the virus to unsuspecting partners due to the assumption that someone deliberately infected them. Secondly, the possibility of the self-testing client not seeking confirmatory tests or treatment in a health care facility due to the assumption that they will be stigmatised and discriminated against by the 'observing community' and even the health care service providers. Thirdly, the possibility of suicide for those persons who are not able to manage the outcome of the test. To overcome these potential risks, all participants were of the view that engagement in HIV testing needs organised support in the form of counselling, which should be obtained from a trained health care service provider at an HIV testing facility. Extracts 86-89 taken from interviews with four participants are used to illustrate this theme.

Extract 86 below, is taken from a black male international student participant.

Extract 86

224 Betty: There is also the idea of self-testing where you go to a pharmacy and buy the kit, and
225 you go home to test. Have you heard about it?
226 Andrew: No, not yet.
227 Betty: Okay, but how do you feel about that?
228 Andrew: That is so great, but it increases the risk.
229 Betty: How is it increasing the risk?
230 Andrew: Because now I know that I have a deadly disease, and if I want to revenge, it is very
231 easy because I am the only one who knows I have it. Nobody else who may be walking into a
232 hospital will see me. Nobody will give my girlfriends warning shots when they saw me in the
233 tents. So, if I do it on my own, it is very private, and I will be the one to demolish them because
234 this thing came from somebody, so it has to end with somebody, that is risk am talking about.
235 You definitely need counselling because HIV is chronic, and you have to be on medicine to
236 live.

(24, M, B, KEN, PG, Tested)

In response to how he feels about the idea of self-testing, Andrew uses the words ‘That is so great’ (line 228) to position the act of self-testing for HIV as good. He follows this up with a switch ‘but’ and then the words ‘it increases the risk’ (line 228) to construct self-testing as risky, which minimises his earlier statement related to its goodness. To justify his position further, he uses the words ‘now I know that I have a deadly disease’ (line 230), ‘Nobody else who may be walking into a hospital will see me’ (lines 231-23), and ‘it is very private’ (line 233) to position the self-testing client as having privacy and in control of context and their HIV status, and he contrasts this with the process of testing in a medical facility, which for him is public, thereby lacking confidentiality. Moreover, his positioning of the clinic as exposing those who go for testing to the risk of being suspected of having HIV is evident in his use of the words ‘Nobody will give my girlfriends warning shots when they saw me in the tents’ (lines 232-233). This phrase is an interesting construction of the visibility of the testing practice as being protective (of others). In his use of these words, he contrasts testing for HIV at the clinic with self-testing, which is done in private, and the client is in control of the context. The emphasis he has given to the privacy in the process of self-testing and the danger it could involve is evident in his use of the words ‘if I want to revenge, it is very easy’ (lines 230-231), and ‘I will be the one to demolish them because this thing came from somebody, so it has to end with somebody’ (lines 233-234) to position the actor (self-testing subject who tests positive for HIV) as desiring to be destructive because of their own anger and pain of having been endangered by the deceitful activity of someone who gave them the infection, and he imagines himself being that way if he were to test positive, and the risk it could involve (which is transmitting the virus to his female partners).

Andrew also constructs HIV as something permanent and ultimately fatal. He does this through his use of the words ‘deadly disease’ (line 230), ‘HIV is chronic’ (line 235), and ‘you have to be on medicine to live’ (lines 235-236). With these words also, he positions the actor as powerful in giving someone something which is so ‘deadly’ and ‘chronic’ (and in this, he, the HIV positive actor, will have no qualms because he feels he got the disease from someone and s/he has a duty to hand it over to someone else). He uses the words ‘You definitely need counselling’ (line 235) to position the HIV testing process as needing structured support in the form of counselling to deal with the dangers of testing positive, which are the desire to infect others, and the fear of confronting the problem that is deadly, chronic and stigmatising. Overall, Andrew’s construction of the HIV positive person suggests that no one is really trustworthy, and that there are people in the world who are vindictive because of their own anger and pain. It also appears that stigmatising people living with HIV is good, and self-testing prevents this stigma from working as it ‘should’.

The above construction of self-testing as risky is quite evident in Extract 87 below, taken from a black South African female participant. In response to how she feels about the idea of self-testing, Tumi says:

<u>Extract 87</u>

Tumi: I feel like people won’t be encouraged to go to for ARVs if they find out that they are sick because the counsellor is also the influence for us to go to clinics to test because if you are like you were my counsellor and you are doing the test, you would tell me what to do after I test. But if I am at home, no one will tell me what to do, what steps to take if I am HIV positive, then I would just sit down and say, oh, I am HIV positive. Maybe I should just kill myself.
Betty: Okay. So, is it something which should be recommended for young people like you?
Tumi: I wouldn’t; I wouldn’t recommend it because we make permanent decisions based on temporary feelings. If I am feeling suicidal or just depressed, I am going to do something drastic.

(19, F, A, SA, UG, Tested)

In her use of the words ‘I feel like people won’t be encouraged to go for ARVs if they find out that they are sick’ (lines 133-134), Tumi links HIV with sickness, and positions people who test positive as hesitant to initiate treatment to manage it. She uses the words ‘the counsellor is also the influence for us to go to the clinics to test’ (line 134), and ‘But if I am at home, no one will tell me what to do, what steps to take if I am HIV positive’ (line 136), all of which position her as needing to be directed, as needing support and help. She also uses these words to construct the HIV testing process at the clinic as initiated by the health care service provider and as comfortable and safe, and position the client as passive and as needing to be encouraged and guided on how to respond to a positive test result, and she contrasts this with doing self-testing, particularly being alone, as risky. In her account, the risk of testing positive for HIV when alone is evident in her use of the words ‘I would just sit down and say, oh, I am HIV positive’, and ‘Maybe I should just kill myself’ (line 137). In using these words, she constructs the discovery of the HIV positive status alone as devastating and discomforting, and she imagines herself being subjected to this feeling if she were to test for HIV on her own at home in private.

Consequently, in response to whether self-testing should be recommended amongst youth like herself, she uses the words ‘I wouldn’t; I wouldn’t recommend it because we make permanent decisions based on temporary feelings’ (lines 139-140) to position the emotions of young people as fickle, and them as not being able to make the appropriate decisions. She positions them as being made vulnerable by the discovery of their HIV positive status on their own. To elaborate on this, she uses the words ‘If I am feeling suicidal or just depressed, I am going to do something drastic’ (lines 140-141) to construct young people’s ways of responding to their negative emotions as dire.

Extract 88 below, taken from a black South African male participant, is a continuation of my interview with him but, this time, related to whether he will consider using the self-testing kit.

Extract 88

168 Zazi: Let us say, for example, I buy that self-testing kit and then when I am in my room I test
169 and then if maybe I were to be positive, I would just be vulnerable because I did alone, a lot of
170 thoughts would go through my mind at that time which would be different from when I am
171 with a nurse or a doctor who will advise me if they see that I am positive, then they can counsel
172 me. Now being alone would make me think more about the positive result.
173 Betty: So, do you think it is something that should be encouraged?
174 Zazi: I think it is something that should not be encouraged because a lot of people who
175 ‘unyathele icable’ ((step on a live wire)) will end up committing suicide because you need to
176 be counselled.

(22, M, A, SA, UG, Tested)

In lines 168-172, Zazi contrasts two HIV testing scenarios, doing it on your own (which creates vulnerability), and doing it with a trained health professional. He constructs the discovery of an HIV positive status on your own as dreadful, as sparking intense negative ‘thoughts’ (line 170), as exacerbating ‘vulnerab[ility]’ and fear, and he contrasts this with doing it in front of someone else, particularly ‘a nurse or a doctor’ (line 171) who will give you ‘advice’, and ‘counsel[ling]’ which for him is essential; since a diagnosis needs support and advise. The words ‘*unyathele icable’* (line 175) means to step on a ‘live wire’. A ‘live wire’ is a common metaphor in South Africa for becoming HIV positive. With these words, he is raising the idea that we step on wires all the time, and sometimes, through bad luck, one of those wires is ‘live’.

Here is commenting on his perception about the randomness and bad luck for people who get HIV from something we all do (walk/have sex). Overall, Zazi creates a scenario to show how scary a positive HIV status might be if one was alone. This raises an additional threat, the risk of ‘committing suicide’ (line 175) if no adaptive or coping behaviour is facilitated in the form of counselling.

While the above participants constructed HIV testing as needing organised support in the form of counselling, another participant called Londi constructed the process of counselling in the context of HIV testing differently. Sharing her experience at the Pietermaritzburg campus health clinic, she positioned the counselling process that accompanies the process of testing as anxiety-provoking. For her, it seemed like the counsellor was pre-empting her HIV result as positive, which she constructed as threatening and irritating. Her views are presented in Extract 89 below.

Extract 89

283 Betty: Um, so now in that testing room, what did you do?
284 Londi: I came in and then so this guy he was a male, he was friendly trying to cheer me up and
285 then he asked me some questions he was writing something that he was supposed to give it to
286 me, the paper that has my results. So, he was still filling in my names and student number and
287 all that. So, while he was doing that, he was trying to cheer me up, and there was nothing to
288 cheer up for. I was just waiting for him to finish and do what I am here to do. Then he tried to
289 talk about the counselling thing, but I couldn’t hear anything because I was panicking. I just
290 wanted first to do this, and then we can talk after that like I couldn’t even listen to him; I was
291 just like, okay, waiting for this thing. And even the whole process of talking was making me
292 more anxious. I was irritated that he is offering the services as if he knows me. I want to know
293 what am I am here for, and from the moment I got in there, I was irritated because I felt like he
294 was trying to comfort me already; I think because he had asked me why I wanted to test, and I
295 told him that. So now he was like comforting me, telling me, oh, you can live with it, you know.
296 He made me feel that I have it already. I just wanted to get tested. Maybe while we are waiting,
297 he can talk, but I didn’t have time for friendship or friendly conversation and all the counselling.
298 I could not hear anything before that. But even counselling should also be interactive, meaning
299 I will tell you the information, then I want you to tell me what you have heard or what you
300 have learned from it, and then ask questions like from here onwards, how will you protect
301 yourself from getting HIV if you are not HIV positive.

(24, F, A, SA, PG, Tested)

In her use of the words ‘he was friendly trying to cheer me up’ (line 284), Londi constructs the HIV testing counsellor in the Pietermaritzburg campus health clinic as being a male subject. She also constructs him as hospitable, which is a positive construction. She uses the words ‘I was just waiting for him to finish and do what I am here to do’ (line 288), ‘I couldn’t hear anything’, ‘I was panicking’ (line 289), ‘I couldn’t even listen to him’ (line 29), and ‘whole process of talking was making me more anxious’ (lines 291-292) to construct the process of counselling as creating a sense of waiting, of anticipation, of being in suspense and anxiety.

With the use of the words ‘I was irritated because I felt like he was trying to comfort me already’ (lines 293-294), ‘telling me oh, you can live with it’ (line 295), and ‘He made me feel that I have it already’ (line 296), she positions the HIV testing counsellor again as pre-empting her HIV status, as allowing for the possibility that she might have HIV. She constructs this situation as annoying and making her anxious about her HIV status, which is a negative construction of the counsellor and contrasts with her earlier positioning of the counsellor as ‘friendly’ (line 284). She also positions the process of HIV counselling as needing to be ‘interactive’, client-centred and involving the application of skills (line 299). She constructs such skills as including the appropriate timing for introducing it, summarisation, active reflection, listening, probing or questioning, and giving direction, or a potential way forward on how to protect oneself from HIV infection. She does this through her use of the words ‘counselling should also be interactive’ (line 298), ‘I will tell you the information, then I want you to tell me what you have heard or what you have learned from it’, ‘then ask questions’ (lines 298-300), and ‘from here onwards, how will you protect yourself’ (lines 300-301). Her use of all these words serves to position her as drawing her constructions of the approach to HIV counselling from the dominant basic counselling skills discourses. Overall, Londi’s construction of the HIV counselling on the Pietermaritzburg campus health clinic suggests that it lacks adequate timing. It is as if the service is presented to the client prematurely and is therefore counterproductive and undesirable.

5.4.5 Trends and conclusions arising from findings on research three

Some key findings were identified in relation to how participants’ constructions of, and positioning in relation to HIV risk relate to their practice of HIV testing. Firstly, some interesting contradictory trends in relation to participants’ construction of the importance of the practice of HIV testing were identified. This is because, although the activity of testing was constructed as being the required protective health behaviour, as being of great significance, and as providing a linkage to treatment and support where the result comes out positive, of the 20 participants interviewed, three (all female), positioned themselves as never been tested at the time of the interview. In justification, they positioned people who need to know their status as those who know they have risked themselves and contrasted this with themselves. Even though 17 participants reported being tested, inconsistencies and contradictions in their account were noticeable. Their justifications of their practices position HIV testing as not something they actively and regularly engage in, but something essentially incidental in their lives, and often as frantic responses to their engagement in risky sexual encounters, or a remedial reaction to their experience of cheating partners, or a response to visible symptoms suggestive of the AIDS, such as losing weight and being diarrhoeic.

Secondly, this hesitancy to take an HIV test was related to four forms of fear, particularly where they feel unsure of the HIV status of those they have engaged with sexually. Firstly, the fear of confronting the problem of HIV due to the assumption that the infection manifests itself physically and visibly. Secondly, the HIV testing facilities are located in visible places and are very exposing, which makes those who go for testing vulnerable to being suspected of having HIV and being stigmatised and discriminated against by other people. Thirdly, the fear of being judged by healthcare providers. Fourthly, the fear of one's life changing irrevocably (loss of future aspirations related to marriage, family and having healthy children). In light of the above four forms of fear, some participants constructed HIV testing as demanding courage and readiness. In perceiving it in this way, they position it as a health practice that is both threatening and challenging to face. There was one outlier (Sane) in this positioning, who constructed HIV testing as something in which she engages in regularly and which gives her confidence and pride.

Thirdly, the study found that participants constructed HIV testing as a simple one-off process, with only a few mentioning the window period, or the need for a confirmatory test.

Finally, all participants constructed self-testing as something fearful and unmanageable, especially if the result was positive. All of the participants disliked the idea of self-testing and constructed the process of getting one's HIV diagnosis as requiring supportive counselling

5.5 Synopsis of the chapter

This qualitative study explored youth constructions of HIV risk and the implications of these for their health practices, specifically HIV testing, using a discursive analysis/social constructionist approach. The findings suggest that the majority of participants (16) constructed HIV as being an immense and overwhelming threat in terms of its prevalence in South Africa and on the Pietermaritzburg campus, and a few (4 participants) constructed it as being a minimal threat. The justifications and rationalisations of those who constructed HIV as being a huge threat focussed on increasing prevalence, the invisibility of the threat of HIV, high-risk sexual practices of youth, and the tendency of people to ignore the threat of HIV. The justifications and rationalisations of those who constructed HIV as a minimal threat focussed on increasing awareness and interventions in South Africa and on the Pietermaritzburg campus. All these justifications and rationalisations seem to be drawing on existing discourses in advertisements, the mass media, educational awareness programmes, health research, interactions with health care service providers and peers, and their experiences of health care on, and off campus.

In terms of participants' positioning in relation to the threat of HIV, 13 of the 20 participants interviewed positioned themselves as being at risk, and 7 participants positioned themselves as not being at risk. Ten of the 13 participants who positioned themselves as being at risk also positioned themselves as potential victims of health policies. ARV's were constructed as invisibilising HIV, and therefore, exposing them to risk. The consequence for these participants is that they have to defend themselves (by implication, if they could see it, or if those who have it could disclose their status, then they could protect themselves), but they cannot, and for them, this is their primary concern. Three of the 13 participants who positioned themselves as being at risk positioned other people (cheating sexual partners and rapists), and other non-sexual routes of transmission as being responsible for creating the risk for them.

Overall, the majority of the participants drew on a victim discourse, which assumed that other people were responsible for their HIV status and their risk. Although most participants (17) reported being tested, there were contradictions in their accounts. For example, testing was incidental, in response to a crisis (engaging in unprotected sex or becoming aware of a partner's infidelity), or thinking that visible symptoms might be AIDS.

In the next chapter, the significance of these findings will be discussed and engaged with, with reference to the literature reviewed.

CHAPTER SIX: DISCUSSION OF FINDINGS

6.1 Introduction

This chapter discusses the significance of the findings presented in the last chapter (Chapter Five). However, before embarking on this, it is first important to reiterate that this qualitative and discursive analytic study explored how sexually active youth aged 18-24 years at the University of KwaZulu-Natal constructed HIV risk; how they constructed and positioned themselves and others in relation to this risk; how their constructions and positioning worked, and what they achieved by using them in this way, in relation to their practice of HIV testing, in the sense of whether and how they engaged with it as a protective strategy. Convenience, purposive and snowball sampling methods were used to recruit five male, and 15 female student participants. In-depth interviews were conducted with all participants. The data were analysed discursively in relation to the three research questions of this study. A brief summary of the key findings of this study is highlighted in the next section.

6.1.1 Summary of the key findings of the study

It is clear from the findings of this study that students construct HIV as manifesting itself primarily physically and visibly (for example, being wounded, losing weight, being diarrhoeic). In their view, the emergence of ART treatment has contributed to complicating these stereotypes by its ability to invisibilise the presence of HIV in people. They noted that this is a dilemma as some youth tend to depend on the above physical signs of HIV infection to identify a person who has it, in order to take appropriate action in defence of their health. It is such constructions of the threat of HIV as being visible that creates the possibility for risk for students in the context of HIV and AIDS.

In this study also, some participants constructed HIV infection as being synonymous with AIDS. When talking about the potential threat of HIV, the focus was on the lack or loss of control over HIV, and being burdened by the dreadful images of a wounded, degraded, attacked and devastating AIDS body, giving rise to one eventually dying from it. This finding suggests a considerable level of stigma attached to people living with HIV, let alone having AIDS, and has implications for one’s engagement with HIV testing. It seems the avoidance of HIV testing observed in this study is a form of fear or resistance to the discovery that one has a disease with an adverse outcome like AIDS. In their view, such outcomes include the death that it would bring; the changes that it will impose on one’s patterns of life; the belief that it will make one have awful symptoms; the way it acts as a barrier to obtaining one’s dream; the idea that it will deny one a chance to lead a normal life fulfilled by sexual partnerships, sexual pleasure, marriage, and childbearing; and the fact that it exposes one to the risk of stigma and discrimination. These constructions show that their avoidance of HIV testing relates to this fear of being positive, which is a negative identity. They also suggest that health messages targeting youth need to clarify the distinction between HIV and AIDS, and to alter youth perceptions and knowledge that conflate these two social constructs.

It is clear from the findings of this study that some students positioned themselves as at no, or low risk of HIV, despite not using protective measures in their sexual activities, or even engaging in couple HIV testing in their relationships. Instead, they assumed that as long as their partners’ HIV status is negative, they have nothing to worry about, which is risky, especially when sexual partners do not adhere to the principle of mutual faithfulness. The whole trend suggests that some educated youth do not construct HIV as a risk, or their behaviour as problematic.

Another significant finding in this study is the different expectations in terms of gender, which positions women as less powerful but also to blame, and men as more powerful but blameless. Women’s practices in relation to HIV testing are in this context. They cannot act outside of this context of sexual relationship, unless with difficulty (there are very few instances of them doing this), for example, women testing for HIV and they do so alone; they seem to test in reaction to the actions of their partners, and they seem to do this after the relationship, rather than whilst still in it. This is important because it suggests that the relationship context does not facilitate or make available the position of a ‘testing’ subject, or a neutral position and one which is free of stigmatisation.

Related to the above is the issue of men depending on female partners to know their HIV status by proxy. While this positions men as not agentive, it is a risky practice due to the possibility of a seronegative partner in the serodiscordant couple. Thus, it can be speculated that the main reason students do not think in a similar way to the doctors/health promoters/interventionists in fighting the HIV epidemic is that they cannot do this alone. They cannot act outside of this context of gender inequality in heterosexual relationships.

Another significant finding of this study closely related to the above is how the construction of youth’s sexual relationships may serve to justify passivity and inaction on engagement with HIV prevention services, such as HIV testing. In this study, it was evident that the importance of relationships may outweigh the risk of HIV. Additionally, HIV risk may not be actively thought of within youth’s sexual relationships, and not form part of the discourses used to construct or think about sex within a relationship. Thus, unless actively engaged with about these topics, or approached by service providers, these discourses of risk may not have importance in students’ day-to-day practices, and so HIV testing may have very little importance in a real-world relational context.

Moreover, there seems to be a consistent construction of HIV testing through medical facilities and ad hoc mobile testing tents as a far more complex activity than often imagined. The complications, in this case, emanated from the risks of exposure in the testing process as the facilities are located in public vicinities. In addition to this is the discomfort in the HIV testing interactions between the client and the healthcare provider, particularly during the pre-test information and counselling stage. Another complication is the fear of being stigmatised by a health care service provider. Some participants remarked that people who suspect themselves as having HIV might cocoon themselves in secrecy to avoid these potential risks of engaging in HIV testing. This sheds light on the need to review existing responses to HIV risk through HIV testing to expand delivery options that have the potential to address them.

In the HTS policy, the assumption is that the current barriers to HIV testing uptake can be assuaged by HIV self-testing, a new modality to HIV testing aimed at shifting the focus away from the traditional HIV testing facility to the comfort and security of an individual’s home. Participants’ constructions of this health initiative were also explored in this study, and the findings are discussed in this chapter. However, what those findings demonstrate is that, while the introduction of HIV self-testing or HIV self-screening, as it is being referred to in South Africa, has the potential to address the current barriers to HIV testing uptake within public settings, as highlighted above, most participants have identified some risks that are associated with it. They argued that self-testing clients would not be able to emotionally handle a positive result if they conducted the test on their own and alone. To overcome the potential risks of self-testing, all participants constructed the activity of HIV testing as needing organised support in the form of counselling. This is crucial as more methods to prevent the risk of HIV infection amongst youth are urgently needed, including ways that do not rely on one going to a health care facility to do an HIV test or to access a condom, which is too exposing; or the option of sex abstention, which is not always possible in a romantic relationship; or taking of regular or near-daily pre-exposure prophylaxis pills. The overall aim of this chapter, therefore, is to discuss the significance of these findings.

According to Parker (1992, 2002) and Willig (2008), discursive researchers should draw on other existing discourses on the same research problem to formulate a critique of the discourses functioning in a text. In line with this perspective, in this chapter, I critically comment on the degree to which the discourses identified in this study are congruent or discordant with those in the epidemiological and demographic HIV and AIDS projections, existing health and academic research with youth, the global HIV and AIDS reports, South Africa's National Health Reports, South Africa's National HIV Testing policies, and the popular media health reports, reviewed in the prior chapters. The discussion will also attempt to provide new insights in relation to the current research problem of HIV risk and HIV testing, and some potential ways forward.

Parker (2002) also argues that discourses are intertwined, which means that when people are referring to a particular discourse, they draw on other existing discourses. This discussion will also explore other discourses intertwined in participants' constructions, positioning and HIV testing practices, and discuss their significance.

With these preliminary observations made, the discussion and interpretation of the discourses drawn on by participants in their constructions of HIV risk and how these relate to their HIV testing practices, will now be undertaken.

6.2 Constructions of HIV risk and implications for HIV testing practices

The social constructionist approach contains the assumption that people rely on a common stock of knowledge entrenched within existing discourses, everyday language, and shared meanings and understandings in their constructions of their world (Burr, 2003; Parker, 1992; Maticka-Tyndale, 1992). Maticka-Tyndale (1992) further noted that multiple discourses exist in our world, but we selectively choose particular ones from our stock of knowledge under the process of selective appropriation, while leaving others. Given this understanding, a fundamental trend identified in this study is that the category of youth that served as participants in this study have a way of describing, accounting for, or explaining the seriousness of HIV risk to themselves and others, which suggests that they are drawing on existing discourses on HIV risk and HIV testing in advertisements, the mass media, educational awareness programmes, health research, interactions with health care service providers and peers, and their experiences of health care on, and off campus. The basis for this argument arises from the accounts of the majority of participants (16), which revealed that they constructed HIV as a huge risk, an idea that reflects the messages contained in the above sources of knowledge on HIV available in their everyday interactions. In closely analysing their constructions and rationalisations in this regard, nine major discourses were identified. They include the discourse of the seriousness of HIV risk, the discourse of unsafe sex as being very risky, the discourse of avoidance of HIV testing, the discourse of othering HIV risk, the discourse of silence about HIV risk and HIV testing, the discourse of prioritisation of pregnancy rather than HIV risk, the discourse of the feminisation of HIV risk prevention through HIV testing, the discourse of the invisibility of HIV risk, and the discourse of the visibility of HIV risk. Even the few participants (4) who constructed HIV as being a minimal risk can still be seen in their responses as being influenced by their interactions with the health messages around HIV risk. Their constructions draw on the information, education, and communication health (IEC) framework.

The interpretation of the findings in relation to the discourse of the seriousness of HIV risk in South Africa and how this relates to the HIV testing practices of youth will now be presented and discussed.

6.2.1 The discourse of seriousness of HIV risk

In large scale surveys such as the SABSSM (Shisana et al., 2014; Simbayi et al., 2019); small scale surveys (George et al., 2019; Mabuto et al., 2019); modelled data (Johnson & Dorrington, 2020; UNAIDS, 2020); South Africa's National Health Reports (Department of Health, 2018; SANAC, 2017); and South Africa's National HIV Testing policies (Department of Health, 2000, 2010, 2016), HIV risk is constructed as being immense and almost overwhelming in terms of its prevalence in South Africa. Similarly, in most of the present study's participants' constructions of HIV risk in South Africa, in general, and on the Pietermaritzburg campus, in particular, there were references to phrases such as 'very serious', 'very widespread', and 'prevalent', which appears to be drawing on a discourse of the seriousness of HIV risk in South Africa. To understand how serious they take HIV risk in relation to themselves and others, participants were asked to estimate the number of people living with HIV in South Africa and on the Pietermaritzburg campus using a scale of one to ten people. The majority of participants' responses ranged from 5 to 6 people amongst people outside the university (the general population), and 1 to 5 people amongst students on the Pietermaritzburg campus. If one compares these estimates, it is clear that they seem to construct the problem of HIV risk as affecting students less than it affects the general population, which is a distancing strategy.

In the participants' attempt to justify their constructions of HIV risk as prevalent in South Africa, they made reference to words like 'statistics', 'news', 'research', 'research organisation', and 'university modules'. These words are significant since they position these participants as being knowledgeable about HIV research, statistics, patterns and trends, and their accounts as factual and accurate. In line with the assumption of the social constructionist approach that knowledge implies social action (Burr, 2003; Gergen, 1999; Lupton, 1992), the use of the above words position these participants as drawing on a discourse of experience and credibility related to formal knowledge, and has implications. A consequence of drawing on this discourse is that this group of youth are positioning themselves as responsible health subjects, as informed, as educated, and as low-risk subjects. There are, of course, contradictions in this positioning. One would expect them to apply their knowledge and awareness to their own lives to exercise sound judgment in risky situations, and engage actively in protective practices such as HIV testing and condom use, but this does not seem to be the case. One of the significant findings of this study is that the sexual practices of the Pietermaritzburg campus students are often unsafe and that these students are resistant to, and fearful of, HIV testing. Hence, it is as if this positioning of the responsible and knowledgeable health subjects they adopted is a process of psychological distancing and denial. Perhaps they prefer to view themselves as knowledgeable health subjects and 'safe' from HIV, even though they know they are actually at risk. It is as if they are protecting themselves from the HIV identity, which is a negative identity.

6.2.2 The discourse of unsafe sex as being very risky

In a dominant discourse in biomedical health research, HIV is problematised in terms of its transmission, acquisition, and infectivity. It is also problematised in terms of its characterisation of the key population, and risky practices. Research has shown that university students in South Africa (HEAIDS, 2010; Heeren et al., 2013; Higher Health, 2020; Maughan-

Brown & Venkataramani, 2018; Mbelle et al., 2018; Paul et al., 2014), including the University of KwaZulu-Natal students (Chebitok, 2017; Gwala, 2019; Kunda, 2008; Mthembu, 2017; Mulwo, 2008; Mutinta et al., 2013; Nene, 2014; Ngidi et al., 2016; Okelola, 2019; Van der Riet & Nicholson, 2014), are sexually active, and their patterns of sexual practices take place with people in their context and beyond. Consistent with the above studies, participants in this study constructed students on the Pietermaritzburg campus as being sexually active and their practice as unsafe. In their justifications, phrases such as 'we engage ourselves in unsafe sexual activities, yet there are condoms', 'people enjoy unprotected sex even if they do not know the other person's status', 'we just date', 'there is a lot of sexual intercourse that is actually happening, and HIV is high that way', 'we think that young people here ((campus)) do not get infected', 'we tend to trust fellow students a lot'. These words draw on the discourse of unsafe sex as being very risky, and the discourse of youth as the main group at risk of HIV infection. The use of the word 'we' in many of those accounts is significant as it positions the participating students as aligning themselves with this discourse. However, their use of the word 'just' positions them as downplaying the significance, or importance, or the 'badness' of the activity of dating.

According to Heeren et al. (2013), the university is a closed community, and students share social, religious and cultural backgrounds. Heeren et al. (2013) argued that social ties facilitate students mingling with each other easily, and provides access to a more expanded network of potential sexual partners, creating several opportunities for students to make new sexual contacts. It also promotes risky sexual practices such as casual sexual partnerships, concurrency, and incorrect or non-condom usage (Heeren et al., 2013). Given this understanding, the risky sexual activities that students on the Pietermaritzburg campus engage in may, in part, be explained by the size of the student population and the context of the university being a closed community. This means that their practices in socialising, mingling and the kinds of practices that occur in sexual relationships are constructed, negotiated, shared and perpetuated in these networks. This suggests that in a university context, sexual relationships happen, and that there is a particular social network. There is also a particular set of practices and norms related to sexual relationships, all of which tend to be unsafe sexual practices. It is in this context that students are drawing on discourses related to sexual activity and risk. What they tend to be doing here is normalising the risky sexual practices (this can be seen from the use of the word 'just' above). In this context of the university, it seems students' investment in unprotected sexual activity is, therefore, an identity investment, consistent with the findings in Van der Riet et al.'s (2018) study on the interaction of identity development and sexual relationships amongst youth in a rural area in South Africa.

Describing the social constructionist assumption about how knowledge is produced and sustained by social processes, several researchers (Alldred & Burman, 2005; Brown, 1995; Burr, 1996, 2003; Gale, 2010; Gergen, 1999) argue that individuals and their social practices are continually constructed, reconstructed, negotiated and determined through interactions between members of the same society or culture and with their social world. Therefore, in this social context (Pietermaritzburg campus), the particular social processes related to sexual relationships construct, maintain, and sustain particular kinds of practices, which are risky in terms of HIV transmission. This means that it is in the context of campus life, and students in their 'community', which construct, determine, and negotiate particular kinds of practices in sexual relationships, which create HIV exposure. It is, therefore, interesting that students do not personalise the risk of HIV, despite their awareness of the prevalence of HIV on campus, and despite their engagement in activities that expose them to HIV infection. However, such a contradiction in people's positioning is not peculiar in discursive research but considered a key feature of the discursive analytic approach to research (Alldred & Burman, 2005).

To justify this disregard of the threat of HIV amongst students on the Pietermaritzburg campus, a female participant constructed unprotected sexual activity as being used by a young woman for three reasons. Firstly, as a means of pleasing the boyfriend. Secondly, as a reward to the boyfriend for his commitment to maintaining the relationship for a more extended period. Thirdly, as a mutual desire for both partners in a sexual relationship. Overall, this construction of an unprotected sexual activity is quite interesting. It is as if through the activity of sex that a woman is invested with value in the relationship, a position which appears to be drawing on the have/hold discourse. The have/hold discourse contains the assumption that a woman is concerned about satisfying a man's sexual desire and holding on to him, because of the status and thus power through being attached to, and 'keeping' a man (Hollway, 1984). According to Van der Riet et al. (2018), this investment has implications for a woman's safe sex practices in the context of HIV and AIDS. It is as if young women prioritise this different form of self-care (investment in the relationship) above personal sexual safety and health protection strategies such as condom use. If indeed young female students at the University of KwaZulu-Natal operate within such conditions, it is not surprising that they are said to be disproportionately affected by HIV risk compared to their male counterparts (HEAIDS, 2010).

This notion of a young woman using sex to maintain the desired partner, the desired relationship, and her status of being in a relationship is not peculiar to the findings of this study. It has been reported in several studies on HIV risk amongst female students in South African universities (Chebitok, 2017; Chimbala-Kalenga & Makuwira, 2016; Gwala, 2019; Mthembu, 2017; Nene, 2014; Ngidi et al., 2016; Okelola, 2019; Van der Riet & Nicholson, 2014). For example, Ngidi et al.'s (2016) study reported that some female university students conform to risky sexual activities because of the notion of love, the fear of losing a partner, and the desire to prove to their peers that they can not only attract a man, but also keep him. Ngidi et al.'s (2016) study concluded that sexual activity in such a context is viewed as something that could strengthen the relationship between two people, provide a woman with some sense of security in the relationship, and contribute to her positive self-image. Additionally, a similar finding to the social construction of sexual activity reported in the present study has been reported in an extensive survey on sex, grades, and power amongst university students in Ghana and Tanzania (Morley, 2011). Morley's (2011) study concluded that young women are less able to make independent decisions on sexual issues in heterosexual relationships. Overall, these findings suggest that there is a possibility that a young woman can prioritise one investment over another just to maintain the social reputation of being in a sexual relationship.

In their constructions of unsafe sex as risky also, some participants positioned students on the Pietermaritzburg campus as engaging in social activities such as 'campus parties', alcohol use, and alcohol abuse. These social activities were also constructed as being irresponsible, as disregarding potential HIV risks, and as creating conditions that facilitate HIV transmission, and the sexual activity itself is constructed as risky. Several studies on university students' risk-taking behaviours have argued that the social activities of students, particularly substance use and alcohol use and abuse, provide context for sexual risk-taking behaviours (Evans et al., 2018; HEAIDS, 2010; Heeren et al., 2013; Kabiru et al., 2013; Maughan-Brown & Venkataramani, 2018; Musemwa, 2011; Mutinta & Govender, 2012; Mutinta et al., 2013; Paul et al., 2014). This suggestion was also evident in some studies that found that peer interactions influence students' actions, practices and sexual behaviours (HEAIDS, 2010; Kabiru et al., 2013; Musemwa, 2011; Nene, 2014; Paul et al., 2014). What is significant in the findings of the present study, and all the above studies is that the social activities of university students demonstrate a different set of priorities for them, but these priorities are the cost of prioritising their own safety in the time of HIV and AIDS.

However, this risk of HIV is not generated by the individual alone. While it is generally acknowledged in most research that individual sexual behaviours and activities transmit HIV (George et al., 2019; Kharsany & Abdool-Karim, 2016; Mbelle et al., 2018; Parker et al., 2014; Shisana et al., 2014; Simbayi et al., 2019), youth in the university context do not exist in social isolation. It is clear from the findings of this study and other previous studies mentioned above that students' activities tend to be influenced and reinforced by peers. Thus, it is not a question of the individual student not being rational, or not taking risk into account. Instead, their risks relate to the context of the university where peer influence and the dynamics of sexual relationships can encourage students to engage in particular kinds of activities which expose them to HIV infection. A similar position is taken by Glanz and Reimer (2008, p. 397), who argued that "health promotion programs that focus on behaviour change through educational activities or other intrapersonal level change strategies alone often neglect the social and environmental context in which those behaviours occur and are reinforced." This means that the social interactional context of sexual activity, and its related HIV risk need to be more carefully considered.

To conclude this section, the significance of the findings of this study specific to the discourse of unsafe sex as being risky, is that, even though students on the Pietermaritzburg campus have some orientation about safe sex, it is not consistent or sustained (they do mention condom use). This suggests the need to question the assumption of positivist approaches that position educated people as being the ideal health subject, as being rational, self-controlled or reflexive, and their behaviour as being predictable, as planned, and as sustained (Ajzen, 1991; Brown, 1995; Glanz & Reimer, 2008; Kenyon et al., 2010). However, in place of such assumptions about educated people as health acting subjects, comes the need for an alternative approach for youth at the university to counter the threat of HIV in their context. One such alternative approach is the need to prioritise taking regular tests for HIV, but this is still far from being achieved, which is one of the significant findings of this study.

6.2.3 The discourse of avoidance of HIV testing

In line with Parker's (1992) argument that a discourse is a coherent system of meanings, participants in this study offered interesting constructions of what HIV testing meant to them.

The majority of participants constructed HIV testing in two significant ways. First, as being the required protective health behaviour, which gives one self-assurance in knowing your HIV status, and somehow elevates you above those who have not engaged in HIV testing. Secondly, as a means of linking those who test positive for HIV with ART treatment and support. Such constructions are consistent with how the HIV testing service is constructed in public health policies. The HTS policy has a clause that states that clients who test positive for HIV are linked to ART treatment and clinical care, and given information on ways to reduce the risk of transmission and re-infection (Department of Health, 2016). Given that youth involved in this study were able to view the HIV testing service within these dimensions, one would assume that this group of youth put their knowledge into practice by engaging actively and regularly in HIV testing. However, the trend identified in their accounts suggests that students on the Pietermaritzburg campus do not engage actively in HIV testing. Phrases such as ‘people don’t even test’, ‘many students are actually not even testing at all’, ‘they fear to test’, ‘I have not been tested’, ‘it is a big thing’, ‘you will get what you are looking for’ in their accounts which appear to be drawing on the discourse of avoidance of HIV testing. The use of the words ‘they’, ‘people’, ‘students’, ‘person’, repeatedly in their accounts is significant. When interpreted discursively, each word tends to position the speakers (participants) as distancing themselves from this construction whilst positioning themselves as being serious about the issue of HIV testing.

While on the one hand, this discourse which tends to position youth at the university as not engaging actively in HIV testing, is consistent with findings from the research amongst university students in South Africa (Blignaut et al., 2015; Gwala, 2019; Haffejee et al., 2018; HIGHER HEALTH, 2017, 2020; HEAIDS, 2010; Heeren et al., 2013; Kabiru et al., 2013; Mthembu, 2017; Okelola, 2019; Paul et al., 2014), on the other hand, it differs from the findings reported in another South African study on proximate determinants of HIV testing uptake amongst young people (Peltzer & Matseke, 2013). Peltzer and Matseke’s (2013) study suggests that participants who had a higher level of education generally had high knowledge of HIV, including risk and were likely to engage in HIV testing.

Similarly, while the lack of knowledge of, and access to the HIV testing service has been reported in other South African studies as significant issues impacting on HIV testing uptake amongst youth (Evans et al., 2018; MacPhail et al., 2009; Peltzer & Matseke, 2013; Tenkorang, 2016; Tylee et al., 2007), this link between knowledge and access to the HIV testing service, and actual uptake of HIV testing seems not to apply to the context of the Pietermaritzburg campus students. The participants of this study described knowledge and access to the HIV testing service as being very high on campus. Additionally, as highlighted earlier, students have been exposed to health messaging about HIV risk from various sources on the Pietermaritzburg campus. The HIV testing service is also being offered through several sites, such as the campus health clinic, the CHASU offices, and ad hoc mobile testing tents, making it convenient for students. The service is free in the above sites, and is being provided in line with the 5C (consent, confidentiality, counselling, correct test results, and connection) framework proposed by WHO (2015), and adapted by the South Africa National HTS policy released in 2016. To encourage students to consent to HIV testing in the above sites, emphasis is placed on keeping their HIV test result confidential. To ensure correct test results, the rapid diagnostic test kit is being used in all the above testing sites. The students who test positive for HIV are provided with immediate emotional support by a trained counsellor and linked with care and treatment initiatives on campus. The Pietermaritzburg campus is also located in an urban setting and close to several public and private health care facilities that offer HIV testing services, another indication that access to the service is not a problem to students on this campus.

Given the above resources to support routine HIV testing behaviour and sustained behaviour change, one might expect that the university students on the Pietermaritzburg campus would welcome the idea of being tested, with this expectation being more applicable to those who are sceptical about this health practice or, suspect themselves of having HIV, but this was not necessarily the case. The findings of this study suggest that just providing youth at the university with HIV related information and making HIV testing services available does not address how these students make meaning of HIV testing, or stop them from rationalising infrequent testing as ‘acceptable’. Such a contradictory trend suggests that these findings corroborate the argument highlighted in the first chapter of this thesis that one cannot use logic to predict the HIV testing practices of young people as assumed by positivist (cognitive models) and post-positivist approaches, which seemingly reinstate the agentic individual to take responsibility for HIV testing. It is generally acknowledged in discursive approaches to research that individuals construct their social reality, with the same reality constructing the individual and their social practices through the discourses they draw on (Burr, 1996; Gergen, 1999). In line with this perspective, the avoidance of HIV testing amongst students suggests that they do not construct it as a preferred practice in the management of HIV risk and protection. This means that attention needs to be given to the constructions related to HIV risk.

Moreover, when one closely analyses students' 'talk' about HIV risk, the link between their constructions of this risk and their practices of not testing can be seen. This avoidance of testing amongst students relates to issues ranging from the positioning of HIV as being other people's risk and themselves as being educated and responsible health subjects; avoidance of an HIV identity; the fear of an HIV diagnosis; the prioritisation of the relationship above their health and safety; the feminisation of HIV risk prevention; the assumption that HIV testing is for people with obvious and distinct symptoms; gender inequality in youth relationships, to the discomfort with a health care service provider in the HIV testing interactions. These issues are explored in various sections of this chapter, beginning with the participants' constructions of HIV as not a threat to themselves but a problem for other people.

6.2.4 The discourse of othering HIV risk

The construct of othering, according to Burr (2003), Goldstein et al. (2003), and Parker (1992), is used to refer to a situation whereby people (subjects) refuse to identify with particular views and responsibilities through their positioning in the interaction. Goldstein et al. (2003) noted that othering is common in discursive qualitative discussions about HIV. Similarly, in this study, some participants, when talking about who is most at risk of HIV and why, avoided relating the risk to themselves and their specific practices, but viewed it as something for other people to worry about. In their justifications and rationalisations, three specific categories of people whom the participants believed should worry about the risk of HIV were identified. These include the black African subject; the ignorant, uneducated, uninformed, and rural youth; and the young female student. These positions and constructions overall other HIV risk, and create fear and possibly paralysis in relation to it. This appears to be drawing on the discourse of othering HIV risk. The significance of these subject positions and what participants achieved by discussing them in this way in relation to their practice of HIV testing are presented and discussed below.

6.2.4.1 The discourse of HIV as a risk for black Africans

In this study, a few participants (1 coloured man and 2 Indian women) constructed HIV as a problem for black African people and black young women in South Africa. The coloured male participant positioned his knowledge in this regard as based on statistics which, according to him, indicate that black people in South Africa have a high HIV prevalence. In terms of the two Indian female participants, one positioned her knowledge in this regard as based on scientific research and statistics, while the other one positioned her knowledge as based on a university (anthropology) module she has done. By citing the above sources of knowledge as the basis for their constructions of HIV as being a risk to black people, especially young women, these three participants positioned themselves as being familiar with the facts, perhaps in order to render their accounts credible. While this construction is in line with the findings of Van der Riet and Nicholson's (2014) study on the gendering and racialising of sexual risk amongst South African youth, the racial stereotypes came from white participants in that study.

However, this construction of HIV as a problem for black African people and black young women in South Africa is an artefact of history, and has nothing to do with differences in behaviour. Epidemiologically, HIV prevalence amongst black Africans and black young women in South Africa is higher compared to Africans of Indian descent or African young men (Shisana et al., 2014; Simbayi et al., 2019; UNAIDS, 2019). More black Africans may have HIV now because the epidemic first emerged in western equatorial Africa (UNAIDS, 2019). Another confounding factor is that black Africans in South Africa were systematically (and continue to be economically) excluded from the highest quality health services. Thus, it is not that black Africans have more HIV or more risky sex. It is because, historically, they were not privileged enough to access quality health services.

Similarly, women biologically have a higher risk of transmission per sex act (Chersich & Rees, 2008; Eastment & McClelland, 2018; Goldstein et al., 2003; Jangu, 2014). Young women in South Africa are also more likely to have a slightly older (2-5-years) partner whose likelihood of having HIV is higher (Evans et al., 2018; George et al., 2019; Heeren et al., 2013; Maughan-Brown & Venkataramani, 2018; Mutinta & Govender, 2012), and most sexual relationships amongst university students in South Africa are intraracial (Heeren et al., 2013). George et al.'s (2019) study found that 18-year-old female students are more likely to be having sex with 22-year-old men, whilst 18-year-old male students are more likely to be having sex with 16-year-old women. The 22-year-old men are much more likely to have HIV than the 16-year-old women because of time and more partners since their debut. The 22-year-old men are also likely working, and their sexual life is socially applauded.

Moreover, this discourse of HIV as being a risk for black Africans is not uncommon in the HIV prevention messaging. The information around HIV prevention and risk (in campaigns, initiatives, health programming etc.) often position black African women as most vulnerable and, by extension, positioning other races as less vulnerable. This highlights problems with how most formal information and prevention campaigns (in South Africa at least) reinforce these ideas. This is because they are targeted at young black women, and may serve to enhance racial stereotyping and construction of risk as different depending on your race – which then becomes the evidence for risk identity construction.

This tendency of some people to position another category of people as being the source of HIV risk and transmission has been criticised by Lupton (1992), who underscored that HIV chooses its victims indiscriminately and that people of all races can fall victim to it at any point in time. Lupton's (1992) observation notwithstanding, it would seem that an interesting question is why they make this construction and not another one during my interview with them? What are they doing with their words here, and what does it 'do' for them? Concerning these questions, it might seem that a salient explanation for understanding the participants' othering of HIV as a risk for black Africans is the view credited to Gergen's study (1985, as cited in Burr, 2003) that our ways of understanding the world, the concepts we use and the discourses we draw on are historically and culturally specific. In line with Gergen's perspective, one can therefore speculate that why these participants had tended to stereotype African people as almost synonymous with HIV risk is based on a reason that is historically entrenched within the South African context, and takes us back to the racial segregation of the white, black, coloured and Asian/Indian race groups created by the apartheid supporters and colonialists. Connelly and Macleod (2003) noted that the ideologies of the white antagonists positioned images of African people as the centre of the HIV risk, with these being fuelled by the HIV and AIDS statistics that painted this category of people as being 'diseased', as 'infected', as 'contaminated', as 'impotent', as 'malfunctioning', as 'threatening', and therefore to be avoided. Connelly and Macleod (2003) asserted that the ideological effects of the apartheid supporters and colonialists promoting the negative image of African people are carried forward from generation to generation in the form of narratives, social interactions and cultural knowledge (and in the context of this research during the interview I had with them). Hence, it is not surprising that one of the findings of this discursive study is the stereotype of othering HIV risk as a black risk, and may serve to justify why other races position themselves as low risk.

Commenting on the issue of othering sexual risk and responsibility, Van der Riet and Nicholson (2014) noted that it creates a form of stigmatisation and influences one's prevention practices. Consistent with this perspective, the construction of HIV as being a risk that is prevalent amongst black people positions this other category of people and their race as being the problem in terms of HIV risk and transmission. This positioning renders the people from the other race (the participants' own race) as being outside of this risk, or as being protected from it, and therefore, as not needing any form of prevention, particularly when they are courting people of the same race as theirs.

Another concern with othering HIV risk is that the responsibility for managing it through HIV testing is displaced onto the people being seen as at risk. In my interactions with the two Indian female participants, one positioned herself as never being tested for HIV. The other one positioned HIV risk as not within her context and herself as not needing to go for HIV testing. The HIV testing practices of the coloured male participant suggest that testing is not something he actively and regularly engaged in, but something essentially incidental in his life.

However, this tendency of some youth to position HIV as a problem for other people and not for themselves might concern interventionists seeking to encourage sexually active youth to personalise risk and engage actively in HIV testing.

6.2.4.2 The discourse of HIV as a risk of the ignorant, uneducated, uninformed, rural youth

A dominant discourse portrays HIV as the disease of the ignorant and powerless body operating in an under-resourced context in South Africa (Linganiso & Gwegweni, 2016; Van der Riet et al., 2018). In explaining why this positioning could be seen to make sense, Lupton (1992) identified the construction of the uneducated and underprivileged health subject as a victim of complacency, apathy and illiteracy, all understood as promoting HIV transmission. Although the participants in this study did not use the words 'complacency' and 'apathy' in their construction of HIV risk as being prevalent amongst youth who live in rural areas in South Africa, they implicitly referenced issues such as lack of resources, ignorance and rurality. In doing this, they drew on the discursive practices, such as people's low level of education, and insufficient health care (clinics) and education facilities (schools) in rural areas. This discourse tends to position the clinics and the schools as vital social resources in containing the spread of HIV amongst youth in South Africa (Connelly & Macleod, 2003; Goldstein et al., 2003; SANAC, 2017). Given the scarcity of these resources (schools and clinics) in the rural areas in South Africa, as noted by the participants of this study, this positions rural youth as not knowing enough about HIV risk and HIV testing, and as less able to take responsibility for themselves, and as not engaging actively in HIV testing. This trend is consistent with the findings reported in two South African studies (Connelly & Macleod, 2003; Tenkorang, 2016). This highlights interesting issues around young people in rural areas and how ill-informed they are and unprotected (by knowledge), and how they are potentially victims in their under-resourced, traditional context.

The social constructionist approach assumes that people have identity investments in drawing on certain discourses and incorporating them into their repertoire, particularly those that bolster or affirm their self-identity and exclude others (Parker, 1992), which has consequences for their actions and practices. In this study, the repeated references to HIV as a risk associated with the ignorant, the uneducated, the uninformed and the rural youth operating in an under-resourced context suggests the existence of another subject, who is privileged, enlightened, rational (such as participants themselves), who operates in a resourced context (such as the university), and is responsible for their health and safety against HIV risk. There are, of course, contradictions in this positioning. As indicated in prior sections, participants tended to position students in general as engaging in risky sexual activities and social activities on campus, and as not engaging actively in HIV testing.

Another category of subject constructed in relation to the threat of HIV is the young subject, particularly a young female student in her first year of university education.

6.2.4.3 The discourse of HIV as a risk for a young woman

The vulnerability to HIV infection has long been constructed in the dominant discourse within the realm of gender and heterosexuality. The recent HSRC survey found that young women aged 15-24 years were four times more vulnerable to HIV risk and being infected at an earlier age compared to young men within the same age range (Simbayi et al., 2019). This disparity in HIV infections between young men and women has predominantly been the focus of investigation and concern, with the majority of research linking it with the intersection of sex-based biological features (Chersich & Rees, 2008; Eastment & McClelland, 2018; Goldstein et al., 2003; Jangu, 2014); the social positioning of a woman as being subordinate in heterosexual relationships (Chebitok, 2017; Chimbala-Kalenga & Makuwira, 2016; Coates et al., 2011; Higgins et al., 2010; Hollway, 1984; Jangu, 2014; MacQueen et al., 2016; Mthembu, 2017; Nene, 2014; Shisana et al., 2014); a demographic fact there are more women than men, which encourages concurrency (Ngidi et al., 2016; Patterson & Keefe, 2008); and age (being less than 24 years old) (Johnson et al., 2009). Similarly, in this study, young women, particularly those in their first year of university education, were constructed as being at risk of HIV. In their justifications, some participants created two contrasting contexts, the safe haven of the home under benign parental oversight, and the dangerous university context.

The danger in the context of the university was discussed in relation to the first-year female students' age and minimal sexual experience. The young female university students were constructed as relatively innocent/naive and ignorant of the risks of their activities of sex and the demands and expectations in relationships, as not having the same power with their male partners. They were also constructed as easily taken advantage of by older male partners, as being less able to make rational sexual decisions in situations of risk (for example, demanding an HIV test or condom use). The construction of young women as being vulnerable to older male partners concurs with the findings of three South African studies on the social and environmental determinants of sexual risk behaviours and HIV prevention practices amongst university students (Evans et al., 2018; Maughan-Brown & Venkataramani, 2018; Mutinta & Govender, 2012). Both Evans et al. (2018) and Maughan-Brown and Venkataramani's (2018) studies constructed young women as being uninformed and less experienced. Maughan-Brown and Venkataramani's (2018) study concluded that the way young women are being positioned by their male partners as subordinate in sexual decision making creates challenges for their ability to protect themselves from becoming infected with HIV. This suggests that this construction of young women is also about their being disempowered, vulnerable, and defenceless.

On the other hand, Mutinta and Govender's (2012) study drew attention to the issue of the 'gold rush', a situation where people (senior male students) rush into sexual relationships to take advantage of the vulnerable, disempowered and defenceless first-year female students who are most likely to be inexperienced about campus life. In such context, the young woman is constructed as the 'gold' or treasure, or something to be grabbed, rushed at, and a scarce resource. This construction serves to objectify a young woman.

The other danger in the context of the university was discussed in relation to the first-year female subject's freedom on campus. The young female student was constructed as engaging in alcohol abuse and can easily be taken advantage of by a man when drunk. This suggests that a young woman is positioned as being at risk of HIV partly because of her behaviour (drinking) and also her vulnerability (she is a target to be taken advantage of by predatory men). There is also a construction of blame as she has the freedom to make choices (so the choices are hers). However, this positioning of a young woman who uses alcohol as partially responsible for any danger that she suffers as a result of the dominant man subjugating her after getting herself drunk, clearly works to consolidate alcohol consumption by a female student as problematic, as subverting her 'standard' feminine role as the primary agent in managing HIV risk for herself. This significant finding echoes Day et al.'s (2004) study, which constructs alcohol use by women as seriously damaging their health.

However, a man who uses his social position to lure a drunk woman into satisfying his sexual needs invariably places himself at the risk of HIV infection. Of course, there are a number of dynamics that might come to his rescue in the face of such a risk, including the HIV status of the woman in question, whether a condom is used or not, and whether he is circumcised or not. Research has shown that circumcised men present less risk in relation to HIV transmission, and are partially protected from the female-to-male transmission by up to 61% (Department of Health, 2016; SANAC, 2017). Given this understanding, a man's risk of HIV infection in sexual activity is minimal as compared to that of a woman.

According to Hollway (1984), discourse is a terrain of power struggle. It testifies to the continuing power struggles over who may define, position and categorise sex and gender (Hollway, 1984). In line with this argument, what is significant in this construction and positioning of a young woman in relation to HIV risk is the different expectations in terms of gender. A young woman is constructed as vulnerable and less able to protect herself against HIV risk, but also as partly responsible for her risk. On the other hand, a man is constructed as more powerful, and his activities are normalised, but he is also not responsible for the risk he creates for a woman. However, a nuance to reflect on this particular positioning of women versus men in relation to HIV risk is how social norms justify and 'allow behaviours' for men versus women. Men rushing into sexual relationships, drinking etc., for example, is sanctioned by other men, and often by societal norms, which value male virility and sexuality (Coates et al., 2011; Higgins et al., 2010; Jangu, 2014; MacQueen et al., 2016). While these behaviours put men at risk of HIV infection, they are not often positioned (in many campaigns and HIV resources) as the transmitters of infection, which acts to silently excuse their behaviour. In addition, women are positioned as high risk and bear the burden of seeking out and thinking about HIV prevention – something they then struggle to negotiate due to structural issues. A young woman's risk of HIV and safety, therefore, needs to be understood in the context of the gendered social organisation of students' relationships.

However, it is important to acknowledge that the female participants in this study, including those in their first year, did not link these dangers experienced by young female university students to their own life. The participants positioned themselves as not engaging significantly in alcohol use, as being older, and as sexually experienced, as able to take charge of their sexuality, and as being invulnerable to HIV risk. This positioning is reflected in their use of the word 'they' when referring to young female students' risks of HIV infection in the context of the university. They also positioned themselves as being serious about HIV, and as able to, and engaging in, protecting themselves from it. Interestingly, these participants positioned themselves differently at different times in the interview (as engaging in risky sexual practices, as avoiding HIV testing, as victims of HIV, as knowledgeable and responsible subjects). This is a very different reality from the cognitive model's assumption of the subject as unitary, stable and consistent. Thus, interventions which assume that they are focussing on a consistent subject position, and which do not account for contradictions in positions, might fail.

While this positioning of HIV as a risk for young women was not directly mentioned by a male participant called John, he made direct references to the clinic spaces as being female spaces. This positioning of hospital spaces has been an issue for men in previous research in South Africa (Coates et al., 2011; Kilembe et al., 2015; Mabuto et al., 2019; Orr et al., 2017), and Tanzania (Jangu, 2014), and may be enhanced by the findings in this study which positioned women as high-risk subjects. This positioning of women in relation to HIV risk allows men to be passive about seeking out services and positions health-seeking behaviour as being a female priority. This is also a significant finding of the recent Higher Health annual report in South Africa's institutions of higher learning (Higher Health, 2020).

The avoidance of HIV testing identified in this study also relates to the stigmatisation of HIV and HIV testing.

6.2.5 The discourse of silence about HIV risk and HIV testing

South African research has shown that communications between partners regarding risks in sexual activity have positive outcomes in negotiating risk, and in adopting risk prevention strategies, particularly couple testing (Coates et al., 2011; Department of Health, 2016; Kilembe et al., 2015; Parker et al., 2014). However, the present study found that discussions about HIV risk and HIV testing health practices are not a significant part of university students' life. Two forms of silences were identified in participants' accounts: the silence between partners in casual dating relationships, and the silence amongst university students themselves, both of which appear to be drawing on the discourse of silence about HIV risk and HIV testing.

In terms of the silence about HIV risk and HIV testing between partners in casual dating relationships, the issue was raised by almost all of the female participants. However, no male participants talked about it. The majority of female participants positioned themselves and other young women as being responsible for initiating the topic of HIV risk and HIV testing in their relationships. They also indicated that they find it challenging to address the issue or propose HIV testing to a partner in a way that facilitates the maintenance of confidence and trust in the relationship. To further clarify what is involved, they said that broaching the topic raised suspicions of infidelity (their partners', and their own), and of HIV positivity (themselves or their partners). They went further to construct this exchange about HIV risk and HIV testing as often leading to the loss of trust in the relationship, and in some cases, weakening the relationship. They constructed the silence about HIV risk and HIV testing in the context of relationships between male and female students as an adaptive and defensive practice to maintain the desired or idealised image of a partner, a relationship, or oneself.

The majority of female participants also highlighted that when they tried to negotiate HIV risk, or persuade, or influence a partner to engage in HIV testing, their partners were defiant and insistent that they were HIV negative even though they had neither been tested, nor been faithful. Their positioning of their male partners as defiant, and as more powerful than themselves in making decisions about safe sex practices, including engaging in HIV testing, serves to position themselves as disempowered and unable to be self-protective about their own sexual health.

In Coates et al.'s (2011) study, discussions around HIV risk and the need to engage in HIV testing amongst sexual partners arose in the context of the need to have children, or concerns related to raising children. In this study, some female participants reported that such discussions were motivated by cheating, or suspicions of infidelity in their relationships. Still, they had to negotiate these discussions carefully, for example, managing how, when and what issue or information to share with a partner. This finding is significant as it shows that young women are in an intractable position. They are aware of potential risks because of their partner's behaviour, but they cannot address the risk with the partner because of gender power issues, and their own investments in the relationship (which is not just an individual decision, it is very important socially to have the link to a partner). In line with the social constructionist assumption that all social practices have a discursive aspect or meaning (Hall, 1992), young women's powerlessness in sexual health decision making is an example of how a decision is not completely individually driven; the motive here is socially defined. Society decides that being linked to a man is very important, and the woman tries to sustain that.

According to Van der Riet et al. (2018), young women's tendency to prioritise keeping the relationship, above the opportunity to negotiate HIV risk with their partners does not mean that there is no self-investment, or neglect of self-care, or an abdication of self-care. Instead, in 'doing' the activity of silencing HIV risk and HIV testing the relationship, a young woman is demonstrating what Van der Riet et al. (2018) refer to as a different form of care, which is an investment in self, or the care of oneself, or one's social reputation. In doing this, a woman accrues power and status with being associated with a man, and this leads to her taking up the position of the object in the male sex drive discourse, which is not as a passive victim but rather as an active investor (Van der Riet et al., 2018).

However, this prioritisation of the relationship, above the opportunity to negotiate HIV risk with a sexual partner, ultimately impedes the subject's engagement in health prevention strategies like HIV testing. This has been reported in other South African studies with students at the University of KwaZulu-Natal on the Pietermaritzburg campus (Nene, 2014), and in other South African universities (Chimbala-Kalenga & Makuwira, 2016; Evans et al., 2018; Mbelle et al., 2018), amongst women (Coates et al., 2011; MacQueen et al., 2016), and youth (Peltzer & Matseke, 2013; Tenkorang, 2016; Van der Riet et al., 2018). In these studies, it is argued that this form of investment in the self creates the possibility for risk amongst youth in the context of HIV and AIDS. Similarly, the finding of the present study regarding the silence about HIV risk as negatively affecting a university student's negotiation of, and engagement with, HIV testing in sexual relationships, has also been reported in studies conducted amongst university students in South Africa (Buldeo & Gilbert, 2015; Chimbala-Kalenga & Makuwira, 2016; Haffejee et al., 2018; HEAIDS, 2010). Overall, the findings of the present study, and of the previous studies suggest that there is a vast social structure of inequality in gender in heterosexual relationships amongst youth. Thus, in line with Hollway's (1984) argument that gender power relations infuse meanings into human behaviour, facilitating positive or negative changes, young women's practices in relation to testing need to be understood in this context of a sexual relationship (they cannot act outside of this context). It seems that the relationship context does not facilitate or make available the position of a 'testing' female subject – a neutral position, free of stigmatisation, which is something that health interventions are not taking into account.

In terms of the silence about HIV risk and HIV testing amongst students on the Pietermaritzburg campus, most participants in this study positioned other students as wanting to hide their HIV status and not expose themselves through testing practices. In their justifications, the primary aspect revolved around the difficulty and sensitivity of contracting HIV, and they seemed to allow for the possibility that people around them might have HIV, but just that they do not talk about it. This suggests that this form of silence about HIV risk and HIV testing amongst students is because an individual could have HIV and does not want other students to know about it, which is stigma-related. The fear of potential risks of disclosing an HIV positive status to other people evident in this study is also a significant finding in Pillay's (2020) study amongst students at the University of KwaZulu-Natal. Pillay's (2020) study investigated the experiences of students living with HIV, specifically the challenges and facilitators of their self-disclosure to others. Pillay (2020) found that some students who have HIV are afraid to disclose an HIV positive status to a friend or a roommate at the university, and their justifications focused on the fear of being judged, or stigmatised, or labelled as 'HIV positive'. The participants' positioning of students as afraid to be identified as HIV positive draws on a discourse of HIV as a stigmatised and risky identity. HIV is something one does not discuss openly, and that includes HIV testing.

It is worth noting that both male and female participants in this study called for action, emphasising that students who have HIV or suspect that they are positive need organised 'support', confidentiality, and 'help' on campus, which is also significant. This positions the 'other' students as weak, as fragile, and as needing assistance. Here, there is no positive discourse, for example, of an empowered, agentive person who knows their HIV status and lives healthily. Hence, what their ‘talk’ does is reinforce a very particular position available to students, which is not helpful. Their positioning in this regard continues to draw on the discourse of HIV positivity as being risky and potentially damaging. This discourse is also interesting and significant because the Pietermaritzburg campus has an array of health promotion agencies (for example, the campus health clinic, the Student Support Services, the CHASU offices, to mention a few) which offer HIV related information, for example, the normalisation HIV and living with it, and the value of knowing one’s status. These health agencies also offer support to all students, and their services are strictly confidential. These services made available to students are significant in relation to the current research problem. Firstly, it means that the health messages on campus have not worked with these particular individuals. A normalisation of HIV and HIV testing would mean that students would speak openly about HIV risk in their context (relationships and campus), negotiate it, and engage actively in HIV testing as their protective practice. Secondly, it means that while the services to assist students on campus are available, this does not change their constructions and discourses drawn on.

In contrast to this discourse which positions students as being silent about HIV risk and HIV testing in their relationships and amongst themselves on campus, is a discourse which positions students as not being silent about the risk of pregnancy and being proactive in managing it.

6.2.6 The discourse of individual and joint responsibility for the management of the risk of pregnancy rather than HIV

The majority of female participants (10) and two male participants constructed students in general (themselves included) as engaging in unprotected sexual activities but taking steps to prevent pregnancy through contraceptive use. According to these participants, this measure was usually consistently adhered to. However, when I analysed their constructions in this regard, I noticed that the position taken by the female participants differed slightly from that of the two male participants.

The female participants positioned hormonal contraception as the preferred method of protecting themselves because they prioritised the risk of pregnancy. Their justification was that hormonal contraceptives prevented pregnancy. However, the problem here is that this positioning prioritises pregnancy prevention but does not address HIV risk. The interesting question becomes, why do they do this? Why do they prioritise pregnancy prevention over HIV prevention? Perhaps, the reason is that these women worry about and make investments in pregnancy prevention because pregnancy affects an individual more than just the couple; it particularly affects the young woman. Pregnancy also has social implications, and the whole family is drawn in, and it is visible (it cannot be hidden). It is for these important and significant reasons that the female participants tended to prioritise pregnancy prevention. These trends, however, are problematic as research (Evans et al., 2018; Gwala, 2019; HEAIDS, 2010; Higher Health, 2020; MacQueen et al., 2016; Mbelle et al., 2018; Moodley, 2007) has shown that it is not contraceptive use but correct and consistent use of the condom that is the most effective and practical self-protective method against all risks in sexual activity (STIs, HIV, unplanned pregnancy).

However, the prioritisation of the threat of pregnancy in sexual activity rather than HIV risk is not unique to this study. A similar finding is reported in several pieces of research (Chebitok, 2017; Mbelle et al., 2018; Nene, 2014; Van der Riet & Nicholson, 2014), which argue that women are more affected by the consequences of an unplanned pregnancy than men. It also seems to be drawing on the construction of women in the above studies as having social and individual responsibility to manage the risk of pregnancy. In particular, Nene (2014) and Van der Riet and Nicholson's (2014) studies conducted with the Pietermaritzburg campus students reported that young female students understand their risks of HIV infection but have a greater fear of falling pregnant. Van der Riet and Nicholson's (2014) study concluded that youth tend to prioritise pregnancy due to its visibility and respond to it accordingly. The findings of this study and Van der Riet and Nicholson's (2014) study thus suggest that while HIV has serious individual and social consequences, pregnancy may have more immediate impacts – such as economic impacts, the visibility of pregnancy, and school drop-out and familial exclusion. While HIV can have many of these impacts, it is largely hidden, and does not necessarily impact on school completion or future economic prospects because the person has control over their disclosure – tying into the invisibility of HIV concerns. Pregnancy does not offer this anonymity.

Although it is clear from the findings of the present study that students positioned themselves as being threatened by HIV and the risk of contracting it, this reality that they prioritise pregnancy prevention does not mean that they do not do so for HIV. Instead, not prioritising HIV is a passive response rather than deliberate. It is as if they do not consider it 'important enough' to know about through testing. This perhaps relates to their view that knowing about it negatively affects their identity and social status in the relationship, a context where an HIV identity is vilified.

However, when I analysed the constructions of the two male participants in this study who positioned students as prioritising the risk of pregnancy in sexual activity and not the risk of HIV, I noticed that while their justifications mirrored some of the findings of two studies conducted with students on the Pietermaritzburg campus (Nene, 2014; Van der Riet & Nicholson, 2014), particularly the notion of visibility of pregnancy risk and the invisibility of HIV risk, they did not arrive at the same conclusions. In these two studies, their participants constructed pregnancy as more visible and physical (unlike an HIV positive status), and thus a detrimental result of sex. In the above two studies also, pregnancy was constructed as affecting one's social status as an educated student. In contrast, in my study, the two male participants constructed pregnancy risk as posing a more significant threat to them compared to an HIV diagnosis. They constructed pregnancy as having an impact on both partners. However, they did not construct HIV as a joint prevention responsibility, possibly because it is not experienced 'jointly' (although ironically, it would be if partners infected each other). In their justifications, the two male participants drew on the immediacy of the impact of unplanned pregnancy on their ability to provide for their child as university students. However, this construction relates to the ways in which pregnancy and HIV risk are positioned in the family and society. Pregnancy is often constructed as affecting all while HIV is positioned within the individual; it is an individual who experiences it and suffers from, and 'punished', for it (De Zoysa et al., 1995). However, this construction is flawed in the sense that HIV also has significant individual and social effects.

Overall, this practice of restricting attention to pregnancy management rather than HIV risk identified in this study is consistent with Parker's (1992) description of discourse that echoes Foucault's perspective. According to Parker (1992), a discourse draws attention to particular issues or practices that are considered significant and legitimate, and foregrounds them (for example, pregnancy risk), and transfers those aspects that are considered less important to the background and silences them (for example, HIV risk). However, this practice of prioritisation of pregnancy rather than HIV risk has implications for HIV transmission. It is also at odds with the construction by many participants of HIV as being a significant facet of life, and a risk. This prioritisation of pregnancy also seems to be in tension with their construction of obtaining an HIV diagnosis through testing as extremely difficult and frightening. Indeed, some participants constructed HIV testing as anxiety-provoking, and the possible discovery of the fact that one has an illness that could affect all of one's future possibilities as far as one's tertiary education, subsequent potential career development, finances, marriage, having children, and sexual pleasure, are concerned. This trend is consistent with the findings of other South African studies on the theme of factors responsible for students' apprehension of engaging in HIV tests (Cilliers et al., 2018; HEAIDS, 2010; HEAIDS, 2010; Heeren et al., 2013; Kabiru et al., 2013). These findings suggest that from the earlier twenties, other priorities related to future aspirations (career, marriage, family and having healthy children) emerge for young people at the university.

It is clear from the findings of this study that students positioned HIV as very serious, and as a threat to most students, and in some cases, to themselves. So, the assumption here is that this would translate into a protective strategy of HIV testing, especially since the services are available in their setting. However, the most interesting aspects of this study's findings are the nuances about this construction. Firstly, most participants do not think they are at risk of HIV (they position themselves as 'safe' in various ways, for example, through 'knowing and trusting a partner'). If they do think they are at risk, some do engage in testing. Secondly, and most importantly is that being HIV positive is still being constructed as an extremely stigmatised identity, which is a negative identity to be avoided at all costs. It is almost as if it is better just to avoid and deny HIV and the possibility of having it than to live with it. The consequence of this positioning is that investment in a particular form of social reputation is prioritised, and the HIV testing practice is constrained. This means that much work is to be done around destigmatising and normalising HIV amongst youth in South Africa.

In contrast to this discourse that positions students as quite ready to take individual and joint responsibility for managing the risk of pregnancy as opposed to that of HIV risk, another discourse identified in this study tended to position the task of preventing HIV risk through testing as a woman's responsibility. This will constitute the theme for further discussion in the next section.

6.2.7 The discourse of the feminisation of HIV risk prevention through HIV testing

Several researchers have demonstrated the gendered nature of sexual relationship expectations (Chebitok, 2017; Chimbala-Kalenga & Makuwira, 2016; Coates et al., 2011; Connelly & Macleod, 2003; Jangu, 2014; Mbelle et al., 2018; Nene, 2014; Van der Riet & Nicholson, 2014;

Van der Riet et al., 2018). A predominant theme connecting these works is that young women in heterosexual relationships are considered the primary agent in sexual risk management and prevention, while men are, for the most part, excluded from this responsibility. Similarly, a discursive pattern noted in the accounts of most participants in this study tended to construct and position women as being the ones expected to undertake HIV testing within the relationship. In this study, some male participants described situations where they had entrusted HIV testing to female partners, and believed that their own HIV status would be the same as that of their female partners. This tendency to rely on a partner's HIV status to ascertain one's own HIV status draws on the framework of proxy/surrogate testing. However, the tendency to rely on proxy HIV testing is risky given that proxy HIV testing does not guarantee an accurate HIV status of the partner not engaged in the testing. This is due to the possibility of a seronegative partner in the serodiscordant couple, which refers to a situation in which sexual partners exhibit a mixed HIV status (Ndirangu, 2017, as cited in Simbayi et al., 2019). The recent HSRC survey reported a significant national prevalence rate of 11.3% in serodiscordant couples in South Africa (Simbayi et al., 2019). Hence, some male students' dependence on surrogate testing reported in the present study is quite concerning, given the likelihood of a seronegative partner in the serodiscordant couple. The consequence of this is that as the viral load of the partner (man) who is not engaged in HIV testing progresses, the person becomes vulnerable to AIDS-related illnesses. This situation may explain higher AIDS-related morbidity and mortality rates in young South African men compared to women, even after initiating ART treatment (Orr et al., 2017; SANAC, 2017; Simbayi et al., 2019).

Furthermore, some female participants who reported that they had been tested for HIV also said that they are unable to insist on joint testing but are also aware that they have been exposed to risk. They, therefore, tend to resort to their own HIV test result to determine a male partner's HIV status. This finding is significant as it suggests that a young woman assumes the full weight of the responsibility for HIV testing because she is aware that a male partner is not ready to do it. This is significant as it reveals that men position women as responsible for HIV testing. What is concerning about this finding is that, even though the female students may undertake responsibility for engaging in HIV testing, this still does not mean that they are no longer at risk. Hence the public health policy assumption that testing will lead to safe sex practices is undermined. This does not seem unexpected since the gender positioning articulated by the participants seems to lead specifically to this. It is also important to acknowledge that their constructions are within the context of intimate heterosexual relationships; one does not really confront HIV in other ways as young people. According to Van der Riet et al. (2018), relationships are intricately related to gender and identity investments. So, what they 'do' with constructions of HIV risk cannot be separated from constructions of gender in relationships or what is expected of men and women. This construction concurs with Parker's (1992) argument that discourses often embrace power relations and ideologies and construct how this is enacted and resisted.

Overall, what is concerning here is that this feminisation of HIV risk prevention is not a powerful position but has something to do with responsibility and blaming (it is not empowerment). It is like condom use, in which the responsibility for preventing HIV risk is handed over to women, which means that men can be 'free' from responsibility and worry. It means that men can then blame women if they come back with an HIV positive result. It is thus not a position that empowers women but rather burdens them. This highlights interesting issues around female sexual autonomy and how gender norms serve to disadvantage young women. A pertinent question, therefore, is whether women should try and resist this. From the perspective of this study, some signs of women tending to do this were evident, particularly amongst women who were cheated on, or had left their relationships. For example, some women seemed to test in reaction to the actions of their partners, and they seem to do this after the relationship, which suggests that they *are* taking responsibility for themselves. However, the issue is that it seems difficult to do this within the confines of the relationship. In such a context, space for considering HIV is not allowed as it sparks suspicion and accusation amongst the partners. But once a woman is out of those confines, she can act, she has agency, and it is a decision for herself. This is important because it suggests that the relationship context does not facilitate, or make available the position of a 'testing' subject, a neutral position free of stigmatisation. Therefore, in the face of ongoing empowerment programmes on the Pietermaritzburg campus, emphasis should be directed towards the encouragement of shared responsibility in decision making related to HIV risk and HIV testing. The issue of power relations and concerns around the attribution of responsibility to women for managing and containing the spread of HIV need to be addressed in health messages targeting male students.

The othering of HIV risk; the avoidance of HIV testing; the silence about HIV risk and HIV testing between partners in casual dating relationships and amongst students themselves; the focus on individual and joint responsibility for the management of pregnancy risk but with the lack of focus on HIV risk; and the positioning of women as being responsible for managing HIV risk through HIV testing all appear to be exacerbated by constructions related to the visibility of HIV. It is this angle of the discussion that is addressed below.

6.2.8 The discourse of invisibility of HIV risk

The construction of HIV as a greater risk to young people on account of its invisibility in everyday life was identified in the accounts of ten participants. These participants tended to position themselves as needing to defend themselves against the unseen threat of HIV (by implication, if they could see it, or if those who have it could disclose their status, then they could protect themselves). However, with the threat of HIV as constructed by them being invisible, they cannot do this, and in this way, they are placed almost in a disadvantaged position.

Another issue which the participants in this study constructed as complicating their uncertainty in protecting themselves against the threat of HIV further is that, with the emergence of ART treatment, they assumed that usual signs of the manifestation of AIDS in the body were suppressed. The words such as ‘nowadays people take ARVs’, ‘they look alike’, ‘they look normal and healthy’, ‘you cannot even tell or see if they are infected or not’, were identified in some participants’ accounts. This construction draws on a discourse of HIV as being a silent and obscured risk. Here, there are two constructions of ARVs, as ‘bad’ because they help to conceal HIV, and as helping ‘those’ who have HIV to live with it. In constructing ARV treatment this way, these participants position themselves as resenting and being critical of it. It is as if they (as people who position themselves as not having HIV) are saying that, with the availability of ARVs, this creates uncertainty for them. It is as if they are not able to distinguish those who have HIV from those who do not, merely by looking at their physical appearance. They position ARVs as enabling the concealment of the HIV positive body. These participants positioned this reality that HIV risk is hidden as a threat, because they are unable to defend themselves against the risks posed by particular people, specifically HIV positive people. So, it is as if they feel that the ‘undisclosed’ HIV positive people are a threat and contribute to their own risk. This appears to be drawing on a victim discourse. In this discourse, one is disadvantaged by the silence maintained by those with HIV, making it difficult for one to avoid sexual contact with HIV positive people. One is also disadvantaged by the health policies that treat HIV with ART, rendering its presence as HIV in everyday life invisible. The positioning of ARVs as allowing for people to hide their HIV status also positions HIV positive people as *intentionally deceptive* – and supports the victim discourse. Ironically, it is not possible to know if a person has HIV by just looking at them. In fact, HIV often presents no physical symptoms regardless of whether one is on ART treatment or not (UNAIDS, 2015). Even someone who has HIV may not know that they have been infected if they have not tested. A consequence of the victim discourse and positioning is that other people are made responsible for creating one's HIV risk, and one is dependent on these people for protection against HIV transmission.

Perhaps what is particularly interesting but quite concerning is that these negative constructions of ARV treatment contrast heavily with how they are constructed in health policies. For example, in the HTS policy, the following phrases are used to describe ARV treatment: it provides maximal and lasting viral load suppression, it restores and preserves immunity, it reduces the risk of continued transmission, it prolongs life expectancy, and it improves the quality of life and reduces opportunistic diseases (Department of Health, 2016). The construction of ARV in this study as being a problematic intervention, therefore, highlights a contrast between how certain discourses are drawn on in the HIV testing policies, and the experiences or realities of those who receive them, for example, youth at the university. Hence drawing on Maticka-Tyndale's (1992) argument that health messages conveyed in health policies and educational campaigns and programmes drawn on these policies are often transformed, or misread by those receiving them, the findings of this study illustrate that educated youth do not draw on the existing discourses around HIV risk passively or literally, but they actively engage with them and may refuse some of the meanings attached to a particular intervention, for example, ARV treatment.

Interestingly there is some evidence of some students (although very few) taking on the constructions evident in public health discourse, such as that one 'can live with HIV', and it is 'not so bad'. They also constructed ARVs positively, as life-extending, as a relief to those living with HIV, as a mechanism to enable adaptation, and as helping one to live normally. However, this focus on the sickness, relief and support, which serves to entrench the power of medicine (ART) in managing the seriousness of the disease, draws on the medicalisation of HIV and AIDS discourse, as highlighted by Goldstein et al. (2003). The question still remains why this is 'not enough' to enable students to feel that knowing their HIV status is a positive thing.

Moreover, what is even more concerning is that despite the idea that the threat of HIV is invisible in everyday life, and that those who have it might not be willing to disclose their status to others, and might not be able to engage in safe sex practices such as condom use, there is very little change in safe sex practices in relationships in relation to HIV risk. There is also little change in HIV testing practices, despite awareness. It is clear from the analysis of the participants' 'talk' that their practices are embedded in their positions and constructions, and it is this kind of analysis that helps to understand why behaviour change has not happened. Thus, it is in the minutia of how young people talk about, and engage in relationships (and HIV risk management), that the 'explanation' of why a behaviour is how it is, is to be found, rather than just focussing on increasing students' knowledge and awareness of HIV risk.

In contrast to these constructions of HIV risk as being invisible, significantly few participants constructed it as being a visible threat in those who have it.

6.2.3 The discourse of visibility of HIV risk

In this study, only a few participants (4) actively named, labelled and called HIV a visible sickness. In their justifications, terms such as the following were used: 'diarrhoea', 'weight loss', 'sick', 'wounds', 'dark marks or spots', 'deadly', 'AIDS people'. These images of deteriorating health, and a body severely constrained physically, appear to be drawing on the dominant constructions of HIV as being a visible sickness in the 'everyday' life (Brown, 1995; Conroy et al., 2013; Goldstein et al., 2003). Goldstein et al. (2003) further commented that the focus on the visibility of the disease, an ill body which will be rejected and spurned by the world (as is the case in this study), draws on the stigmatisation of HIV and AIDS discourse.

Esther, an international female student participant, positioned youth close to her (her sister and a friend) as believing that only people with the above obvious and distinct symptoms are HIV positive. She also positioned this group of youth in her social network as using such stereotypes about a sick AIDS body to decide whether to negotiate HIV testing or not, or to make judgments about a partner's HIV status. Esther's positioning of these other youth suggests that they are engaging in some form of stigmatisation. Moreover, Esther's construction of other youth is consistent with the findings of research in South Africa that, in the absence of HIV testing, some youth use stereotypes about HIV illness to diagnose themselves and others (Steinberg, 2008), or to identify and isolate potential sexual partners whom they think to have the disease (HEAIDS, 2010), or to make decisions about getting tested for HIV (HEAIDS, 2010; MacPhail et al., 2009). Drawing on Esther's construction, one can conclude that there is something about HIV that underpins this extreme stigmatisation of the HIV body.

Perhaps, this extreme HIV stigma relates to how HIV has been constructed in the past as a curse or punishment for aberrant behaviour. According to Goldstein et al. (2003), some people construct HIV infection as divine retribution for the sin of sexuality. Thus, although a few participants constructed HIV as being a visible sickness, this focus on the visibility of the condition relates to participants' fear of the HIV identity, and has implications for their responses to HIV testing. It is as if the extreme avoidance of HIV testing identified in this study is an adaptive and defensive practice against the potential consequences of confronting the problem of HIV, a disease with adverse outcomes (getting a name as HIV positive, being wounded, losing weight, being diarrhoeic, being marked, and being exposed to the risk of stigma, discrimination, and social ostracism). This is similar to discourses used in relation to cancer, which contains the assumptions that:

> … is 'invasive' and 'attacks' the body. If treatment goes well, the cancer is in 'retreat'; if it goes bad, the cancer 'returns'. The patient and the doctor are 'allies' in the struggle against the cancer; the patient is (and should be) 'fighting' against it and is either 'winning over' or will be 'losing to' the disease if they are not cured. (Hansen, 2018, p.217)

Relating the above quotation to the participants' constructions of HIV, it is possible that young people and health messages are not on the same side; that they are missing each other, on different hills in the battle. Young people and health messages both perceive HIV as the threat/enemy, but they are not yet united in the same war against it. Like cancer, HIV is 'invasive' and 'attacks' the body. So, if ARV treatment goes well, the HIV is in 'retreat'; if it goes bad, the HIV 'returns', in the form of AIDS. In this perspective, the student and the doctor/health professional/clinic nurses/health promoters are 'allies' in the struggle against HIV; the student is (and should be) 'fighting' against it and is either 'winning over' or will be 'losing to' the disease if they are not cured.

The reason why it is interesting to view the above interesting set of constructions about cancer in the context of university students and their constructions of HIV and risk as identified in this study is that they will help one to see where the problems are. This is said because the youth, as seen from the perspective of this study, seem not to be on the same page as the doctors/health promoters/interventionists. It is clear from the findings of this study that students are also not fighting against the threat of HIV (like health promoters), as they still engage in unprotected sexual activities, and avoid HIV testing. In particular, male students tend to avoid engagement in HIV testing and leave that fight mostly to women. Yet, it is a virus that transmits mainly through heterosexual sex, and both men and women need to be involved (unlike cancer which is in the individual body). HIV involves partners, and here also, gender plays a role, as it sets up the expectations for young people. According to Van der Riet et al. (2018), young people's investments in sexual relationships is mainly on their identity, or a different prioritisation of the self through relationships, and these are fundamentally more important than investments in health. For this reason, gender inequity and the prioritisation of identity performance amongst youth meant that the position of youth in this 'battle' is different from that of health promotors. Thus, gender and the importance of particular male and female identities, which are constructed, built and maintained through sexual relationships, and the construction of an HIV identity as problematic, all work to undermine the value of testing. Thus, it can be speculated that the main reason why students are not thinking in a similar way with the doctors/health promoters/interventionists in fighting the HIV epidemic is that they cannot do this alone. They cannot act outside of this context of gender.

Similar to the discourse of cancer, it is as if some youth assumed that being HIV positive is permanent, and they would never 'win' their battle with this disease. From my interpretation of their perspectives on this matter above, we have seen why health promoters and interventionists indeed cannot expect to win that battle if some students, as evident in this study, were to continue to shift the responsibility for that fight onto others (partners, health policies that threat HIV with ART, rendering it invisible). Several South African studies amongst youth (MacPhail et al., 2009; Peltzer & Matseke, 2013; Ritchwood et al., 2019), including university students (Buldeo & Gilbert, 2015; Chimbala-Kalenga & Makuwira, 2016; Evans et al., 2018; Haffejee et al., 2018; HEAIDS, 2010; Higher Health, 2020; Musemwa, 2011; Paul et al., 2014) report this link between the fear of the potential consequences of having the disease, and delayed testing, or the decision not to test, or even to approach a health care facility for sexual health information and treatment. It was established in some of the above-mentioned studies that the fear of the potential consequences of having HIV was further exacerbated by the assumption that being HIV positive means that one's entire life would drastically change for the worse (see Buldeo & Gilbert, 2015; Evans et al., 2018; HEAIDS, 2010).

Overall, in line with the social constructionist assumption that particular practices, patterns of behaviour, actions, and sets of beliefs are continually constructed, reconstructed, negotiated, determined, and produced or identified through discourses drawn on by subjects to tell about themselves and others (Burr, 2003; Hall, 1992; Parker, 1992), students' constructions of HIV as being a visible and stigmatising illness suggest that, indeed, the meaning of HIV risk and practices associated with its prevention such as testing are indeed socially constructed, which is related to individual experience and context.

In contrast to the discourses presented in this chapter, all suggesting that participants constructed HIV as being a huge threat to themselves and others, is another discourse identified in the accounts of a few participants who tended to construct HIV as a threat but not a significant one.

6.2.4 The information, education and communication health framework

In this study, significantly few participants (4) constructed HIV as being a minimal threat in South Africa in general and on the Pietermaritzburg campus in particular. In their justifications, they focussed on four issues. Firstly, they positioned students as being educated, and as being aware of HIV risk, and as acting on their knowledge and awareness to protect themselves against HIV risk. Secondly, they positioned people who do not have HIV as adopting the fundamentals of the ABC framework to protect themselves against the threat of HIV. Thirdly, they positioned people who have HIV but know their status as engaging in protected sexual activities with the aim of protecting those who do not have it from being exposed to it. This category of people was also constructed as adhering to the ART treatment, and as no longer being stigmatised and discriminated against by other people. Fourthly, they positioned HIV as no longer as deadly an illness as it used to be in the early years of the epidemic, such as in the early 80s and 90s. All these justifications appear to be drawing on a discourse of the information, education and communication health framework. It is to be recalled that the primary goal of the IEC health framework is to encourage and sustain positive and healthy practices by increasing individual awareness. In this framework, it is expected that individual knowledge and awareness about HIV risk and prevention practices will translate into agency and readiness to make the right health decisions, such as identifying and avoiding risky practices and pursuing health-seeking behaviours like HIV testing, safer sex and adherence to pre-exposure prophylaxis and ART treatment (SANAC, 2017).

Taken together, the above goals of the IEC framework work to position the problem of HIV as being normalised, and people as being rational, as taking responsibility for themselves and for others. However, this tendency to position people living with HIV and aware of their HIV status, as being responsible for their own and other people's safety, and as being health acting subjects to contain the spread of HIV and minimise the seriousness of HIV infection in their bodies, is at odds with the high rates of HIV prevalence, new HIV infections, and low levels of HIV testing, amongst youth aged 15-24 years in South Africa, according to the recent HSRC survey (Simbayi et al., 2019). The HSRC survey findings imply that some youth have not adopted the health messages drawing on the information, education and communication health framework. A normalisation of HIV and HIV testing would mean that students would speak openly about HIV risk in their context (relationships and campus), negotiate it, and engage actively in HIV testing as their protective practice.

The discourses drawn on by participants to describe, account for, or explain the seriousness of HIV risk to themselves, and to others presented in this section, position this group of youth as knowing about HIV, as being threatened by it and the risk of contracting it, and as being aware that the university population is at risk of exposure to HIV, and that it is their responsibility to protect themselves from HIV (through their own agency or personal responsibility), particularly the ability to initiate and sustain a health practice like HIV testing. However, tensions and contradictions within each participant's positioning were identified in terms of their positioning in relation to HIV risk. This will constitute the theme for further discussion in the next section.

6.3 Participants' positioning in relation to HIV risk and implications for HIV testing practices

In this study, two subject positions and their corresponding discourses were identified in the analysis of participants' 'talk' about how they positioned themselves in relation to HIV risk. They include the at-risk subject, drawing on the at-risk subject discourse, and the no, or low-risk subject, drawing on the no, or low-risk subject discourse.

6.3.1 The at-risk subject

In this study, the majority of participants (13) positioned themselves as being at risk of HIV. In their justifications and rationalisations, three subject positions were identified. Firstly, the at-risk subject, with the risks of HIV attributed to their own activities of unsafe sex, but did not prioritise HIV testing. Secondly, the at-risk subject, with the risks of HIV attributed to their own activities of unsafe sex, but prioritised HIV testing. Thirdly, the at-risk subject, with the risks of HIV attributed to other people's destructive behaviours, such as rape, or non-sexual routes such as exposure to contaminated blood or 'touching others', but did not prioritise HIV testing. The significance of these subject positions and their implications for participants' engagement in HIV testing practice will now be presented and discussed, beginning with the first.

6.3.1.1 The at-risk subject due to one's own activities of unsafe sex but does not prioritise HIV testing

Out of the 13 participants who positioned themselves as being at risk of HIV in this study, 11 of them (4 men and 7 women) attributed their risks to their activities of unsafe sex. This positioning appears to be drawing on a discourse of the at-risk subject. Research has shown that people who construct themselves as being threatened by HIV or the risk of contracting it, and as feeling exposed to it, and as believing that HIV testing would decrease their risk of being infected, particularly after engaging in unprotected sexual activity with a new partner of unknown status, would act to test (Mabuto et al., 2019; Okelola, 2019; Peltzer & Matseke, 2013; Tenkorang, 2016). Contrary to these studies, the at-risk subject position identified in the study appeared to have had little or no influence on some participants' engagement with HIV testing as their primary protective strategy. This is because only eight participants (5 women and 3 men) out of the 11 participants who attributed their risks to their activities of unsafe sex reported engaging in HIV testing. However, their engagement in testing was their strategy of reassurance.

Furthermore, the disparity in terms of sexes in the source of the threat of HIV being managed through HIV testing was noted in this study. In the accounts of four out of the five female participants who positioned themselves as at-risk due to their activities of unsafe sex, the use of the rapid diagnostic test in response to the HIV risk caused by a cheating partner or suspicions of cheating, was dominant. Their accounts also revealed that HIV testing was not something they engage in, in the absence of cheating, and in the absence of suspicions of cheating. However, different findings are reported in Parker et al.'s (2014) study, which investigated the concerns about partner infidelity as a possible barrier to the adoption of HIV-prevention methods amongst young South African couples. Parker et al.'s (2014) study concluded that fears of partner infidelity tended to prevent the adoption of HIV prevention strategies, such as HIV testing and condom use.

Additionally, the four female participants in this study did not consider doing a follow-up test (confirmatory test) as recommended in the National HTS policy. In that policy, the rapid diagnostic test users are encouraged to do confirmatory tests using the ELISA to rule out multiple errors at various points along the HIV diagnostic continuum (Department of Health, 2016). However, no participant in this study talked about ELISA, which is constructed in the HTS policy as highly reliable and useful for clinical diagnostic purposes. This suggests that this HIV testing assay is not popular amongst students. This may relate to the fact that they all said that they received HIV negative test results, so they did not need any further investigation with ELISA, which focuses on the accuracy of the result. The same tendency may also relate to the fact that the ELISA tests are not being done in mobile clinics, free-standing HIV testing sites on, and off campus since they involve laboratory work and can take up to a week for the results to be out. Hence, most testing sites resort to doing rapid HIV tests, which takes about 20 minutes for the client to receive the test result. It might also relate to the idea that the health care service providers do not often suggest to their clients the need for confirmatory tests, especially when a person's HIV status is negative and has no history of risky sexual behaviours and practices.

In the accounts of the three male participants who attributed their risks of HIV to their activities of unsafe sex, rapid diagnostic tests were undertaken in response to the threat of HIV posed by their activities of unprotected sex with a casual partner. This positions their HIV testing practices as an ad hoc type aimed at helping them prove to themselves that they are still HIV negative. This positioning of HIV testing as a man's risk prevention strategy, particularly after engaging in an unprotected sexual activity with a partner of unknown status, is not peculiar to the behaviours of participants in this study. It has also been reported in Okelola's (2019) study at the University of KwaZulu-Natal. In Okelola's (2019) study, the male participants who positioned themselves as feeling exposed to HIV would act to test. However, when asked what they did after receiving their HIV negative result, it was clear from these three male participants' responses that their HIV negative results did not motivate them to change their sexual behaviours. This finding is consistent with most studies that provide evidence that HIV testing does not considerably affect sexual behaviour or HIV incidence in the at-risk individuals who receive negative test results (George et al., 2019; HEAIDS, 2010; MacPhail et al., 2009; Mohlabane et al., 2016; Okelola, 2019; Paul et al., 2014; Tenkorang, 2016). This idea that HIV testing does not affect sexual behaviour also departs from how the HIV testing service is being constructed in the National HTS policy as having a moderately positive influence on the testing subject's sexual behaviour (Department of Health, 2016). Hence, the finding of this study highlights a contrast between how certain discourses are drawn on in the HIV testing policies, and the experiences or realities of those who receive them. Similar to the HIV testing practices of the four female participants in this study (who attributed their risks of HIV to their activities of unsafe sex), there was no mention of the confirmatory test, or the need for it in the accounts of those three male participants. One of them sought out the HIV testing service a few hours after engaging in an unprotected sexual activity with a casual female partner.

Another worrying similarity in the HIV testing practices of all the seven participants (three men and four women) who attributed their risks of HIV to their activities of unsafe sex, is that they tended to construct individual HIV testing as being their preferred approach, and justified this by constructing the practice as minimising the risk of being stigmatised, or rejected by a partner if one were to test positive. This finding is consistent with the findings from the research of others in South Africa (Parker et al., 2014). In Parker et al.'s (2014) study, for instance, the threat of stigma and partner rejection due to an HIV positive status was disproportionately higher for women compared to their male counterparts. However, this trend was not mirrored in this study in the sense that both male and female participants positioned themselves as being worried about being tested in the presence of their partners and testing positive for HIV. This is expected because of the nature of your people's relationships (and that HIV is so difficult to talk about and confront). Again, this is not a trend that the HTS policy has intended as couple testing has been emphasised as a practice recommended before first partnered sex (Department of Health, 2016). In this policy, the assumption is that only couples engage in sex, and that they would have open communication, and that in the relationship, both partners are equal and have equal decision-making power, and are equally invested in health protection. Thus, the reality that youth do not consider couple testing in their relationships is another instance of the disjuncture between how certain discourses are drawn on in the HIV testing policies (and interventions designed to implement these policies), and the experiences or realities of those who receive them, for example, youth at the university.

However, one female participant (Londi) expressed her intention to insist on couple testing before engaging in a sexual relationship. She constructed it as something compulsory and a ‘prerequisite’ at the start of the relationship in her life. In her justification, Londi seemed to be relying on the notion of the initial result as her means of deciding whether to commit or not to commit to a relationship. However, there is a problem with her construction of this as a once-off, but perhaps she needs to be given credit for engaging in testing at the start of a relationship as that positions her as an active health subject. Also, there is something in Londi’s experiences of relationships that is worth commenting on. She was exposed to an untrustworthy partner and felt at risk, and has acted on that, or says she has, which is significant as it positions her as agentive, as prioritising herself, or valuing herself and her future. This is in contrast to the views of other participants (both men and women) who prioritised the status and power accrued for being in a relationship. In doing this, the relationship gains outweighed the need for engaging in health strategies such as couple testing before starting a relationship.

Furthermore, as earlier highlighted, only eight participants (5 women and 3 men) out of the 11 participants who attributed their risks of HIV to their activities of unsafe sex, reported having been tested. In terms of the HIV testing practices of the rest (three participants), two of them justified not engaging actively in HIV testing by positioning themselves and their partners as not presenting with AIDS-related symptoms, which they translated into not having HIV. Hence, in their assumption, their avoidance of HIV testing is ‘justified’. The two participants also indicated that they would undertake an HIV test only if they ever experienced visible symptoms suggestive of an HIV infection in their bodies, such as losing weight and being diarrhoeic. It is interesting that educated participants still have these assumptions and an ‘inaccurate’ understanding of HIV. One would wonder whether this means they are still in HIV denial, and why could this be happening, despite all their constructions about the danger and the threat that HIV presents. This shows that there are still some perplexities to be faced when one examines closely the constructions and positioning of these participants.

What is, however, clear from the analysis of participants’ ‘talk’ is that most of them are related to this extreme fear of being positive and what this would mean for their lives. So, these constructions enable them to avoid testing, ignore it, or delay it. It might be that the stigma related to HIV is the overwhelming framework in which they act and interact, and this makes any other response extremely difficult (the question conceptually is what is ‘afforded by’ or ‘allowed’ in the context of discourses in which they exist). Overall, these findings are consistent with the findings from other studies (Brown, 1995; HEAIDS, 2010; Jangu, 2014; Parker & Aggleton, 2003; Patterson & Keefe, 2008; Stewart & Dancy, 2012), which showed that such stereotypes about the sick AIDS body are said to affect the personalisation of risk, and the agency to self-protective practices (such as HIV testing).

The other participant (Carol), who positioned herself as being at risk of HIV but reported not being tested, justified this by citing her fear of finding out that she has HIV and the possibility of her life changing. However, in response to the question related to her plans around HIV testing, Carol expressed her intention to take an HIV test at her next gynaecological visit (2019, May). While this suggests that her practice will be incidental, it is also an indication that my interactions with her in the interview seemed to have empowered her.

Departing completely from the above positioning adopted by the 12 participants as being at risk of HIV due to their activities of unprotected sex but not prioritising HIV testing is another subject position, identified in the account of one female participant, called Sane. She positioned herself as being aware that she is at risk of HIV and adopted the positioning of a sensible, rational, reasonable and responsible health subject in terms of HIV testing. The next section presents a discussion and interpretation of what is entailed in this subject position, namely that of a rational and responsible health subject.

6.3.1.2 The at-risk subject due to one's own activities of unsafe sex but prioritises testing

Sane engaged in a lot of discursive work to rationalise her position as a highly responsible subject in terms of HIV testing and called attention to four key issues. Firstly, she gave credit to her mother's actions as the principal source of her inspiration to take regular tests for HIV. She positioned her mother as being serious about HIV risk and as being the principal actor in normalising HIV testing health practices for her children. However, it is worth noting that only Sane could position her mother as a health acting subject if we were to compare her position with that of other participants in this study (and possibly the general student population on the Pietermaritzburg campus). Sane's positioning of her mother as being a health acting subject contrasts sharply to the ones identified in the findings of three South African studies amongst youth (Kempf and Hilke, 2012; Peltzer & Matseke, 2013; Tenkorang, 2016). Peltzer and Matseke (2013) and Tenkorang's (2016) studies reported that most parents are not involved in open discussions about HIV risk with their children.

Peltzer and Matseke (2013) and Tenkorang's (2016) studies attributed this to the misconceptions that doing so would encourage youth to engage in high-risk sexual behaviours. Kempf and Hilke's (2012) study attributed the silence about HIV risk in African homes, in particular, to social norms adhered to in families, within a community, or society at large. Kempf and Hilke (2012) concluded that HIV risk is being constructed in such contexts as a moral issue, rather than a health concern. Kempf and Hilke's (2012) conclusion may say something about the pattern identified in the present study, which positions students as not prioritising HIV testing in their lives. Sane's position, therefore, suggests that perhaps her mother was a health practitioner, or she was trying to educate her children, or prepare them for the future, or ease her suspicion about their behaviour.

Secondly, Sane positioned her HIV testing practices as motivated by incentives in the form of material rewards given to students who engage in HIV testing in ad hoc mobile testing tents on the Pietermaritzburg campus. This suggests that her HIV testing practices are not always driven solely by her rational response to the threat of HIV posed by her activities of unsafe sex, or pursuit of the health reward that comes with it, namely, the security in knowing that she is still HIV negative, or the mere act of taking responsibility for herself, but rather, over and above these others, the incentive arising from the material reward she gains from taking the test. The use of incentives in the form of material reward to encourage people to engage in HIV testing health practice and increase uptake of HIV testing services has been reported by several South African research conducted amongst youth (HEAIDS, 2010; MacPhail et al., 2009; Mohlabane et al., 2016; Pettifor et al., 2012).

Thirdly, Sane constructed herself as feeling 'proud', 'happy', 'relieved', and 'satisfied' anytime she tests for HIV and gets a negative result, which positions her as someone who has internalised a particular good/ideal health subject and how one should behave in the light of that ideal. This positioning contrasts sharply with the position taken by the majority of participants in this study in the sense that they constructed HIV testing as a once-off process without recourse to confirmatory tests.

Fourthly, Sane positioned herself as aware of how serious the problem of HIV is in South Africa and on the Pietermaritzburg campus, and as knowing that she might be at risk and that testing is her appropriate practice in response to it. So, for her, testing for HIV regularly is done so that when she tests positive, she accesses care quickly and minimise the negative outcomes of the virus. She also indicated that she keeps a record of her HIV result.

Sane presented herself in her interview with me as a sensible, rational, reasonable and responsible health subject. She is almost like a perfect subject that is a representative of what the health belief model proposes, namely, that an individual should anticipate vulnerability to a specific health risk (HIV infection), assess the efficacy of a recommended health behaviour (HIV testing), and make decisions in favour of their health (test regularly) (Glanz & Reimer, 2008).

Sane also positioned her partner as not being faithful. However, still, she did not insist on condom use or joint/couple testing in her relationship (as all the HIV tests were hers). Her positioning in this regard runs counter to what several researchers (George et al., 2019; HEAIDS, 2010; Kabiru et al., 2013; MacPhail et al., 2009; Miller et al., 2017; Mohlabane et al., 2016; Peltzer & Matseke, 2013; Pettifor et al., 2012; Ritchwood et al., 2019; Shisana et al., 2014; Walensky et al., 2011) have argued, based on studies of HIV risk and prevention through HIV testing. Contrary to Sane’s positioning, in one of these studies (see George et al., 2019), which investigated the impact of HIV testing and ART services on risky sexual behaviour amongst youth in the uMgungundlovu district in South Africa, participants who said that they engaged actively in HIV testing, just like Sane, also reported having gained skills to support positive living, such as negotiating safe sex in relationships, assessing HIV risk, and leaving risky sexual relationships. In relating this finding to Sane’s position, not negotiating condom use in her relationship suggests that she is not adhering to these norms found amongst participants in George et al.’s (2019) study, which showed that those who engage actively in HIV testing (like Sane in this study) try as much as they could (unlike Sane), to minimise engagement in unsafe sex practices. It is possible that Sane’s regular engagement in HIV testing is her strategy of reassurance.

The contradictory position adopted by Sane highlighted above is, however, not uncommon in health research. Several researchers have found that self-reports of health practices, actions and adherence may, at times, be unreliable (Emanuel et al., 2004; Gale, 2010; Magnani et al., 2005; Ulmer & Wilson, 2003). Moreover, in line with Parker’s (1992) argument that discourses make it possible for different and particular forms of self to be identified (such as the positioning of a responsible and extremely in control health subject adopted by Sane), Sane’s contradictory positioning suggests that perhaps she is trying to present a good health subject to me. Also, the practice of HIV testing is not a condition that can be externally assessed, and so it is easy for an individual to give a socially desirable response. On the other hand, Sane's positioning presents a reassuring impression that some students (no matter how few they are) are taking seriously the health messaging made available to them via the IEC channels.

In contrast to the subject position adopted by participants in this study, who acknowledged their risk of HIV due to their activities of unsafe sex, another subject position identified in the accounts of a few other participants tended to position other people as being responsible for creating the threat of HIV for them, and themselves as victims.

6.3.1.3 The at-risk subject who is a victim but does not prioritise HIV testing

Out of the 13 participants who positioned themselves as being at risk of HIV, two of them (all female, Nicole and Liz) attributed their risks to other people's destructive behaviours, such as the risk of one being raped by an HIV positive man, or being exposed to someone else's contaminated blood and 'touching somebody'. While the assumption that HIV can be transmitted through casual contact is not 'logical', it appears significant in two ways. Firstly, it seems to allow these two participants to shift blame and responsibility to other people in the sense that being infected with HIV in this manner would be viewed as someone else's fault and not related to the fact that one is sexually active, and engages in unsafe sexual practices. This subject positioning as not responsible for the risk of HIV infection appears to be drawing on a victim discourse, and is significant in two ways. Firstly, the HIV risk discourse and prevention science position an HIV negative status as indicative of 'goodness', or being 'not at fault', which acts counter to the discourse of not stigmatising HIV positive people. Therefore, admitting risk is akin to admitting that you have been 'bad'. Secondly, people may not position themselves as at risk at only an individual level but also at a relational level as well, and these may serve to mediate each other.

This victim discourse also seems to have had implications for these two participants' HIV testing practices. For example, Nicole said that she had not been tested for HIV, while Liz said that she had been tested but only once, and positioned her practice as for a pragmatic reason (sickness). This is also significant as it suggests that while HIV risk perception may be necessary for behaviour change, it is an insufficient driver of behaviour change. However, these two female participants constructed HIV testing as their primary risk management strategy under uncontrollable situations of rape, or blood contamination, or ‘touching somebody’, but at the same time, positioned themselves as never having been exposed to such conditions. This, in their view, renders their lack of engagement with HIV testing as ‘justified’. Secondly, it positions these two participants as having limited knowledge about HIV transmission routes, consistent with the finding of Daftary et al.’s (2007) study on the HIV testing practices and TB screening amongst patients at a hospital in South Africa.

In contrast to the above discourse of the at-risk subject due to one’s own activities of unsafe sex, or other people’s actions, another discourse identified in the accounts of some participants positioned them as being at no, or low risk of HIV. This subject positioning they adopted seemed to have reduced their need to adapt or engage actively in HIV testing.

6.3.2 The no, or low-risk subject and does not prioritise HIV testing

Out of the 20 participants interviewed for this study, seven participants (6 women and 1 man) positioned themselves as being at no, or low risk of HIV. What is concerning in examining this particular subject positioning further is, as Durojaiye (2011) comments, the higher the perceived threat of HIV, the higher the probability of one’s engagement in behaviours that will reduce their risks of contracting HIV, such as taking an HIV test and engaging in protected sex. Based on this understanding, what is problematic about the no, or low-risk subject positioning identified in this study is that these seven participants assumed that they are not in danger of contracting HIV and do not see the need to engage in HIV testing. Thus, when talking about their HIV testing practices, words such as ‘it has never come up’, ‘not a priority in my list’, ‘what is the need for HIV testing’, ‘never really thought about it’, were identified in the accounts of some of these participants. These words suggest that HIV testing is not something they engage actively in.

In terms of the HIV testing practices of these participants, one female participant reported being tested but once. She said that her testing practice occurred when she participated in the health and wellness day at the University of KwaZulu-Natal. She said that she used that opportunity to know her HIV status, an indication that her practice was unplanned and incidental. To justify her lack of active engagement with HIV testing, she positioned herself and her partner as not being at risk of HIV and, consequently, as not needing to get tested.

Three other participants (2 women and 1 man) stated that their most recent HIV testing activity took place in the ad hoc mobile testing tents on the Pietermaritzburg campus. Their accounts suggest that they took the test because they saw a mobile testing test, an indication that their practices were also unplanned and incidental. These narratives are in line with the notion of the random and spontaneous nature of the HIV testing practices of university students reported in the recent Higher Health annual report on HIV, TB and STIs screening, and mental health in South African tertiary institutions. Higher Health (2020) noted that most students who took part in the wellness programmes in their respective universities between 2019 and 2020 admitted that they find it easier to test for HIV during the health and wellness days on their campuses.

In terms of the HIV testing practices of the rest (three female participants), they said that they have once been pregnant and located their most recent HIV testing activity in the antenatal health clinic. They positioned this test as being for a pragmatic reason (getting to ascertain the health of their developing foetus), consistent with the findings of two South African studies on factors that facilitate HIV testing amongst young people (MacPhail et al., 2009; Peltzer & Matseke, 2013). Moreover, the construction of HIV testing as being mandatory for pregnant women for a pragmatic reason is consistent with how the service is constructed in the HCT and HTS policy documents. In these policies, the pregnant women are included in the specific category of people identified in the policy as being the target for the HIV testing service (Department of Health, 2010, 2016). Here, the HIV testing service is constructed as laying the foundation for preventing mother-to-child transmission of HIV during pregnancy, birth, through breastfeeding or parental exposure (Department of Health, 2010, 2016).

However, it is important to note that while mandatory HIV testing as a diagnostic tool in the event of pregnancy has practical benefits stated in the HTS policy document, it has generated controversy. Rennie and Frieda (2006) argued that subjecting a pregnant woman to mandatory HIV tests is tantamount to invasion of her body, thereby denying her the right to voluntary testing, and the option to opt-out or to choose to do it in the course of her pregnancy. Another concern raised by Rennie and Frieda (2006) is that a pregnant woman who receives a positive HIV result may position herself as being an ‘unfit/bad mother’, as a ‘not a good enough mother’, or as ‘guilty’, all of which could have negative emotional implications for her psychological health and her confidence for parenting. Rennie and Frieda (2006) asserted that such a woman could reflexively adopt the unfit/bad and guilty subject positioning through engaging in discursive practices that support it, such as not displaying adequate affection or even exposing the child to other health risks.

Another primary concern was raised by Walensky et al. (2011), who remarked that the pre-test and post-test counselling services are minimal in a mandatory HIV testing situation. This, according to Walensky et a. (2011), exposes a client who tests positive to psychological distress, which, incidentally, is something that the HIV testing policies purport to prevent. Although none of the three female participants mentioned any of the above potential consequences of enforcing mandatory HIV tests on pregnant women, their positioning in this discourse suggests that most testing by students is incidental and not decided by them.

To further justify this positioning of a no, or low-risk subject, some participants did a lot of discursive work to present themselves as sexually responsible, despite not engaging actively in HIV testing. Their justifications appeared to be drawing on the fundamentals of the ABC framework. Moodley (2007) argued that within the ABC framework, youth are issued with three conditions to consider. They include the “A” health messages whose focus is on sexual abstinence, or delaying sexual debut for a designated length of time (perhaps until marriage). If this is not possible, they are encouraged to adopt the “B” health messages, whose focus is on being in a monogamous relationship with an uninfected sexual partner, or reducing the number of sexual partners. If this is still not possible, they are encouraged to adopt the “C” health messages, whose focus is on correct and consistent condom use. The relevance of these three conditions of sexual activity, and therefore, three subject positions, and how these relate to the participants’ HIV testing practices, will now be presented and discussed.

6.3.2.1 The currently sexually abstinent subject

Out of the six female participants who positioned themselves as being at no, or low risk of HIV, two (Esther and Londi) justified their position by constructing themselves as not sexually active at the time of the interview. This position draws on the “A” health messages, specifically secondary sexual abstinence. Secondary sexual abstinence is a situation whereby a person who was formerly sexually active refrains from sexual intercourse due to various reasons such as individual choice, academic, religion, culture, or moral reasons (Moodley, 2007). Esther, an international female student participant, positioned herself as being in South Africa for academic purposes, and as being a focussed student. She contrasted this positioning with other students, implying that other students are not focussed, and are at risk of HIV. However, her justifications for her position suggested that Esther had relied on her partner’s words that he is not HIV positive as convincing and conclusive evidence that he is HIV free, without recourse to HIV testing, particularly couple testing. This indicates that her motive for being sexually abstinent at the time of the interview was related to the fact that she was away from her home country for a significant reason (academic), and not about protecting herself from the threat of HIV *per se*.

On the other hand, Londi’s motive for being sexually abstinent at the time of the interview was related to the position she adopted as not being in any romantic relationship at the time of the interview, and not about protecting herself from the threat of HIV. She indicated that she would be at risk of HIV if she were in a romantic relationship. This direct link between being in a romantic relationship and the risk of HIV infection is not peculiar to Londi in this study. It has also been reported in three other South African research conducted with university students (Gwala, 2019; Mbelle et al., 2018; Ngidi et al., 2016). Gwala’s (2019) study investigated the sexual practices of university students; Mbelle et al. (2018) explored students’ perceptions and attitudes about male and female condom use, and Ngidi et al. (2016) investigated social factors that influence sexual risk-taking behaviour amongst students. In particular, Gwala’s (2019) study concluded that being in a romantic relationship significantly predicts students’ sexual activities and acts as a barrier to their engagement in sexual abstinence or condom use. Londi also indicated that she had tested for HIV after leaving her past relationship. She said that she left that relationship because of her partner’s infidelity. She stated that she is confident that she is HIV free, and used that to justify her position that she does not need to take regular HIV tests.

While the subject positioning adopted by these two female participants is similar to findings in other South African studies amongst university students (Evans et al., 2018; Haffejee et al., 2018; HEAIDS, 2010; Ngidi et al., 2016; Paul et al., 2014), including the University of KwaZulu-Natal students (Gwala, 2019; Mthembu, 2017), it contrasts with how HIV testing is being constructed in the National HTS policy as service everyone should be given irrespective of whether they engage in low or higher-risk practices and sexual behaviours, or show indicators of a possible HIV exposure (Department of Health, 2016).

6.3.2.2 The monogamous healthy subject

Four out of the six female participants who positioned themselves as being at no, or low risk of HIV justified their positioning by constructing themselves and their male partners as being monogamous. This positioning appears to be drawing on the dominant fundamentals of the ABC framework, specifically the "B" health messages, whose focus is on one's sexual and emotional exclusivity to one uninfected romantic partner. In the accounts of some of those participants, words such as 'I have one partner', 'we are both faithful', 'I have only been with him', 'we are in a long-term relationship', 'it is just love', 'I believed him', 'I trusted my partner', 'he said he is fine', were identified. These words position these participants as feeling that their risks of HIV are automatically cancelled by being monogamous in their relationships. This positioning draws on the have/hold discourse, which contains the assumption that women aspire always to an ideal intimate relationship, and to trust, and to love, and to make a man happy (Hollway, 1984). According to Hollway (1984), it is through being desirable, and obtaining, and being invested in the status of being in a relationship, and 'keeping' a man, that a woman accrues her power. This implies that the characteristics of relationships become tools to support and justify behaviours concerning HIV testing for women.

It is important, however, to mention that all four participants who positioned themselves as monogamous healthy subjects did not report using any protective measures when talking about their sexual activities, or engaging in couple HIV testing but assumed that their partners' HIV status was negative. They believed the negotiation of HIV risk and HIV testing as a prevention practice is not expected, or seen as unnecessary amongst sexual partners. However, this positioning of a monogamous healthy subject is not a finding that is peculiar to this study. It has been reported in three other South African research conducted with university students (Gwala, 2019; Mbelle et al., 2018; Ngidi et al., 2016). In particular, Ngidi et al.'s (2016) study concluded that this is risky, especially when sexual partners fail on mutual faithfulness.

Ironically, when talking about situations that may place them at risk of HIV infection, three of these female students focused on the possibility of a male partner cheating and exposing them to the threat of HIV. This is an important finding as it suggests that these young women are aware that emotional fidelity (trust and love) and sexual fidelity in a relationship is not effective in protecting one against HIV infection. It also highlights the difficulty of young women holding on to relationships. Therefore, drawing on the concepts of trust and love to rationalise not negotiating HIV risk, or demanding HIV testing, or insisting on condom use, could be their response to their lack of power in determining the conditions of sexual activity in their relationships. It is as if they prefer to view themselves as being 'safe' from HIV even though they know they are actually at risk, rather than to acknowledge their powerlessness in sexual health decision making in their relationships. This has particular consequences for a woman's vulnerability to HIV infection. Van der Riet et al. (2018) argued that in this gendered organisation of sexual relationships, it is not that a woman does not know enough about HIV risk, or that she deliberately abdicates responsibility for her own safety, but rather she has little power in the relationship.

Moreover, by referring to the possibility of a partner's infidelity, which might create a risk for themselves, they seemed to position themselves as potential victims of HIV, and on a victim discourse. This positioning and discourse have implications for one's engagement in HIV testing as a protective strategy. Despite taking responsibility for themselves by remaining faithful to one partner, it is difficult to know if a partner is faithful, or to control his sexual behaviour. The woman's safety from the threat of HIV, therefore, rests on the faithfulness of a male partner. This, according to Lupton (1992), depicts the human side of HIV, that even the responsible body (innocent) can suffer. However, the notion of a woman been made a victim of HIV infection due to her partner's risky sexual behaviours is reported in a Tanzanian study on the social construction of HIV risk and prevention amongst educated women (Jangu, 2014). In that study, some participants who were tested for HIV and received a positive result indicated that they were alarmed by the test result because they had believed that their faithfulness in their relationships should have protected them from HIV infection. Jangu's (2014) study concluded that commitment to one partner with the assumption that the other partner is also faithful could be constructed as a regular feature of a relationship that increases a woman's susceptibility to HIV infection.

It is worth noting that all female participants in this study positioned themselves as not having more than one sexual partner at a time. This is unlike most male participants who reported being in multiple concurrent sexual relationships or engaging in casual sex. In my interactions with three of the five men who took part in this study, a common response was the absence of expectation of sexual monogamy on a man's part. They constructed men as supposedly wanting multiple women to satisfy their sexual needs. This trend draws on the assumption of the male sex drive discourse. Under the male sex drive discourse, men are constructed as wanting their physical aspects of sex (satisfaction and release) to be met (Hollway, 1984). The social positioning of a young man in this study as needing multiple women could also be driven by the fact that men are not committed as they will go anywhere and do everything to get their drive satisfied, a significant finding in another South African study conducted with youth (Van der Riet et al., 2018). This being the case, it would then mean that women have to put up with this if they want a man at all in their lives. These constructions of women as monogamous and primarily invested in the relationship, and men as polygamous and desiring subjects, thus reveal gender-differentiated discourses concerning sexuality (Hollway, 1984).

However, three female participants in this study emphasised that young women also engage in multiple sexual relationships, which puts them at a greater risk of HIV than their counterparts who practice sexual monogamy. This acknowledgement of female sexuality suggests that the positioning of a sexually responsible subject evidenced in this study may not be entirely what most female students practice as they claimed. By positioning themselves as monogamous healthy subjects, these women might have been trying to demonstrate their ‘good’ self and behaviour to me as the researcher. Several studies conducted with university students in South Africa have shown that, often, young women, in general, tend to under-report the number of their sexual partners (Chimbala-Kalenga & Makuwira, 2016; Gwala, 2019; Maughan-Brown & Venkataramani, 2018; Mbelle et al. 2018; Mthembu, 2017; Ngidi et al., 2016). This relates to the gendered structure of the society in which men are excused for having multiple women while women are criticised as ‘whores’ if they were to have multiple partners (Van der Riet, 2009, as cited in Van der Riet et al., 2018). Given this understanding, the position which the female participants in this study adopted as monogamous is an indication of their significant investments in their sexual relationships, an investment which is related to social reputation, and thus reflecting a different prioritisation of the self. This is similar to the findings of Van der Riet et al.’s (2018) study on how identity investments interface with sexual relationships and safe sex practices amongst youth in a rural area in South Africa in the context of HIV and AIDS. Hence, the views of the three female participants who referred to women’s desire for multiple partners can be interpreted to mean that irrespective of gender, there is a tendency amongst young men and women at a university in South Africa to engage in multiple sexual relationships even when they know that this behaviour places them at a high risk of HIV.

6.3.2.3 The condomising health subject

In this study, one male participant (Alfred) presented himself as taking responsibility for HIV risk by using a condom with casual partners. However, his overall account showed that even while taking this precaution, there was a lack of consistency in his practice of condomisation. This positioning of a condomising health subject draws on the dominant fundamentals of the ABC framework, specifically the 'C' health messages. In using these words also, he positions himself as being a sensible, rational, and good health subject, but also as one who is not able to comply fully with the HIV risk prevention strategies, and as not entirely in control of his situation, but as not risking himself deliberately. His practice of condom use with casual sexual partners and in unstable partnerships is in line with the findings of some South African studies conducted with university students (Chebitok, 2017; Gwala, 2019; Heeren et al., 2013; Mbelle et al., 2018). However, Alfred's inconsistency in condom use suggests that although he is in an environment (Pietermaritzburg campus) where condoms are widely marketed, distributed, and easily reachable, that does not contribute necessarily to lowering his risks of HIV but give him a chance to have multiple concurrent sexual partners. An alternative approach for youth like Alfred (and other participants in this study) to protect themselves against HIV infection is to prioritise HIV testing, particularly couple testing before a first partnered sexual encounter. However, this was not the case with Alfred, as his HIV testing practices were his responses to risky sexual activities.

Having identified and discursively explored the significance of the discourses drawn on by participants to construct, change, explain, and elaborate on their understandings of HIV risk and positioning in relation to it, and implications of discourses for their HIV testing practices, in the prior sections, I now discuss some issues in participants' accounts that could hinder youth from taking an HIV test. These are presented and discussed in the next section.

6.4 Challenges raised in students' engagement with HIV testing practice

Tylee et al. (2007) argued that an individual is likely to avoid taking an HIV test if s/he believes that the consequence of the action can cause a burden, be it emotional, physical, mental, or financial. Similarly, a discursive analysis of participants' justifications of their HIV testing practices identified HIV testing as a complex activity, which negatively affects participants' engagement with it. In their accounts, these complexities emanated from three critical circumstances. The first one is the risk of exposure in the HIV testing process to the view of onlookers and passersby as the facilities which offer the service are located in open spaces on, and off campus. The second element of this complexity is the discomfort with a health care service provider in the HIV testing interactions. The third is the fear of being stigmatised by a health care service provider. The significance of these three major disincentives to HIV testing practices amongst youth, will now be presented and discussed.

6.4.1 Risks of exposure in the HIV testing process

While one can argue that the emergence of different facilities that offer the HIV testing service on, and off the Pietermaritzburg campus could provide relevant alternative opportunities for students to know their HIV status, most participants (15) who said that they had been tested constructed their experience and the testing process in the ad hoc mobile testing tents and the campus health clinic, as being risky and embarrassing. In their justifications, the ad hoc mobile testing sites were constructed as being in public spaces, near busy 'buildings', 'shops', and on the 'library lawns', and thus too visible. Participants constructed the public nature of this testing process as uncomfortable, and as exposing those who go for testing to the scrutiny of other people. The other people were constructed as being suspicious of the person who goes for testing, and as being able to discern the HIV status of people by simply looking at their facial expressions. They constructed this exposure in the process of HIV testing as one in which stigma, humiliation, and discrimination could occur, and they imagined this situation for themselves, particularly the risk it could involve if they were to receive an HIV positive result. They all seemed to fear these negative experiences very much.

A review of the confidentiality principle in the HTS Policy and the HCT Policy contains a clause that positions the health care service provider as being responsible for keeping the client's information related to HIV test result, sexual behaviours, substance abuse, and the use of illegal drugs, confidential, (Department of Health, 2010, 2016). Drawing on this clause, the participants' construction of the HIV testing process as very public and exposing the actor (testing subject) to the risk of being stigmatised and discriminated against by other people, provides evidence that the ethical principle of confidentiality being emphasised in HTS policy is not maintained. This means that even though the HIV testing policy provides guidelines to ensure that the client is given sufficient information to make rational decisions before taking the test, the fear of exposure in the testing process appears to be a considerable critical disincentive to the actual practice of testing amongst youth. This, therefore, implies that any initiatives based on these kinds of health policies might not work amongst people who believe that going for an HIV test is a risky venture. Thus, participants' construction of the testing process needs to be taken into account.

Similarly, previous South African research has shown that sexually active youth who suspect a seropositive HIV test result and believe that they will be stigmatised based on their HIV status are likely to decline or delay HIV testing (Buldeo & Gilbert, 2015; Cilliers et al., 2018; Evans et al., 2018; Haffejee et al., 2018; HEAIDS, 2010; Peltzer & Matseke, 2013; Ritchwood et al., 2019; Steinberg, 2008; Tenkorang, 2016; Van der Riet & Nicholson, 2014). In particular, Evans et al.'s (2018) study on knowledge about HIV, risk perceptions, and access to HIV health care services across six universities in the Gauteng province reported that part of university students' reluctance to HIV testing was linked with the stigma attached to accessing the service, and the fear of possibly being labelled 'HIV positive' at the end of the whole process.

To justify their discomfort in the HIV testing process at the health clinic on campus, some participants commented that students who go for testing are routinely isolated from other students who seek general health care services. Participants constructed this isolation as one in which stigma and judgement from other students could occur, and positioned themselves as being very scared to go for testing as it makes them vulnerable and exposed to this risk. This observation also highlights how the discourses drawn on the HIV testing policies might be different from the realities of the testing subject. For example, South Africa's National HTS Policy guidelines released in 2016 proposed that public and private health sectors should integrate HIV testing services with other health care services, such as family planning and treatment of TB, STIs and other illnesses in public and private health sectors (Department of Health, 2016). This integration effort is intended to mitigate the problem of stigmatisation when the client is seeking the HIV testing service, and to encourage HIV testing uptake. However, judging by the participants' constructions of the HIV testing process in this study, it would seem that the service is not fully integrated into the general health care services given to students on the Pietermaritzburg campus health clinic. This limitation is inconvenient to some youth who would like to get tested at the campus clinic. This could explain why some participants relied on ad hoc mobile testing tents to know their HIV status, which they also constructed as exposing. Overall, then, these fears of the risks of exposure in the HIV testing process may be part of the reason why students have a long build-up to the action of testing and their avoidance of HIV testing.

In this study also, three participants who said that they had been tested constructed their experience and the testing process, in the ad hoc mobile testing tents and the campus health clinic, as a risky activity. However, they indicated that they felt safe (since they all tested negative for HIV), and were not affected by this risk of the visibility of the HIV testing process. Perhaps, their positive reflection of the HIV testing process and their feelings and experiences towards testing could have been different if their results had been different (if they had tested positive). This may serve to maintain their position as ‘good’ health seekers. It allows them to maintain their position of behavioural superiority within the comfort of knowing that they were HIV negative when doing this interview.

Certainly, all participants in this study positioned themselves as being critical of this exposure in the process of testing at the ad hoc mobile testing facilities and in the campus health clinic, and called for the establishment of a proper and better-protected environment for the HIV testing process. They constructed students going for an HIV test at the campus health clinic as needing to be anonymised to minimise the risk of exposure in the testing process. Most of the participants also constructed the HIV testing practice as needing confidentiality. They recommended that the HIV testing sites need to be located in isolated places (places that are not busy and not visible to the public). Their constructions in this regard appear to differ from how the HIV testing service is being constructed in the National HTS policy. This policy focuses on scaling up the HIV testing service in rural and urban areas, making the service available and easily accessible to the public, and normalising the testing service (Department of Health, 2016). Hence, an important point to highlight in this study is this fundamental concern, which students have about being known to have HIV, and how the testing conditions, the site, the people involved, are facilitative or supportive of exposing or keeping the process confidential. This is critical as it sheds light on the need to review existing discourses in the HIV testing policies to expand delivery options that have the potential to address the current barriers to HIV testing uptake identified in this study, including social stigma, discrimination, and unintentional breach of confidentiality in the health care facilities that offer the testing service.

6.4.2 Risks in HIV testing interactions with health care service providers

The national HIV testing policies (HCT and HTS) have a section on the role of the pre-test counselling (HCT policy), which is referred to as pre-test information in the HTS policy, and the post-test counselling service in both HCT and HTS, in encouraging and supporting a client to get tested for HIV. In both policies, the health care service provider is positioned as being responsible for ensuring that the HIV testing process includes counselling before and after the test. The pre-test counselling and information address: the benefits of HIV testing; testing procedures; interpreting test results; management and prevention options; encouragement of partner testing; the right to decline to test; and potential risks of testing (Department of Health, 2010, 2016). All of these constructs the process of HIV testing and diagnosis as somehow 'dangerous', or something which could 'harm' the client. To moderate these potential risks of the HIV testing process, the client is given information and counselling. However, in this study, counselling in the process of HIV testing was constructed by some participants as being very uncomfortable, irritating, and harmful.

Some participants noted that their interactions with the HIV testing counsellor made them feel as if the counsellor was almost pre-empting their HIV status as positive even before the HIV test takes place. They also constructed the length of time in receiving the pre-test information and counselling as being 'very long', with this long waiting period (before the test is taken) as creating much anxiety related to the HIV result. This finding suggests that the aim of the pre-test information and counselling session, which is to protect the client from the possible emotional harm of the practice they are encouraged to engage in, as proposed by the HCT policy and the HTS policy is not being realised, but rather exposes the client to the risk of emotional harm. To minimise the experience of this discomfort and tension in the HIV testing interactions with a health care service provider, some participants indicated that they prefer not to receive pre-test counselling and information if they were to seek the HIV testing service. This again is another indication that some health policies are very disconnected from the lived experience of youth in their context and that any initiatives based on these kinds of policies may need to be reviewed by the policymakers.

Furthermore, in the HCT and the HTS policy documents, the post-test counselling service is emphasised more than the pre-test information and counselling service. In the HTS policy, in particular, there are post-test counselling services for four categories of clients: those who receive positive HIV test result, those who receive negative HIV test result, those who receive HIV-inconclusive result, and those who receive discrepant test results (Department of Health, 2010, 2016). The predominant theme in the post-test counselling service tends to construct the service as laying the foundation for encouraging the client to adopt various forms of behavioural and biomedical methods of HIV prevention and management. In contrast to the HCT and the HTS policy's constructions of the post-test counselling service as being about the management and containment of HIV and also the control of the effect of an HIV positive diagnosis on the individual's life, some participants in this study constructed the post-test counselling service as not needed by a client who receives a negative HIV result, and they related this to themselves. To justify their constructions in this regard, they positioned such a client as being satisfied with the HIV negative result, and as not needing to be counselled because they are out of danger of being HIV positive.

Drawing on their experiences, some participants said that they do not pay much attention to what is being said in the counselling session after being exhilarated by the type of result they are pleased to have (HIV negative). This construction suggests that some youth do not view the post-test counselling service in the context of a negative HIV result as a significant and beneficial service, which directly contrasts with how the service is being constructed in the HCT and the HTS policies. In those policies, a client, particularly unmarried youth, who tests negative for HIV is assumed to be in need of post-test counselling, particularly information related to self-protective practices to remain HIV negative, and the importance of taking regular tests for HIV (Department of Health, 2010, 2016). This perspective positions the HIV negative client, particularly youth, as still risky and the activities they engage in as still unsafe and therefore as needing to be regularly tested, as others and the country are at risk from exposure to such a person. It is also based on the assumption that the counselling and testing process is a preventative intervention, and that the health care service provider is responsible for making this to happen. It might be specifically these kinds of issues in the HIV testing interactions that youth are resisting rather than being opposed to the post-test counselling service *per se*.

6.4.3 Risks of stigma and discrimination from health care service providers

In the dominant health policies, the health care provider is constructed as the implementor of the health interventions inherent in the policy. For example, the HCT policy contains the assumption that a health care worker is mandated to inform all clients who receive health care services of the risks of HIV infection and routinely offer and recommend an HIV test service to them (Department of Health, 2010, 2016). In this study, however, some participants highlighted the challenges they face in getting tested for HIV in front of the health care provider, particularly the nurse. In their justifications, some participants constructed the nurse as ‘older’, as asking harsh and judgemental questions related to their age and sexual behaviours, and as raising suspicions of HIV infection amongst youth who seek the HIV testing service. They constructed themselves as being possible victims of exposure to these risks.

The fear of being stigmatised and discriminated against by the health care provider presents a formidable barrier to HIV testing as in both the present study and in those reported in several South African studies amongst youth (De Zoysa et al., 1995; MacPhail et al., 2009; Ritchwood et al., 2019), including university students (Buldeo & Gilbert, 2015; Chimbala-Kalenga & Makuwira, 2016; Haffejee et al., 2018; HEAIDS, 2010; Higher Health, 2020; Musemwa, 2011; Paul et al., 2014; Pillay, 2020). For example, in Buldeo and Gilbert’s (2015) study, some participants constructed the HIV testing process as upsetting and embarrassing, particularly when asked, after receiving an HIV diagnosis, about what love and sex mean. De Zoysa et al. (1995) attributed the negative attitudes of nurses towards unmarried sexually active youth to social, religious, and cultural practices that limit sex to marriage. Embraced in this religious and socio-cultural perspective is a set of assumptions that being sexually active as a youth, is undesirable behaviour, and that being HIV infected is a punishment for this behaviour, rather than being a health problem. This construction of the health care service provider as stigmatising is also reported in a study from Botswana, which explored the psychosocial factors influencing young people’s willingness to engage in HIV testing (Fako, 2006), and three Nigerian studies on HIV risk perceptions and implications for HIV testing amongst youth (Durojaiye, 2011; Nwachukwu & Odimegwu, 2011; Obidoa et al., 2012).

The negative constructions and positioning directed at the health care personnel, as noted in this study, and other studies in South Africa and other African countries, suggest that even when the HIV testing resources are available, they might still remain inaccessible to young people because of the fear of being discriminated against or judged for their sexual behaviour or lifestyle. Similarly, this negative construction of the health care service provider highlights some divergence that tends to occur between how certain discourses are drawn on the HIV testing policies and the experiences or realities of the policy’s receiver or the testing subject.

Of course, it is important to note that this positioning of a health care service provider as stigmatising the youth who go for HIV testing were the constructions of the participants, and not necessarily their actual experiences of being judged or stigmatised by a nurse based on one’s age or sexual behaviour. This caveat notwithstanding, it is vital to note that some participants avoided HIV testing as an adaptive and defensive practice against being judged and stigmatised by the nurses. This finding is consistent with the finding in several South African studies that perceived social stigma precedes and can surpass enacted stigma (Buldeo & Gilbert, 2015; Daftary et al., 2007; Haffejee et al., 2018; HEAIDS, 2010; Mohlabane et al., 2016; Paul et al., 2014). In Daftary et al.'s (2007) study on the HIV testing practices and TB screening amongst patients in Durban, South Africa, participants who suspected that they would be stigmatised if they were to test positive for HIV were reluctant to seek out the testing service. Daftary et al.'s (2007) study concluded that people who believe in the possibility of being stigmatised as a result of being tested and testing positive for HIV and avoided engaging in HIV testing to overcome these potential risks of the testing practice, have little opportunity to experience enacted stigma.

Overall, the three disincentives to HIV testing practice presented above suggest that although some participants positioned themselves as being threatened by HIV infection, and as being at risk, and constructed HIV testing as being the correct response to this risk, the fear of exposure in the process of testing at the primary health care facility (clinic), or in the mobile testing tents, and the belief that this exposure could result in stigma and discrimination from other people, including the health care service providers, seem to constitute a formidable hindrance to their engagement with HIV testing, especially for those who know that they have risked themselves. These concerns are significant and demonstrate the mystery and fear surrounding HIV testing, and the stigma permeating the everyday 'realities' of young people. All these play a vital role in shaping their responses to HIV testing health policies.

However, the current barriers to HIV testing uptake can be addressed by HIV self-testing, a new modality to HIV testing aimed at shifting the focus away from the traditional HIV testing facility to the comfort and security of an individual's home. Participants' constructions of this health initiative were explored in this study, and the significance of the findings in relation to it are presented and discussed in the next section.

6.5 HIV self-testing practice

HIV self-testing (HIVST) is the latest intervention mentioned and strongly encouraged by South Africa's National Health Department. In the HIVST discourse, the assumption is that the subject collects their specimen (oral fluid or blood) and then screens it for HIV using a rapid diagnostic test and interprets the result, often in a private location, either alone or with assistance from someone s/her trusts (Department of Health, 2016). This constructs self-testing as removing structural, logistic and social obstacles to HIV testing cited in the prior sections, such as the concerns regarding the lack of confidentiality in traditional HIV testing facilities, and the potential stigma around HIV testing and health care access. However, in this study, most participants (18) positioned themselves as not being aware of the availability of the HIV self-testing kit, and no participant reported ever collecting their own specimen and performing an HIV test on their own. This finding differs slightly from the trend highlighted in the recent Higher Health (2020) 2019-2020 annual report, which tended to construct the university students in South Africa as being aware of the availability of the HIVST compact kit and as something some students (about 500) in 2019 appeared to prefer due to its privacy.

Moreover, in response to whether youth should be encouraged to test for HIV on their own, most participants constructed self-testing as ill-advised and as a problematic intervention for youth, particularly those who receive a positive result. In their justifications, three forms of risks were identified. Firstly, the possibility of the self-testing client spreading the virus to unsuspecting partners. Secondly, the self-testing client may fail to seek confirmatory tests or ART treatment in a health care facility. Under this theme is the assumption that a health care facility is public, and the subject may fear what other people, including the health care service providers, might say about them if they were to be seen seeking the HIV testing service. Thirdly, the psychological and emotional burden related to self-testing, which comes from the stress one endures after discovering that s/he has HIV, was constructed as significant.

Overall, the potential risks of self-testing for HIV appear to contradict and conflict with how the service is being constructed in the HTS policy as an alternative, which can facilitate the early detection of HIV, increase HIV testing uptake and frequency, especially in the previously untested population, the hard-to-reach population, and young key population, all of which are associated with decreased HIV-related morbidity, death, and transmission (Department of Health, 2016). In addition to this, the dominant language in the HTS policy tends to focus on making the HIV testing services available by increasing the number of points of service, such as self-testing, but fails to note that the number of points of service does not translate into access or use because of HIV-related stigma and the fear of testing positive.

However, despite the high hopes which the Department of Health (2016) places on the HIV self-testing initiative as enumerated above, the views of participants in this study on the negative consequences of testing positive for HIV under the self-testing modality could not be ignored. This is because this finding is consistent with the one reported by Govender and Schlebusch's (2013) study on the stress levels of HIV-infected clients in the immediate post-diagnosis period at a South African hospital. Govender and Schlebusch's (2013) study found that clients who receive an HIV diagnosis are often less able to distinguish between their sense of self and the virus, and in turn, construct and position themselves as being unhealthy, as infected, as contaminated, as powerless, as malfunctioning, and as hopeless. This negative self-talk exposes clients to potential harms, such as depression, guilt, the fear of degenerating health and later dying, suicidal ideation, and the desire to be vindictive (Govender & Schlebusch, 2013). A similar finding is reported in Goldstein et al.'s (2003) study on the social construction of HIV and AIDS in South Africa, and in Ritchwood et al.'s (2019) study on the utilisation of HIVST amongst rural youth in South Africa. Participating youth in Ritchwood et al.'s (2019) study, in particular, expressed concerns about whether the HIVST could be trusted due to the possibility of getting a false positive and negative result and whether the testing client could emotionally handle a positive result if they conducted the test on their own and alone.

While the low acceptance of HIVST observed in this study may partly relate to participants' limited knowledge about its availability and their lack of experience of self-testing for HIV in a private location, it is still in direct contrast with the report of previous research in South Africa demonstrating the acceptability of the HIVST amongst adults (Pérez et al., 2016), youth (Ritchwood et al., 2019), and university students (Higher Health, 2020). It also contrasts with the findings of a meta-analysis of initial trials on attitudes and acceptability of HIVST amongst key populations globally (Figueroa et al., 2015). For example, Figueroa et al.'s (2015) study concluded that most people (about 88%) who refused the healthcare-based approach to HIV testing due to HIV social stigma accepted the HIVST option, and the majority were young people. In the light of the findings of this study, therefore, it is important to note the point made by Day et al. (2004) that sometimes, the 'scientific evidence' available in the public domain in support of a particular discourse or health practice (for example, HIVST) is often presented in an oversimplified and exaggerated form. Overall, the findings of this study are critical, as they shed light on how strategies and interventions aimed at encouraging sexually active educated youth to know their HIV status outside traditional HIV testing sites (health clinic and ad hoc mobile testing tents) have worked, in comparison with the findings of successful trials globally and in South Africa.

In light of the findings of this study under this theme (HIV self-testing practice), it may be necessary to suggest that to overcome the potential risks of self-testing, and of testing positive for HIV, all participants constructed HIV testing as an act that needs organised support in the form of counselling. The counselling was constructed as a service provided by trained health care service providers in ad hoc mobile testing tents or primary health care facilities, including the campus health clinic. This suggestion is consistent with the findings in Ritchwood et al.'s (2019) study. However, this positioning of health care facilities as being safe and the construction of the health care service providers as protecting the client from the risks of self-testing contrasts with, and contradicts participants' earlier constructions of the HIV testing facilities as too visible and exposing, and their positioning of the health care providers as being judgemental, as stigmatising and as being suspicious of youth who go for HIV testing. This complexity suggests that with the introduction of HIV self-screening, there is an urgent need to develop relevant health services initiatives (such as hotline telephone counselling), which students at risk following the outcome of their HIV self-testing process can use for professional assistance.

6.6 Synopsis of the chapter

The significance of the findings of this discursive qualitative and exploratory study on university students' constructions of HIV risk and implications for their health practices, specifically HIV testing, were discussed and interpreted in this chapter. Some interesting trends that stand out from interpreting the significance of the findings of this study in relation to the three research questions of the study deserve some mention. These questions are: (1) How do sexually active university students draw on different discourses to construct HIV risk? What discourses do they draw on to construct HIV risk?; (2) How do sexually active university students construct and position themselves and others in relation to HIV risk? What rationalisations or justifications do they give for their position?; and (3) How do sexually active university students' constructions of, and positioning in relation to HIV risk, relate to their practice of HIV testing?

The significance of the findings of this study in relation to research question one is that young people have a way of describing, accounting for, or explaining the seriousness of HIV risk to themselves and others, which suggests that they are drawing on existing discourses of HIV risk in advertisements, the mass media, educational awareness programmes, health research, and interactions with health care service providers. In their justifications and rationalisations of their constructions of HIV risk, ten major discourses were identified. They include the discourse of seriousness of HIV risk; the discourse of unsafe sex as being very risky; the discourse of avoidance of HIV testing; the discourse of othering HIV risk; the discourse of HIV as a risk for black Africans; the discourse of HIV as a risk of the ignorant, uneducated, uninformed, rural youth; the discourse of HIV as a risk for a young woman; the discourse of silence about HIV risk and HIV testing; the discourse of prioritisation of pregnancy rather than HIV risk; the discourse of the feminisation of HIV risk prevention through testing; the discourse of the invisibility of HIV risk; the discourse of the visibility of HIV risk; and the information, education, and communication health framework.

The significance of the findings of this study in relation to research question two is that although most participants constructed and positioned themselves as being aware of how serious the threat of HIV is in their setting, they distanced themselves from this risk. This relates to the negative identity of being HIV positive, having a visible sickness, with a body severely affected, wounded, degraded, and attacked, which then also puts one at risk of stigma. In this situation, the positions which are available to them are limited, and the discourses that are available in their context limit their health actions and practices, particularly their engagement with HIV testing as a protective practice. It is as if prioritising HIV prevention through testing does not help them in the development of their desired identity. In fact, it seems to generate a negative HIV identity, and this works to undermine the value of HIV testing in their everyday life. Thus, their avoidance of HIV testing is one of their many small actions to protect themselves from the negative identity, and from knowing it, and others from associating it with them.

The significance of the findings of this study in relation to research question three is that young people do not test for HIV regularly, and that testing is not part of their management of risk. Those who reported testing did it in a crisis. They were concerned about being infected with HIV after engaging in unprotected sex, or concerned about being betrayed by a partner and being exposed to HIV risk, or concerned about symptoms related to having AIDS. Therefore, this means that HIV testing itself does not reduce the risk for these participants. Testing is about earlier access to care when they test positive to minimise negative treatment outcomes and encourage onward transmission prevention.

To conclude this thesis, the next chapter will give an extended summary of what the study was all about, its conclusions and implications, and strengths and limitations, and some recommendations for public policy and practice as well as for future research.

CHAPTER SEVEN: CONCLUSION

7.1 Introduction

The key argument of this thesis, it would be recalled, is that although many pieces of research on HIV risk and the HIV testing practices amongst university students in South Africa exist, most of such studies had tended to focus on the use of the traditional research design (such as the questionnaire) to investigate students' perceived susceptibility to HIV risk, descriptive barriers to, or motivators for HIV testing, and attitudes towards HIV testing. Most of them had done this drawing largely on the assumptions of the positivist approach, which tended to construct knowledge as something intrinsic in people's cognitions, rather than being inherent in the community and culture in which people were born and raised. This study deviated from this more common focus into adopting a qualitative research design informed by a discursive approach to explore, identify, label and interpret discourses drawn on by student participants in their discussion of HIV risk and the positions they take in relation to this risk, and their implications for HIV testing practices in one university in South Africa. Thus, the rationale behind this study was based on the assumption of the discursive approach, that discourses imply social action, which means that discourses structure and order people's lives in terms of behaviours, activities, and practices (Alldred & Burman, 2005). Given this understanding, this thesis argued that engaging in a discursive analysis of university students' constructions of HIV risk and HIV testing and discourses they draw on would potentially produce much knowledge about their positioning in relation to HIV risk and HIV testing practice, and whether or how they engage with testing as a protective strategy. In this chapter, the conclusion of this study is, therefore, presented. The chapter begins by mapping how each research question has been addressed, followed by concluding remarks. It also provides an account of the contributions of this study and recommendations on ways to promote HIV testing and the frequency of testing amongst youth. This is followed by a presentation of the limitations of the study, and suggestions for further research on the topic of HIV risk and HIV testing.

7.2 Research Question One: How do sexually active university students draw on different discourses to construct HIV risk? What discourses do they draw on to construct HIV risk?

The majority of participants constructed HIV as being a severe threat in their setting, and felt threatened by this risk, or the risk of contracting it. In their justifications and rationalisations, they focussed on the presence of ART treatment, rendering HIV risk invisible in the ‘everyday’ life. They also referred to the silence surrounding HIV and HIV testing amongst students on campus and in their relationships, which is related to HIV stigma. They also talked about the fear of potential consequences of having HIV, such as losing weight and being diarrhoeic, a severely degraded body. These constructions seemed to be directly related to their extreme fear of being positive and what this would mean for their lives. A few participants constructed HIV as a threat but not a significant one. However, the main issue here is that being HIV positive was still being constructed as an extremely stigmatised identity, and it is to be avoided at all costs. Overall, these justifications and rationalisations suggest that these participants drew their constructions of the seriousness of HIV risk to themselves and others on existing discourses in advertisements, the mass media, educational awareness programmes, health research, interactions with health care service providers and peers, and their experiences of health care on, and off campus. This is in line with the social constructionist assumption that people rely on a common stock of knowledge entrenched within existing discourses, everyday language, and shared meanings and understandings (Parker, 1992; Maticka-Tyndale, 1992).

7.3 Research Question Two: How do sexually active youth construct and position themselves and others in relation to HIV risk? What rationalisations or justifications do they give for their position?

Tensions and contradictions within each participant’s positioning were identified in terms of their positioning in relation to HIV risk. Some participants positioned themselves as at risk of HIV and as being responsible, but gaps in their protective practices (condom use and HIV testing) were identified in their accounts. Others positioned themselves as being invulnerable to HIV risk, but they did not report any protective measures when talking about their sexual activities or engagement in couple HIV testing. Others reported having more than one sexual partner, but positioned their partners as being responsible for creating the risk of HIV for them while ignoring their own multiple partnering. Others constructed HIV as being present in everyday life but not directly related to themselves, and viewed it as a risk for other people (other university students and rural youth). Others positioned themselves as being at risk of HIV, but not at fault. These participants positioned other people as being responsible for creating a risk for them, such as a cheating partner, a violent male rapist who is HIV positive, or at risk from non-sexual transmission routes, such as exposure to contaminated blood, or ‘touching others’. Others positioned themselves as being potential victims of health policies designed ostensibly to ‘help’ people living with HIV were turned on them. These participants constructed the availability and use of ART treatment as a threat to them because of the way in which it invisibilises HIV. There are, of course, contradictions in this construction in the sense that HIV is never visible, whether one takes ART or not. However, this subject positioning of one being at risk of HIV but not being entirely responsible for creating it (because other people cause it through their problematic practices such as cheating, raping, or treating HIV with ART) found amongst the majority of participants positions them as unable to defend themselves against HIV. This positioning draws on a victim discourse, and has implications. It makes one a ‘better person’, and enables a distancing from risk. In other words, it enables one not only to surrender responsibility for HIV risk, but also to paralyse it (one cannot be agentive).

7.4 Research Question Three: How do sexually active university students’ constructions of, and positioning in relation to HIV risk, relate to their practice of HIV testing?

Drawing on the key issues identified in relation to Research Question One and Two, this study concludes that, although most participants constructed and positioned themselves as being aware of how serious the threat of HIV is in their setting, they distanced themselves from this risk. This relates to the negative identity of being HIV positive, a visible sickness, a body severely affected, wounded, degraded, and attacked, which puts one at risk of stigma. In this situation, the positions which are available to them are limited, and the discourses that are available in their context limit their health actions and practices, particularly their engagement with HIV testing as a protective practice. The HIV testing practices of most participants suggest that they do not test regularly, and that testing is not part of their management of HIV risk. Those who reported testing for HIV did it in a crisis. They were concerned about being infected with HIV after engaging in unprotected sex, or concerned about being betrayed by a partner and being exposed to HIV risk, or concerned about symptoms related to having AIDS. The participants’ practices in relation to HIV testing suggest that this group of youth do not engage in it in the way that is medically advised, that one should ‘do the initial test’, then ‘do a confirmatory test’, and ‘maintain a testing behaviour’. This, by implication, represents a missed opportunity in getting university students to know their HIV status through testing and offering them HIV prevention and management options.

This study’s conclusion in relation to this research question is guided by the assumption of social constructionism that people have identity investments in drawing on certain discourses and incorporating them into their repertoire, particularly those that bolster or affirm their self-identity and excludes others, and this has consequences for their actions and practices (Parker, 1992). In line with this assumption, it is as if young people at the university prioritise their sexual relationships and identity, which they have constructed, built and maintained through their sexual relationships. This relates to the benefits an individual accrues in these processes. It is as if, for them, prioritising HIV prevention through testing does not help them in the development of their desired identity. In fact, it seems to generate a negative HIV identity, a blemished identity (one blemished by sores on the body, a wasted body etc.), and this cannot be their preferred identity. This problematic HIV identity works to undermine the value of HIV testing in their everyday life. For youth, HIV testing comes with multiple possibly stigmas-HIV positive outcomes, admission of sex, admission of risky sex and infidelity. Therefore, HIV testing of oneself may be avoided. Thus, this avoidance of HIV testing is one of their many small actions to protect themselves from the negative identity, and from knowing it, and others from associating it with them.

Moreover, it is clear from the analysis of participants' constructions and positioning that there is little power in a person knowing their HIV status. There is more power in one acting as if they are still HIV negative, i.e. avoiding knowing about it. As soon as one is confirmed HIV positive through testing, there is an immense loss of power and status, and one is stigmatised.

Overall, this discursive study of HIV risk and HIV testing has opened up space for several issues elucidated by some students at a South African university to be heard. The next section will attempt to present what this study has contributed to the current research problem.

7.5 Contributions of the study

One of the significant contributions of this study is the effort it has made to explore how sexually active students at a South African university engage with HIV risk, how they construct and position themselves in relation to it, what discourses they draw on, and where they place themselves in terms of HIV testing. This broad and more focussed way of identifying, describing, understanding and interpreting discourses at work in participants' accounts has enabled me as the researcher to understand how discourses facilitated and limited, enabled and constrained what can be said about HIV risk and HIV testing by this category of youth. This has enabled me to understand how the practice of not testing works amongst this group of youth.

For example, most participants constructed HIV testing as risky, and as exposing one to the risk of stigma in the context where an HIV identity is vilified. This has, therefore, enabled me to see participants' lack of testing as not irrational as assumed in many interventions drawn on the assumptions of the positivist approaches, but as doing something very particular in their life. In fact, I have come to the realisation that not testing for HIV does not mean that this group of youth does not know enough about HIV risk, or that they are deliberately abdicating responsibility for their own safety. Instead, not testing is their way of protecting themselves from stigmatisation, and from the fear of knowing that they have HIV. An investment in not testing is, therefore, an identity investment. I also learnt that if these youth happen to test for HIV, the activity is fraught with difficulties; they test infrequently, or in crisis. Most participants also did not see self-testing for HIV as a viable option for them and others to know their status. This is related to their fear of an HIV diagnosis, which is a negative identity. The significant contribution of this study, therefore, is the idea that HIV testing is not part of youth's everyday practices for significant and fundamental reasons. It is this different perspective, and reality about HIV testing health practice that needs to be considered in health policies and interventions designed to implement these policies.

Almost related to the above, another important point to highlight in this study is the concern that students have about being known to have HIV, and how the testing conditions (the site and people involved) are facilitative or supportive of exposing, or keeping the process confidential. This concern sheds light on the need to review discourses in HIV testing policies to expand delivery options that have the potential to address risks related to stigma and unintentional breach of confidentiality in testing sites.

Another significant contribution of this study is that heterosexual relationships amongst young people in the university context have particular dynamics. In such relationships, the only thing possible is for women to be responsible for HIV testing. This is the only position 'allowed', or 'afforded'. It is not possible for men to take on testing responsibility (there is no position for that). When women take it on, they might do it 'through the back door', i.e. secretly, alone (and perhaps this is to some degree exercising agency); it is in a fraught and difficult way. Women in such situations are fearful, cannot communicate the outcome of their action (testing) to their partners, and are blamed and held responsible for their actions. The contribution of this study, therefore, is the idea that while HIV prevention interventions encourage youth to take responsibility for HIV testing, particularly couple testing in sexual relationships, it is not always that simple. A woman cannot engage in a process (HIV testing) regularly and 'properly'; it has substantial social costs for her (the risk of being stigmatised, or rejected by a partner, or losing the relationship). Her action also depends on whether her partner agrees to it.

Related to the above, another novel contribution of this study to the field of HIV risk and HIV testing among youth in South Africa is that young people tend to use their sexual relationships to explain their actions. For instance, in some of the participants' accounts, it seemed less about the positioning of the female or male as mere victims of their partner's behaviours, but that the construction of love/trust and relationships was used to justify why they did not position themselves as at-risk. This positioning of a low-risk subject justified their passivity regarding HIV testing, and allowed them to maintain the status quo even though they previously mentioned their concerns as individuals in a relationship.

This study has also generated data that has affirmed the idea emphasised in the discursive research literature (Alldred & Burman, 2005; Brown, 1995; Conroy et al., 2013; Day et al., 2004; Goldstein et al., 2003), that certain discourses in the health initiatives on a given health practice like ART, might not match or reflect the experiences or realities of the receivers of the health messages. For example, the dominant medical discourse constructs ART treatment as having the potential to transform the HIV-infected body, and make the subject look healthy and lead an ordinary life (Department of Health, 2016). In this study, this treatment approach was constructed as a problematic intervention. In participants' view, with the impact of ART, the usual signs of the manifestation of AIDS in the HIV-infected body are suppressed, and therefore invisibilised. Participants argued that their ability to manage HIV risk or defend themselves from this risk is compromised, which is their primary concern. Therefore, they are at the mercy of silent HIV and silent (undisclosed) people, and this construction appears to be drawing on a victim discourse, and has implications. A consequence of these constructions is that these participants are positioned as not doing anything about their practices, but perhaps wish and desire to have HIV visible (maybe to face a known risk), or those who have it to do self-disclosure, and then they would feel more able to respond to it.

Moreover, there is a general lack of recognition of the position of youth who are the receivers of the health care services in public health debates and interventions. Often young people are placed in the 'lay' position, as passive subjects. There is little recognition that youth may have distinct perspectives concerning the health practices they are encouraged to engage in. This discursive study of HIV risk and HIV testing with youth has shown that young people are active in telling their stories, ideas, experiences, or cultural meanings of HIV risk, how they negotiated it, alongside what they do to protect themselves from it, might not be in the way which is desired medically. In my discursive exchange with participating students, I noticed that they seemed to reflect on some of the issues about HIV risk and HIV testing as we talked about. In some instances, before rounding up the interview session, I asked each participant if there were anything they would like to take out, or add to our discussion. Their responses suggested that our conversations enabled them to reflect on their past, on their present, and on their future status in relation to their sexual, and HIV testing, practices in the context of HIV and AIDS. While I am uncertain if the chance to reflect with me was beneficial to the study participants, this study somehow has offered some social value to the students who took part in it, which is something stressed by Emanuel et al. (2004) and Wassenaar and Mamotte (2012), who remarked that good researchers must have a social value or something important to contribute to transforming the lives of the people. Overall, this study has highlighted two significant issues. Firstly, youth tend to prioritise investment in self (and the relationship), and in doing this, personal safety against HIV infection is constrained. Secondly, the disjuncture between how certain discourses are drawn on in the HIV testing policies (and interventions designed to implement these policies), and the experiences or realities of those who receive them, for example, youth at the university. This means that interventions and services drawn on these policies might not meet the health needs of students. Taking this reality into account, the next section, therefore, illustrates some recommendations for improved health policies and any planning of interventions to implement these policies.

7.6 Implications of the findings of the study for policy

It is evident from the findings of this study that the ad hoc mobile testing tents are public, visible and exposing those who go for testing to the risk of being stigmatised, and this raises critical issues for planning health intervention. The ad hoc mobile testing tents are highly effective in getting people through the door (compared to fixed-site clinics). So, despite the challenges, they still ‘work’. It is, therefore, recommended that a review of the processes through which HIV testing services are being provided in non-medical sites is needed. In doing this, attention needs to be given to the privacy and anonymity of HIV test clients, and client-provider interactions to ensure that the testing environment makes students feel completely safe and comfortable.

7.7 Implications of the findings of the study for practice

It is clear from the findings of this study that HIV testing needs to be understood in the context of the gendered social organisation in this University context. It is clear from the findings of this study that there is a vast social structure of inequality in gender in heterosexual relationships, and young women find communication about HIV risk and HIV testing very difficult in such context. In their view, it is not possible to test for HIV as a couple (mostly) due to the fear of partner rejection if the results turn out to be positive. Health interventions, therefore, need to acknowledge the construction of self (identity) in the context of a sexual relationship. Interventionists can perhaps build small groups with young female students in this University where harmful gender norms can be challenged. Women also need to be encouraged to continue with such discussion in their relationships. Such initiatives could contribute to enhancing women's agency to self-protection.

Related to the above, the act of men not being willing to listen to, or accept the idea of couple testing in their relationships, is problematic. It is, therefore, recommended that HIV testing service provision to young men needs to be thought of differently. Perhaps having discussions with young men to challenge harmful gender norms and de-stigmatise HIV testing, or places where men can talk about sexual health, is useful. However, such initiatives need to be in an online platform, which is anonymised (for example, SAfm radio has a slot about men's health, and it is quite remarkable how many men are asking questions).

While the trend in the accounts of most participants in this study had constructed HIVST as a problematic intervention, particularly if one was to receive a positive HIV result, this finding must not be considered in isolation from the findings of the initial trials in South Africa. The initial HIVST trials demonstrate the acceptability of self-testing amongst adults (Pérez et al., 2016), youth (Ritchwood et al., 2019), including university students (Higher Health, 2020) in South Africa. This is said because most participants (18) in this study positioned themselves as not being aware of the availability of the HIVST kit. This thesis, therefore, maintains that, if strengthened, the HIVST has the potential to address the current barriers to HIV testing uptake, including social stigma, discrimination, and breach of confidentiality. This is because self-testing shifts the focus away from the traditional testing sites where these barriers were located. It also gives students more opportunities to know their HIV status at their places of residence or home, especially now that the university operates virtually to control the spread of the coronavirus. It is, therefore, recommended that the health promotion agencies on the

Pietermaritzburg campus (CHASU, campus health clinic, Student Support Services) need to intensify and expand their focus to increase awareness, distribution and social marketing of the HIVST compact kit. The awareness programmes should also involve sexual partners, peers, family, and the health care service providers as they are critical influencers of decision-making processes.

The HIVST compact kit is currently available in commercial outlets only in South Africa. A casual perusal of its cost is between R70 to R80, depending on the pharmacy, an indication that it may not be affordable to youth within the age range of 18-24 years as the majority are full-time students, either at the undergraduate, or honours level. Thus, making the HIVST kit accessible for free in less traditional access points on the Pietermaritzburg campus, such as dispensing machines at the toilets, university hostels, the CHASU offices, the Student Support Services offices, and the campus health clinic, in the same way, the male condom and female condom is being distributed, may motivate students to use it to know their HIV status. The peer education mentors may be used to do secondary distribution of the HIVST kit to students on, and off campus residence. Furthermore, given that the university is currently operating remotely, technological alternatives, such as online videos, hotline telephone numbers, Telegram, Instagram, Facebook, Twitter, WhatsApp, Zoom, to mention a few, can be utilised for assistance on how to use the HIVST kit. They can also be used to make support services immediately accessible in the event that the result is positive, that the self-testing student cannot handle it.

The recent Higher Health (2020) annual report observed a decline in HIV testing figures by about 41% in 2019 and 2020 compared to the previous year (2018) in South African tertiary institutions. Higher Health (2020) attributed this to the decline in the health and wellness days in many university campuses in South Africa. In this study, one female participant (Sarah) referred to her participation in the health and wellness day (AIDS WALK), and constructed it as normalisation of HIV testing. She said that she used that opportunity to know her HIV status, and called for more such activities on the Pietermaritzburg campus. In line with Sarah's suggestion, it is recommended that the health promotion agencies on the Pietermaritzburg campus consider organising more health and wellness days on campus to give students more opportunities to know their HIV status.

Given, as indicated in this particular section, that youth at the university are still reluctant to engage in HIV testing despite high access to the testing resources on, and off campus, the production of alternative HIV prevention approaches is suggested. These should include ways that do not rely on one going to a health care facility to do an HIV test, or to access a condom, which might expose one to the risks of stigma or coronavirus infection; or sex abstention, which is not always possible in a romantic relationship; or taking regular or near-daily pre-exposure prophylaxis pills. The long-acting pre-exposure prophylaxis injection could serve as this alternative. In what is being constructed as a significant collaborative and breakthrough clinical trial in seven sub-Saharan countries, Prof Sinead Delany-Moretlwe reported that cabotegravir pre-exposure prophylaxis injection is 89%, or nine times more effective in preventing the threat of HIV amongst women compared to the daily pre-exposure prophylaxis pill (Van Tilburg, 2020, November 2020). Based on this understanding, it is recommended that the University of KwaZulu-Natal management need to consider making the cabotegravir pre-exposure prophylaxis injection available to its students to supplement existing HIV prevention methods on its campuses.

Although it might be challenging to implement all these recommendations, particularly in this period of the coronavirus pandemic, which has necessitated that all universities adopt remote learning, these recommendations should not be ignored. Perhaps most importantly, their implementation can start by creating a platform for engagement, which may take the form of student dialogues, individual discussions, and an interdisciplinary partnership with various university stakeholders. Such engagements could chart ways to encourage youth to adopt alternative ways to protect themselves from the threat of HIV, for instance, adherence to pre-exposure prophylaxis, correct and consistent condom use, and HIV testing.

However, there are a few limitations to this study, as shown in the next section.

7.8 Limitations of the study

While every effort was made to recruit an equal number of male and female student participants as much as possible in this study, this was not achieved as only five out of the 20 participants interviewed were men. Only female participants responded to my advert placed on the University’s noticeboard calling for volunteers. I approached over ten potential male participants through snowball sampling. Although all of them tentatively agreed to be interviewed on the agreed date, only five showed up for the interview. Incidentally, while the findings and conclusions of this study represent the ideas of the majority of female participants (15) and a few male participants (5), there were, interestingly, no significant differences in their constructions and positioning. Therefore, while I acknowledge not recruiting more male participants as a potential limitation, I am confident that this could have had little effect on my findings and conclusions.

Moreover, at a more conceptual level, as much as have I tried to be objective in presenting my findings and conclusions, I cannot claim that this is free of my bias. I am aware that being the author of this work, I am presenting a particular kind of knowledge about HIV risk and the practice of HIV testing amongst sexually active educated youth, which is subjective, and located within a specific time and context, and therefore open to debate. This was addressed critically in Chapter Four, where I reported all the research processes I followed, all the research decisions I took, and my perspectives about the research problem.

Finally, I would like to propose some areas that require further investigation concerning the current research problem.

7.9 Suggestions for future research

Shenton (2004) argued that understanding human behaviour and practices emerge slowly and non-linearly. This study focused on the topic of HIV risk and HIV testing amongst students on the Pietermaritzburg campus of the University of KwaZulu-Natal, only. One of its significant finding is the gendered structure of sexual relationships amongst educated youth. This was evidenced in the way young women prioritised keeping the relationship with a man, and compromised their own safety, particularly in relation to negotiating HIV risk and HIV testing practice. Thus, more work related to how communication happens in heterosexual relationships in the context of sexual and health risks, is suggested. In particular, more focussed work with young male university students on whether and how they construct themselves as safe, or unsafe in relation to HIV risk, is proffered. The findings of such studies may help to stimulate the promotion of constructive dialogue amongst policymakers, interventionists, and university students who need to engage in debate on discourses in use to craft compelling messages that encourage youth to personalise the threat of HIV and prioritise HIV testing in their everyday life.

In this study, rural youth were constructed as not knowing enough about HIV risk and HIV testing, and as less able to take responsibility for themselves, and as not engaging actively in HIV testing. More research amongst rural youth in South Africa would be valuable since such group of youth might reflect different constructions of, and positioning in relation to HIV risk, and related shifts in identity.

Although making the HIVST compact kit accessible to youth has been recommended in this study, as having the potential to address the issue of stigma and mistrust in the medical system, and of course, the spread of coronavirus, the findings of this study suggested that some educated youth have little knowledge about it. This finding contradicts the findings of initial trials in South Africa (Higher Health, 2020; Pérez et al., 2016; Ritchwood et al., 2019) and elsewhere (Figueroa et al., 2015). Further research on how much youth know about it and specific situations, circumstances or experiences of using it is, therefore, recommended. Such research may shed light on how strategies and interventions to encourage youth to know their HIV status outside a clinic setting have worked, and compare them with the findings of this study, and the above initial successful trials in South Africa.

Lastly, the difficulties of creating private, confidential and youth-friendly HIV testing avenues was evident in this study. Youth involvement in a participatory study to 'design' an HIV testing process is suggested. Such a study may guide health promotion agencies and policy reviewers to chart ways to enhance the confidentiality of the testing subject.

To end this thesis, I wish to reiterate the position I have maintained throughout this discursive study about the absence of objective reality but a socially constructed reality. Social identifiers are constructed in social constructionist research as influencing how subjects position themselves in the discussion (Burr, 1996; Gale, 2010; Silverman, 2013; Parker, 1992). This being social constructionist research, I was mindful that each participant's way of responding to the questions I asked during my interaction with them might be related to who they think I was and how they were trying to present themselves to me in relation to the research problem, and that my interpretations of their accounts can only be limited to these participants. I do not, therefore, claim that my understanding of their constructions and positioning and the broad discourses I identified in this study have intrinsic value or general 'truth'. My focus was to analyse and interpret the data to represent social reality concerning the research problem or, at least, represent 'reality' as interpreted by the participants. With inspiration from Parker's (1992) emphasis on the co-existence of multiple ways of constructing an object depending on the perspectives of the receiving audience (for example, the researcher like myself), I am confident that the conclusions I have reached in this final chapter should be taken to reflect the understanding that I have acquired after a journey of exploring the problem of HIV risk and HIV testing health practice in my interactions with 20 educated youth aged 18-24 years at a university in South Africa.

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APPENDICES

Appendix 1: Advert

ARE YOU A SEXUALLY ACTIVE STUDENT AGED 18–24 YEARS?

I am looking for students from the University of KwaZulu-Natal, Pietermaritzburg campus to be part of my PhD study, which focuses on HIV testing amongst youth.

This will be done through an individual interview session with you.

If you are interested in participating in this study, please contact me by:

- Email- hivtestingstudy29@gmail.com
- Call or SMS- **contacts deleted**
- Send a "please call me" to- **contacts deleted**
- WhatsApp-**contacts deleted**

PLEASE NOTE: THE DISCUSSIONS ARE CONFIDENTIAL!!!

hivtestingstudy29@gmail.com **cell no: contacts deleted**	hivtestingstudy29@gmail.com **cell no: contacts deleted**	hivtestingstudy29@gmail.com **cell no: contacts deleted**	hivtestingstudy29@gmail.com **cell no: contacts deleted**	hivtestingstudy29@gmail.com **cell no: contacts deleted**	hivtestingstudy29@gmail.com **cell no: contacts deleted**	hivtestingstudy29@gmail.com **cell no: contacts deleted**	hivtestingstudy29@gmail.com **cell no: contacts deleted**	hivtestingstudy29@gmail.com **cell no: contacts deleted**	hivtestingstudy29@gmail.com **cell no: contacts deleted**	hivtestingstudy29@gmail.com **cell no: contacts deleted**

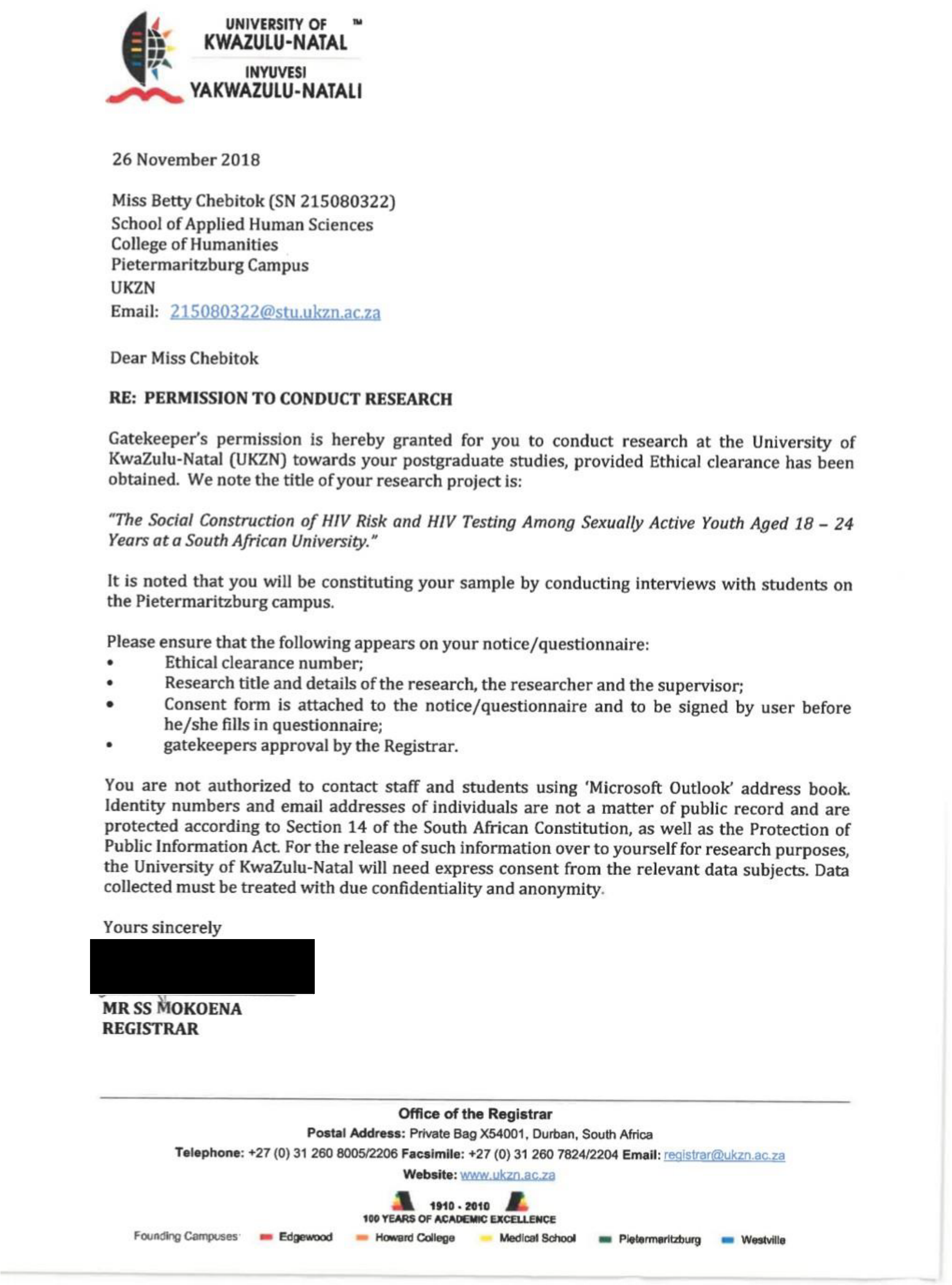
Appendix 2: Demographic sheet

PLEASE NOTE: The information is collected to save time during the actual interview sessions, and I guarantee you that your identity will be kept CONFIDENTIAL
(Please tick option(s) that describes you)

What is your name? (please choose a pseudonym/ fake name)								
What is your age in years?		18	19	20	21	22	23	24
What is your gender?			male	female	other (specify)			
What is your race?	African	White	Coloured	Indian	other (specify)			
What is your nationality?		South African citizen			other (specify)			
What is your marital status?		married living with husband/wife		married not living with husband/wife			Not married living with boyfriend/ girlfriend	
		single	Widowed/divorced/separated/ registered partnership			other (specify)		
What is your College and Discipline/course? (Please specify)								
What is your level of university education?			undergraduate		postgraduate			
What is your sexual orientation		Heterosexual/LGBTIQ+/Other						
What is your type(s) of sexual relationship		one sexual partner		more than one sexual partner				
		Partnership in exchange for money/gift				other (specify)		
How old is your partner? (Please specify age in years)								
Do you have a child? If yes how many								
Religion								
Setting (home)		Rural area Urban area Township semi-urban area						

Please remember to carry this form when coming for the interview session.

Appendix 3: Gatekeeper's permission



UNIVERSITY OF KWAZULU-NATAL™
INYUVESI YAKWAZULU-NATALI

26 November 2018

Miss Betty Chebitok (SN 215080322)
School of Applied Human Sciences
College of Humanities
Pietermaritzburg Campus
UKZN
Email: 215080322@stu.ukzn.ac.za

Dear Miss Chebitok

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 studies, provided Ethical clearance has been obtained. We note the title of your research project is:

"The Social Construction of HIV Risk and HIV Testing Among Sexually Active Youth Aged 18 – 24 Years at a South African University."

It is noted that you will be constituting your sample by conducting interviews with students on the Pietermaritzburg 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

[redacted]

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

Appendix 4: Ethical approval

UNIVERSITY OF KWAZULU-NATAL™
INYUVESI YAKWAZULU-NATALI

17 August 2021

Ms B Chebitok (215080322)
School of Applied Human Sciences – Psychology
Pietermaritzburg Campus

Dear Ms Chebitok

Protocol reference number: HSS/0005/019D
Project title: The social construction of HIV risk and HIV testing among sexually active youth aged 18-24 years at a South African university
Amended title: The social construction of HIV risk and implications for HIV testing health practices amongst sexually active youth at a South African university

Approval Notification – Amendment Application

This letter serves to notify you that your application and request for an amendment received on 14 December 2020 has now been approved as follows:

- Change in Title

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form; Title of the Project, Location of the Study must be reviewed and approved through an 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.

All research conducted during the COVID-19 period must adhere to the national and UKZN guidelines.

Best wishes for the successful completion of your research protocol.

Yours faithfully

[redacted]

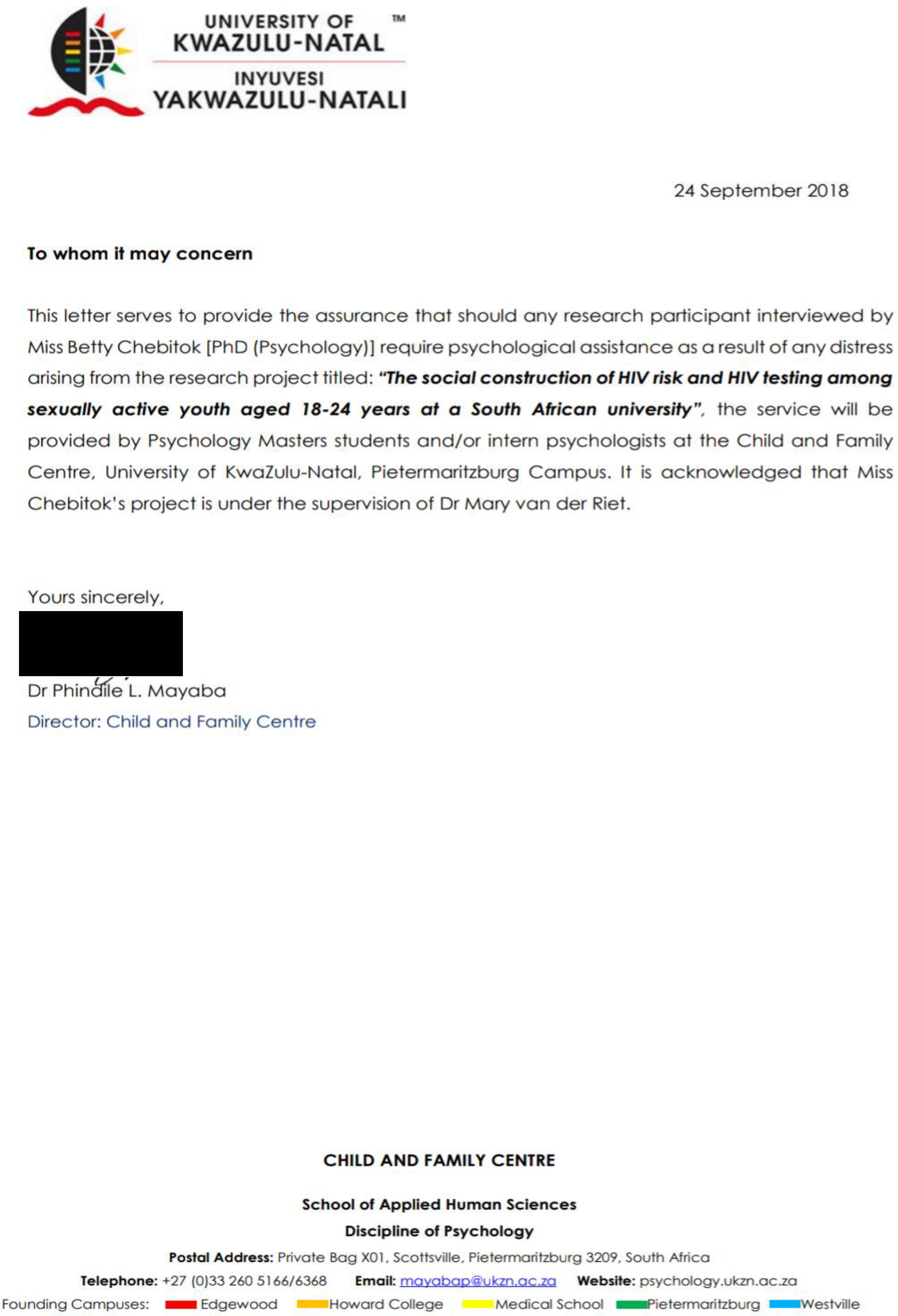
……………………………………………
Professor Dipane Hlalele (Chair)

/ms

Humanities & Social Sciences Research Ethics Committee
UKZN Research Ethics Office Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Tel: +27 31 260 8350 / 4557 / 3587
Website: http://research.ukzn.ac.za/Research-Ethics/
Founding Campuses: 🟥 Edgewood 🟧 Howard College 🟨 Medical School 🟩 Pietermaritzburg 🟦 Westville

INSPIRING GREATNESS

Appendix 5: Permission from the Child and Family Centre



UNIVERSITY OF KWAZULU-NATAL™
INYUVESI YAKWAZULU-NATALI

24 September 2018

To whom it may concern

This letter serves to provide the assurance that should any research participant interviewed by Miss Betty Chebitok [PhD (Psychology)] require psychological assistance as a result of any distress arising from the research project titled: ***"The social construction of HIV risk and HIV testing among sexually active youth aged 18-24 years at a South African university"***, the service will be provided by Psychology Masters students and/or intern psychologists at the Child and Family Centre, University of KwaZulu-Natal, Pietermaritzburg Campus. It is acknowledged that Miss Chebitok's project is under the supervision of Dr Mary van der Riet.

Yours sincerely,

[redacted]

Dr Phindile L. Mayaba
Director: Child and Family Centre

CHILD AND FAMILY CENTRE

School of Applied Human Sciences
Discipline of Psychology
Postal Address: Private Bag X01, Scottsville, Pietermaritzburg 3209, South Africa
Telephone: +27 (0)33 260 5166/6368 **Email:** mayabap@ukzn.ac.za **Website:** psychology.ukzn.ac.za
Founding Campuses: 🟥 Edgewood 🟧 Howard College 🟨 Medical School 🟩 Pietermaritzburg 🟦 Westville

Appendix 6: Individual Interview questions

1. You have volunteered to be part of a study on HIV testing, why?
2. How serious do you think the HIV epidemic is in South Africa?
    a. Are some people more at risk of HIV than others? If yes, how? If no, why?
3. How serious do you think the HIV epidemic is on the Pietermaritzburg campus?
    a. How does that make you feel about your risk of HIV?
4. What does HIV risk mean to you?
    a. Explain to me then when do you think you might be at risk of HIV?
5. What does HIV testing mean to you?
6. Have you ever tested for HIV?
7. If no, where are you with the idea of testing for HIV?
    a. What are your reasons for not going for an HIV test?
    b. Will you consider testing for HIV at all? Why? Why not?
8. If yes, please tell me about your experience regarding your most recent HIV test.
    a. What were your reasons for testing? When was it?
    b. Where did you visit for the test? Can you explain why?
    c. How did you expect the actual HIV testing activity to be like?
    d. Whom did you go with? Can you explain why?
    e. What did you do? How did it make you feel?
    f. What did you do with the test result?
    g. How did you feel about the counsellor who attended to you?
    h. How do you wish HIV testing had happened differently?
    i. Will you consider going for an HIV test again? Can you explain why?
9. How do you see this new idea of self-testing for HIV?
    a. Would you recommend it? If yes, how? If no, why?
10. Has HIV risk ever been of concern to you and your partner? When? How
    a. How is HIV testing decided/negotiated?
    b. How do you feel about testing for HIV together?
    c. How is your partner's attitude towards HIV testing? How do you deal with it?
    d. Have you experienced any violence in your relationship? Can you explain how?
        i. How did you deal with it?

Appendix 7: Interview Information sheet

25/07/2018

Introduction

Thank you for agreeing to participate in the individual interview. This document is intended to provide you with information about the study and your role within it. To participate in the study, you MUST be a student registered at the University of KwaZulu-Natal, Pietermaritzburg campus and aged between 18 and 24 years. If you do not meet all these requirements, kindly note that you will not be allowed to participate in this study. My name is Betty Chebitok, a Doctoral student in Human Sciences (Psychology) from the Discipline of Psychology, School of Applied Human Sciences, College of Humanities at the University of KwaZulu-Natal, Pietermaritzburg campus. If you have any questions, you would like to ask, and you are welcome to contact me at (**contacts deleted** or email (hivtestingstudy29@gmail.com). You can also contact my research supervisor Prof Mary van der Riet at (033 260 6163 or email vanderriet@ukzn.ac.za).

The interview processes

You are being invited to consider participating in a study that involves sexually active students' talk about HIV risk and HIV testing at the University of KwaZulu-Natal on the Pietermaritzburg campus. I will not discuss your HIV test status with you unless you are willing to talk about it. If you choose to enrol and remain in the study, the duration of your participation is expected to be one hour. At the session, I will ask you to talk about how you understand HIV risk, whether you have been tested for HIV. If you have, I will ask you to talk about your experience and what motivated you to take up the test, and if you have not tested, I will ask you to talk about why you have not tested. I will also ask you to talk about your role in negotiating HIV risk in your relationship, the challenges that confront you and how you resolve them. I am looking at your accounts of the practice of HIV testing. Therefore, there is no right or wrong answer. You are encouraged to talk freely and informally. Please note that your participation is voluntary, and you are not being coerced to be part of the study. You are also free to leave the session any time you wish to with no adverse consequences. At this time, I do not foresee any circumstance that will result in your termination from the study should you meet the participation criteria described in the introduction section. The interview session also will involve procedures highlighted in the next sections.

Confidentiality

The data will be available to me as the researcher and my supervisor. All the information that you will give during the session is strictly confidential. The notes and records that identify you will be kept confidential to the extent possible by law. Your identity will be kept confidential in the process by using a pseudonym of your choice, and your name will not be disclosed or linked to their data.

Recording the discussion

The interview will be recorded with two digital devices, and you will be asked to consent to the recording. This is done to ensure my full focus on the interview and not get distracted by taking detailed notes. However, I might take small notes as the discussion goes by. I will personally transcribe these recordings into a written form. In the process, I will still refer you by your pseudonym. I will then delete all the recordings on the digital recorders. I assure you that your name will not be linked to the recording or the written information from the recording. I will use the code/fake name of your choice, for example, Participant 1, Yellow etc.

The use of the data

The transcriptions will then be analysed, and a report will be produced. This report will be used for my PhD degree in Psychology, and it will be examined by two national examiners and one international examiner in the Discipline of Psychology. The data may also be analysed further in future studies. The findings of the study might also be reported at the conferences, and they may be used to write journal articles. In all these, your identity will be kept confidential by using a pseudonym assigned to you. A brief synopsis of the findings will be made available to you upon request.

Storage of the research data

The transcriptions of the discussion will be kept for future research purposes, such as additional analysis. They will be stored for five years in a locked cabinet in my supervisor’s office and any other materials relating to the research; after that, they will be destroyed. Moreover, to keep your identity confidential, all the data will be stored separately from information that links it to your actual name.

Possible risks of participating in the study

At this time, I do not foresee any risk that the research may cause you by participating in it. However, HIV is a sensitive issue, and discussions related to it might raise social or emotional distress. Please note that you have no obligation to answer any of the questions you do not want. I have organised free counselling services for you at the Child and Family Centre (CFC) in the Discipline of Psychology at the University KwaZulu-Natal, Pietermaritzburg Campus. At the CFC, you can contact Mr Zamani Zwane (Tel. 033265166 or email ZwaneZ@ukzn.ac.za) for an appointment with the student psychologist or an intern psychologist. There are also free counselling services available at the Student Support Service Unit for all students on this campus. You can book an appointment by contacting Mr Mike Murray at the College of Humanities (Tel. 033 260 5233 or email: murray@ukzn.ac.za) or Ms Shelley Barnsley at the College of Agriculture, Engineering & Science (Tel. 033 260 5697 or email: barnsley@ukzn.ac.za). Should you need further psychosocial support, HIV testing, management of HIV and AIDS, or learn how to protect yourself from transmitting or contracting HIV, you can visit the CHASU offices or contact either Mr Mlondi Sithole (033

2606160 or email: sitholem@ukzn.ac.za) or Ms Snikeziwe Mkhize (033 260 6059 or email mkhizes@ukzn.ac.za).

Possible benefits of participating in the study

By participating in the research, you could benefit directly from discussing the issues about HIV testing with me. At the end of our discussion, I will give you some information on how a person can acquire or transmit HIV, behaviours that can put a person at risk of HIV, ways to reduce these risky behaviours, the importance of early HIV diagnosis, which is made possible through routine HIV testing, HIV testing processes and discuss five core principles of testing (informed consent, confidentiality, counselling, correct test results and linkage to HIV treatment, care and support to prevent continued transmission). I will also tell you the meaning and implications of a negative and positive test result, what the window period means, the importance of informing your sexual partner(s) about your HIV status, where to obtain HIV testing services on, and off campus.

I will also give you additional materials at the end of our discussion related to HIV testing, HIV treatment, support and care, post-exposure prophylaxis, pre-exposure prophylaxis, the male condom, the female condom and sexual advice sourced from the Campus clinic and the CHASU office. I will also give you materials related to the nature of psychosocial services offered at the Student Support Services on the Pietermaritzburg campus. However, should you choose not to participate, all this information and materials will still be given to you. You could benefit indirectly from the research as the findings may assist in designing interventions for young students surrounding awareness of HIV, promote HIV testing and easy access to HIV related services when needed.

Campus clinic services

If you need advice on further health management, you can visit the campus clinic. You can get information and assistance on HIV testing, HIV and AIDS management, post-exposure prophylaxis, pre-exposure prophylaxis, condom, STIs management, pregnancy testing, sexual advice, and information about contraceptives at the clinic. You can book an appointment with Sr Gugu Zondi (Tel. 033 2606105 or email: zondiz@ukzn.ac.za).

Cost of your participation

There are no financial expenses you will incur as a result of participating in this study.

Compensation

There is no financial incentive given to you as a result of participating in this study. You will be issued with the Hexagon Coffee Shop voucher worth R35 as a way of compensating you for your time and effort given in participating.

Funding

This study is not funded.

Additional

This study has been ethically reviewed and approved by the University of KwaZulu-Natal Humanities and Social Sciences Research Ethics Committee (approval number **HSS/0005/019D**).

In the event of any problems or concerns/questions, you may contact me at (Cell: **contacts deleted** Email: hivtestingstudy29@gmail.com) or my research supervisor Prof Mary van der Riet at 033 260 6163 or Email: vanderriet@ukzn.ac.za or the University of KwaZulu-Natal 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

Appendix 8: Consent form for Interviews

I ____ have been informed about the study entitled "The social construction of HIV risk and implications for HIV testing health practices amongst sexually active youth at a South African university" by Betty Chebitok.

The purpose of this study has been explained to me. I understand what is expected of me in terms of my participation in this study and the time commitment I am making to participate.

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 the available compensation for my time and effort given in participating.

If I have any further questions/concerns or queries related to the study, I understand that I may contact the researcher at (Cell: **contacts deleted** or Email: hivtestingstudy29@gmail.com) or her supervisor Prof Mary van der Riet, at (033 260 6163 or email vanderriet@ukzn.ac.za).

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 researcher, then I may contact:

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

__________________ ________________________

Signature of Participant **Date**

________________________ __________________________

Signature of Witness **Date**
(Where applicable)

________________________ __________________________

Signature of Translator **Date**
(Where applicable)

Appendix 9: Consent to audio record interview

The interview will be recorded with two digital devices. This is to ensure my full focus on the interview, and I do not get distracted by taking detailed notes. However, I might take small notes as the discussion goes by. I will personally transcribe these recordings into a written form. In the process, I will still refer you by your pseudonym. I will then delete all the recordings on the digital recorders. I assure you that your name will not be linked to the recording or the written information from the recording. I will use the code/fake name of your choice, for example, Participant 1, Yellow etc.

I hereby provide consent to:

Audio-record my interview YES

NO

_____________________ _____________________

Signature of Participant **Date**

_____________________ _____________________

Signature of Witness **Date**

(Where applicable)

_____________________ _____________________

Signature of Translator **Date**

(Where applicable)

Appendix 10: Simplified Jeffersonian Transcription Conventions

Jefferson, G. (2004). Glossary of transcript symbols with an introduction. In G. H. Lerner (Ed.), *Conversation analysis: Studies from the first generation* (pp. 13–31). John Benjamins. https://doi.org/10.1075/pbns.125.02jef

Annotation	**Meaning of transcription annotation**
[ ].	Square brackets indicate overlapping speech.
(word).	Round brackets indicate a possible transcription.
( )	Empty round brackets show a complete inability to distinguish the word/ missing words.
((description))	Double round brackets indicate a description rather than a transcription.
(.3)	Indicates the timed number of seconds elapsed between speech.
(.)	Indicates a short pause or an untimed pause of less than 0.2 sec.
=	Indicates there was no time lapse between speakers.
________	Indicates that the word or syllable was stressed.
CAPS	Words in capital letters indicate an increase in volume.
,	Comma indicates a continuing intonation with a slight upward or downward contour.
:	Colon(s) indicates sustained enunciation of a syllable.
::::	Shows that a syllable was elongated. The number of colons indicates how long the sound was held for.
><	Greater than signs indicate portions of an utterance delivered at a noticeably quicker tone.
<>	Less than signs indicate portions of an utterance delivered at a noticeably slower tone.
.hhhh	Indicates an audible in-breath.
hhhh	Indicates an audible out-breath or sigh.
↑	Indicates a rising intonation, where a question was not asked.
↓	Indicates a lowered intonation.
°word°	Shows that the word was spoken more quietly than surrounding speech.
Ha ha	Indicates loud laughter.
He he	Indicates softer laughter.