UNIVERSITY OF KWAZULU-NATAL
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FACTORS INFLUENCING THE INVOLVEMENT OF MALE STUDENTS IN SEXUAL AND REPRODUCTIVE HEALTH AT THE UNIVERSITY OF KWAZULU-NATAL

By

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Submitted in fulfilment of the requirements for the degree of Master of Science in Public health in the College of Health Sciences, School of Nursing and Public Health, Discipline of Nursing

Supervisor

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November 2023

DECLARATION

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ACKNOWLEDGEMENTS

Words cannot express my gratitude to my supervisor Dr TS Mudau, for being patient throughout this research journey. I thank you for your constructive feedback, kindness and mentorship and for bringing light at the end of the tunnel.

To my mother and father, I appreciate your consistent support and loving hearts. I thank you for always believing in me and instilling self-confidence and the love for God.

To my manager, Mr Muzi Mthembu, I would like to thank you for the motivation, kindness and support. You cheered for me even before I made my first submission, and listened to my stresses.

Akhona Gumede, Lunga Hlongwa and Nompumelelo Nkosi, you are angels on earth; I have no doubt that God sent you to me. I thank you for being special and making sure that my well-being was taken care of.

To all the participants in this study, I appreciate your time and contribution, I know how dedicated and passionate you are about this subject, and I know that we-both are going to fulfil our goals into making the change as we had discussed. I thank you for the support you rendered.

ABSTRACT

Background: In the dynamic landscape of sexual and reproductive health (SRH) initiatives, understanding the extent and determinants of the involvement of male students' sexual health issues is pivotal in promoting comprehensive and equitable SRH outcomes at the University of KwaZulu-Natal (UKZN). Male involvement in SRH is essential in preventing sexually transmitted infections (STIs) and unplanned pregnancies, and in promoting safer sexual practices. In contrast, deferring healthcare leads to morbidities and mortalities, which could mostly be avoided through seeking early primary healthcare and preventative health as diseases are not responsive to gender. Recognising that SRH encompasses physical wellbeing and broader societal and interpersonal dimensions, this study offers a comprehensive analysis of the factors influencing the involvement of male students in sexual and reproductive health at the University of KwaZulu-Natal. Exploring the intricate web of socio-cultural, educational, and healthcare system factors, this study aims to provide insights into the challenges encountered by male students in the context of SRH.

Research methodology: The qualitative, participatory action research approach was employed to explore and describe factors influencing the involvement of male students in sexual and reproductive health at the University of KwaZulu-Natal (UKZN) in South Africa. The objectives of the study were: to explore and describe factors affecting male students' involvement in SRH at the UKZN and; to explore and describe strategies that will enhance male students' involvement in SRH at UKZN. In total, 24 male student participants were conveniently and purposely sampled to share their views and opinions on factors influencing the involvement of male students in SRH at the university in question.

regarding SRH services received at the UKZN campus health clinic. The data collection methods employed included semi-structured interviews, focus-group discussions (FGDs), and virtual meetings. The researcher collected data using an interview guide, an audio recorder, and taking field notes. The thematic analysis method was conducted to identify codes and themes emerging from the generated data. Findings revealed the students' attitudes towards HIV tests, condom use, staff-related issues, stigma and stereotyping, attitudes towards SRH programmes and campaigns, infrastructural issues, and solutions to the identified challenges.

Conclusion: Involving male students in SRH in campus health clinics at UKZN is marred by socio-hegemonic orientations related to masculinity-related roles, cultures, and male-friendly services, and it is necessary to delve into issues around stigmas and stereotypes. It is therefore important to enhance health promotional campaigns and reviving male-friendly programmes in comfortable environments that are not formal for male students' involvement.

Recommendation: Topics on ways of breaking the gender stereotypes affecting young males and ways of enhancing male involvement in SRH matters have to be generated and explored. Nurses working in campus health clinics should be trained on Adolescent and Youth-Friendly-Services (AYFS). The necessity of developing policies that enhance interventions, strategies, and goals to close the gap of male SRH on the campus cannot be overemphasized.

Keywords: Sexual and reproductive health. Male involvement. Culture. Male students. Male sexual and reproductive health. Social norms. Sexually transmitted disease.

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

AYSRH: Adolescent and Youth Sexual Reproductive Health

CHC: Campus Health Clinics

GBV: Gender-Based Violence

HIV: Human Immunodeficiency Virus

HSSREC: Humanities and Social Science Research Ethics Committee

ICPD: International Conference on Population and Development

LMICs: Low-Middle-Income Countries

NICHD: National Institute of Child and Health Development

PAR: Participatory Action Research

SHC: Student Health Centre

SRH: Sexual Reproductive Health

STI: Sexually Transmitted Infection

UHC: Universal Health Coverage

UKZN: University of KwaZulu-Natal

WHO: World Health Organization

CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 Introduction

Sexual health is an individual's state of physical, emotional, mental, and social well-being regarding sexuality; it does not merely relate to the absence of disease, dysfunction, or infirmity, but encompasses all matters relating to the reproductive system and its functions and processes (World Health Organization, 2022). Sexual health requires the adoption of a positive and respectful approach to sexuality and sexual relationships; it embodies the possibility of having pleasurable and safe sexual experiences, and freedom from sexual coercion, discrimination, and violence (Gruskin et al., 2019). Sexual and reproductive health education has several benefits, including improved knowledge about contraception, contraception uses at first intercourse, increased chance of contraceptive use in a lifetime, and effective usage of contraceptives (Seidu et al., 2022). Males' involvement in SRH-related matters is poor, even though females, in most cases, rely on males, friends, and families to make decisions regarding their SRH. Instead of just being passive observers in matters related to SRH, males should equally be involved, together with their female counterparts, in matters such as sexual and reproductive relationships, marriage, and family building (Shabani, 2021). There is increasing recognition that men and boys can play a role in either supporting and championing or damaging and denying the health and rights of women and girls (Ruane-McAteer et al., 2019).

1.2 Background

In 1994, representatives from 78 countries gathering in Cairo, Egypt, for the International Conference on Population and Development (ICPD) agreed on improving adolescent and youth sexual and reproductive health (AYSRH) through disseminating age-appropriate information on sexual and reproductive health (SRH) (Muchabaiwa & Mbonigaba, 2019). The 1994 ICPD argued for the designing of policies, programmes, and reproductive healthcare services that are shaped by a concern for quality healthcare and not demographic objectives (Mmusi-Phetoe et al., 2019). Sexual reproductive health is defined as a person's right to a healthy body and autonomy,

education, and health care, including the right to freely decide who to have sex with and how to avoid sexually transmitted infections or unintended pregnancies (Marie Stopes International, 2020). Shabani (2021) adds that Sexual reproductive health includes freedom from the risk of sexually transmitted infections (STIs), the right to regulate one's fertility with full knowledge of contraceptive choices, and the ability to control one's sexuality without being discriminated against based on age, marital status, income, or similar considerations. Achieving universal health coverage (UHC) and ensuring that all people, including vulnerable populations, receive quality, rights-based, non-discriminatory SRH services without financial hardship are underpinned by the strengthening of the healthcare system and the elimination of barriers in the broader political, economic, social, cultural, and gender spectra (WHO, 2022).

With 1.8 billion young people aged 10 to 24 years in the world today, the cohort of adolescents and youths is the largest in history (Pulerwitz et al., 2019). Millions of adolescents are confronting challenges in SRH issues, including high rates of unmet need for contraception, unintended pregnancy, and clandestine and unsafe abortion. Globally, Africa has the highest number of births given by women aged 15-19 per 1000 women in that age group (99 births/1000 adolescent females) in comparison with other regions worldwide (WHO, 2020). Adolescent sexual and reproductive health (ASRH) continues to be a major public health challenge in sub-Saharan African countries where child marriages, adolescent childbearing, HIV transmission, and low coverage of modern contraceptives are common (Melesse et al., 2020). In two studies conducted in Ethiopia, most respondents mentioned the challenge related to the cost of SRH services (21%) and (41.2%) the lack of money needed to travel to healthcare facilities as the distance or time taken is costly (Ninsiima et al., 2021). In countries such as Malawi and South Africa, about 74 % of men agree that SRH matters are women's responsibility and that men should not worry (Kok et al., 2020; Kriel, 2019; Department of Statistics South Africa, 2021).

In 2019, 10 million unintended pregnancies among women aged between 15 and 19 years were a consequence of the unmet need for modern contraceptives in low-middle-income countries (LMICs) (Sadinsky & Ahmed, 2021). Globally, nearly a quarter of adolescent girls are married, with 16 million giving birth each year, 95% of whom are from LMICs (Ninsiima et al., 2021). Approximately, 17% of all women in sub-Saharan Africa, and 23% of married or in-union women, have an unmet need for

family planning methods (WHO, 2020). In Zimbabwe, the barriers to SRH include a lack of provision of comprehensive social and behaviour-change communication materials; lack of life skills education, inadequate adolescent sexual and reproductive health outreach services, and prohibitive transport costs when accessing referral health facilities (Muchabaiwa & Mbonigaba, 2019). In Ghana, the implementation of SRH services, such as child health, safe abortion, and post-abortion care, GBV, is stifled by a lack of funding (Akazili et al., 2020). South African young women are affected by unsafe and/or coercive sex associated with gender-based violence, resulting in unplanned pregnancies, STIs, and HIV (Pillay et al., 2020). Although students have greater awareness and understanding of the risks linked with unprotected sexual intercourse, most students do not see themselves as personally being at risk (Mazibuko, Saruchera, & Okonji, 2023).

In 1859, campus health services evolved after President Stearns, the Head of Amherst College in the United States of America, indicated that students abandoned their studies at higher education institutions (HEIs) due to poor health (Ricks et al., 2010). Campus health centres are convenient for college students to obtain the health care services provided by licensed staff and trained professionals that generally offer similar services as off-campus health institutions (Perrault, 2018). Furthermore, college-based healthcare services are the focal point of organisational resources supporting students' sexual health, including a wide variety of offerings availed to meet their needs, such as peer education, condom distribution, online health information, social norms campaigns, and support groups (Eisenberg et al., 2012). In South Africa, campus health services were established through trial-and-error methods and with no set guidelines, thus resulting in diverse standards being implemented on different campuses (Ricks et al., 2010). In 2019, Higher Health emerged from the Higher Education and Training HIV and AIDS Programme (HEAIDS), which was established in the early 2000s by the then Department of Education and international development partners to reduce the impact of HIV and TB on higher education students (Higher Health, 2021).

Perrault (2018) discovered that some students use alternative healthcare services because they are concerned about the low quality of healthcare the campus healthcare centres provide, with some students expressing doubt about the campus healthcare professionals' technical competence; concerns were raised regarding staff

competence among medical personnel. Studies reported several barriers as hindrances to students' use of campus healthcare services. Among the universities in the United States of America (USA), students preferred seeking medical care at off-campus healthcare centres as the student health centres (SHC) lacked advanced technological resources (Garcia et al., 2014). While at the University of Miami in the United States of America, students expressed uncertainty about the SHC location which lacked confidentiality that should characterise the reporting of sexual violence-related matters; other concerns were raised regarding whether or not the students' reported incidents would reach other campus officials (Halstead, Williams & Gonzalez-Guarda, 2018). A study conducted by Khumalo et al. (2021) at the University of KwaZulu-Natal in South Africa, reported that male students saw no need to access SRH and care from campus health services as they could access SRH information from the Internet and their peers. However, not all campus healthcare services cater for sexual assault cases. Due to the forensic evidence required after sexual assault, survivor files charges against the perpetrator, forensic examinations are done by forensic nurses which schools do not have (Buchholz, 2015).

The World Health Organization (WHO) (2021) developed core strategies of improving or integrating SRH service delivery in universal health coverage through the Primary Health Care approach, which encourages the integration of Sexual Reproductive Health (SRH) within other health programmes by motivating healthcare providers to give multiservice. The WHO has continued to encourage the involvement of other stakeholders in the integration of the SRH services into their models such as Social Services and Education, including the involvement of civil society organisations, community members, and religious figures for the improvement and large-scale mobilisation of SRH, especially in Primary Health Care. The South African National Integrated Sexual and Reproductive Health and Rights Policy 2019 creates conditions under which South Africans can enjoy quality SRH across their lifespan (Department of Health, 2019). Given the burden of disease in South Africa’s health and socio-economic systems and the social determinants of health and socio-cultural norms that affect SRHR services, this policy intends to highlight these issues, simultaneously seeking ways of tackling the multifaceted nature of SRH service delivery. However, the implementation of the various programmes has been facilitated by separate guidelines that anchor this policy document (National Integrated SRH Policy, 2019).

In most parts of the world, men access health services less frequently than women, and this trend is unrelated to differences in the need for such services (Dowden et al., 2019). Men identify the severity of an illness as a legitimate reason for seeking health care and they endure the pain caused by minor ailments to maintain their perceived masculinity (Novak et al., 2019). Hohn et al. (2020), discovered that men improve their visits to primary healthcare services after hospitalization. More significantly, they might have been reluctant to engage with primary healthcare before experiencing a health shock. However, the involvement of males in matters related to sexual reproductive health (SRH) can produce positive results. In South Africa, women reported fear of physical abuse following initiating or discontinuing use of contraceptives without their male partners' knowledge, and this power imbalance was reported more in marriage settings where men assume ownership of female fertility (Kriel et al., 2019). It is important to note that males should be their female partners' advocates concerning good SRH issues; this can be led by providing them with the necessary SRH information and services, mostly targeting male adolescents (Shabani, 2021). Young university students in KwaZulu-Natal reported their unwillingness to seek healthcare services for fear of being noticed walking out of the campus clinic by fellow students (Khumalo et al., 2021).

1.3 Problem statement

Men are reported to be the primary decision-makers regarding sexual and reproductive health issues in the family; however, they admitted to having far-reaching unmet needs of sexual and reproductive health and all sexual morbidities and mortalities (Matenga et al., 2021). Furthermore, sexual, and reproductive health is an important component of men's overall health and well-being. Males have been overlooked or intentionally excluded in discussions based on reproductive health, with such issues as contraception and infertility having been perceived as female-related (US Department of Health and Human Services, 2021). Similarly, low usage of SRH services by men has been reported in sub-Saharan countries. Men perceive SRH including family planning as women's responsibility (Ousafor, Akokuwebe & Idemuda, 2023). Regardless, male non-involvement in SRH matters is a consequence of unintentional fatherhood and poor sexual health (Mvula, 2023). Furthermore, the non-involvement of young men in SRH leads to early sexual debut and unhealthy sexual lifestyles resulting in unplanned pregnancies and sexually transmitted infections.

Accordingly, involving men in SRH matters mitigates the possibilities of unhealthy SRH lifestyles, open communication about family planning, and unified sexual decisions (Fletcher et al., 2022).

Globally, and in the South African context, university students' knowledge of SRH is limited (Mwamba, Mayers & Shea, 2022). About five years ago, 87% of young men in northern KwaZulu-Natal were sexually active, reporting their sexual debut from the age of 12 years, with 57% sceptical of using condoms during sexual intercourse (Rogers, Mfeka-Nkabinde & Ross, 2019). Gollub, Beauvais, and Roye (2022) discovered that male students at Pace University in the United States of America lacked interest in learning more about contraceptives. Van der Riet, Akhurst, and Wilbraham (2019) reported that both female and male students' levels of education might not guarantee the students' engagement in sexual self-care and protection. A study conducted at the University of KwaZulu-Natal reported barriers to using campus health clinics (Khumalo et al., 2021). However, factors influencing the involvement of male students in SRH matters have not been explored, hence the need for this study.

1.4 Aim of the study

This study aimed to explore and describe factors influencing the involvement of male students in sexual and reproductive health matters at the University of KwaZulu-Natal (UKZN) in South Africa.

1.5 Research objectives

1. To explore and describe factors affecting male students' involvement in SRH at the UKZN
2. To explore and describe strategies that will enhance male students' involvement in SRH at UKZN.

1.6 Research questions

Roberts (2020) defines a research question as an inquiry that is answered through research about a topic.

The research questions guiding this study are as follows:

1. What are the factors affecting the involvement of male students in SRH at the UKZN?

2. What strategies can be used to enhance the involvement of male students in sexual and reproductive health matters at UKZN?

1.7 Significance of the study

The significance of a research study is explained through the importance of the work and its potential benefits to various stakeholders (Badaru & Adu, 2022). Therefore, from the findings of this study, nursing practices will be empowered in structuring comprehensive nursing care, nursing research will identify healthcare service gaps, and nursing education institutions will generate topics on young male involvement in SRH matters.

1.8 Operational definitions

Male: Having a gender identity that is the opposite of female (Webster, 2023). In this study, a male is anyone who identifies themselves as male.

Student: This is a person who is learning at a college or university (Webster, 2023). In this study, a student is a male student registered for learning in the 2023 academic year at UKZN.

Sexual and reproductive health (SRH): This is a state of complete physical, mental, and social wellbeing as reflected in all matters relating to the human reproductive system (Shabani, 2021). In this study, the term SRH refers to a male student's healthy sexual behaviour, encompassing a person's ability to exercise their sexual rights for the good of their health and those they live with.

Campus health clinic: Grace (1997) describes a campus clinic as a university's healthcare centre that addresses students' minor walk-in health complaints and chronic health issues, where health centre staff manage and prevent the spread of potentially deadly infectious diseases, providing students with immunisations and wellness education and treating students' mental health issues. In this study, the campus health clinic is a health facility that provides all healthcare needs, including SRH, to university students and staff, in good partnership with other university health programmes.

1.9 Theoretical framework

Bookchin's Social Ecology Theory (SET) suggests that human conduct is influenced by both social and environmental factors (Bookchin, 1994). Furthermore, SET analyses the intricate and dialectical relationship between nature and society and sees human beings as products of both natural and social evolution (Bookchin, 1993). Nevertheless, roles related to masculinity are learned and acquired from the environment and societies surrounding them. Novaket al. (2019) discovered that masculine roles are a consequence of poor healthcare-seeking function amongst males, as males are taught to toughen up and endure the pain. Moreover, gender stereotyping seems to allow men to consider themselves powerful individuals amongst the other genders. Bookchin (1994) describes patriarchy as resulting from commanding humans, especially men, to determine how to behave This promotion of the power of men by society leads to male dominance that results in what Connell (1995) calls hegemony masculinity. The SET and Connell's hegemony masculinity theory suggest that men's decision-making is determined by the social socialisation subtly passed through community involvement. Both theories give the researcher an understanding of how a society promotes male dominance and inspire men's decision-making. Details are in Chapter 2.-

1.10 Research methodology

This section represents the research design, research setting, population, sampling, and recruitment method.

1.10.1 Research design

A research design is a systematic elucidation of the whole research process, including methods and techniques, starting from the planning of the research, execution (data collection), data analysis, and the drawing of a logical conclusion based on the obtained results (Singh, Vadakedath & Kandi, 2023). The study engaged in qualitative, participatory action research (PAR), a research method used in qualitative research to enhance a fruitful alliance between participants and the researcher to bring about the desired change about the discovered research problem (Fogg et al., 2022). This alliance involves identifying the research problem and acting to implement steps meant to solve the problem.

1.10.2 Research setting

The research setting is the physical, social, or experimental context within which research is conducted (Insights, 2020). This study was conducted at UKZN, in KwaZulu-Natal Province, South Africa. The researcher chose to conduct the study at the UKZN because the researcher was an employee of the institution. UKZN was established in 2004 and has four campuses around Durban, with one other campus being in Pietermaritzburg, South Africa (UKZN website, 2023). UKZN is one of the highly ranked universities in South Africa, having been ranked 370 out of 500 top universities in the world, and number 4 out of 26 in South Africa in 2023 (Businesstech, 2023).

1.10.3 Population sampling and recruitment method

Population refers to a set or group of all the units on which the findings of the research are to be applied (Shukla, 2020). The targeted population in this study involved male students who were registered in the UKZN in 2023, at Howard College campus. Sampling is a process involving the selection of research participants from a larger population using the research study's criteria (Turner, 2020). The researcher used non-probability, convenience, and purposive sampling to recruit a minimum of 18 students from their study area. Chapter 3 details the research methodology.

1.10.4 Data generation methods and instruments

Data generation comprises activities such as searching for, focusing on, noting, selecting, extracting, and capturing data (Göran, 2019). The researcher executed the study using in-depth interviews and focus-group discussions. Focus groups provide deeper and richer information through social interactions (Gundumogula, 2020). Individual interviews allow for in-depth exploration and allow individual participants more privacy in their responses (Schuster et al., 2022). An interview guide is a research instrument or tool developed to contain a set of questions meant to solicit participants' views, opinions, and feelings on a particular inquiry (Muzari, Shava & Shonhiwa, 2022). The researcher employed face-to-face semi-structured interviews, team meetings, and focus-group discussions to elicit data.

1.10.5 Data analysis

Data analysis is a process of inspecting, cleansing, transforming, and modeling data to discover useful information from data, thus informing conclusions, and supporting decision-making (Sarker, 2021). The researcher utilised the thematic data analysis method. Thematic analysis was used as it aims to discover participants' views, opinions, knowledge, experiences, and values from a set of qualitative data (Caulfield, 2022). This is further detailed in Chapter Section 4.2.2.

1.10.6 Measures of ensuring trustworthiness

In this study, trustworthiness was applied in line with Lincoln and Guba's (1986) strategies, which are credibility, transferability, dependability, and confirmability.

1.11 Ethical considerations

Ethical considerations are principles that guide research design and practices. Furthermore, researchers must always adhere to a certain code of conduct when collecting data from participants (Bhandari, 2022). In this study, ethical clearance was obtained from the University of KwaZulu-Natal Humanities and Social Science Research Ethics Committee (HSSREC) to ensure that respect, dignity, privacy, disclosure of information, and fair treatment are upheld throughout the study and that no harm results from participating in the research study.

1.12 Division of chapters

The study is presented through the following chapters:

Chapter 1: This chapter presents an overview of the study. It gives the background to the study, the research problem, the study's aims and objectives and as well as the research questions. Operational definitions of the concepts related to this study and the significance of the study are also discussed. The theoretical framework underpinning the study is explained, together with a brief description of the methodology. Finally, the ethical considerations and trustworthiness are discussed in this chapter.

Chapter 2: This chapter reviews the literature on the factors influencing or determining the involvement of male students in sexual and reproductive health at UKZN. The

chapter is itemised into sub-topics dealing with such issues as: in-depth discussion of the theoretical framework that grounds this study; a brief review of the literature and a detailed literature review under topics such as masculinity and healthcare-seeking behaviour, the importance of male involvement in SRH**,** the implications of non-involvement of males in SRH matters, traditional masculine roles, and culture. Lastly, interventions to break harmful masculinity are developed.

Chapter 3: The chapter outlines the research methodology used to determine factors influencing the involvement of male students in SRH. This chapter discusses the research approach, research paradigms, research design, research setting, population, sampling and recruitment methods, data generation methods, data analysis processes, measures taken to ensure trustworthiness and a detailed presentation of ethical considerations.

Chapter 4: The chapter presents data analysis, interpretation, and a discussion of findings. Thematic analysis was used to transcribe collected data into themes and sub-themes. The following themes were developed: Attitudes towards HIV test; condom-related issues; staff-related issues; stigma and stereotyping; socio-cultural issues; attitudes towards SRH programmes and campaigns; infrastructure and solutions to the identified challenges. Literature supporting these findings is included in the analysed data.

Chapter 5: The chapter presents a summary of the findings, conclusions, recommendations, and limitations of this study, with regard to the factors influencing and determining the involvement of male students in SRH.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The study aimed to determine factors influencing the involvement of male students in sexual and reproductive health (SRH) at the University of KwaZulu-Natal (UKZN) in South Africa. This chapter reviews the literature detailing the factors influencing the involvement of male students in sexual and reproductive health matters at the University of KwaZulu-Natal. This enabled the researcher to familiarise with studies conducted on the factors influencing the involvement of male students in SRH in order to find gaps that exist within the literature, and to prevent duplication. Firstly, the chapter focuses on the theoretical framework underpinning the study. Secondly, it focuses on a discussion of the literature, particularly aspects such as masculinity and health-seeking behaviour, the importance of male involvement in SRH, the implications of males' non-involvement in SRH matters, and traditional masculine roles and culture, as well as interventions developed to break harmful masculinity.

2.2 Theoretical framework

Through the 1990s, Murray Bookchin, an innovative social theorist, developed the theory of "Social ecology", which is based on the conviction that nearly all people's present ecological problems originate in deep-seated social problems. Bookchin (1994) avers that human conduct is influenced by social and environmental factors. Gerontocracy is a creation of the patriarchal society, where elderly men's high rankings in hierarchal structures lead to male dominance (Bookchin, 1993). This male domination aims to express masculinity, as per societal expectations. Male dominance over women is embodied in what Connell (1995) calls hegemony masculinity. The author further describes hegemony masculinity as the configuration of gender practice which embodies the currently accepted answer to the problem of the legitimacy of patriarchy, which guarantees the dominant position of men and the subordination of women. The Social Ecology Theory by Bookchin (1994) and the Masculinity Theory by Connell (1995) concur on the hegemonic masculinity phenomenon as men's expression of power, not only over women but over other masculinities.

Hegemonic masculinity, which is embedded in society's classification of men as the stronger of the two sexes, with women being the weaker sex, influences men's attitude towards health care (Olanrewaju et al., 2019). Furthermore, for men, seeking medical help undermines the norm of being strong. Male norms include values such as adventure and considerable amounts of toughness in mind and body and a certain level of aggression (Sexton, 1969). Similarly, Mazibuko, Saruchera and Okonji (2023) discovered that gender norms can aggravate concepts of masculinity that foster sexual prowess, virility, and male control over women. Fundamentally, hegemonic masculinity contends that women exist as potential sexual objects at men disposal while fellow men are negated as sexual objects for men (Donaldson, 1993). This patriarchal phenomenon is passed on through generations. Patriarchy results in masculinity and male dominance; these construct the manliness that is expected by society, with male norms encouraging the notion of man-power over others.

Male dominance becomes extremely active, which ultimately yields a world that is managed by male elites who dominate not only females but other males as well (Bookchin, 1993). This means that any act against masculinity, as would have been learned from society, is considered non-masculine. Consequently, males become too reluctant to be viewed as being feeble by society. Therefore, they avoid seeking health interventions. Regardless of this attitude, males' health is as important as other genders. The severity of a discomfort or illness is a legitimate reason for seeking help by men, after they have endured the pain in an attempt to maintain their masculinity (Novak et al., 2019). Therefore, men generally perceive seeking help as being feeble and non-masculine as per gender norms. This means that men would rather endure the pain than seek health interventions to fulfil those masculine norms (Khumalo et al., 2021). However, health-seeking is an act performed in an attempt to improve one's life, and comparing it to general help-seeking is unjust to men's overall health.

2.3 Literature review

Conducting a literature review in qualitative studies can be characterised by controversy. In this study, the researcher conducted a literature review to gain knowledge on what is already known about the topic, identify gaps to avoid wasting resources by duplicating previous studies (Boumezrag, 2022). In this regard, the researcher found a study conducted at UKZN by Khumalo et al. (2021), focused on

the insight of male students on barriers and potential solutions to campus health care services access. The literature review was used to guide the study methods and instruments-based strengths and gaps. The researcher employed bracketing during the data generation process to minimise theoretical bias by misrepresenting the participants' meaning, perception, and experiences (Stahl & King, 2020).

Studies conducted in universities have focused on factors impacting health-seeking behaviours and sexual and reproductive health, health-seeking behaviour in males of all age groups. Among studies conducted on university students, Nuwamanya et al. (2020) discovered that gender norms play a significant role in SRH matters and health-seeking behaviour among Ugandan university students. While Khumalo et al. (2021) discovered that a lack of knowledge about programmes offered on campus health centres, negative perceptions, and attitudes towards seeking health care from campus health care and negative experiences are barriers to proactive health-seeking behaviours at the University of KwaZulu-Natal in South Africa. Furthermore, male students would rather get advice from their peers or live through the health problem until the pain becomes so unbearable that it compels them to seek help from off-campus clinics. University students' age engage in risky sexual behaviours and unhealthy lifestyles (Shabani, 2021). Hence, healthcare-seeking is essential to this group, as it allows students to gain knowledge on good health.

Several studies accede to gender norms, masculinity, and culture as barriers to healthcare-seeking among men, and SRH health-seeking behaviour. Lantiere et al. (2022) discovered that gender norms, lack of knowledge, and religious and cultural beliefs are barriers to men's involvement in SRH care and family planning decision-making among Filipino men. While Baraoudi (2021) reports that social and gender norms hinder men from seeking help on SRH and that affects men's sexual well-being in Nordic countries. Lastly, Hohn et al. (2020) reported that men are reluctant to engage with primary health care before experiencing a health shock.

Masculinity and health-seeking behaviours are closely linked. Men's attitudes towards health often differ from those of women. Research suggests that men adopt beliefs and practices that are consistent with their notions of manhood (Hasan & Aggleton, 2020). Similarly, Khumalo et al. (2021) discovered that males reported being against seeking help when ill due to cultural beliefs that consider men to be always strong.

Furthermore, as previously learned from the Social Ecology Theory by Bookchin (1994), societal pressures can create a rigid definition of masculinity, making it difficult for men to express their vulnerability, as they are taught how to conduct themselves from younger ages. Several studies have revealed how masculine roles justify health-seeking behaviours. Olanrewaju et al. (2019) discovered that men categorise the nature of the illnesses they experience, which determines their decision whether to endure the pain or seek medical attention. Similarly, Novak et al. (2019) discovered that men report being seen as masculine when they endure pain when experiencing an illness; health intervention is determined by the severity of the illness. Lastly, previous studies show poor health-seeking behaviour in men.

2.4 Masculinity and health-seeking behaviour

Several studies justify men's poor health-seeking behaviour because of masculinity. Initially, Novak et al. (2019) discovered that men would rather spend their time at work, and provide for their families than seek healthcare as this will take time off work. Similarly, Rochelle (2020)has reported that men have less time to engage in health behaviours due to work-related factors, in trying to make income. Furthermore, Rogers, Mfeka-Nkabinde, and Ross (2019) reported that men do not find time in between their work schedules as healthcare centres close earlier than the men's dismissal time. Men associate healthcare-seeking behaviour with weakness, expressing that health-seeking behaviour is not worth missing a day's salary (Dowden et al., 2019). Literature reports on cultural influences aiding the masculinity roles in India and Nigeria (Sivarkumar & Manimekalai, 2021; Olanrewaju et al., 2019). However, deferring healthcare seeking often results in morbidities and mortalities, which mostly could be avoided through seeking early primary healthcare and preventative health, as diseases do no choose gender.

Traditionally, SRH has been perceived solely as a women's domain, and women have been the bearer of the greatest amount of responsibility for SRH outcomes (Shand & Marcell, 2021; Shabani, 2021). Several studies have discovered that masculinity has an impact on SRH-seeking behaviour, as societal expectations and norms can affect men's attitudes and behaviours related to SRH. Men's SRH-seeking behaviour is embedded in psychosocial and cultural norms and in that regard, expressing any kind of sexual concern is considered taboo (Azmi et al., 2022). Lantiere et al. (2022)

reported that individual men are influenced by other people, local organisations, available resources and institutions, and social norms and policies into masculinity norms. Baroudi et al. (2021) discovered that traditional gender norms and values related to masculinities provide important pieces in explaining men's health-seeking behaviours. South African young men's patriarchal attitudes toward poor SRH exist against the backdrop of rurality, with socio-cultural structures being defined and dominated by men, thus propping up traditional masculinity (Rogers, Mfeka-Nkabinde & Ross, 2019). Accordingly, traditional masculinity negatively impacts men's SRH-seeking behaviour, with poor SRH leading to unhealthy sexual life.

2.5 The importance of male involvement in SRH

The involvement of males in SRH is essential in preventing sexually transmitted infections (STIs) and unplanned pregnancies and promoting safer sexual practices. Young men with frequent parental communication face the likelihood of STI acquisition and condom use (Zou et al., 2022; Gollub, Beauvais & Roye, 2020). Munyimani and Nunu (2022) report that men sleeping with men in Zimbabwe are aware that it is within their rights to seek SRH, as this will enable them to have better health outcomes. Shabani (2021) reports that the utilisation of SRH care services by South African young men is key to improving their unmet needs and decreasing the SRH-related challenges young men face every day. Accordingly, studies concur on the point that an improvement in the quality of life and healthy lifestyle depends on the involvement of males in SRH. Condom use remains the number one preventative measure against STIs and unplanned pregnancies (WHO, 2022). This implies that males get to decide with their partners when to have a family or to prevent infections for them to have better future.

2.6 The implications of uninvolved males in SRH matters

Lack of involvement of males in SRH leads to negative outcomes in overall sexual health. WHO (2022) reports that more than 1 million new STIs are recorded every year worldwide. World Population Review (2023) reports that Sub-Saharan African countries are among the top-ten countries with the highest rates of HIV prevalence, with Eswatini having the highest rate of 27% and at the bottom there is Equatorial Guinea with 7.3%. Masculinity, patriarchal norms, and culture have a significant influence on poor health-seeking behaviour in men (Azmi et al., 2020; Lantiere et al.,

2022; Baroudi, 2021). The inconsistent use of condoms and contraceptives, and a lack of open communication between sexual partners have led to the acquisition of STIs, HIV, and unplanned pregnancies in Zimbabwean and South African universities (Mazibuko, Saruchera & Okonji, 2023; Delany-Moretlwe et al., 2023). South Africa is a multicultural country that has traditions promoting patriarchal norms; it is one of the countries with polygamous marriages and is among the top-ten Sub-Saharan African countries with a concerning HIV rate of 19.1% (World Population Review, 2023), considering the view that polygamy may be associated with high HIV prevalence (Gazimbi et al., 2020).

WHO (2023) estimates that one woman in every three has experienced physical and/or sexual intimate partner violence in their lifetime. This finding is in line with those of studies conducted by Pun et al. (2020) and Huynh et al. (2019) which established that men in Nepal and in India use physical and/or violence to express masculinity. Furthermore, these men believe that a woman must be forced into submission through violence, and this makes her passive, respectful and submissive to her sexual partner. Park et al. (2022) found that men in Uganda perceive hormonal contraceptives as the main reason their partners refused to have sex with them. South Africa is the world's rape capital, with 10 818 rape cases having been reported in the first quarter of 2022 (Govender, 2023). Globally, a total of 38% of the murders of women are committed by intimate partners (WHO, 2021). Furthermore, the rate at which women are being killed by intimate partners in South Africa is five times higher than the global average. Patriarchal norms that promote male dominance have negative implications for gender-based violence (GBV) (Mshweshwe, 2020). In SRH, GBV has implications such as unintended pregnancies, STDs, and other complications that may lead to the death of female partners.

2.7 Traditional masculinity roles and culture

Traditional masculinity includes norms that encourage many aggressive behaviours and personality traits such as aggression, self-affirmation, social dominance, and lack of consideration for others (Malonda-Vidal et al., 2021). Hegemony is associated with traditional masculinity. This is supported by a study conducted by Lacoviello et al. (2022), which found that traditional masculinity norms are generally defined as hegemony as they maintain men's favourable position in gender hierarchy. Reflecting

on Connell's theory, which describes hegemony masculinity as male dominance and subordination of women, traditional masculinity is evidently in support of patriarchal norms. This aligns with the findings of Krivoshchekov, Gulevich, and Blagov (2022) who reported that traditional masculinity leads to violence and is disadvantageous to women. Furthermore, the reported forms of violence were sexual harassment and both physical and psychological rape. Conversely, this further affects men's health-seeking behaviour, as traditional, masculine men perceive themselves as stronger than women (Staiger et al., 2020). Consequently, the harmfulness of traditional masculinity is embedded in the notion that men disregard not only their own health but their partners' as well.

2.8 Interventions designed to break harmful masculinity

The systematic review indicates that while harmful masculinities are an issue of global concern, only 8% of interventions that involve men and boys challenge male norms or unequal power dynamics privileging men over women (Ruane-McAteer et al., 2019). According to the Ruane-McAteer and colleagues, programmes and interventions engaging men and boys need to intentionally promote gender equality by explicitly focusing on harmful gender norms, including masculinities and challenging unequal gender power relations that privilege men, simultaneously subordinating women. In South Africa, sexual and reproductive health rights are enshrined in Section 27, act 108, 1996 of the Constitution, which provides that "everyone has the right to have access to healthcare services, including reproductive health care" (Department of Health, 2019). There is limited literature focusing on male university students' involvement in SRH matters. Nuwamanya et al. (2020) reports that utilisation of SRH information among university students lies in understanding their perceptions and deep thoughts on the matter. Significantly, intensifying SRH information through peer education, universities intranet, and university magazines would fulfil the objective.

2.9 Chapter summary

In this chapter, a literature review was presented. In view of the Social Ecology Theory, men are impacted by both internal and external forces to reach a decision. Major highlights are that there are various hegemony masculinities which are consequences of male domination which reinforces power over women and other masculinities. Social cultures and traditions differ in some gender norms, meaning that men are set

to behave distinctly from other genders. However, culture and traditions share the same view regarding how men should conduct themselves in terms of help-seeking, SRH-seeking, and general health-seeking behaviours. This uniformity of masculinity and gender roles and norms creates barriers to care-seeking among men, thus resulting in high rates of STIs and many other chronic health conditions. The World Health Organization has developed measures meant to address gender inequalities that have been propping up harmful masculinities.

In this chapter, the reviewed literature was related to the study topic's interest. The theoretical framework in which this study is grounded was also discussed in depth. The next chapter presents a detailed research design and methodology underpinning this study.

CHAPTER 3

METHODOLOGY

3.1 Introduction

This study aims to explore and describe factors influencing the involvement of male students in sexual and reproductive health (SRH) at the University of KwaZulu-Natal (UKZN). This chapter describes the research process, including the procedures and plausible methods taken during the research process, known as the research methodology (Haradhan, 2018). Research methodology is the path through which researchers formulate their problems and objectives and present the results from the data obtained during the study period (Jilcha, 2020). In this chapter, the researcher focuses on describing the various stages taken during the research action in aiming to determine factors influencing the involvement of male students in SRH UKZN. The first focus is on the research approach, research paradigm, research design, research setting, population sampling and recruitment method, data generation methods and instruments, and data analysis. These are followed by the discussion of measures to ensure trustworthiness, ethical considerations, and conclusion.

3.2 Research approach

Research approaches are plans and procedures for research that span the steps from broad assumptions to detailed methods of data collection, analysis, and interpretation (Creswell & Poth, 2016). In the current study, the researcher employed a qualitative research approach. The qualitative research approach refers to research about people's lives, lived experiences, behaviours, emotions, and feelings (Taherdoost, 2021). It can also focus on organisational functioning, social movements, cultural phenomena, and interactions between nations (Rahman, 2020). Islam and Aladaihani (2022) reported that the qualitative research approach can be applied when a researcher wants to understand the settings or contexts in which participants or objects can address/outline an issue or problem. The qualitative approach discusses two criteria which are the way you do things and the outcome of the task (Taherdoost, 2021). To align the qualitative research approach, the researcher sought to achieve the research aims and meet the objectives by collecting data in a natural setting.

3.3 Research paradigm

A research paradigm is a worldview or philosophical framework, including ideas, beliefs, and biases that guide the research process (Ulz, 2023). Furthermore, the research paradigm within which a study is situated helps to determine how the research will be conducted. A paradigm investigates how knowledge is understood and researched, and it explicitly outlines the objective, motivation, and expected outcomes of the research process (Abbadia, 2022). Moreover, an understanding of the research paradigm provides researchers with a clear path to examine the topic of interest.

In this study, the researcher used interpretivism as the paradigm of choice. The interpretive paradigm is used in most qualitative research conducted in the social sciences; it is predicated on the existence of numerous realities rather than a single reality (Abbadia, 2022). According to interpretivists, human behaviour is complex and cannot be predicted by predefined probability designed by the researcher alone in the laboratory. Interpretivism considers differences such as cultures, circumstances, as well as times leading to the development of different social realities (Alharahsheh & Pius, 2020).

In the current study, the researcher considered the socio-cultural differences and other personal factors that may influence participants' opinion of the research inquiry. Additionally, the sociocultural background that the participants originate from or are currently staying may sway the participants' views on the subject. Lastly, participants' ethnicity may affect their perspectives. UKZN accepts local and international students. The diversity of the participants in the current study setting was considered because it brought a different meaning and outcome of the research phenomenon. Moreover, using an interpretivist paradigm answers 'how' questions on the lived realities and experiences of participants.

Considering the nature of qualitative participatory action research (PAR), which is a collaborative, iterative, often open-ended, and unpredictable endeavour, that prioritises the expertise of those experiencing a social issue and uses systematic research methodologies to generate new insights (Cornish et al., 2023). The interpretivist paradigm corresponds with PAR as it holds that people construct their understanding of the world through experiencing and reflecting on those experiences (Ulz, 2023). Interpretivist researchers conducting action research are expected to be

part of the social phenomenon and the specific role and participation in the research process must be explained in detail when analysing data (Pervin & Mokhtar, 2022). Furthermore, the researchers need to check all the aspects of the analysis carefully when documenting the data systematically.

3.3.1 Philosophical perspectives

Research philosophy refers to the underlying beliefs and assumptions that guide the researcher's approach to conducting research (Saunders, Lewis & Thornhill, 2009). Whether one is consciously aware of them at every stage in the research process, one will make several types of assumptions (Alele & Malau-Aduli, 2023). These include assumptions about human knowledge (epistemological assumptions), the realities one encounters in their research (ontological assumptions), and the extent and ways in which values influence one's research process (axiological assumptions). Philosophical perspectives help researchers to answer questions such as; *How are we to discover and validate what we think exists?* and *What methods will we select to collect data?* (Tombs & Pugsley, 2020).

Research paradigms consist of four philosophical elements namely axiology, ontology, epistemology, and methodology (Alele & Malau-Audi, 2023). The four elements are described below.

3.3.1.1 Ontology

Ontology deals with the philosophical assumptions about the nature of reality or existence (Khatri, 2020). Moreover, during research, ontology makes the researcher seek the answers to such questions as: *Is there reality out there in the social world, or is it a construction, created by one's mind?* Ontology helps researchers recognise how certain they can be about the nature and existence of objects they are researching (Moon & Blackman, 2017). For instance, what 'truth claims' can a researcher make about reality? Ontological assumptions of interpretivism define reality as internally experienced and socially constructed through interaction and interpretation and is based on the definition people attach to it (Tombs & Pugsley, 2020). Thus, in the current study, the researcher sought to explore factors influencing the involvement of male students in SRH at the UKZN. Scilicet, masculinity, stigmas and stereotypes were the assumptions that the researcher had in mind before the data generation

process. However, the data analysis in Chapter 4 discusses varieties of factors influencing the male students' involvement in SRH and confirm the pre-assumptions made by the researcher.

3.3.1.2 Epistemology

Epistemology is the branch of philosophy that deals with the study of knowledge and belief (Alele & Malau-Audi, 2023). This paradigm highlights the relationship between the inquirer and the known – what is recognised as knowledge. In research, epistemology is used to describe how we come to know something; and how we know the truth or reality (Khatri, 2020). Moreover, it focuses on the nature of human knowledge and comprehension that the researcher or knower can acquire to be able to extend, broaden, and deepen understanding in the field of research. Epistemology incorporates the validity, parameters, and methods of acquiring knowledge. Therefore, to understand the epistemological element of a paradigm, it is important to ask the very important question of how we know what we know? This question is the basis for investigating the truth (Kivunja & Kuyini, 2017). Epistemological assumptions of interpretivism show that knowledge is based on the abstract descriptions of meanings, formed from human experiences (Žukauskas, Vveinhardt & Andriukaitienė, 2018). In this study, the researcher approached the male students with an assumption that their knowledge and perceptions of SRH may be impacted and influenced by social, cultural, religious, and other life factors. For example, the research instrument was guided by questions focussing on aspects such as:

a) What are the factors influencing male students to be involved in SRH subjects at UKZN?
b) What strategies can be used to enhance the involvement of male students in sexual and reproductive health matters at UKZN?

3.3.1.3 Axiology

The term axiology refers to the researcher's understanding of values and their role in research (Alele & Malau-Audi, 2023). The purpose of using axiology, in terms of the study and exploration of human values is to enable us to identify the underlying beliefs and values that influence our perceptions and interpretation of life experiences,

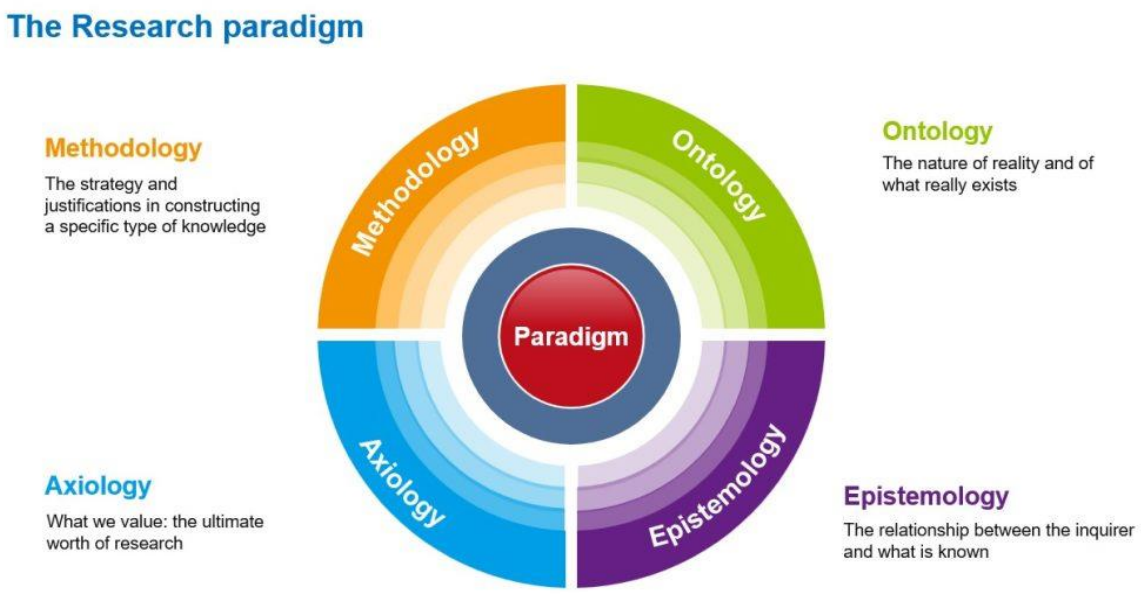
decisions and actions is to understand clearly why we do what we do (McArdle, Hurrell & Muñoz Martinez, 2013). The inquiry axiology strives, questions what the meaning of life is and how we should live (Ajay, 2021). Moreover, axiology also challenges whether our research is neutral or do the personal values and opinions of the researcher affect the shape of how we do research. Similarly, the researcher followed all the ethical principles. Significantly, the researcher valued and respected the participants' views and opinions, as this study will benefit not only the participants but the rest of male students at UKZN and other institutions of higher learning.

In this study, the data analysed was a true reflection of the participants' perceptions and views. The axiological assumptions of the interpretivist paradigm accept that research is value bound, and the researcher is part of what is being researched, cannot be separated and so will be subjective (Al-Ababneh, 2020). In terms of axiology, questioning the value of the research, the researcher in collaboration with the participants determined factors influencing the involvement of male students in SRH at UKZN.

3.3.1.4 Methodology

The term methodology refers to the study design, methods, and procedures employed in a well-planned investigation to find answers (Alele & Malau-Audi, 2023). The methodology is a combination of different techniques used by scientists to explore different situations (Žukauskas, Vveinhardt & Andriukaitienė, 2018). It is inferred that methodological considerations in a paradigm simply include participants, instruments used for data gathering, and measures for data analysis through which knowledge is gained about the research problem (Khatri, 2020). Moreover, the methodology articulates the logic and flow of the systematic processes followed in conducting a research project, to gain knowledge about a research problem. Methodologies in the interpretivist paradigm use unstructured interviews, ethnography, observation, focus groups, case studies, and action research. The current study applied qualitative participatory action research approach, non-probability purposive sampling methods, semi-structure interviews and focus group discussions for data collection, data analysis was conducted using thematic analysis.

Figure 3.1: The research paradigm



Source: Bunmi Malau-Aduli and Faith Alele (2023)

3.4 Research design

McCombes (2019) describes a research design as a plan to answer a set of questions and a framework that includes the methods and procedures to collect, analyse, and interpret data. The research design involves outlining the overall approach and methods that will be used to collect and analyse data to answer research questions or test hypotheses (Singh et al., 2023). Moreover, a well-designed research study should have a clear and well-defined research question, a detailed plan for collecting data, and a method for analysing and interpreting the results. This study sought to answer the following questions:

1. What are the factors influencing the involvement of male students in SRH at the UKZN?
2. What strategies can be used to enhance the involvement of male students in sexual and reproductive health matters at UKZN?

The researcher used qualitative, participatory action research (PAR). PAR emerged around 1970 when social scientists who shared a particular concern about life conditions among the rural poor, became dissatisfied with training, with its emphasis

on practice in conditions of exploitation and poverty (Jacobs, 2016). Moreover, PAR originated in third world countries such as Brazil, Colombia, India, Mexico and Tanzania. PAR is an approach that aims to effect context-specific change or development, through shared decision-making and promotion of equality of the voices of the participants (Fogg et al., 2022). Participatory research is a process through which members of an oppressed group or community identify a problem, collect, and analyse information, and act upon the problem to find solutions and promote social and political transformation (Gray et al, 2020). Furthermore, PAR is a community organising and problem-solving tool with objectives that include the solution to practical problems within a community.

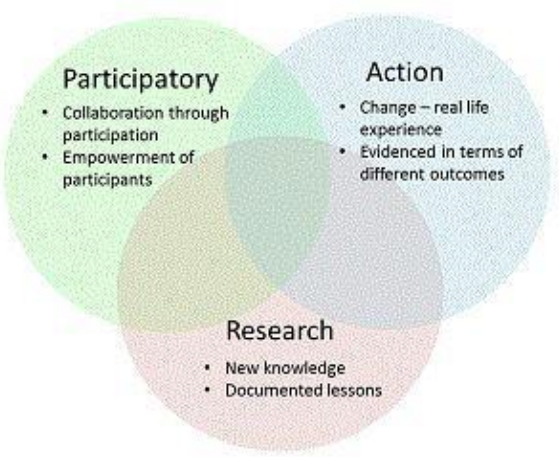
PAR is rooted in both action research and participatory research. Action research refers to methodologies that use strategies that can explain and improve a particular situation, whereas participatory research refers to having individuals who would benefit from the research outcome (Wester et al., 2021). Furthermore, PAR is a systemic investigation that (a) emphasizes participants maintaining an equal and active role in the production of knowledge throughout the entire research process and (b) uses findings for actionable goals of systemic social change. PAR involves a spiral of self-reflective cycles of the following: planning a change, acting, and observing the process and consequences of the change, reflecting on these processes and consequences, re-planning, acting, and observing again, reflecting again and so on (Kemmis & McTaggart, 2007). After possible solutions have been found, action is taken to implement the solutions in partnership with the participants (Thirsk & Stahlke, 2022). The process is cyclic and messy because of the back-and-forth actions of plan-act-reflection and replan (Kemmis & McTaggart, 2007).

Several studies have been conducted applying PAR with successful results. In considering that PAR encourages context specific change through shared decision making as cited above, researchers in collaboration with participants identify the problems, act on those problems by developing and implementing strategies to develop the communities and improve the wellbeing of the participants as well as their peers (Wessels & Woods, 2019; Letsela et al., 2019; Soerdawo et al., 2022).

In this study, male students were not treated as subjects of the study because they collaborated with the researcher to identify the origins of the conduct that serves as a

barrier for male students at UKZN to access SRH. Essentially, using PAR in this regard encourages a sense of involvement and sense of relevance by the participants. PAR allowed the participants to present recommendations and solutions based on the data generated. Initially, following the participants' recruitment and signing of consent forms, both the researcher and participants engaged in a critical dialogue aiding mutual consensus on the reality of the research questions, considering the study's objectives. During the planning stages of the study, the researcher together with the participants concurred on the research methods (interviews and FGDs), data collection techniques (face-to-face and virtual meetings), and the timelines for this study. Action, observation, and reflection stages occurred simultaneously as a way of discovering whether the implemented interventions such as the installation of condom dispensers, and health talks are addressing the discovered challenges (see Chapter 4, figure 4.1). The participants as co-researchers, suggested the timelines of the study based on their availability according to learning responsibilities. Further, the themes developed by both the researcher and participants in Chapter 4, came with recommendations that were implemented This aided in planning further interventions, which will target a greater audience as the participants and the researcher have committed to the implementation of the findings continuously. Referring to data analysis in Chapter 4 under the quotes, it is noticeable that the participants in this study did not only identify problems, but they came up with opinions on how to solve the problems.

Figure 3.2: Participatory Action Research illustration



Source: Allen (2016)

3.5 Research setting

Study setting refers to the physical, social, or experimental context in which the research is conducted (Fonseca, 2023). Furthermore, this includes the location, period, population, and environmental factors. This study was conducted at University of KwaZulu-Natal's (UKZN), Howard College campus, in KwaZulu-Natal province, South Africa. UKZN was established in 2004 and has four campuses around Durban, and one in Pietermaritzburg (UKZN website, 2023). The overall number of enrolled students at UKZN was 44 864 in 2022 which increased slightly from 44 068 in 2021 (UKZN Annual Report, 2022). The University is a multicultural environment, and a home to international students from various countries. Most full-time students are from the SADC region and the rest of Africa, UKZN also attracts full-time students from China, India, Europe, the United States of America, and elsewhere (UKZN at Glance, 2022). Moreover, the UKZN is ranked number 4 on the list of the best universities in South Africa. Lastly, the 2022-23 edition of the global 2000 list by the Centre for World University Rankings (CWUR) ranked UKZN in the top 2.5% worldwide, coming in at 484 out of 19 784 universities.

All the five UKZN campuses have a campus health clinic, manned by administrative staff, professional nurses, and twice weekly medical doctor's visits. The researcher chose the Howard campus because it is easily accessible, a decision based on seeking to minimise costs since the study is self-funded. Campus health clinics are university health centres that address students' minor walk-in complaints and ongoing chronic issues (Grace, 1997). Furthermore, campus healthcare staff manage and prevent the spread of potentially deadly infectious diseases, providing students with immunisations and wellness education and treating students' mental health issues. The campus clinics operate from 08h00 to 16h00 on week days only. Approximately, 60 to 70 students visit these clinics every day, with an annual headcount of 31 761 (UKZN Annual Report, 2014). The researcher selected UKZN as the study setting because she is an employee there. She observed the poor attendance by male students when it comes to seeking health care compared to their female students. The campus health clinic visits are comprised 90% of female students and 10% of male students (UKZN Annual Report, 2017). A total of 1 026 cases of STIs were treated across all the campus clinics in 2022, with 341 of those cases from Howard College (Campus Health Clinic Statistics, 2020).

3.6 Population, sampling, and recruitment methods

Casteel and Bridier (2021) describe the population as the principal group about which the study is concerned. Furthermore, the population of interest comprises individuals, dyads, groups, and organisations one seeks to understand. The targeted population in this study were male students who were registered at UKZN in the 2023 academic year. The study focused on Howard College campus. Sampling is the selection of a group of individual population members that represent the entire target population (Stratton, 2023). The researcher used non-probability convenience sampling and purposive sampling. Convenience sampling is where samples are selected from the population only because they are conveniently available to the researcher, whereas purposive sampling selects the samples based purely on the researcher's knowledge and credibility (Fleetwood, 2023). Furthermore, purposive sampling refers to a group of non-probability sampling techniques in which units are selected because they have characteristics that the researcher needs in their sample (Nikolopoulos, 2022). The researcher wrote a letter to the UKZN Registrar to seek permission to conduct the study (Appendix G). This was followed by ethical clearance application from the Humanities and Social Sciences Research Ethics Committee (HSSREC/00005823/2023) (Appendix A). Ethical clearance was granted, which lead to the initiation of recruitment process. Howard College's campus clinic's boardroom was used for the physical interviews. This setting was used after securing the researcher's manager verbal permission and consultation of the participants.

3.6.1 Recruitment

The researcher randomly recruited a total of 27 participants. These were drawn from the researcher's study area. Owing to pressing academic commitments, three participants were not available to attend during the data collection period. They were writing tests. Male students who were registered in 2023 academic year at UKZN were recruited. The researcher conveniently recruited random students from students' social media groups such as WhatsApp, and cafeterias during their lunch break times. Social media can be defined as any online and mobile resource that provides a forum for generating, sharing, or discussing ideas and content (Havard Catalyst, 2017). Social media has shown early signs of effectiveness as a recruitment tool, including

among historically hard-to-reach populations, and its popularity as a recruitment tool is growing (Andrews, 2012). The researcher availed the study information, aims, and objectives to all male students in the above-mentioned groups. The male students who expressed their interest in the study were allowed to participate. This study was open to all male students, regardless of age, ethnicity, and race.

The researcher approached students who were either sitting outside the clinic or those who were attending the clinic if they were willing to join the study. Lastly, the researcher purposely recruited participants who were already in programmes like peer-to-peer educators through their social media group and monthly meetings. Peer-to-peer educators are the most influential and relatable group of students as this group mentor students to good health. The peer educators' recruitment attained the purpose of PAR through the sharing of views and in turn addressing the outcome of the study, through restructuring of the wellness programmes.

Student leadership (student representative council (SRC) and campus representative council members) was recruited from a social gathering they had at the student centre area. The SRC is the students' representative body that is critical to effective communication between students and the college administration while protecting all rights of students (Subramanian et al., 2009). Therefore, student leadership is the voice of students and a respected group of students by other students, their views, concerns, and participation in this study was of importance, as they may have received information and the views of other students during their campaigns. Furthermore, the SRC represents students in important structures of the university where the study findings may have a positive representation through the leadership. The recruitment of the student leadership assisted in the plenary of events to encourage the involvement of male students in SRH. These events will commence in 2024 during the orientation of first-year students, to fulfill the action part of PAR, this is later explained in Chapter 5.

Nursing students were recruited during visits to the campus health clinic. They were recruited to add the health perspective to the study, as they will usher the study from the health care perspective. The researcher considered the peer educators, nursing students, and student leadership as the nursing students are already role models and

the most influential groups to their fellow peers and a better listened to by fellow students.

During the recruitment of all three groups, the researcher approached (student leadership and nursing students) seated in groups. The peer-to-peer educators responded to their social media group, when the researcher went to meet them the first time, they had already grouped themselves. This simplified the need for the researcher to set up groups. The information sheet (Appendix B) that entails the context of study was circulated to the participants through email and social media as these participants shared their contact details during the brief introduction when the researcher approached the participants for recruitment of this study at their respective gatherings as mentioned above.

The minimum number of 18 recruited participants as planned in Chapter One was reached, and there was no new data generated– thus saturation was reached (Daher, 2023). More so, the researcher considered that qualitative research approach is concerned with depth and richness of data and not numbers (Singh, Vadakedath & Kandi, 2023).

3.7 Data collection methods

Different methods for gathering information regarding specific variables of the study aiming to employ them in the data analysis phase to achieve the results of the study and gain the answer to the requested questions are referred to as data collection (Taherdoost, 2021). The researcher conducted interviews and focus group discussions, using the interview guide (Appendix D). An interview guide is a research tool which is developed by the researcher and it contains a set of questions meant to elicit the participants' views, opinions, and feelings on a particular inquiry (Muzari, Shava, & Shonhiwa, 2022). Interviews create an opportunity for the researcher and participants to engage in a discussion so that the participants' experiences and perceptions are shared, and the phenomenon under study is explored (Lucian et al., 2019). Data collection was conducted during the examination week at the UKZN, considering the notion of social justice, which emphasizes the equitable treatment of participants. Participants were not all readily available entirely, the researcher used

the times selected by participants to conduct the interviews effectively. Before the start of the interviews, the researcher and the participants laid down ground rules after the introductions, to avoid interruptions to promote mutual respect.

3.7.1 Semi-structured interviews

The researcher conducted six semi-structured interviews with participants. The primary benefit of using semi-structured interviews is that an opportunity is created for interviews to be focused while still giving the investigator the autonomy to explore pertinent ideas that may come up during the interview (Adeoye-Olatunde & Olenik, 2021). All the interviews were conducted by the researcher. The researcher used open-ended questions, followed by probes to enhance the depth and to obtain a better understanding to fulfil the objectives of the study. The researcher achieved this method by asking “why” and “how” questions to participants in aiming to attain answers with explanation, when there was new information arising the researcher followed up with more questions. The researcher opened the interview with broad questions. For example, a) What are the factors affecting the involvement of male students in SRH at the UKZN? b) What strategies can be used to enhance the involvement of male students in sexual and reproductive health matters at UKZN?

In a semi-structured interview, there is flexibility to ask additional probing questions and if the participant introduces a new concept (that has not been identified) then the researcher may choose to follow this line of inquiry (Luciani, 2019). Similarly, after the main question, the researcher followed by a probing question to obtain a deeper understanding of the phenomenon of interest. The interviews were conducted in English or IsiZulu as some of the participants were not comfortable with either IsiZulu or English (Appendix D). A total of six interviews lasting about 45 minutes were conducted. Interviews conducted in isiZulu were translated to English. The researcher allowed the participants to express themselves freely without interruptions. A more positive research experience for participants during the interviews was created through nodding by the researcher as a sign of active listening, which led to more in-depth responses from the participants. Field notes were taken to guide the follow-up questions where the researcher sought to get clarity and obtain a deeper understanding of the experiences shared by the participants. Two follow-up interviews

were conducted to delve deeper into the participants' responses from the previous interview.

3.7.2 Online interviews

Online interviews were conducted on Zoom and MS Teams with students who were not physically available during the period of data collection. The researcher conducted one interview on Zoom and two on MS Teams. Online interviews are less costly because the researcher saves on travel expenses and they are flexible to schedule (Keen, Lomeli-Rodrigues & Joffe, 2022). The advantage of conducting online interviews in this study was that the researcher was able to interview more than one person per day. In the same way as face-to-face interviews, the researcher followed the interview guide and asked open-ended questions followed by probes. The researcher gave a summary of each interview to the participant before concluding the interview. This assisted in the confirmation of the trustworthiness of field notes and the emergence of themes. UKZN students receive monthly data for internet use, and this helped to facilitate online interviews as this could have been a negative factor in conducting interviews online. To avoid the problem of poor internet access, researchers should first assess the feasibility of using online interviews within a setting (Akyirem et al, 2023).

3.7.3 Focus group discussions

Focus groups provide deeper and richer information through social interactions (Gundumogula, 2020). The advantage of focus groups is that participants get to add comments and more information beyond their original responses. A total of three focus groups of six people each were conducted in the campus clinic's board room at Howard College, and one focus group was conducted at the HIV/AIDS offices where peer educators indicated that they were comfortable. This aligns with the principle of PAR promoting democracy and social justice (Stern, 2019). The focus group discussions were conducted over an average time of 60 minutes. The researcher stopped collecting data when saturation was reached. This was when there was no new information forthcoming (Braun & Clarke, 2021). The discussions were audio recorded with participants' consent. Recording helped to ensure that all the details were captured accurately. During the focus group discussions, participants raised their

hands when they wanted to express a point, and this rule was made by participants during an introductory process by laying ground rules. The researcher nodded when it was necessary as an indication of an understanding of what the participants expressed, with no interruptions. This gesture promoted active participation amongst participants, and it contributed to trusting the researcher.

Both focus groups and individual interviews elicit participants' views and experiences and are often used in qualitative research (Gondumogula, 2020). The methods can be used as sole data collection method or may be included in a multi-method design (Lesley, 2019). Furthermore, focus groups can generate rich data through interactions but it is not always easy to predict recruitment and attendance, so individual interviews may be added to ensure inclusion of particular individuals' views. Consequently, using both in-depth interviews and focus group discussions helped to generate nuanced data that was not obtained from an individual perspective but from a group as well. The use of method triangulation provided the researcher with rich and thick data that would not have been generated using one method. The researcher was fortunate to have active and goal-driven participants, who weren't holding back information or distractive; they stuck to the rules as a way of respect during the interviews. Thus, there was no need for a moderator.

At the end of data collection process, the participants gave the researcher permission for further communication for follow-up interview questions and continued participation during implementation also. One focus group and two in-depth interviews were conducted. These follow-up interviews took about 15-25 minutes..

3.8 Data analysis

Data analysis is simply the process of converting the gathered data into meaningful information (Taherdoost, 2020). The researcher used the thematic data analysis method. Thematic analysis is a qualitative technique where the researcher aims to discover participants' views, opinions, knowledge, experiences, and values from a set of qualitative data (Caulfield, 2022). The thematic analysis approach has seven phases, which include preparing and organizing the data, transcribing the data, becoming familiar with the data corpus, memoing the data, coding the data, producing categories and themes from the underlying coded passage, and making the analysis

process transparent (Lester, Cho & Lochmiller, 2020). In this study, the researcher organised the transcribed data into summary that were shared with the participants during the meetings detailed in Chapter 3. This type of member checks aided in the ensuring the trustworthiness of the data collected. This also promoted transparency and trust by the researcher to the participants. Considering PAR, both the researcher and participants concurred on the themes and sub-themes that emerged from.

3.9 Trustworthiness of the study

In this study, trustworthiness was achieved by applying Lincoln and Guba's (1986) strategies, which are, credibility, transferability, dependability, and confirmability.

3.9.1 Credibility

Lincoln and Guba (1986) claimed that the credibility of a study is determined when researchers or readers are confronted with an experience, and they can recognise it. Credibility can be achieved through a careful description of the data analysis and verification of sources of data obtained with participants from whom the data was collected (Daniel, 2019). One method of promoting credibility is through the various processes of triangulation (Stahl & King, 2020). Roughly stated, triangulating means using several sources of information or procedures from the field to repeatedly establish identifiable patterns. In this study, credibility was achieved by comparing field notes and revising audio recordings and online interviews conducted by the researcher. This is a technique in which the data, interpretations, and conclusions are shared with the participants called member checking (Daniel, 2019). It allows participants to clarify what their intentions were, correct errors, and provide additional information if necessary (Complete Dissertation, 2023; Polit & Beck, 2021). The researcher recited the summary of transcripts to participants to clarify errors and whether the researcher had highlighted the participants' intentions. Participants added pointers that the researcher had missed, and eventually everyone was satisfied with the transcripts. Member checking is a technique through which the data, interpretations, and conclusions are shared with the participants to establish the credibility of the study (Polit & Beck, 2021).

3.9.2 Transferability

Transferability means that the findings are also applicable to other contexts (Kyngäs, Kääriäinen & Elo, 2020). Transferability is established by providing readers with evidence that the research study's findings could apply to other contexts, situations, times, and populations (Polit & Beck, 2021). It is, in summary, not the naturalist's task to provide an index of transferability, it is the researcher's responsibility to provide the database that makes transferability judgments possible on the part of potential appliers (Lincoln & Guba, 1986). Consequently, in this study, the researcher established transferability by providing detailed descriptions of the study in detail, including, methods, time frame, duration of the data collection, and data analysis.

3.9.3 Dependability

Dependability can be achieved by examining the process by which the research has been carried out (Amin et al., 2020). Keeping records of the raw data, field notes, transcripts, and a reflexive journal can help researchers to systemise, relate, and cross-reference data, as well as ease the reporting of the research process. All these are means of creating a clear audit trail (Stalhl & King, 2020). In this study, dependability was achieved by safekeeping audio recordings and field notes to be reviewed for audit trails. Dependability is established through assurances that the findings were established, despite any changes within the research setting or participants during data collection (Hasan et al., 2021). Using another researcher to read and react to field notes, with their embedded researcher interpretations, is a confirmation that creates a tacit reality for the researcher (Stahl & King, 2020). Therefore, in this study, transcripts were sent to an independent coder for audit trails, reviewed and discussions for census. No major disagreements were noted.

3.9.4 Confirmability

Confirmability of qualitative data may be ensured by checking and rechecking data throughout the data collection and analysis process to determine repeatability and as one indicator of total data reliability (Sombilon et al., 2023). This is established when the study conclusions are validated by the data gathered and have not been significantly altered because of researcher bias (Principe, 2022). According to Lincoln and Guba (1986), confirmability is established when credibility, transferability, and

dependability are all achieved. Confirmability concerns the aspect of neutrality of the research (Kasirye, 2021). The interpretation should not be based on the researcher's preferences and viewpoints but rather, it must be grounded in the data. Therefore, the data collected ought to be treated as unique, and researchers must detach themselves from the assumption of the study research process through bracketing. Bracketing is a qualitative technique that aims to set aside one's own beliefs to avoid misinterpretation of the research data (Habibullah, Mohammed & Hamza, 2023). In this study, confirmability was established by providing rich quotes from the participants that describe emerging themes. Furthermore, data analysis was a continuous cycle of reflection and action, meaning, data presentation was done concurrently with data collection. This provided an opportunity for both the researcher and the participants to agree on emerging themes at the end of the interviews. The audit trails completed by the independent coder also established confirmability.

3.10 Ethical considerations

Ethics in research signals scientific ethical values (Hasan et al., 2021). Furthermore, ethical principles are essential to protect the dignity and rights of research participants. Researchers must always adhere to a certain code of conduct when collecting data from the participants (Bhandari, 2022). The research ethics code was created to protect the participants from abuse and violations by researchers (Davis & Lachlan, 2017). Moreover, all research involving human beings should be reviewed by an ethics committee to ensure that the appropriate ethical standards are being upheld. Ethical clearance was obtained from the University of KwaZulu-Natal's Humanities and Social Science Research Ethics Committee (HSSREC/00005823/2023) to ensure respect, dignity, privacy, disclosure of information, and fair treatment and protect participants from any harmful effects because of participating in the research study. In this study, the researcher obtained informed consent (Appendix C) from the participants, the UKZN Humanities and Social Science Ethics Committee, and the researcher's manager (to use the clinic's boardroom).

The researcher applied the following ethical principles during all the phases of the research:

3.10.1 Informed consent

Informed consent is a document that confirms the fact that the study participants are recruited only after being thoroughly informed about the research process, risks, and benefits, along with other important details of the study like the time of research (Singh, Vandakedath and Kandi, 2023). Informed consent advises research participants of their rights as research participants (Josephson & Smale, 2021). In this study, the researcher obtained consent (Appendix C) from all the 24 participants who participated in the study, with no withdrawals. Participants were informed that their participation was voluntary, and they may withdraw from the study at any time without consequences. Essentially, voluntary consent means that the person involved should have the legal capacity to give consent; and should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved to enable him to make an understanding and enlightened decision (Arellano, Alcubilla & Leguízamo, 2023).

3.10.2 Confidentiality and anonymity

Anonymity involves not collecting data that can be identified or traced to an individual or an organisation, while confidentiality refers to the protecting of the raw data and only publishing the aggregated results that cannot be traced to an individual or an organisation (Badampudi et al., 2022). Confidentiality is about ensuring that only authorised individuals have access to protected data and information (Elkoumy et al., 2021). The bestowal of confidentiality and anonymity in interviews allows researchers to obtain reliable qualitative data on sensitive topics, ensuring that any statements made by interviewees cannot be traced back to them (Doughtery, 2021). Direct quotations might be paraphrased to hide idiosyncratic speech patterns (Doughtery, 2021). In the current study, the researcher avoided specifying portfolios when reporting the findings generated through focus groups. During focus group discussions, the researcher assigned pseudonyms when referring to participants, to protect the participants' identities. The setting of the interview was private and secure and prevented people from overhearing the discussions. The audio recording and field notes of the interviews are filed and locked in a password-encrypted file to

accessibly only to the researcher and supervisor. All these files will be disposed of and shredded after 5 years as per university rules.

3.10.3 Beneficence, respect, and justice

Beauchamp and Childress (2019) reported beneficence as an act for another's benefit with the aim being to help further an individual's important and legitimate interest. Beneficence may be accomplished by avoiding or mitigating possible harm (Beauchamp, 2019). During data collection, the researcher must focus on respecting the participants, their culture, and the setting (Wa-Mbaleka, 2019). Furthermore, the researcher must give the participants a voice to contribute to improving their lives. The researcher respected the participants' views and opinions. The information provided by participants was treated as important and it was not used against them, equally for all participants without the researcher imposing her own opinions.

Hein (2023) believes that the goal of justice is full and equal participation of all groups in a society that is mutually shaped to meet their needs. The right to fair treatment means that researchers must treat people who decline to participate (or who withdraw after initial agreement) in a non-prejudicial manner, that they must honour all agreements made with participants (including payment if promised), that they demonstrate respect for the beliefs, habits and lifestyles of people from different background or cultures (Rashid, 2022). In the current study, there was no harm reported, participants' views and opinions were valued and noted, and all the participants were treated equally, and given a chance to participate with no distractions. The researcher listened to the participants attentively until the participants were done talking, to avoid interfering with the flow of information. Considering that UKZN is a multicultural setting, the researcher ensured that all the participants who met the inclusion criteria were given the opportunity to be recruited and participated, regardless of culture, educational level, and background, and were free from discrimination. This study was conducted during the examinations week of the university, however, in ensuring equal participation of the participants, the researcher and participants collaborated in conducting interviews when the participants were free.

Listening and valuing what participants had to say, and being sensitive to their backgrounds, livelihood, and religious or cultural requirements is central to showing

respect for participants (Jenkin, 2020). Respect also involves ongoing honest and open communication between researchers and participants. The findings were shared with the participants.

3.10.4 Fair recruitment of participants

The selection of research participants must be sufficiently inclusive to ensure that the research in question fairly benefits participants (Mackay and Saylor, 2020). Only male students registered in the 2023 academic year at UKZN were recruited in this study. The academic year assisted the researcher to be sure that the male students belonged to UKZN. The researcher considered the aim and objectives of the study in her recruitment, to limit participants who were not appropriate for the study. In this study, the researcher fairly recruited all male students who fit the inclusion criteria. The researcher allowed everyone who wanted to take part in the study, regardless of race, age, and ethnicity to participate. However, not everyone can constitute the study sample.

3.10.5 Social value

The anticipated benefits that can justify human research consist of direct benefits to the research participants and societal benefits, also called social values (Habets, Delden & Bredenoord, 2014). Societal value can be achieved if the research has both societal relevance and societal impact (Lindgreen et al., 2021). Furthermore, societal relevance entails research activities providing results for use and benefit to society, while, societal impact is the demonstrable contribution that research makes to society, value measured in terms of qualitative measures. In this study, following data analysis, the researcher and participants collectively came up with solutions to improve services, meeting the objectives and aim of the study. Consequently, this will benefit not just the participants but the rest of the male students in Howard College, UKZN.

3.11 Conclusion

In this chapter, the researcher described the methodology, demonstrating how the research process unfolded. The research methodology, including the research designs, setting, population sampling, recruitment and methods, and research

paradigm centred around the study were thoroughly discussed. Followed by data generation and instrument, measures of trustworthiness, and ethical consideration. The next chapter, Chapter 4 is the presentation of findings and interpretation of data, and coherent themes that emerged during the data analysis process.

CHAPTER 4

DATA ANALYSIS AND DISCUSSION OF FINDINGS

4.1 Introduction

The aim of the study was to explore and describe factors influencing the involvement of male students in sexual and reproductive health at the University of KwaZulu-Natal. This chapter presented the analysis and interpretation of data, as well as the discussion of such findings. As indicated in chapter 3, semi-structured interviews were conducted to collect data on factors influencing the involvement of male students in sexual and reproductive health (SRH) at the University of KwaZulu-Natal (UKZN).

The data collection process was performed following the cyclic nature of PAR of plan-act-reflect at UKZN, Howard College. This was done to respond to the study objectives espoused in this study, which are as follows:

1. To explore and describe factors affecting male students' involvement in SRH at the UKZN
2. To explore and describe strategies that will enhance male students' involvement in SRH at UKZN.

The study utilised the thematic data analysis. A thematic data analysis approach was used to analyse the themes that emerged from the collected data. The chapter presented the demographic information of the research participants first, which was followed by data analysis. Lastly, the concluding remarks were presented.

4.2 Presentation of findings

A thematic data analysis approach was used to analyse the themes that emerged from the collected data. To enhance coherence the discussion of findings followed each finding presented.

4.2.1 Demographic data of participants

The demographic data was presented to give an overview of the participants and the related group dynamics. The dynamics were important in this study because they gave

the researcher a contextual understanding of socio-cultural, religious, and ethnic factors that have an impact on participants' meaning-making of SRH issues.

All the participants were Africans, South Africans (n=21) IsiZulu speaking (n=2) IsiXhosa speaking, and one (n=1) Sesotho speaking male students. Most of the participants were Zulu people because UKZN is geographically located in an indigenous AmaZulu area.

4.3 Background of participants: Individual interviews

Table 4.1: The participants' demographic information

Participants	Faculty and course	Year Level	Previous Consultation at the campus health clinic	Age	Ethnicity
1.	Engineering	4th	yes	28	Zulu
2.	Masters	1st (Masters)	yes	24	Zulu
3.	Law & Management	4th	yes	21	Zulu
4.	Humanities	2nd	yes	20	Xhosa
5.	Engineering	4th	yes	21	Zulu
6.	Masters	2nd	yes	23	Zulu

Source: Researcher

4.3.1 Background of participants: Focus Groups of student leadership, Peer educators, and nursing students

This study had three focus groups, with six participants in each group. The groups comprised six student leadership, peer educators, and nursing students. More details are given in section 4.2.1.

4.4 Thematic findings

Theme	Sub-themes
1. Attitude towards HIV test	-Using sexual partners' HIV statuses as a test. -Waiting to be sick in order to go for the test. -The perception that they will never be infected with HIV.
2. Condoms-related issues	-No condom on a pretty girl -Condoms disturb intimacy. -Western interventions do not work. -Unsatisfactory availability of condoms.
3. Staff-related issues	-Healthcare workers' judgment -Age and gender of healthcare providers
4. Stigma and stereotyping	-healthcare seeking as a male weakness -Men must be strong. -Scared to be judged
5. Sociocultural issues.	-Men are known as family providers. -Religious affiliations. -The advantage of residential origin
6. Attitude towards SRH programs and campaigns	-Health talks regarded as uninteresting
7. Infrastructure	-Less clinic working hours -Overhearing events next door. -Campus clinic location as a barrier.
8. Solutions to the identified challenges.	-Intensify residences health talk. -Condom distribution within residences

Thematic analysis was employed to analyse the data and to transcribe the audio recordings to identify themes and sub-themes. A total of eight themes (Table 4.2) emerged from the transcribed data, and these include attitude towards HIV test, condom-related issues, staff-related issues, stigma and stereotyping, socio-cultural issues, attitudes towards SRH programmes and campaigns, infrastructure, and solutions to the identified challenges. A description of themes and sub-themes was done as presented in Table 4.2, with direct quotations from participants to support the themes and discussion of data.

Table 4.2: Themes and sub-themes

Source: Researcher

4.4.1 Theme 1: Attitude towards HIV Test

Thematic analysis revealed attitude towards HIV tests is a main theme with four subthemes, which include using sexual partners' HIV statuses as a test, waiting to be sick to go for the test, perception of a compulsory HIV test, and the perception that they would never be infected with any diseases.

4.4.1.1 Using sexual partners' HIV statuses as a test

The research findings have revealed that male students use their sexual partners as a test for their HIV status. Participants expressed that if their partners are HIV-negative then it means the participants would have similar results with their partners. The following responses from the focus groups help illustrate this point:

> *"Even though males do not sleep with one partner, they will have the same HIV status with the one they do unprotected sex. They use their girlfriends to know their HIV status. If the girl is HIV negative, it means the guy is HIV negative as well."*

The participants' response is worrisome given the virologic responses after an HIV infection. In addition, a couple would have one partner that has a sexually transmitted disease (STD) such as HIV, while the other partner does not have or is in the window period after an infection (Clinical info HIV, 2020). This is evidence that testing HIV using a partner's status is not reliable. Therefore, the avoidance of HIV testing by male students is detrimental to their own health.

As Makusha et al. (2022) observed, there is a rise of 4.1% in HIV prevalence in young men aged 15-24 years. Most university students fall within this age group, even the participants themselves were within this age range. This is the vulnerable age group that gets involved in risky sexual behaviours (Anyanwu & Mbarara, 2023). Therefore, this underscores the importance of young men's involvement in SRH. The avoidance of HIV testing by male students disturbs the South African Sustainable Development Goals (10), which aim for a healthy life for all by 2030 (Sustainable Development Goals Country Report, 2019). It is thus vital for men to test their HIV status so that the country achieves '95-95-95 targets' (Frescura et al., 2022).

According to Gupta, Granich and Williams (2022), when males as the dominant sexual partner take the leadership role to stay healthy, the transmissions to partners and their

offspring are reduced and makes individuals able to live healthily, regardless of their HIV status. Furthermore, early detection of an HIV-positive status prevents complications and the development of severe diseases (Calvin, 2019). This is possible as South Africa has moved to the 'universal test and treat' programme, which means that there is no reason to wait for antiretroviral treatment soon after an HIV test becomes positive (Girum et al., 2020).

4.4.1.2 Waiting to be sick in order to go for a test

The findings revealed that male students believe in not knowing their HIV status unless they are sick. Participants expressed that they would rather be tested on a deathbed than be tested while they are still healthy-looking. These responses are against the health promotion and disease prevention strategy. The following responses from the same focus group discussion help illustrate this point:

> *"The most prominent thing that male students are scared of is testing for HIV. They still think that when you get to the clinic it's compulsory to test for HIV, otherwise you will not be assisted".*
>
> *and*
>
> *"What you do not know will not kill you".*
>
> The following expression was shared by a 2nd year master's student.
>
> *"As a man, I cannot go to the clinic for minor things, I need to be sick first, otherwise I won't be a real man, it would mean I am a cry-baby."*

These findings concur with Desmon (2019) who observed that for male partners, physical death is preferable to the social death. When one tested positive would feel like dead because of stigma attached to an HIV positive test. Furthermore, male partners blame health practitioners for instilling fear of HIV in previous years.

Such thinking is based on the fact that the stigma is inevitable because it occurs at the individual, family, community, and workplace levels (Kazuma-Matululu Nyondo-Mipando, 2021). It is disturbing that stigma becomes a hindrance to access to health care services, especially among men. It influences one's decision to access HIV testing and ART services. Male partners perceived the consequences of HIV-related

stigma like shame, fear, and isolation. At all these levels men would navigate the options of accessing the services while risking stigma and discrimination.

Also, Sharma (2019) observes that men's vulnerability to HIV can be partially attributed to masculine gender norms. Hence, men do not want to be perceived as weak due to seeking health care. This narrative reinforces the fact that acquiring the knowledge of HIV early can prevent complications and severity of the disease. According to Sharma (2019), healthcare facilities should be sensitive to service access barriers and create an accommodative environment to relieve fear and anxiety among men.

HIV testing is an entry point to a comprehensive continuum of care. Once an individual has been tested for HIV, prevention can be reinforced and referral made to available treatment, care, and support services (Department of Health, 2019). Furthermore, HIV testing must always be voluntary and free of coercion. Essentially, HIV testing is not compulsory, but it is necessary. Participants' fear of HIV testing is comprehensible as no one wants to have an incurable disease. Consequently, knowing one's HIV status improves the quality of life. Healthcare professionals can diagnose an individual correctly, while excluding HIV or any related infections for effective treatments in cases of ill health. Knowing one's HIV status gives one powerful information that enables him or her to take steps to keep the couple healthy (HIV.gov, 2023).

4.4.1.3 The perception that they would never be infected with HIV.

Some participants revealed that they never get infected with HIV. Hence, HIV infects people with risky behaviours, and therefore there is no need for an HIV test. The following response from focus group discussion helps illustrate this point:

> *"I do not think I will ever get infected by HIV. I am very strong; I am just not the type to ever have HIV, that's all. I am not the outgoing type."*

Male students may feel stigmatised and discriminated against by these sentiments which imply that only those with unhealthy lifestyles may be infected with HIV. This is erroneous because there is evidence that an estimated 39.0 million people were living with HIV worldwide in 2022, and 2.58 million were children aged 0-19 (UNICEF, 2023). Furthermore, each day in 2022, approximately 740 children became infected with HIV and approximately 274 children died from AIDS-related causes. The major contributing

factors to such mortalities are mostly because of inadequate access to HIV prevention, care, and treatment services. Consequently, this is evidence that HIV is not only a lifestyle disease, but it can also be acquired maternally and other routes of transmission.

Mokgatle and Madiba (2023) observe that stigmatisation of people living with HIV leads to non-disclosure of people in fear of being discriminated against. This is again more evidence that health education needs to be inclusive of ways of transmission for better understanding and to break the stigma and discrimination behind HIV positive people.

4.4.2 Theme 2: Condom-related issues

Further analysis revealed that condom-related issues emerged as a major theme with sub-themes such as no condom on a pretty girl, condoms disturb intimacy, Western interventions do not work, irregular use of condoms to prove one's manhood, and unsatisfactory availability of condoms. These sub-themes are discussed in subsequent sections.

4.4.2.1 No condom on a pretty girl

The participants' responses from the focus group have revealed that engaging in unhealthy sexual lifestyles is regarded as important for males in order to prove their manhood and masculinity. The participants have intimated that if one shares with their peers that they are using condoms with a beautiful girl, they are in turn mocked and teased by the same peers. The following response from focus group discussions helps illustrate this point:

> *"Us, male students, will laugh and tease each other for using condoms on a pretty girl, like, why? You are told to be a real man and go skin to skin."*
>
> *"When we see a beautiful girl passing by, we already imagine not using condoms with her."*

University students are at a stage of self-discovery. Mazibuko, Saruchera, and Okonji (2023) discovered that university-attending students engage in risky behaviours, including unprotected sex and alcohol use. Furthermore, this is mostly common in

males due to peer pressure. Anyanwu and Tamwesigire (2023) also observe that students who are 18 years and older are more likely to be sexually active, and practice risky sexual behaviours.

Moreover, being involved in risky sexual behaviours is a risk factor for HIV. Peer pressure was a driver of risky sexual behaviour among university students in South Africa (Mthembu, Maharaj & Rademeyer, 2019). Consequently, those who succumb to peer pressure and engage in risky sexual behaviours would be at risk of unplanned pregnancies, STIs and STDs, including HIV. Attractive women may be more sexually active on average because those who are in the market for new partners invest more in these types of material goods (Frye & Chae, 2017). Female attractiveness may also be positively associated with HIV risk due to men's sexual risk behaviour, specifically their reduced likelihood of practicing safe sex with women whom they consider attractive (Kruse & Fromme, 2005). Moreover, in sub-Saharan Africa, local understandings of male sexuality suggest that men become impulsive and unthinking when faced with attractive women.

4.4.2.2 Condoms disturb intimacy

The participants' responses from the focus groups have revealed that condom use disturbs sexual intimacy between partners. The following response from focus group discussions helps illustrate this point:

> *"Imagine during foreplay and now you must pause and reach for the condom and open it! It kills the mood."*
>
> And,
>
> *"Condoms kill the mood; you have to feel the girl properly."*

Participants in this study expressed myths and perceptions on condom use resulting in loss of pleasure during sex. Condoms are a major contraceptive in SRH and it protects nearly all STIs and STDs, including unplanned pregnancies. Similar findings were reported by Mbachu (2021) from a study conducted in Nigeria regarding condom use as interference with sexual pleasure. Moreover, many adolescents appear to know that consistent use of condoms during sexual intercourse protects individuals from unwanted pregnancy and STIs, although not a hundred percent full proof. The

aforementioned indicates a knowledge gap among the participants which needs to be addressed to enhance universal health coverage.

According to Milhausen et al. (2019), pleasurable sexual intercourse is determined by the relationship the individuals engaging in it have. Hence, in casual sex partners, sex may be pleasurable with or without a condom compared to committed relationships. This demonstrates that health-protective activities do not necessarily contravene pleasure. Regardless, non-use of condoms increases the risks of STIs, STDs, and unplanned pregnancies. One would have to weigh options of a healthy sexual life and engage in more meaningful sexual intercourse or delay sexual activities to avoid burdens that come with unhealthy sexual intercourse. This statement aligns with Rodrigues (2023) who discovered that people focused on prevention are more aware of sexual health costs and more likely to consider postponing a potentially rewarding sexual experience in favour of their safety.

4.4.2.3 Western interventions do not work

The participants' responses from focus group have revealed the impact of socio-values and practices on one's life. The sub-theme on Western interventions that do not work affirms male students' worldview which results from social influence. Participants have intimated that these teachings come from societal influences, viewing condom use as a western intervention. The following response from focus group discussions helps illustrate this point:

> *"When we are doing our condom distribution as peer educators, some male students would tell us that they prefer unprotected sex because condoms do not work for them. They have this perception that they will never be infected with diseases; they will be fine even if they do not use a condom, as they learned that from people back home saying that Western style doesn't work."*
>
> And
>
> "*We Africans knew nothing about condoms before, with or without them, if you are supposed to have an STD you will have it."*
>
> One participant from the focus group agreed with the above quote saying;

"As long as you can use traditional herbs as enemas, you will be fine, that is how, we-Zulu men cure illnesses by cleansing our bodies."

Health promotion packages encourage the use of condoms during sex to prevent infections such as STIs, STDs, and unplanned pregnancies. In contrast to this some countervailing norms actively discourage condom use as expressed by the study participants. This concurs with some studies which revealed that condoms are inconvenient, and that their religion prohibits condom use (Farrington, Bell & DiBacco, 2016). On the other hand, some studies report issues of power and dominance that it is the male partner's responsibility to decide on condom use (Olamijuwon & Odimegwu, 2022; Pincock, 2017).

According to Bookchin's social ecology theory, society influences the conduct of individuals and these learned behaviours are transferred through generations. This study was dominated by participants of Zulu culture. The researcher had to consider the Zulu beliefs. AmaZulu believes that the cause of an un-well body is due to an imbalance in nature and pollution from evil spirits and the traditional healer is still needed to fix this problem (Bahamonde, 2015). Ultimately, the aim is to ensure that every person is free from disease, regardless of the type of medicine used. These are some of the reasons that led to the integration of traditional and Western medicine (Mokgobi, 2013). Eventually, this would promote good health, accommodating people's beliefs and sustainable outcomes.

4.4.2.4 Unsatisfactory availability of condoms

The participants' responses from the focus group have revealed that the availability of condoms in public spaces is not satisfactory. Participants have revealed that there are many empty condom dispensers around campus toilets and in some residences. The following responses from focus group discussions help illustrate this point:

> *"Sometimes you have to ask the residence committee members for condoms, as they will not be anywhere in residence."*
>
> And,
>
> *"Even in some of the toilets around campus, there are no condoms".*

Procurement of male and female condoms and lubricants in South Africa is through a 3-year national tender managed by the national treasury (NT) as contract managers with the National Department of Health (NDOH) providing technical support (NODH, 2019). Moreover, universities are in the database for condom distribution. All UKZN campus clinics and AIDS programmes receive condoms from the Dept of Health as needed. The unavailability of condoms at strategic areas in the university raises concerns as participants in this study further affirmed that residence assistants have a responsibility to distribute condoms at residences for students' access. The university management needs to strengthen these responsibilities if students' health and SRH is to be promoted and maintained. Ultimately, the unavailability of condoms leads to inconsistent use of condoms (Ajayi, Ismail & Akpan, 2019; Rodrigues, 2023). In a high HIV setting, consistent condom use promotion is one of the tools to combat the spread of HIV, especially among adolescents and young adults (aged 15-24) who are known to have the highest rate of new infections (Ajayi, Ismail & Akpan, 2019).

In view of the principles of action research of plan-act-evaluate-reflect, the researcher and the participants planned on addressing some challenges identified during the discussions and interviews. For example, the researchers and the participants approached the eThekwini KwaZulu-Natal Department of Health's district office to provide condoms dispensers. The student leadership ensured that the containers were mounted at strategic places such as toilets, classroom corridors, and student centre corridors for easy access by students (see Figure 4.1).

Figure 4.1 condom dispenser mounted at the Student Centre corridor

Source: Researcher

4.4.3 Theme 3: Staff related issues

Staff-related themes emerged from participants' verbatim responses as other barriers preventing the male students from attending the campus healthcare facility. The sub-themes include healthcare workers' judgment and gender of healthcare providers.

4.4.3.1 Healthcare workers' judgment

The participants' responses from in-depth interviews and the focus group have revealed that the staff attitude discourages male students from seeking SRH services. Female healthcare workers are viewed as the ones with the worst, judgmental attitudes by male students. One participant, 4th year, shared the following two quotes;

> *"The mamas (mothers) at the clinics are very disrespectful, even by the way they look at you when they realise that you are sexually active."*

> *"The sister in the clinic once reminded me that, I am not here for girls, but books, and that I won't pass girls when I write exams."*

The findings are worrisome because Health facilities are supposed to be places where comprehensive health care is not compromised, a safe place for everyone. In addition, health care workers are to show kindness and courtesy to those seeking health services. One participant , 2nd year, shared the following;

> *"The clinic has to be an environment that is friendly to the extent that students can use it even when they do not need it."*

The following was expressed in a focus group discussion;

> *"I once went to the clinic with an STI, the way I was told how bad of a person I am, and that I play girls, I will never forget."*

*A*nd,

> *"They will look at you funny, judge you, and shout at you at the clinic if you have sexually related issues."*

A shortage of staff may also be causing frustration among staff members who are required to see many students per day, as revealed in one of the focus groups. Participants believe that the judgmental attitudes of healthcare workers may be the result of being understaffed, a way of acting out of proportion as a cry for help. The following responses from focus group discussions help illustrate this point:

> *"Perhaps if the university hires more staff so that all the consulting rooms are filled, maybe the pressure on members of staff will be less."*

> *"As soon as someone says a negative experience about the clinic, the rest of the guys would never want to go to the clinic to avoid experiencing the same thing."*

The findings in this theme have revealed the reality of health care challenges in South Africa and globally, especially related to access of SRH services among youth and adolescents. South African healthcare institutions are facing increasing challenges as a new era of health reform has developed (Abrahams, Thani & Kahn, 2022).

Furthermore, this results in an increasing need for more human resources. The shortage in the health workforce does not only refer to the number of healthcare workers but to a workforce of competent and scarce-skilled health professionals (Asif et al., 2019).

Simultaneously, human resources need to consider more staff recruitment, especially in Howard College, which has more than 4000 students in residences on campus alone, excluding the students in private accommodations. When reviewing 2022 headcount statistics, 7160 students used the clinic services (UKZN campus clinics stats, 2022). This translates to approximately 40 to 60 students or more seen a day. This number could increase if there were more hands. Thus, staff attitude could be a result of being overworked by healthcare workers.

Similarly, according to the study by Oleribe et al. (2019), staff shortage is a critical issue in countries such as Mozambique, Nigeria, Botswana and Malawi, resulting in poor health services from burned out healthcare workers. However, that does not justify bad attitudes and ill-treatment of clients. It is disappointing that such reports of negative attitudes happen when the DOH has a programme that was introduced a decade ago, where healthcare workers were trained on youth-friendly services according to the requirements and policies of the DOH (Nkosi et al., 2019).

4.4.3.2 Age and gender of health care providers

The participants' responses from in-depth interviews have revealed that the healthcare workers' gender was vital for SRH-seeking by male students in this study. Male students did not feel comfortable reporting sexual-related problems to female health workers. The male students express that it is disrespectful to talk about SRH to older staff members, especially females, as they view these healthcare workers as their mothers. The following responses from help illustrate this point:

> *"At home, we were taught to respect older people, we view them as our mothers, and that is why it is uncomfortable to talk freely about sexual things."* (1st year master's student)

> *"If the university could hire more male nurses, and maybe have a men's clinic, it would be better."* (2nd year master's student)

and

“I really think that male nurses make the environment more comfortable for other males, plus they will understand the bro codes when you want to speak about sexually related things.” (2nd year master’s student)

Other studies such as that of Dowden et al. (2019) discovered that males prefer to use men's clinics when accessing SRH. This concurs with the study conducted by Mursa, Patterson, and Halcomb (2022), that internal barriers reported to have an impact on men's health-seeking and engagement include fear and embarrassment, as well as issues relating to masculinity. Accordingly, men feel embarrassed to engage with female healthcare workers when seeking SRH, expressing that they fear being judged and seen as weak by female healthcare workers.

Interestingly, gender-preference on health care provision can be huge impediment because generally, health facilities staffing ratios shows high number of females than males (Lasater et al., 2021). Considering the ethnicity majority in this study’s participants as shown in Table 4.2, in Zulu culture education of boys and girls about sexuality rules was done by older women and older men during puberty rituals through songs, dances, and talks (Mthiyane & Dolamo, 2019). Perhaps this could be the reasons that are making males uncomfortable around female health care workers when seeking SRH help from health care facilities.

Furthermore, another source of information was older sisters and older brothers for girls and boys respectively. Consequently, this is the root of gender norms and gender stereotypes as both sexes were taught to behave a certain way according to that specific gender. Eley et al. (2019) concur with the statement that young men’s healthcare-seeking behaviour is directly and indirectly taught by how their fathers have done or by the examples fathers set during these young men’s childhoods. Moreover, health-seeking is considered contradictory to the male gender norm of being tough and strong.

4.4.4 Theme 4: Stigma and stereotyping

Stigma and stereotyping emerged as a main theme on the attitude of male students to SRH seeking. Theme has the following sub-themes: healthcare-seeking as a male weakness, men must be strong, and scared to be judged. These subthemes connect and concur with masculinity and gender norms. Stigma and stereotyping of data

analysis revealed that society and hegemonic masculinity influence male students' decision making in SRH matters. These themes are discussed in the following section.

4.4.4.1 Healthcare-seeking as a male weakness

The participants' responses from in-depth interviews have revealed that male students' manhood is challenged if they seek healthcare before trying to make means to overcome the health problem on their own. Peer pressure and stigma by society that men must be strong are factors influencing males not to seek health interventions on time. This statement was expressed by the 4th year engineering student:

> *"If you are seen at the clinic as a man, other students assume that you are a sickly person.''*
>
> *"I only attend the clinic after I have tried home remedies and saw that they do not want to work.''* (4th year engineering student)
>
> *"Even with PreP, why would I want to take a pill every day to avoid taking a pill every day, it's the same thing."* (2nd year Humanities student)
>
> *"Talking about anything that relates to SRH is taboo in my culture; you will be viewed as weak by other men." (2nd year master's student)*

According to Connell's theory of hegemonic masculinity, and Bookchin's Social Ecology Theory, hegemonic masculinity is an expression of power by men. Hegemonic masculinity refers to a gendered pattern of behaviour that maintains men's power over women and represents the most culturally valued form of masculinity (Connell & Messerschmidt 2005). Furthermore, rather than characterising "real" men, hegemonic masculinity consists of behavioural ideals that help guide men's actions and are reinforced through interactions. Hegemonic masculinities are socially and culturally influenced, determining when and how the male gender expresses this masculinity and the appropriate behaviour (Messerschmidt, 2019).

Accordingly, the emergence of masculinity among participants is a result of poor SRH-seeking behaviour, which then hinders care-seeking, knowledge access and sharing, and taking healthy and protective decisions such as HIV prevention through condom use or consulting the clinic. It is therefore important that continuous health promotion

activities, using various platforms such as social media, are required to break these stereotypes as they are unjust to men. According to Bookchin's Social Ecology, as elucidated in Chapter two, the theory states that men were socially influenced on how to conduct themselves.

Moreover, these teachings encourage masculinity and gender roles. Accordingly, university students have internet access, and they read and see the importance of SRH and how it can negatively affect one's health if a disease related to it is left untreated. WHO (2019) determines programmes and interventions engaging men and boys to break these harmful masculinities, promote gender equality, and break stereotypes and stigma.

4.4.4.2 Men must be strong

The participants' responses from the focus groups have revealed that male masculinity is a result of non-healthcare-seeking behaviour. Men are socialised from an early age to take care of themselves and toughen up as 'men do not cry'. The following responses from focus group discussions help illustrate this point:

> *"Men live with illnesses; some are sexual in the hope that they will eventually get better."*
>
> *"Back home if you have anything in your private part that is wrong, they conclude that you have been bewitched with that you have to see a traditional healer."*

4.4.4.3 Scared to be judged

The participants' responses from in-depth interviews have revealed that male students are scared to be judged when collecting condoms. Male students negatively influence each other's unhealthy sexual behaviours. One 4th year law and management participant shared the following;

> *"Other students will think that I think I'm better for doing the right things, even when I use condoms with my partner, I lie.*
>
> "*Even if you have erection problems, you cannot tell anyone as you will get judged. I never say I do not have because I do get laughed at." (*24th year old, 4th year engineering student),

Studies have been conducted among university students, where researchers have linked masculinity as the barrier to healthcare-seeking behaviour. Khumalo et al. (2021) found that male students at UKZN were against seeking healthcare as they perceived that men must be strong. Earlier, Nuwamanya et al. (2020) had found that gender norms played a significant role in SRH matters and health-seeking behaviour among Ugandan university students. Therefore, strategies targeting the unlearning of stereotypes must be cautiously designed and implemented. Essentially, these strategies must be sensitive to culture and people's beliefs, while promoting good health and encouraging health-seeking as a norm for males at large. Masculinity may result in unhealthy sexual behaviours. Considering the study by Closson et al. (2020) about 'youthful masculinity' men assume controlling behaviours not only in their lives but to the opposite gender as well. Furthermore, this kind of masculinity may lead to non-consensual sex increasing gender-based violence cases in South Africa, as this country is known for high cases of GBV (Mshweshwe, 2020).

4.4.5 Theme 5: Socio-cultural issues

The participants' responses from in-depth interviews have revealed that society and culture are some of the hurdles to SRH-seeking behaviour by the study participants. Emerging subthemes that men are known as family providers, religious affiliation and the advantage of residential origin.

4.4.5.1 Men are known as family providers

In most African cultures men are heads of families, and they always need to be strong and provide for their families. Men put their families first before themselves. Participants argued that men neglect their health issues to take care of their families. This means that men would rather go to work than visit a health facility. The following statements were raised during one of the focus group discussions;

> *"Men do not prioritise their health, also, due to learned behaviour from a young age that men deal with their problems on their own, by using traditional medicine and home remedies rather."*
>
> *"A man's job is to take care of his family''.*
>
> and,

“I always see my older brother when he was complaining of burning urine, he asked his colleagues what to do instead of going to the clinic.”

“If I was working too, I would never bother going to clinics unless I'm dying, I am a Zulu man, and I will be fine. Our fathers never went to see doctors, but they survived. Money first.”

The participation of people, especially men, in reproductive health care is affected by cultural and social factors (Roudsari, Shafari & Goudarzi, 2023). Furthermore, social norms are one of the barriers to men’s participation in reproductive health services. In communities, the presence of men in reproductive health centres was unfamiliar (Teklesilasie & Deressa, 2020). Similarly, to the study conducted by Firouzan et al (2019) mentioned gender roles, negative attitudes towards men's participation, taboos, and stigmas related to this issue in society as the cultural barriers.

Furthermore, women are responsible for home affairs and the care of the children, and men for earning income for the management of life. The aforementioned studies relate to statements made by the participants in this study, that society and culture promoted masculine roles to them. Reflecting on Bookchin's social ecology theory, social and environmental factors play a role in human behaviours and these behaviours are passed through generations. This aligns with the study Maina et al. (2022) reports that boys in Kenya believe in male dominance, as 'head of the household' as they have seen and taught by the older generation. Therefore, this verifies that society and culture have an impact on encouraging gender roles.

In this study, the most common theme that emerged from most participants related their etiquette to being of a Zulu culture. A total of 96% of participants in this study were of the Zulu culture as shown in Table 4.1. The Zulu people have a proud and vibrant culture based on tradition and ritual (Wacera, 2023). Moreover, at the heart of this culture is a strong sense of family and community, with men holding a position of authority and respect as the head of the household. Consequently, men as heads of house have a financial, provision, and protection responsibility over their families.

According to Novak et al. (2019), men would rather utilise their time at work and provide for their families than seek health care. Not only men who could prove for their families were viewed as "real men" by the participants, but men with multiple partners as well. In the 1800s when a young man could not afford to get married and become

a respected man he proved his masculinity by having many girlfriends (Hunter, 2004). Thus, having multiple sexual partners is a risk factor for STIs and STDs such as HIV. Therefore, when constructing health education, socio-cultural issues ought to be prioritised.

4.4.5.2 Religious affiliations

The participants' responses from in-depth interviews have revealed that a system of beliefs affect males on their SRH-seeking behaviour. Participants intimated that they are not allowed to use contraceptives and modern medicine in their religion. One participant shared the following;

> *"In my church, we are told that Western medicine does not work, we do not have sex before marriage, even though we do it behind closed doors, with that we do not use any kind of contraceptives, as these will be a giveaway that we are sexually active."* (2nd year master's student).
>
> *"My friends and I are from the same church. Sometimes I do want to collect condoms from the clinic because I am scared that my friends will report me, and I will be cut off from the church since we are not allowed to have sex before marriage"* (2nd year student).
>
> *"I had STIs more than twice last year. I was so ashamed to even go to the clinic, I knew that what I was doing was wrong, I was guilty that I had broken the church's law."* (2ndyear student)

South Africa is a multi-religious country (Erasmus, 2005). The country has about 80% of people identifying as Christian and the rest are African traditionalists, Muslims, and other faiths (Maluleke, 2015). The Department of Justice in South Africa regulated the Bill of Rights, Section 31 that protects the right of persons belonging to a religious community to practice their religion together with other members of that community and form voluntary religious associations. These rights must be respected by others, regardless of their beliefs. A study done by Du Toit (2021) on the Jehovah's witness religion indicates that Jehovah's Witnesses when it comes to medical procedures that might infringe on their religious beliefs, are much more prudent and would rather live according to God's will.

This is confirmation that healthcare professionals need to consider other religions in health matters and decide with their patients by including them in healthcare. This also, indicates the importance of being religion-sensitive during encounters with South Africans, be, it when rendering a health service and/or when having general conversations. Ndinda, Ndhlovu, and Khalema (2017) discovered that communicating messages about contraceptive use in the church removes the binary between what the state advocates in terms of family planning and the message of the church that advocates abstinence before marriage.

Furthermore, state programmes advocating condom use may thus be accompanied by silence or ambivalence from the church regarding that form of contraception, thus, creating confusion in people's minds. Therefore, churches must be open to awareness campaigns on SRH, as it is still their members' choice to take the advice or not.

4.4.5.3 The advantage of residential origin

Male students from multiracial schools and suburban backgrounds are better healthcare seekers compared to students from townships and rural areas. Participants share that educational background has an impact on renewing one's mind and way of thinking, and breaking stereotypes on SRH talks and health-seeking behaviour. One participant shared the following;

> *"Students from cities talk about sex with their parents and they are free to even go ask for help if they need anything from the clinic or talk about it freely to everyone. It must be because they had a good education and internet access, which allowed them to express themselves more, while students from rural areas would be shy to talk about such things, some share it with their friends for advice."* (2nd year Humanities)

Du et al. (2022) discovered that educational background has an impact on SRH services use. Furthermore, the higher the educational level, the more likely to use SRH services. On the other hand, participants with lower educational backgrounds rarely utilised formal SRH services and often experienced discrimination and mistreatment from healthcare providers because of lack of knowledge of SRH issues. As the participants expressed, the leverage of having a suburban background and an

advanced educational background is internet access, social media, and high chances of having educated parents.

Parents regardless of level of education are the most important sources of information to their children as they raise them. SRH talks should be normalised the same way parents teach children social norms and values. Okeke et al. (2022) reported that adolescents in rural Nigeria mention that parents and guardians should be reoriented on how to appropriately and regularly engage their children in SRH discussions. Family members contribute to both an individual's attitudes and values concerning teenage pregnancy; the family shares social risks that influence the likelihood of teenage pregnancy (Mezmur, Assefa & Alemayehu, 2021). This confirms that family and educational background influence healthcare-seeking attitudes from adolescents and youth.

4.4.6 Theme 6: Attitude towards SRH programmes and campaigns

This theme explains the poor attendance of male students in the SRH awareness campaign, with the subtheme health talks.

4.4.6.1 Health talks are regarded as boring

Formal programmes on health talks are viewed as boring by participants, expressing that they become sleepy during programmes. The presence of females in events makes male students uncomfortable to ask relevant questions. The following responses from focus group discussions help illustrate this point:

> *“Health talks are effective when they are done at informal settings such as res get together, games days, and party vibes events where there is entertainment.”*
>
> *“There must be men-only events, girls make us shy.”*
>
> *“As a nursing student, I know I will be told what I know; health talk needs to be deeper to us.”*
>
> *“With us nursing students health talks can be conducted using nursing/medical terms, maybe we will take it seriously".*

“Imagine listening to a health talk after a long week of school, I feel like sleeping.”

“The presentations of these talks take long, sometimes you even lose interest midway through the conversation, or not attend at all.”

Cognitive psychology research shows that information retention by the audience is significantly improved if visual as well as text information is displayed simultaneously (Zayapragassarazan & Mohapatra, 2021). Consequently, seeing something leaves a long-term memory that hearing about it. In this case, students are already exhausted from lectures. Regaining their attention during health talks might require some effort, creating interesting presentations. Johnson and Majewska (2022) discovered that non-formal learning has a long-lasting long-term memory. Considering how youth remember music lyrics, perhaps influential artists should be encouraged to have one or two songs on SRH education. In this study, participants expressed visuals and informal health talks. This would assist peer educators in restructuring their awareness campaigns.

4.4.7 Theme 7: Infrastructure as a barrier

This study's finding revealed infrastructure as a barrier for male students to access the campus health clinic, with the emerging sub-themes which are, clinic working hours, overhearing events next door, the advantage of geographical location and Campus clinic location as a barrier.

4.4.7.1 Less clinic working hours

Participants in this study have intimated that clinic working hours should be 24 hours, to accommodate males who are shy and do not want to be seen attending the clinic. The participants shared the following;

“Men, generally do not want to attend clinics, it would be better at night because no one will see them going in. Also, let girls attend during the day and then guys at night.” (4th year Law and Management student)

> *"Long clinic working hours will accommodate even the ones that come from parties with the need of emergency contraceptives or have headaches."* (4th year law and management)

The need of long service hours of the campus clinic indicates an important primary health care element of access and sustainability. However, given the small community served by campus clinic this should consider several aspects such as staffing and budget allocation. Although the campus clinic does not fall under the administration of the Department of Health, it is at the primary level of care rendering preventive care. In such levels primary health care (PHC) facilities consist of CHCs (community health centres), which deliver 24-hour services and day clinics providing an eight-hours service (Abrahams, Thani & Kahn, 2022).

In line with the study by Mutshatshi and Munyai (2022) PHC facilities are known to have shortage of to run 24-hour shifts. As indicated in the description of setting (Section SSS), the UKZN campus clinics are day clinics. These campus clinics are intended to deliver comprehensive care including preventive and promotive health care. When these campus clinics close, there are ambulance services provided and funded by the university in case of emergency for students. Therefore, the health needs of students are met, 24 hours when considering all these services. However, Khumalo (2021) reported that students at UKZN expressed that they do not attend the campus clinics because of time clashes between their classes and clinic working hours. The main aim of these campus clinics in UKZN is to ensure that all students and the general university community have access to health services.

4.4.7.2 Overhearing events next door

The proximity of consultation rooms emerged as a challenge as participants in this study expressed noise in the next room as a concern during consultation. The participants felt unsettled that conversations can be overheard from next door. One participant shared the following;

> *"I was once in the clinic and heard from the next room someone shouting and a slapping noise as if someone is being slapped in the butt for being scared of an injection."* (28-year-old, 4th year engineering student)

“My roommate says that he overheard someone being shouted at for sleeping with many girls, those walls are very thin” (Focus group).

The physically structure of the clinic appears not to be an “Ideal Clinic” as required by the quality standards. An 'Ideal Clinic' is defined as a clinic with good infrastructure (i.e. physical condition and spaces, essential equipment, and information and communication tools), adequate staff, adequate medicines and supplies, good administrative processes, and adequate bulk supplies (Department of Health, 2016). Furthermore, provided that infrastructure is compromised, the right to privacy is also compromised. The fact that participants mentioned loud voices coming from the consulting room next door, points to the fact the healthcare facilities are unsuitable for clinical work, and that the healthcare providers lack of courtesy and understanding.

Moreover, shouting breaches right to be treated with dignity, privacy and confidentiality of patients. Thus, the patients' privacy should be a priority. Basic things like closing consultation doors and speaking in a normal tone of voice are important. The lack of patients’ respect and good communication skills by staff is disturbing, because it hinders service access and achievement of universal health for all. The findings in this study concurs with that of study conducted in China where participants showed concern over breach of confidentiality based on poor infrastructure (Wang et al., 2017). Similar concerns of respect, dignity, and confidentiality were raised by youth in rural communities of Māori, New Zealand’s (Martel, 2020).

4.4.7.3 Campus clinic location as a barrier

The location of the campus health clinic grounds male students from seeking health services. Participants report that the clinic is in a public space, and everyone sees them queuing to enter the clinic while passing by the cafeterias. And they feel embarrassed that they will get judged by their peers. The participants from the focus group discussion shared the following;

“Some of us like asking girls on dates; now when they see us queueing to the clinic, they will think we are sick and reject us.”

“When you are inside the clinic, and we are sitting next to the cafeteria, we can see when a person moves from one consulting to the other, and assume that they must be sick.”

The right to have access to health care services is a basic human right guaranteed by the Constitution. Section 27 of the Constitution provides that everyone has the right to have access to health care services, including reproductive health care services and no one may be refused emergency medical treatment, announced by the South African Human Rights Commission. Baker et al. (2023) discovered that young people in the Eastern Cape struggle to access health care facilities to access SRH due to distance. Moreover, the situation worsened during COVID-19 due to transport availability. Barriers to access to health include transport, particularly when there are large distances and few facilities in rural areas (Health System Trust, 2017).

However, the UKZN, Howard College campus clinic is situated amid student centres, surrounded by cafeterias and all amenities for students, where easy access is guaranteed. Participants expressed the comfort of attending the campus clinic and being seen by most other students due to this location. In previous years, the Howard College clinic was located in an isolated building, slightly further from the students' amenities area. Students complained about the distance and the location is not wheelchair friendly for disabled students. According to Batho Pele principles by the Department of Public Services and Administration (Pieterson, 2014), all citizens should have equal access to health. Thus, the campus clinic was made available to all.

4.4.8 Theme 8: Solutions to the identified challenge

Suggestions and recommendations made by the participants aiming to find solutions to the problem were grouped into two themes, which include intensify residence talk and condom distribution within residences.

4.4.8.1 Intensify residences health talk

The male students suggested collaborating with the researcher and other stakeholders in the resuscitation of residence health promotional talk. This is because lessons from the campus history were that residence talks assisted with student awareness, especially for students who were only available in the afternoon, and after lectures. The participants from the focus group discussions shared the following:

"We have not had residence talks for long, maybe if we can target students in their residences things will be fine."

"There are students who cannot attend campus events during the day as they are busy with classes, maybe the residents' visits can help; we used to have them in the first year."

When it comes to building a healthy community, the importance of health education cannot be overlooked (Gagnon, 2022). Moreover, health education encourages health awareness and topics that encourage good health. Therefore, male students would benefit from these talks to promote healthy lifestyles. The main advantage of health talks is being able to reach a fair number of people (Prozesky, 2014). Furthermore, health talks support students and give students an opportunity to participate in their own health while interacting with their peers (Holmston & Bostrom, 2021). This means that male students would have the advantage of learning good health conduct, interacting with their peers, and learning from their peers' experiences. The participants encouraged these talks, also, because they can be conducted in residence after academic hours when students are relaxed and in their comfort zone. This would be beneficial, especially for the students who have time clashes between their classes and when there are health awareness campaigns around the university campus.

4.4.8.2 Condom distribution in residences

Participants reported that in the UKZN residences toilet paper is distributed to the students' rooms by the residence assistant. The male students recommend the delivery of these toilet papers with a packet of condoms to each student. One participant shared the following;

"Since our toilet paper gets delivered, why don't we get toilet paper with condoms." (1st year masters student)

The findings in this theme aligns with the South African Higher Health agency's objective in introducing peer-to-peer educators to bridge gaps in students' access to healthcare information (Higher Health, 2020). This is because well-informed students would be encouraged to take care of their health and well-being. This aligns with a study done by Shaikh and Deschamps (2006) that the reinforcement of health talks in

residences would be a crucial step. Moreover, students would rather seek advice from their peers and consume medications without prescriptions and use of condoms. Condom usage among university students is low, as these students build attitudes towards it, some may feel embarrassed collecting and acquiring condoms (Haffejee, Koorbanally & Corona, 2018; Oswalt et al., 2023). Moreover, most students support condom distribution as they believe that it is easy to access while promoting a healthy protective sexual life.

4.5 Conclusion

This chapter explored and described factors influencing the involvement of male students in SRH at UKZN, Howard College, from the male students' lived experiences, opinions, and idle talks. The research findings and data analysis were respectively transcribed and later coded into themes. Themes were discussed. The researcher shared opinions and references to emerging themes. The data was supported by references from the literature. The next chapter covers the discussion and a summary of findings, as well as the conclusions and recommendations.

CHAPTER 5

SUMMARY OF FINDINGS, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

5.1 Introduction

This study aimed to explore and describe factors influencing the involvement of male students in SRH at Howard College, University of KwaZulu-Natal (UKZN) in South Africa. This chapter provides an overview the whole study. Data were analysed and unified into themes and sub-themes. Chapter 4 discussed the findings. Firstly, a brief overview of the research was presented, followed by an overview of the research objectives, methodology, and findings. The chapter closes by providing the limitations of the study, recommendations for policy and future study and the overall conclusions.

5.2 Overview of the study

The study aimed to explore and describe factors influencing the involvement of male students in sexual and reproductive health (SRH) at UKZN, Howard College, South Africa. As discussed in Chapter One, several studies reported men as being overlooked in and excluded from discussions bordering on SRH matters. This study was prompted by the researcher's observation of the non-involvement of male students in SRH activities occurring around the UKZN campuses. This was concerning as students aged 18 years and older are more likely to be sexually active and engage in risky sexual behaviours than the younger adolescents (Anyanwu & Mbarara, 2023). The study used Bookchin's (1994) Social Ecology Theory and Connell's (1995) Hegemonic Masculinity Theory as a lens guiding the researcher. The theoretical framework assisted the researcher in identifying possible causative factors determining male students' involvement in SRH services provided at the UKZN.

Essentially, the study was guided by the following objectives:

1. To explore and describe factors affecting male students' involvement in SRH at the UKZN

2. To explore and describe strategies that will enhance male students' involvement in SRH at UKZN.

The intervention was not traducing the existing healthcare system, but to find strategies of enhancing the involvement of male students in SRH and complement health providers, health promoters, and male-focused societies in discovering and developing ways of luring male students to get involved in sexual and reproductive health matters.

This study employed qualitative, participatory action research (PAR) methods to generate credible results. This study explored the everyday realities of the participants' lived experiences of sexual and reproductive health. A total of 24 male students currently registered at the UKZN for the 2023 academic year were sampled as per the inclusion criteria. Semi-structured interviews and focus-group discussions were conducted to generate data approximately in a period of three weeks. The interviews were directed by an interview guide developed by the researcher (Appendix D). The data generation process followed the data analysis process. The researcher ensured that quality data were elicited, as detailed in Chapter 3, through the assistance of an independent co-coder. The themes and sub-themes were developed and discussed in line with extant literature drawn from credible research sources.

5.3 Summary of the findings

A total of eight (n=8) themes and 19 sub-themes emerged during the data analysis process. The findings were discussed in accordance with the following seven themes:

Theme 1: Attitude towards HIV test

Theme 2: Condom-related issues

Theme 3: Staff-related issues

Theme 4: Stigma and stereotyping

Theme 5: Socio-cultural issues

Theme 6: Attitudes towards SRH programmes and campaigns

Theme 7: Infrastructure as a barrier

Theme 8: Solutions to the identified challenges

5.3.1 The themes and their implications

Theme 1: Attitude towards HIV test was expressed by male students at Howard College campus, UKZN. The male students reported being scared of being tested for HIV, and would rather rely on their sexual partners' HIV statuses as a test. This confidence to use sexual partners as HIV tests originated from the perspective that if one does not use condoms on one person, that person ought to have the same HIV status as the other partner. The male students reported that they preferred knowing their HIV statuses when they were sick, claiming that knowing their HIV statuses while they were still healthy would make them sick. Some male students held the perception that they would never be infected with any disease as they believed that they were not engaging in risky behaviours. The delay in getting an HIV test by male students done may result in more complicated and high-risk disease as male students would not have been diagnosed early. Further, HIV will be easily spread unknowingly, due to the missed opportunity of an early diagnosis.

Theme 2: The male university students reported irregular condom use with pretty-looking females, assuming that such girls were less likely to be infected with STIs. Either way, the male students believed that condoms distracted intimacy and resulted in the sexual intercourse not being pleasurable. Reaching for a condom during foreplay was viewed as a major distraction and as pausing in between the foreplay in order to open and put on the condom was a major 'mood killer'. Some male students reported the availability of unsatisfactory condoms in residences and public spaces around the Howard College campus, UKZN, which resulted in them using condoms irregularly. Based on the nature of PAR, participants and researchers ensured that condom containers were mounted at strategic areas for easy access. Regarding condom use, some male students believed that Western interventions hardly work, expressing the view they had faith that if they were destined to get sick or infected with a disease, they had to, in spite of trying to protect themselves against it. Essentially, irregular condom use disregards the prevention of sexually transmitted infections and including HIV. Furthermore, this will increase the number of unintended pregnancies. Condoms are best prevention tool against STIs, HIV and unintended pregnancies. This signifies the importance of condom use in promoting safe sex.

Theme 3: Staff-related issues included staff age and gender and the attitudes of staff towards healthcare provisions that the male students were dissatisfied with. The male students reported that they preferred being consulted by male healthcare workers, as they found it easier to disclose their SRH to other males, who could understand the language better as they had "bro codes' that females did not need to understand. The unfriendliness of the clinic staff was reported as a causative factor barring male students from attending the clinic. One male student stated that it was sometimes not what a female healthcare worker said to them but it was also the unwelcoming facial expressions given to them while trying to access healthcare that discouraged them from seeking healthcare. Male students have a choice to be treated by the preferred healthcare provider to enhance comfort. Healthcare facilities must respect and support the wishes of male students by assigning the preferred healthcare provider. Otherwise, the opposite would mean that, assessment done to male students during healthcare visits maybe unreliable, leading to misdiagnoses of disease.

Theme 4: The male students regarded an expression of manhood as when men are strong enough to endure the pain, and find other ways of sorting out their health issues, such as use of traditional medicine that induce vomiting and enemas to detox their bodies just to avoid seeking healthcare, which challenges their masculinity. The male university students perceived healthcare-seeking as a weakness, contending that real men do not cry, they suffer stoically, otherwise one would be called a woman. Some male students were mocked by their peers for being seen in a healthcare facility and for being unhealthy. One male student even concluded that male students who visit healthcare facilities are possibly having serious chronic health issues. Initially, the avoidance and delay by male students to attend healthcare facilities may culminate in complications of diseases that are even life threatening. This suggests that male students will miss on the opportunity to participate in preventative health programmes, SRH, health screening, and early diagnosis and treatment of diseases and injuries.

Theme 5: The male students considered a man's job as providing for his family first and putting himself last. The participants vocalised that they were taught all these gender roles when they were still young, and they had seen the older generation of men performing them. Religion determines the conduct of male students, with one male student reporting how bad contraceptive use is viewed by his church. Regardless of the information disseminated by professional healthcare workers, some male

students expressed the view that, if it contradicted their religious beliefs, they would still not comply.

The male students reported that their educational backgrounds and residence or place of origin affected their way of doing things. Thus, health-seeking is dependent on the men's backgrounds, with lavish male students being more inclined towards prioritising their health than other students. This indicates that male students from suburban backgrounds are more likely to openly engage in SRH discussion and value the use of healthcare facilities than those from other backgrounds. Some male participants agreed that it is because their parents might be more knowledgeable about health issues due to their parents' level of education and the opposite is true for male students from rural backgrounds. Some male students concurred that male students in health-related situations renew their minds from SRH stigmas that they acquired from society. In this regard, professional affiliation and healthcare educational backgrounds contributed to the knowledge and skills they now have, having been taught about the physiological aspects of SRH. Therefore, rating one's health, last, as not important will result in complicated and undiagnosed diseases, which can ultimately affect their ability to be able to provide for their families. In SRH related undiagnosed issues lead to sexual threating conditioning, such as infertility.

Theme 6: The male students expressed that SRH programmes were boring. They preferred visual presentations, playful events, and informal settings. Formal events made them feel very sleepy as they were already tired from long academic lectures. Also, playful events like sporting events often attract a large number of male students, as these are extramural activities occurring concurrently with learning. Presentations on male SRH must be conducted by male presenters. The male students reported that if the presenters are males, they will not be shy to ask questions. In this regard, the researcher, a health promoter, one of the male students and the Men of Virtue Society around Howard College held a Teams session to share information on residence life and SRH. Some participants proposed that these male SRH programmes be conducted in the absence of female students. Therefore, poor or none attendance of promotive health programmes by male students limit their knowledge and information on issues affecting their health. Furthermore, this may lead to poor healthcare-seeking behaviours due to lack of knowledge. Hence, male students will in turn not be involved in preventative health, SRH and early diagnosis of disease.

Theme 7: The location of the campus health clinic was viewed as a barrier to health-seeking behaviour by the male students. The campus health clinic at the UKZN, Howard College, is located next to the student cafeterias and leisure centres. The male students reported that the clinic is in an area accessible to everyone, as they were scared of being seen as sickly people. They resented being judged if seen going inside the clinic by their peers and girlfriends. The preference of a 24-hour service clinic was expressed by the male students, reporting that they would rather attend the clinic at night when there would be no one watching them. The infrastructure of the campus health clinic was perceived as a barrier to SRH-seeking by the male students, as they feared that someone in the consulting room next door would hear everything from their consultation, thus breaching their privacy. Healthcare facilities must be accessible to male students. That is, male students ought not to travel nor walk long distances to get to the campus clinic. The removal of a healthcare facility from easily accessible locations will result in poor healthcare and SRH -seeking behaviour due to distance of health facilities.

Theme 8: The male students suggested solutions to the identified challenges. Residences were regarded as safe places to conduct health-related talks for student, especially those that hardly partook in campus activities due to time clashes involving their lectures. The male students felt that resuscitating residence-based talk would be able to reach out to a huge number of students. In collaboration with other stakeholders and the researcher, male students were willing to assist in conducting these health talks. Residence assistants distribute toilet papers to students on a weekly basis. Therefore, the male students suggested that this opportunity be utilised to include condoms in that package, to promote male sexual and reproductive health through protective sex. This will increase and promote the involvement of male students in SRH matters as these suggestions favor the male students.

5.4 Conclusion

Conclusions were drawn based on the findings. The impact of society, culture and religion on the conditioning of men is humongous and should be considered seriously in the SRH services. This conditioning determines men's future conduct and beliefs. Consequently, strategies need to be developed to break all the harmful masculinities,

stigmas and stereotypes the society has instilled in men. Upon accomplishing that mission, a new, well-informed and healthy society will be constructed. The health promotional awareness campaigns can be effectively implemented to achieve the involvement of male students in SRH matters, provided that they are structured in an interesting way that is accommodative to the male students' age group, as suggested in the discussions. These health-related promotional campaigns will improve male students' confidence, knowledge and understanding regarding health-related issues concerning them and be capable of withstanding negative judgments and the mockery that comes from their peers for engaging in healthcare-seeking behaviours and good healthcare conducts.

The study's findings were furthered by the employment of in-depth interviews and focus-group discussions, which allowed broad in-depth conversations between the researcher and participants, and free interactions among the participants. Considering the data analysed in Chapter 4, it is evident that the focus-group discussion brought out most of the themed data. This aligns with the studies cited in Chapter 3, which promoted group discussions when employing interviews to collect data. The collaboration of research design, research approach, data generation methods and data analysis, was vital for this study to achieve its objectives and aims. Moreover, these methodologies enlightened the researcher and guided the research in eliciting the findings. These are the same findings will be used to draft policies and strategies that are meant to address and encourage the involvement of male students in SRH.

5.5 Recommendations

Based on this study's findings, and conclusions drawn from the findings, recommendations have been constructed as follows:

5.5.1 Nursing practice

This study's findings have established the necessity of training nurses working in campus health clinics on Adolescent and Youth-Friendly-Services (AYFS). The training will empower nurses to strategise male-friendly methods and provide comprehensive nursing care and promote the involvement of the youth, especially male youths in SRH (Ninsiima & Chiumia, 2021). While implementing these strategies, the nurses have to collaborate with health promoters.

5.5.2 Nursing research

The findings of this study identified the need for further research to be conducted in other universities to determine the use of SRH by students at the university campus clinic. Further research on different races and various ethnicities in different UKZN campuses is recommended on SRH. Furthermore, SRH on other genders needs to be explored.

Secondly, it is recommended that further studies should focus on the knowledge of university campus healthcare workers to determine the factors impacting the provision of SRH among university students. Exploratory research is recommended on the use of artificial intelligence to share knowledge on SRH among the university students. A study focusing on empowering female students to motivate their male partners to seek SRH care is further recommended.

5.5.3 Nursing education

The study findings oblige nursing education institutions to generate topics on ways of breaking the gender stereotypes of young males and ways of enhancing the involvement of males in SRH matters. This in turn will empower and guide prosperous nursing students to provide comprehensive nursing care that is inclusive of the male gender, and strategise better when consulting male students, simultaneously promoting good SRH seeking behaviours. While training nursing students to become professional nurses, it is recommended that nursing education institutions should up-skill their students with ways of empowering them to be sensitive to culture and religion when providing comprehensive SRH to males.

5.5.4 Policy development

The findings of the study challenge the UKZN management to develop policy interventions, strategies, and goals that close the gap in male SRH on the campus. Strategies may include learning from the COVID-19 preventive strategies shared across various platforms; this includes use of the University website to disseminate SRH-related information, focusing on use of condoms, signs of STDs or STIs. Considering the students' easy access to the Internet, the researcher recommends that these policies be published and availed on UKZN’s online home page and social

media platforms. Television screens available in public places around campus should be used to promote good SRH and to disseminate information about diseases related to SRH.

5.6 Limitations

This study was conducted in Howard College, one of UKZN's five campuses. Therefore, the results do not represent the opinions of all male students in UKZN; hence, the findings may not be generalised to all UKZN campuses. However, the findings of this study can be generalised within Howard College, where the study was conducted. In this study, only Black male students participated, thus the findings cannot be generalised to other races in South Africa. The opinions of campus clinic healthcare workers were not explored regarding the none-involvement of male students in SRH because they were not included in the study population.

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APPENDICES

APPENDIX A: Ethical clearance

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

21 August 2023

Sinazo Sobekwa (223146216)
School Of Nurs & Public Health
Howard College Campus

Dear S Sobekwa,

Protocol reference number: HSSREC/00005823/2023
Project title: Factors influencing the Involvement of male students in sexual and reproductive health at the University of KwaZulu-Natal.
Degree: Masters

Approval Notification – Expedited Application

This letter serves to notify you that your application received on 05 July 2023 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted **FULL APPROVAL**.

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

This approval is valid until 21 August 2024.
To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

HSSREC is registered with the South African National Health Research Ethics Council (REC-040414-040).

Yours sincerely,

[redacted]

Professor Dipane Hlalele (Chair)

/dd

Humanities and Social Sciences Research Ethics Committee
Postal Address: Private Bag X54001, Durban, 4000, South Africa
Telephone: +27 (0)31 260 8350/4557/3587 **Email:** hssrec@ukzn.ac.za **Website:** http://research.ukzn.ac.za/Research-Ethics
Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville
INSPIRING GREATNESS

APPENDIX B: Information sheet for participants

Date: 24 April 2023

Dear Participants

My name is Sinazo Sobekwa, I am a student of master's in nursing research at the University of KwaZulu Natal (UKZN). The topic of the study is, factors influencing the involvement of male students in sexual and reproductive health at the University of KwaZulu-Natal.My contact details are as follows:

Cell phone number: [redacted]

Email address: SobekwaS@ukzn.ac.za

You are invited to take part in research that includes the involvement of male students in sexual reproductive health in UKZN. The purpose of this study is to determine factors influencing the involvement of male students in sexual reproductive health at UKZN. The study is expected to have a minimum of 20 male students. The study will involve face-to-face interviews, however, ZOOM meetings will be available per participants' request, and focus groups of about 6 male students per group. The focus group is for male students who would not mind sharing their opinions in the presence of their fellow students. Should you wish to enroll in the study, the duration of your participation will be 2 months.

The study has no risks or discomforts anticipated. The study may not produce a direct benefit to you as a participant, but it will benefit other students that maybe share the same sentiments as you are, as this study aims to describe the factors influencing the involvement of male students in sexual reproductive health at UKZN.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Science Research Ethics Committee (approval number).

In the event of any problems or concerns/questions you may contact the researcher at UKZN, School of Nursing and Public Health, Howard College, contact details as written above or the UKZN Biomedical Research Ethics Committee at:

Humanities & Social Sciences Research Ethics Administrator

Research Office, Westville campus

Private bag X 54001

Durban

4000

KwaZulu-Natal, South Africa

Tel: +31 260 4557

Fax: +27 260 4609

Email: HSSREC@ukzn.ac.za

Your participation in this research is voluntary. You may withdraw your participation at any time. Should you wish to discontinue your participation, you will not be affected negatively in any way. Your withdrawal from the study can be forwarded to the researcher telephonically or by email before the scheduled meeting dates.

The researcher will terminate the participant from the study if the participant is sick and/or per the participant's request. You will not be paid for your participation in the study, and you will not incur any costs. The researcher may provide refreshments during the interview sessions.

Your name will not appear anywhere on the research documents other than on this consent form which will not be forming part of the research document for dissemination.

For focus group discussions no personal questions will be asked, all questions will be general. Although every effort will be made to ensure that participants will respect the confidentiality of what is disclosed in the group, this cannot be guaranteed. For this reason, you are advised not to disclose personal sensitive information in the focus group sessions.

The researcher will store data safely for the period of this study and 5 years after the study has been concluded.

Supervisor details are as follows:

Name: Dr. TS Mudau

College of Health Sciences

School of Nursing and Public Health

Campus: Howard College

4th floor Desmond Clarence Building

Proposed Qualification: Independent study.

Cell: [redacted]

Tel: 031 260 143

Appendix C: Declaration of consent

I……. have been informed about the study, titled: Determining factors influencing the Involvement of male students in Sexual and reproductive health at the University of KwaZulu-Natal.

I understand the purpose and procedures of the study.

I have been allowed to ask questions about the study and have been answered to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without being coerced or threatened in any way.

Should I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at:

Cell: [redacted]

Email: SobekwaS@ukzn.ac.za

If I have any questions or concerns about my rights as a study participant or any concerns about the aspects of the study or the researcher, I may contact:

Humanities & Social Sciences Research Ethics Administrator

Research Office, Westville campus

Private bag X 54001

Durban

4000

KwaZulu-Natal, South Africa

Tel: +31 260 4557

Fax: +27 260 4609

Email: HSSREC@ukzn.ac.za

SUPERVISOR

Supervisor details are as follows:

Name: Dr. TS Mudau

College of Health Sciences

School of Nursing and Public Health

Campus: Howard College

4th floor Desmond Clarence Building

Proposed Qualification: Independent study

Cell: [redacted]

Tel: 031 260 1433

Email: MudauT@ukzn.ac.za

I hereby provide consent to:

Audio-record my interview/ focus group YES/NO

Signature of participant:…….. Date:……

Signature of witness:…… Date:……

Signature of translator:…….. Date:……

Appendix D: Interview guide

Topic: Determining factors influencing the involvement of male students in sexual and reproductive health at the University of KwaZulu-Natal

Welcoming note:

Greet, welcome participants, and thank participants for consenting to partake in the study. The researcher will introduce herself. The researcher will read out the topic of the study. The researcher will state the participants' freedom of asking questions and clarity when needed.

Read out the aim and objectives of the study.

Background of participants:

Participants	Faculty and course	Year Level	Have you used the campus health clinic?	Age
1.				
2.				
3.				
4.				
5.				
6.				

Ice breaker:

What is your view on SRH?

Main questions:

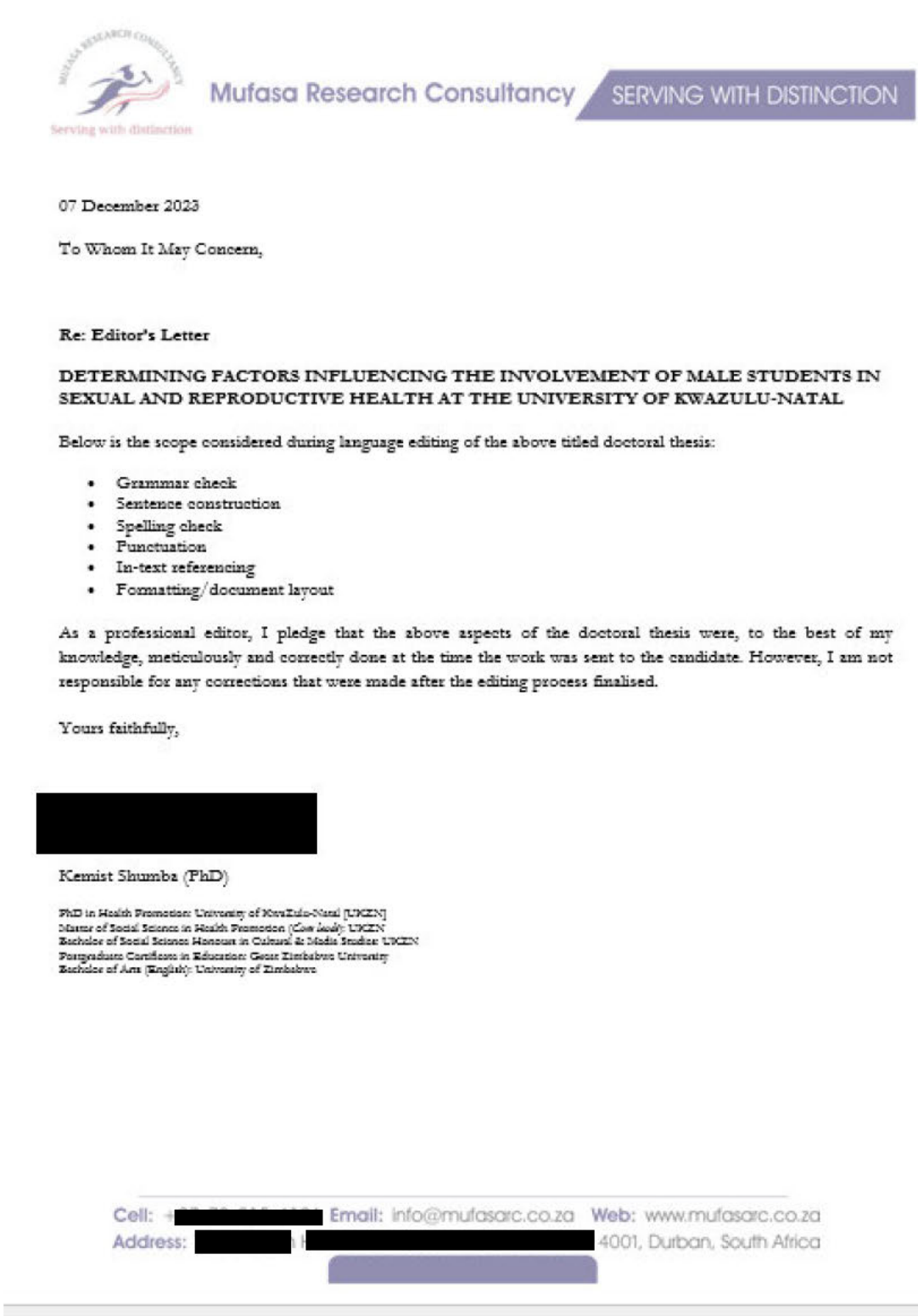
1. What factors influence male students from being involved in SRH subjects in UKZN?
2. How are these factors a challenge in attempting to access SRH services in UKZN?
3. What experiences do you have in aiming to be involved in SRH in UKZN?

4. What measures would help encourage male students in UKZN to be involved in SRH matters?
5. How do you think these measures can be taken to improve SRH involvement in male students in UKZN?

Closing Note:

- Plans on implementation of study outcome by participants.
- The time frame of activities.

Appendix E: Editor's letter



Mufasa Research Consultancy SERVING WITH DISTINCTION

Serving with distinction

07 December 2023

To Whom It May Concern,

Re: Editor's Letter

DETERMINING FACTORS INFLUENCING THE INVOLVEMENT OF MALE STUDENTS IN SEXUAL AND REPRODUCTIVE HEALTH AT THE UNIVERSITY OF KWAZULU-NATAL

Below is the scope considered during language editing of the above titled doctoral thesis:

- Grammar check
- Sentence construction
- Spelling check
- Punctuation
- In-text referencing
- Formatting/document layout

As a professional editor, I pledge that the above aspects of the doctoral thesis were, to the best of my knowledge, meticulously and correctly done at the time the work was sent to the candidate. However, I am not responsible for any corrections that were made after the editing process finalised.

Yours faithfully,

[redacted]

Kemist Shumba (PhD)

PhD in Health Promotion: University of KwaZulu-Natal [UKZN]
Master of Social Science in Health Promotion (*Cum laude*): UKZN
Bachelor of Social Science Honours in Cultural & Media Studies: UKZN
Postgraduate Certificate in Education: Great Zimbabwe University
Bachelor of Arts (English): University of Zimbabwe

Cell: [redacted] Email: info@mufasarc.co.za Web: www.mufasarc.co.za
Address: [redacted] 4001, Durban, South Africa

Appendix G

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

15 May 2023

Sinazo Sobekwa
School of Nursing and Public Health
College of Health Sciences
Howard College Campus UKZN
Email: SobekwaS@ukzn.ac.za MudauT@ukzn.ac.za

Dear Sinazo

RE: PERMISSION TO CONDUCT RESEARCH

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

"Determining factors influencing the involvement of male students in sexual and reproductive health at the University of KwaZulu-Natal (UKZN)."

It is noted that you will be constituting your sample by conducting interviews with male students (Zoom, Skype or telephone interviews recommended) on the Howard College campus.

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

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

You are not authorized to contact staff and students using the '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]

Dr KE CLELAND: REGISTRAR