# EXPLORATION OF KNOWLEDGE AND ATTITUDES TO HIV AND SEXUAL RISK BEHAVIOUR AMONG 18-25-YEAR-OLD YOUTH AT NYANDENI LOCAL MUNICIPALITY IN THE EASTERN CAPE PROVINCE

By

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**DECLARATION**

I, **Lorraine Nokuthula Mntonintshi**, hereby declare that ‘Exploration of knowledge and attitudes to HIV and sexual risk behaviour among 18-25-year-old youth at Nyandeni Local Municipality in the Eastern Cape Province is my individual work and all the sources that I used or accessed have been indicated and acknowledged by means of a complete reference list.

Signed _____ _____

Lorraine Nokuthula Mntonintshi Date

## DEDICATION

The research study is devoted towards my late mother, Nonceba Patricia Mntonintshi-Faku and my grandparents, Elder Nomhle Ngozi-Mntonintshi and Emanuel Kholisile Mntonintshi. You are forever remembered.

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**ABSTRACT**

The study was aimed at exploring knowledge and attitudes regarding HIV and AIDS of the youth between the ages of 18-25, and to explore sexual risky behaviour among youth from Nyandeni Local Municipality. It will further discuss prevention strategies that can be utilised to reduce the spread of HIV amongst youth at Nyandeni Local Municipality.

The study used a qualitative research approach and explorative and descriptive design in order to explore the knowledge and attitudes of youth concerning sexually risky behaviour among youth from Nyandeni Local Municipality. A semi-structured interview guide was used to conduct interviews to 30 youth aged between 18-25 years. They were purposively selected from the designated municipalities. Observation with field notes were utilised to gather and document data, and also inductive thematic analysis was used.

**Results:** The researcher used the objectives of the study as the main themes. The themes were the basis for the analysis and breakdown of the data acquired. Themes are classified as follows: Theme 1: describe level knowledge and attitudes regarding HIV and AIDS among youth 18-25 years. Theme 2: exploration of sexual risky behaviour among youth from Nyandeni Local Municipality. Theme 3: prevention strategies that can be utilised to reduce the spreading of HIV among youth at Nyandeni Local Municipality. Themes were briefly introduced and were followed by direct statements from participants providing the support and clarity on the themes. The study demonstrated that the majority of the participants who were interviewed are aware of how HIV is transmitted and how to prevent its transmission although their awareness is limited. Continuous educational campaigns are mandatory, for instance, the requested implementation of various educational programs in the community could serve this purpose. Recommendations can additionally consist of information on disclosure of HIV and AIDS status which can reduce the stigma and discrimination.

**Conclusion:** The study concludes that continuous educational campaigns are mandatory, for instance, the requested implementation of various educational programs in the community could serve this purpose.

**Key Terms:** Exploration, Knowledge, Attitudes, HIV, Sexual risk behaviour, Youth, Adolescent, AIDS

**LIST OF ABBREVIATIONS**

| | |
|---|---|
| ABC | Abstain, Be faithful and Condom |
| AGYW | Adolescent Girls/ Young Women |
| AIDS | Acquired Immune Deficiency Syndrome |
| ALHIV | Adolescent Living with HIV |
| ART | Anti-Retroviral Treatment |
| ARVs | Antiretroviral Treatment |
| Caprisa | Centre for the AIDS Program of Research in South Africa |
| CSE | Comprehensive Sexual Education |
| DoH | Department of Health |
| DREAM | Determine, Resilient, Empowerment, AIDS-free Mentored and Safe |
| GBV | Gender Based Violence |
| HBM | Health Belief Model |
| HCBC | Home Care Base Centre |
| HIV | Human Immune Virus |
| HSRC | Human Sciences Research Council |
| HSV2 | Herpes Simplex Virus 2 |
| HTC | HIV Testing and Counselling |
| IDP | Integrated Developmental Plan |
| KZN | Kwa-Zulu Natal |
| NGO | Non-Government Organisation |
| NPO | Non-Profit Organisation |
| OR Tambo | Oliver Reginald Tambo |
| PEP | Post-exposure Prophylaxis |
| PLWHA | People Living with AIDS |

| | |
|---|---|
| PLWHIV | People Living with HIV |
| PrEP | Pre-Exposure Prophylaxis |
| PWID | People Who Inject Drugs |
| SRH | Sexual and Reproductive Health |
| SRHR | Sexual and Reproductive Health and Rights |
| Stats | Statistic |
| STI | Sexual Transmitted Infection |
| TVET | Technical and Vocational Education and Training colleges |
| UNAIDS | United Nations Program on AIDS |
| UNESCO | United Nations Educational, Scientific and Cultural Organisation |
| UNICEF | United Nation International Children's Emergency Fund |
| VMMC | Voluntary Medical Male Circumcision |
| WHO | World Health Organisation |

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# CHAPTER ONE

# ORIENTATION OF THE STUDY

## 1.1 Introduction

The research was aimed at exploring knowledge and attitudes of HIV & risky sexual behaviour amongst the youth aged 18-25 years in the Nyandeni Local Municipality in Eastern Cape. According to Nyandeni Local Municipality Integrated Development Plan (IDP) of 2015-2016, it was recorded that in 2014, the HIV and AIDS frequency rate was as high as 50%-60% among tested cases of both young males and females between the ages of 15 to 30. These cases were mostly women who had partaken in voluntary testing during their regular pregnancy visits, and men who reported symptoms of sexually transmitted infections at the local clinics. This might indicate that protection, such as condoms, are not used. Furthermore, this could mean that if there are prevention programs offered by different sectors such as the Department of Health (DoH) and Social Development (DSD), these programs might not be effective. The researcher is concerned regarding the reasons for these reported cases. Most of the youth today are aware of HIV infections as there are various prevention programs offered by Department of Education, Department of Health and different forms of media. The researcher is prompted to enquire whether the negative attitudes towards HIV can be the reason for the youth to be involved in sexual risk behaviour. The researcher has further made a distinction between knowledge and attitude for a more and clearer understanding of the two concepts. It is very imperative for the researcher to provide definition of knowledge and attitude for better understating of what the study entails. Machlup (2014:66) describes knowledge as awareness with something, which includes facts, information and descriptions. These are skills that are acquired through experience or education. Whereas attitude is described according to Russell and Elsenberg (2012:203) as a psychological tendency that is described by evaluating a particular entity with some degree of favoritism. This will include the following key features namely attitudes, tendency, entity & evaluation. These attitudes would mean negative or positive attitudes concerning HIV and AIDS. The researcher used

a Health Belief Model (HBM) to enlighten and predict why the youth participate in behaviours that might compromise their health. The study used a qualitative research approach and explorative and descriptive design in order to explore the knowledge and attitudes of youth concerning sexually risky behaviour among youth from Nyandeni Local Municipality. The semi-structured interview guide was used to conduct interviews to 30 youth aged between 18-25 years. They were purposively selected from the designated municipalities. Observation with field notes were utilised to gather and document data, and also inductive thematic analysis was used.

The area of study, as stated in the topic, are Libode and Ngqeleni Areas which are the sub-areas of Nyandeni Local Municipality. The main intention of the study is the exploration of knowledge and attitudes about HIV and AIDS among the 18-25-year-old youth. It will further make recommends for future preventive strategies in order to address the HIV and AIDS epidemic.

## 1.2 Background of the Research Study

The Nyandeni Local Municipality is estimated to 2 474km² and located within the OR Tambo District in the Eastern Cape Province (Nyandeni IDP: Review 2015-2016). In 2016, it was estimated that 34 600 people in the Nyandeni Local Municipality were infected with HIV (Nyandeni IDP: Review 2015-2016). The number of infections in Eastern Cape Province has increased from 622,000 in 2006 to 786,000 in 2016 (Nyandeni IDP: Review 2015-2016). When looking at South Africa as a whole, it can be seen that the number of people that are infected increased from 2006 to 2016.There was an average annual growth rate of 1.67% (Nyandeni IDP: Review 2015-2016). As already stated in the introduction, this depicts that a large percentage of youth at Nyandeni Local Municipality might be HIV infected. This has encouraged the researcher to conduct research on the reasons for such a high percentage.

The widespread of HIV infection continues to be a worldwide menace to humankind. This HIV infection is spreading at a frightening rate since the first cases were reported in 1983 (UNAIDS 2016 cited in UNAIDS 2017:2). In sub-Saharan Africa, three in four new

infections in 15–19-year old's, are among girls. It is estimated that 75% of young women aged 15–19 report that they do not have a final say in decisions about their own health (UNAIDS 2017:2). In some settings, women who are intimate with their partner and experience violence. They are about 50% more likely to acquire HIV compared to those who do not experience such violence (WHO 2013 cited in UNAIDS 2017:3). According to UNAIDS (2016), cited in UNAIDS (2017:3), it is reported globally that young women are twice as likely to acquire HIV compared to their male counterparts. The researcher is of the view that the youth must have accurate information and understanding of the HIV epidemic. They should have an awareness regarding their HIV status.

## 1.3 Research Problem

The HIV and AIDS epidemic is accumulating at an alarming rate in South Africa, and the Eastern Province is no exception regarding the scourge of this dreadful disease (Nyandeni IDP: Review 2015-2016). Nyandeni IDP: Review (2015-2016) revealed that in 2016, a total of 34 600 people in the Nyandeni Local Municipality were infected with HIV infection.

Government and NGOs (Non-Government Organisations) are disbursing money on HIV awareness education to the communities, using diverse modes of communication such as community HIV and AIDS awareness campaigns at schools, local community radio slots (Mhlobo Wenene radio station, Unitra Community radio, Ingwane Community radio, True FM community radio, Capitol radio) and local newspapers (Express paper and Isolomzi paper). For instance, there is a daily show called 'Khanya Gqiyazana' at Mhlobo Wenene radio station. The show mainly focuses on discussing issues such as HIV and AIDS. This included cancerous illnesses and male gender sexual problems. Although it is perceived that the youth received these messages, the present situation proves otherwise. This is borne out by female cases who have partaken in voluntary testing during their regular pregnancy visits, and males who reported symptoms of sexually transmitted infections at the local clinics. What was perceived in communities showed that, youth are either not getting the messages, or have decided to disregard the presence of the disease. The researcher wanted to know and find out why the HIV contamination

rate in Nyandeni Local Municipality is so high in the age group of 18-25. Is it because the youth lack information about HIV and AIDS? If the youth have adequate knowledge about HIV and AIDS, there will be able to negotiate the use of condom with their partner's in order to prevent HIV infection. According to Stop AIDS (2016), revealed that it is a common knowledge for young people to become sexually active by early adolescence.

The researcher is concerned that the majority of youth, some as young as 14 years old, are falling pregnant. According to Ministry of Health and Population (2008:8), a girl as young as 20 years has two children already, and some boys, as young as 16 years, have impregnated a girl already. Young people are highly vulnerable group to HIV infection. Therefore, it is essential to identify effective deterrence methods to combat HIV. Inspiration for additional investigation to strengthen knowledge of HIV and AIDS problem amongst the youth. For this to happen efficiently, unsafe behaviour needs to be recognised and highlighted. The researcher's concern has also resulted in investigating by exploring the level of knowledge and attitudes of numerous aspects of HIV and AIDS, and risky behaviour among young people. Such information will assist the researcher to identify using participants' responses and program leaders the recommendations for preventive methods to address the epidemic.

### 1.4. Rationale for the Study

Young adults of our country are most susceptible to HIV infection. This is because of their unsafe sexual relationships brought about by their changing sexual values and norms (Ministry of Health and Population, 2008:1). Hence Nyandeni Local Municipality has a TVET college which could have youth from Libode and Ngqeleni attending there, the researcher is also interested in finding out if the youth attending the TVET college has any level knowledge of knowledge and risky sexual behaviour. Relating to a study conducted among students at a TVET college by HEAIDS program, it showed that 83.8% of students had high level of knowledge on the that the presence of sexually transmitted infections puts people at more risk of HIV infection, or re-infection. The study also revealed that the students at the TVET college held negative attitudes to wearing a

condom during sexual intercourse. This negative attitude was revealed in a question which they responded to condom as decreasing sexual pleasure.

Knowledge and attitude about sexual behaviour among youth aged 18-25 years in the Nyandeni Local Municipality will be imperative for planning meaningful prevention strategies in addressing the negative attitude by youth towards HIV and AIDS. This can be done through describing and exploring how informed the youths are on HIV and AIDS, while not excluding their attitudes which could be influencing their reported sexual risk behaviours. Furthermore, the findings from the study will assist local NPOs that specifically deal with HIV and AIDS programs during their program revisions and implementation planning.

## 1.5. Purpose of the Study

The study is aimed at exploring the knowledge, attitudes and risky sexual behaviour among youth aged between 18-25 years old, in the Nyandeni Local Municipality at Eastern Cape Province. The study will assist in identification of their existing level of knowledge and risky sexual behaviour. It will further recommend for future education and training programs as a preventive measure.

## 1.6 Study Objectives

- To describe knowledge and attitudes regarding HIV and AIDS among youth 18-25 years at Nyandeni Local Municipality.
- To explore sexual risky behaviour among youth at Nyandeni Local Municipality.
- To discuss prevention strategies that can be utilised in order to reduce the spread of HIV amongst the youth at Nyandeni Local Municipality.

## 1.7 Research Question

The following research questions were addressed:

- How well informed the youth is among the ages of 18-25 about HIV and AIDS?
- What influenced risky sexual behaviour among youth from Nyandeni Local Municipality?
- What are the prevention strategies that can be utilised in order to lessen the spread of HIV amongst the youth at Nyandeni Local Municipality?

## 1.8 Study Significance

The motivation of the present study is to prevent new infections at Nyandeni Local Municipality. The researcher is of the view that the participation of public and private sectors will be required to curb the spreading of HIV. Sectors of society remain critical in conducting HIV prevention and awareness campaigns to young people to lessen sexual risky behaviours. It is nonetheless anticipated that information received from this study will be beneficial to generate recommendations concerning the epidemic that might assist Nyandeni Local Municipality organisations to implement prevention policies, and implement a program to help reduce the occurrence of risky sexual behaviours by the youth. The study will also be beneficial to OR Tambo Municipality as a whole, as it will add significance to the fight against HIV and AIDS. Government organisations will benefit from the study by being able to identify where the problem lies. The government and existing NGOs will also see whether the current HIV and AIDS interventions are truly working, and reaching all communities in the Nyandeni Municipality. The researcher hopes that the study will assist in increasing levels of knowledge among youth regarding risk sexual behaviour and HIV & AIDS. The key objective of the study should efficiently be to inspire, endorse and influence constructive sexual attitudes and behaviour amongst youth.

## 1.9 Research Process

The researcher has used qualitative research approach, an exploratory and descriptive research design in order to explore the knowledge and attitudes of youth concerning sexually risky behaviour among youth from Nyandeni Local Municipality. A semi-structured interview guide was used to conduct interviews to 30 youth aged between 18-25 years. They were purposively selected from the designated municipalities. Observation with field notes were utilised to gather and document data, and also inductive thematic analysis was used. They were purposively selected from the designated municipalities. Observation with field notes were utilised to gather and document data, and also inductive thematic analysis was used.

The research design and data collection method used for this study was based on the stated research objectives. Hence, the researcher was interested in finding out about how much knowledge the youth has concerning HIV and AIDS. The researcher has used an exploratory research in order to gain more insight regarding the phenomenon. Furthermore, descriptive research design has been used in order to provide clear description of the level of knowledge, attitudes to HIV and AIDS and sexual risk behaviour among 18-25-year-old youth.

About thirty (30) participants were interviewed at two local NPOs. Each interview took about 20 minutes. The researcher requested approval from the DSD to conduct an interview at the two NPOs, namely the Philisa Home Care Based Centre based at Ngqeleni location, and the Nompilo M U Home Care Based Centre project based at Libode location, which are funded by the Department. The researcher further asked permission from the Project Director in charge of the NPOs for permission to conduct interviews using their beneficiaries, which are the youth.

The research questions and searching questions in the interview guide were used to facilitate the interview process.

## 1.10 Research Assumption

The research had these assumptions, or knowledge claim:

- That the youth knows of HIV and AIDS, and that there are barriers that prevent them from preventing HIV transmission.
- That the participants will feel comfortable to talk about their sexual risk behaviours during the interviews.
- That the participants will provide their preferred prevention strategies.

In the present study, a qualitative interpretivism assumptions was considered. The six concepts of the Health Belief Model (HBM) will be described in relation to risky sexual behaviour among youth. The six concepts are perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action & perceived self-efficacy were appropriate to conceptualise the results of this study. The concepts of HBM form a scientific base that will allows the researcher in order to determine the knowledge, attitudes and risk sexual behaviours of the youth between the ages of 18-25 in the Nyandeni Local Municipality at Eastern Cape Province.

## 1.11 Defining Key Concepts

The following defined key concepts are used in this study:

**Exploration**: is described as investigation, search for understanding and answers to questions. Whenever an individual research on something, or investigates it, the person is regarded as doing exploring (Machlup, 2014:108).

**Knowledge:** Machlup (2014:66) describe the knowledge as awareness with something, which includes facts, information, descriptions, skills acquired through experience and education. It is also described that knowledge attainment involves complex cognitive processes such as perceptions, communication, association and reasoning. The knowledge is connected to the capacity of acknowledgement in human beings. For the purpose of this study, knowledge was an awareness that the participants heard about of

HIV and AIDS (how people can get the HIV virus, and preventive measures against the virus).

**Attitudes:** According to Russell and Elsenberg (2012:203), attitude can be described as a psychological tendency that is articulated by evaluating a particular entity with some degree of favour and disfavour. This definition may include the key features of attitudes—namely, tendency, entity (or attitude object), and evaluation. In this study, attitudes would mean negative or positive attitudes towards HIV and AIDS.

**HIV:** According to Wilson, Maartens, Cotton, Venter, Bekker and Meyers (2002:3) HIV is described as an acronym for Human Immunodeficiency Virus. In case of an infection with the HIV, it kills the defense mechanisms of the human being and the person becomes vulnerable to opportunistic infections.

**Risky sexual behaviour:** can be described as the infrequent practice of safe sex behaviours in the realm of contracting HIV. It is a critical factor contributing to this pandemic in Africa (Centres for Disease Control and Prevention (CDC), 2007; Shobo, 2007)**.**

**AIDS**: Ministry of Health (1999a:3) stated that AIDS itself is defined in terms of how much deterioration of the immune system has taken place as seen by the presence of opportunistic infections. Nearly all infected persons will eventually die from the disease, unless they succumb to something else first. Most will be dead within ten years of infection and many will die even sooner.

## 1.12 Summary

Chapter one presented the background to the research in terms of what the study entailed. This chapter also presented the rationale for the research study, the problem statement, the purpose of the study, the research objectives, the research question, the study significance, and the definition of terms.

### 1.13 Dissertation Outline

The exploration study is presented in five chapters:

Chapter 2 contains a literature review involving the exploration of knowledge, attitudes to HIV and risky sexual behaviour. The chapter also discusses other research about the topic and the importance of exploration of knowledge, attitudes to HIV and risky sexual behaviour by the 18-25-year-old youth. The study also focuses on the prevention methods that can be used to decrease the spread of HIV amongst the youth at Nyandeni Local Municipality.

Chapter 3 unpacks the research methodology and provides specifics of the research approaches used, the nature of the in-depth interviews, description and the methods of data collection.

Chapter 4 presents the analysis and results from the interviews conducted with the youth from Nyandeni Local Municipality in the Eastern Cape Province.

Chapter 5 presents the conclusion and recommendations of the study.

# CHAPTER TWO

# LITERATURE REVIEW

## 2.1 INTRODUCTION

This chapter is a review of different literature on the exploration of knowledge, attitudes to HIV, sexual risk behaviour by the youth aged 18-25-year-old in the Nyandeni Local Municipality. The literature reviewed in this chapter is divided according to main headings: theoretical framework Health Belief Model, knowledge on HIV and AIDS, attitudes towards HIV and AIDS and sexual risk behaviour in the South African youth, and prevention strategies. This chapter draws on present studies to determine the occurrence of HIV and AIDS infections among youth in South Africa.

## 2.2 THE THEORETICAL FRAMEWORK

For the exploration purpose of this current study, the researcher has utilised Health Belief Model to guide this study. The researcher considers that the HBM theory is appropriate to understand the content of this study.

### 2.2.1 Health Belief Model

The Health Belief Model is regarded as a humanistic theory. This belief is based on each of the model's meta-theoretical assumptions:

**Epistemology**: This can be described as theory that is comprised of multiple truths because it can be applied to different situations and to individuals in various ways. The knowledge gained is regarded an interpretive in nature.

**Ontology**: This is theory that relies heavily on free will because each individual determines the actions involved. This can be referred to an active theory (Honors, 2001:2).

The HBM is described as a humanistic (qualitative) “theory.” It was used as the theoretical framework for the current qualitative study. The HBM was used in order to determine the knowledge, attitudes and risky sexual behaviour of the youth between the ages of 18-25 in the Nyandeni Local Municipality at Eastern Cape.

### 2.2.2 Assumptions of the HBM

According to Dennill, et al, (1999); Polit and Beck (2004), HBM is described as one of the first theories developed to explain the process of change in relation to health behaviour. Stanhope and Lancaster (2000:252) described that the HBM is beneficial in assessing health protection or disease prevention behaviours.

The HBM has an assumption that that a person will take a health-related action if that person feels that a negative health condition can be avoided (Campus 2005:1). The HBM also further assumes that a person will take preventive action if that person has a positive expectation that by taking a recommended action. The negative health condition must be avoided at all costs (Campus 2005:1). Youth in the current study must perceive the benefits of female and male condoms, before they can initiate and maintain their use in order to prevent HIV infection.

### 2.2.3 Components of the HBM

#### The individual’s perceptions about health

These are described as the component to individual own perception about his or her beliefs of being susceptible to a disease and the seriousness of the illness being a threat to one’s own life (Onega, 2000:271-275). In the present research study, individual perceptions are youth beliefs about their susceptibility to HIV and AIDS and their perceived severity of HIV and AIDS.

#### Modifying factors

Onega (2000:271), described that modifying factors that involve an individual as demographic, socio-psychological and structural variable. This may have emotional impact a person’s insights and incidentally influence health related behaviours. As such

these modifying factors might change an individual's decision to use condoms during sexual intercourse might be influenced.

### 2.2.4 Variables affecting the likelihood of initiating and maintaining action (benefits of taking preventive measures)

The variables in the current study talk about the youth perceived benefits of committed safer sex by using female or male condoms effectively. This is regardless of the perceived barriers to taking action like availability, affordability and acceptability of condoms and this is equivalent to the possibility of taking actions to change behaviours (Onega 2000:253).

### Concepts of the HBM

According to Onega (2000:271), the HBM is described as a value expectancy theory. It has two values which are the need to avoid illness and the belief that specific health actions available to an individual would use in order to prevent the unwelcome consequences. The desire would be to avoid HIV and AIDS infection. The use of specific available health action would be effective and consistent use of condoms during sexual intercourse. This will include undesirable consequences about HIV infection.

The following are the concepts of HBM:

### Perceived susceptibility

Perceived susceptibility is described as an individual's beliefs about the chances of contracting a health condition (Frewen, Schomer & Dunne 1994:39; Groenewold et al 2006:3-4; ReCAPP 2007:3-4). The person's perception that a health problem is personally relevant will contribute to him or her in taking the required action to prevent the health problem. In order for this to take place. There must be activities that increase the individual's perception of one's vulnerability to the health condition. Meekers, Klein and Foyet (2001:8) have done a study the patterns of HIV risk behaviour and condom use among youths in Yaoundé and Douala, Cameroon, aged 15-24. The results revealed that despite high awareness of HIV and the protection condoms provide, only 14% female

participants and 20% male counter parts were consistently using condoms during sexual relationships.

The present study investigated youth susceptibility to HIV and AIDS by exploring their knowledge and attitudes to HIV and sexual risky behaviour in Nyandeni Local Municipality, and whether those who see themselves to be susceptible to HIV and AIDS assumed preventive actions (condom use) against HIV and AIDS infection.

**Perceived severity**

Perceived severity is described as to one's beliefs of how serious a condition and the consequences are (Groenewold et al 2006:3-4; ReCAPP 2007:3-4). When one recognises one's susceptibility to a certain problem or condition. This does not necessarily motivate one to take the necessary precautions and preventive actions unless one realises that getting the condition would have serious physical and social implications. ReCAPP (2005:2) also speculates that it is when one realises the magnitude of the negative consequences of a condition, and therefore one could take the necessary actions to avoid these negative consequences. With regard to the current study, the youth must perceive HIV as a serious infection that has severe consequences and implications on their physical, psychological and social lives. They have to consider this before they would adopt promotion and preventive actions (such as consistent condom use) against HIV infection.

**Perceived benefits**

Perceived benefits is described as one's beliefs in the efficacy of the advised action to reduce the risk or seriousness of impact (ReCAPP 2007:3). The person needs to believe that by taking a certain action will help one to avoid and prevent a problem from occurring (Hanson & Benedict 2002:25).

In the current study, perceived benefits are beliefs about the effectiveness of recommended preventive health actions, such as consistent and correct condom use during sexual intercourse to prevent HIV and AIDS. Condom use by youth was investigated in the current study.

### Perceived barriers

Perceived barriers can be described as to one's belief in the physical and psychological costs of the advised behaviours (Groenewold et al, 2006:4; ReCAPP 2007:4). There could be numerous obstacles that may affect people's decision to take specific actions. Rosenstock, Stretcher and Becker (1988:175) describe that perceived barriers to health actions comprise of phobic reactions, physical as well as psychological barriers, accessibility factors and personal characteristics. It is only when a person's realise that they have the capacity to deal with these barriers and therefore they would be able to take the necessary actions. These barriers, with respect to condom use to prevent HIV and AIDS were identified in this study.

### Cues to action

The HBM cues are described as action or events, personal (physical symptoms of a health condition), interpersonal or environmental (media publicity) that will encourage a person to take action (Groenewold et al 2006:4; ReCAPP 2007:4). Cues to action that influence the individual to have the desire to take the necessary action after believing that one has the capacity to do so. With regard to the current study, personal and environmental events motivating a person to use condoms to prevent HIV and AIDS were identified.

### Self-efficacy

Self-efficacy is described as the strength of an individual's belief in one's own ability to respond or difficult situations. This will also include dealing with any associated obstacles (Peltzer 2001:39). One should feel that one is capable of taking the necessary action correctly because it is that confidence that would motivate one to initiate and sustain the action (ReCAPP 2005:2). In the current study, self-efficacy is described as the confidence in one's ability to effectively use of condoms (Groenewold et al 2006:4).

The current study attempted to establish whether the youth in Nyandeni Local Municipality are using condoms efficiently.

## 2.3 HIV AND AIDS RELATED KNOWLEDGE

The knowledge in the present study can be described as to issues relating to HIV and AIDS. This will include modes of transmission, preventive measures, risk behaviours and implications. Most incidents are regarded as sexual transmitted diseases (UNAIDS, 2012). By taking safety measures to elude the risk of STIs (including HIV and AIDS) indicates a sexual freedom which young people rarely accomplish to attain because youth sexuality is strongly influenced by peer pressure (Coniglio et al, 2010). There is no current cure for AIDS, therefore other preventive measures have been envisaged. Awareness about HIV and AIDS is regarded as the first step in preventing infection (Rudaitis, 2010). In order counteract the prevention of infection, UNAIDS (2018:7) described that in order to decrease new HIV infections, it is critical that young people are the primary recipients of prevention strategies that include increased access to comprehensive sexuality education (CSE). Comprehensive sex education is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality (UNAIDS, 2018:7). It was aimed at equipping children and young people with knowledge, skills, attitudes and values that will empower them to realise their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, to understand and ensure the protection of their rights throughout their lives" (UNAIDS, 2018:7). UNFPA (2016) revealed that recent studies have found that only 59% of young people in South Africa have comprehensive knowledge of ways to prevent HIV (compared to 85% in eSwatini). Only 5% of schools were providing CSE in South Africa in 2016, but over the next five years the government has committed to increasing this to 50% in high burden areas (South African National AIDS Council, 2017).

UNFPA (2012) described that barriers for providing comprehensive sex education in schools include high school drop-out rates and shortage of teacher training because of the seen sensitive nature of the subject matter. UNAIDS (9 November 2016) explained that if young people are able to access sexuality education before becoming sexually active. When they are able to make knowledgeable decisions about their sexuality, and they will be able to approach relationships with more self-assurance. UNAIDS (9

November 2016) continued to explain that sexual education will increase protection use by girls and promote voluntary HIV testing. This will, in turn, reduce adolescent pregnancy. Furthermore, CSE is also known to increase girls' condom use, voluntary HIV testing pregnancy, especially when linked with non-school based, youth-friendly SRHR services, provided in a stigma-free environment.

Even though, the modes of transmission of HIV and AIDS differs all over the world (Marteau et al 2012:1492), WHO has identified three main ways of HIV transmissions among general population. Prominent among them is through all forms of sexual intercourse. The second most common mode of transmission is the exposure to infected blood through transfusion and needles sharing. The third major route of HIV transmission is the prenatal and substantial vertical (mother- to- child) transmission. Other ways of HIV transmission may include breastfeeding (if the mother has HIV), sharing of sex toys such as dildos or vibrators without sterilising them (Adegoke, 2010). It is worth noting that the HIV virus concentrates in the seminal fluid (Barnett & Whiteside, 2006). An occupational risk of HIV transmission exists for health care workers and laboratory personnel after contaminated needle sticks and other occupational exposures.

The true knowledge and understanding of HIV and AIDS is described as a necessary condition for behavioural change (Gregson, Zhuwau, Anderson & Chandiwana 1998:321:329; Uwalaka & Matsuo 2002). Therefore in order to assess the prospects of effective behaviour change, it is crucial to ascertain the depth of the object.This will have to be taken into consideration on, whether it prevails to be hazardous to one's health or presents itself positively to one's own mind, attitudes and behaviours. Being aware of the risks, it will therefore provokes one's realisation of risks that pose a danger to one's life. Mohale (2003:13) revealed that people may learn from campaigns on HIV and AIDS about its causes and may even change their sexual behaviours, and while their basic and deep-rooted attitudes may change little. The risk perception may be based on insufficient knowledge and information. Kiragu (1995:113) described that young peoples' sexual activities are based on insufficient knowledge and misconceptions rather than on a rational consideration of the consequences.Young people may not have enough understanding as to how to protect themselves, and if they do, they may not have the

capacity to act on the knowledge of prevention in view of several cultural and economic constraints.

A study by Unadike et al (2012) in Nigeria agreed with other studies that all of the participants had heard about HIV and AIDS. Eighty-three percent (83%) could identify all known modes of transmission of HIV and 95% agreed that there is no cure for the disease. Coglio et al (2010), Jemmott et al (2010) had concluded that finding effective means to educate and motivate youth to avoid risky sexual behaviour is a challenge. It was suggested that the most common approach used to reach young people was through school based education. Despite this variety of sources, there some gaps that exist because of incomplete and inaccurate information emanating from these sources (Adebola 2005:13-14).

## 2.4 GLOBAL LEVEL OF HIV AND AIDS

The HIV epidemic is regarded as a leading cause of death worldwide and the number one cause of death in Africa (UNAIDS, 2012). Even though cases have been reported in all regions of the world, roughly all those living with HIV (97%) reside in low- and middle-income countries, mainly in sub-Saharan Africa (WHO/UNAIDS/UNICEF, 2013). It is estimated that around 30 million people have died since the emergence of the HIV pandemic.The report also showed that 1.7 million people died of AIDS in 2011, a 24% decrease since 2005 (UNAIDS, 2011). The investigations have shown that women represent the highest of all people living with HIV worldwide and more than half (58%) in sub-Saharan Africa. Gender inequalities, differential access to services, and sexual violence increase women's vulnerability to HIV, and women, especially younger women, are biologically more susceptible to HIV. However, young people, within the age 15–24 years, stands for about 40% of new HIV infections.Young women are twice more likely to become infected with HIV than their male counterparts (Onyene et al, 2010).

Despite these challenges, new global efforts have been mounted to address the epidemic, particularly in the last decade.There are signs that the epidemic may be changing course. The number of people newly infected with HIV and the number of AIDS

related deaths have declined.This is real contributing factors to the stabilisation of the epidemic. The number of people with HIV receiving treatment in resource poor countries has increased from 400,000 in 2003 to 9.7 million in 2012. Although HIV testing capacity has increased over time and enabling more people to learn their HIV statuses.The majority of people with HIV are seems to be unaware they are infected (WHO/UNAIDS/UNICEF, 2013).

## 2.5 ATTITUDES OF YOUTH REGARDING HIV AND AIDS

The current study explored youth attitudes regarding HIV and AIDS and towards PLWHA in order to make recommendations for engendering more positive attitudes in future.

Since the discovery of HIV & AIDS epidemic, words such as death, guilt, punishment, prostitution and several others have been associated with HIV and AIDS (Amo-Adjei and Dartch, 2013). These misrepresentations have somehow built stigmatisation and discrimination of PLHIV (Amo-Adjei and Dartch, 2013:51). The stigma and discrimination undermine the ability of individuals and communities to protect themselves from HIV. This may affect them to remain healthy when they are HIV positive (UNAIDS/WHO, 2013). The HIV and AIDS related stigma may create an environment where people may avoid HIV and AIDS related services especially HIV test (Maughan-Brown, 2013). This will promote silence, dismissal from work, denials, violation of confidentiality and rejection by families (Owolabi et al, 2012). As a result, it will prevent millions of people from coming forward for HTC and ART (e.g. uptake, adherence and retention of treatment) (Sedibe and Goosby, 2013). Attitude is regarded as negative or positive depending on the individual. Media has played a huge part in talking about the importance of HIV testing. This has led to more people, especially the youth, to go for HIV testing, or to keep on being aware of their HIV status.

Maswanya, Brown and Merriman (2009) in their studies revealed that that students were reluctant to use HTC and the main barrier for testing were ‘fear of being stigmatised. This include the fear of discovery of HIV positive status’. The results also showed that there was HIV and AIDS related stigma toward PLHIV (Maswanya, Brown and Merriman, 2009). In order to examine knowledge about HIV and AIDS and their attitudes towards

PLHIV, study in Yemen showed that participants had several serious misunderstandings about HIV and AIDS. They also held negative attitudes towards PLHIV (Badahdah and Sayem, 2010). The study also noted that although female students were less knowledgeable about HIV and AIDS than their male counterparts, they were more positive attitudes towards PLHIV (Badahdah and Sayem, 2010). Similarly, Al-Rabeei, Dallak and Al-Awadi (2012) found that misconceptions about modes of transmission of HIV were high among 41% of the respondents. However, the study found that the attitude of respondents towards PLHIV indicated that 59.8% were more caring and positive. And 86.8% of the respondents were willing to care for PLHIV (Al-Rabeei et al, 2012). A study to assess HIV and AIDS related stigma and discrimination in South Africa indicated that the level of personal stigma was significantly lower than perceived in the communities (Visser et al, 2009). Additionally, respondents who were more stigmatising and discriminating were older, male, less educated and those less knowledgeable about HIV and AIDS (Visser et al, 2009).

South Africa has made impressive progress in recent years in getting more people to test for HIV. UNICEF (2013) stated that increasing access to HTC is vital to prevent further transmission of HIV among young people. Mobile and community testing initiatives are a successful way of reaching young people who are less likely to voluntarily visit a testing Centre. In 2017, South Africa reached the first of the 90-90-90 targets, with 90% of people living with HIV aware of their status.This was up from 66.2% in 2014 (UNAIDS, 2017; South African National AIDS Council,2015). South African National AIDS Council (2015) stated that this progress follows the launch of two nationwide testing initiatives namely the national HIV testing and counselling (HTC) campaign of April 2010.The HTC revitalisation strategy of 2013 focused on getting people from the private sector, farms and higher education to test. The National Department of Health (NDOH) (2017) mentioned their appreciation for campaigns such as these, and more than 10 million people in South Africa test for HIV every year. The Human Sciences Research Council (HSRC) (2014) further added that the progress made in getting people to test has still yet been ueven because in South Africa, women are much more likely to test than men. This is partly because PMTCT programmes enable women to access HIV testing services during routine antenatal appointments.

The HSRC (2014) described that there are other hindrances to men testing. Recent research has showed that men are often reluctant to test.This is because they see health facilities as being ‘women’s places’. They feel that testing for HIV is non-masculine and might be seen as weak. Men report that queueing outside a testing facility is worrying, and will be taken as evidence that they are living with HIV.They also talk of avoiding testing because they are ‘terrified’ of a positive result. The South African government has introduced a number of strategies to mitigate HIV and AIDS. It was done by introducing programmes for women and youth. However, there are only a few programmes designed for men. This may be one of the reasons why men do not attend voluntary counselling and testing (VCT) services as much as women do. It is therefore relevant that there are efforts that should be made to increase men’s health-seeking behaviour. This will include participation in VCT (South African Government 2012). This statement confirms what the researcher raised in her problem statement, where it is mostly females who go for HIV testing during clinic visits and antenatal care.

The researcher believes that once youth practice positive attitudes through proper education, it will be very difficult for them to change their attitudes. There is need to improve HIV and AIDS situation among adolescents.

## 2.6 FACTORS ASSOCIATED WITH SEXUAL RISK BEHAVIOUR

Tadesse, Yakob, (2015:3) noted that there are different causes related to risky sexual behaviours by youth. These may include being effortlessly influenced by peers, poor relationship with and partial support from parents, inappropriate parenting roles, role models, and living in unfavourable environments. Due to the lack of awareness about the risks associated with unprotected sex, youth often acquire sexually transmitted infections whereas the young girls may have unwanted pregnancies. According to Tadesse, Yakob, (2015:3), the behaviour may also be due to inadequate information and basic skills to deal with their emotions, and high peer pressure to experiment with sex.

### 2.6.1. Early sex debut

The early sex debut has been cited as the driving force for new HIV infections among youth (particularly women) and poses as an increased risk to STIs and unplanned pregnancies. Furthermore, early sex debut is a challenge because it is associated with regular sexual intercourse, inconsistent contraceptive use especially a condom, multiple sexual partners, non-consensual sex debut (Patel et al, 2014). STOP AIDS (2016) alluded that it is common for youth to become sexually active by early adolescence. The youth, at that stage of adolescence, like to experiment, without realising the danger they are putting themselves in. UNICEF estimates that between 30-50% of girls will give birth to their first child before age19 (STOP AIDS, 2016). STOP AIDS (2016) continued to mention that while only a small percentage of adolescents will become sexually active before the age of 15, evidence suggests that some children as young as five years are exposed to sexual activities, directly or indirectly. Wand and Ramjee, (2012) in a study of sexually active women in KwaZulu-Natal (KZN), South Africa found that the occurrence of HIV, STIs (chlamydia, gonorrhoea, syphilis) and herpes simplex virus (HSV2) were 41%, 16% and 73% respectively. The highest seroconversion rate of HIV and AIDS was observed among women who had reported to have had sex at 15 years or younger (Wand and Ramjee, 2012). The association of HIV status with younger age at sexual debut may be likely be due to an increased number of lifetime partner (Wand and Ramjee, 2012).

### 2.6.2 Unprotected sexual intercourse

The inconsistent condom use is much less protective than consistent use (Crosby et al., 2012; Wilton, 2013). Shisana et al. (2014) described that consistent condom users are 20 times less likely to be infected after exposure to HIV. In a household survey of HIV prevalence and sexual behaviour conducted among young South Africans aged 15–24 years old examining correlates of consistent condom use.

The study by Liu et al. (2014) concluded that the HIV infection seroconversion incidence rates in an uninfected partner were lowest in the sero-discordant couples with consistent condom use versus the inconsistent condom use group. The effectiveness of condoms depends on how consistently they are used during sexual intercourse (Chandran et al.,

2012; Exavery et al., 2012; Wilton, 2013; Shisana et al., 2014; Crosby et al., 2015; UNFPA, WHO & UNAIDS, 2015). Furthermore, according to Tadesse, Yakob, (2015:3); the use substances either drinking too much or using drugs by injecting can affect decision-making before and during sexual activity. This impacts on condom use can expose to risky sexual behaviour (Tadesse, & Yakob, 2015:3).

Idele, et al, (2014) described that unprotected sexual intercourse is the most common way of HIV infection. WHO (2013, November) also agreed by adding that for some, not having the truthful knowledge about HIV, and how to prevent it, is to blame. It also highlights the need for HIV, sexual, reproductive health and rights (SRHR) education. Youth, especially young girls, are involved in violent relationships where they are unable to negotiate protection during sexual contact. Inconsistent condom use particularly among those in long term/cohabiting relationships is common. Condom efficacy is the lowest among females 15-24 years. This is coupled with the fact that they are more likely to have sex with unfaithful partners; they are particularly vulnerable to HIV (STOP AIDS, 2016).

#### 2.6.2.1 Variables affecting likelihood of initiating and maintaining condom use against HIV and AIDS infection

**Perceived benefits of using male condoms against HIV and AIDS**

Perceived benefits of condom use regarding the current study is described as the belief in the efficacy of condom use to prevent HIV.

**Perceived barriers to condom use**

Receptiveness to condom use can be plagued by barriers including embarrassment or timidity to obtain condoms from sources that require person-to-person contact (UNFPA 2012:1). Therefore, any obstacles in the use of condoms can interfere with their frequent and consistent use as a means of preventing HIV & AIDS. This will include family planning purposes (Adih & Alexander 1999; Estrin 1999; Ford & Koetsawang 1999). Thus, when young people do have sex, they must be able to protect themselves.

### Risk perception

Youth, even though they are aware of HIV risk, they often do not consider this risk with steady partners. They also tend to establish the trustworthiness of their partners with criteria other than sexual history. They have the consequence of not using condoms. This have led to youth saying that learning about partners' sexual history was important, but it rarely happened (Longfield, Klein & Berman, 2002).

### Cues to action for condom use

Regarding the current study, cues are described as personal and environmental events motivating a person to use condoms during sexual intercourse in order to prevent HIV and AIDS (Groenewold et al 2006:4). Despite the recognised effectiveness of condoms for HIV prevention, it is estimated that many sexually active young people use them only infrequently and not at all (Shaffi, Stovel & Holmes, 2007).

### Self-efficacy in condom use

Self-efficacy in condom is described as the belief that one is both capable of and likely to use condoms in sexual situations. This may play a key role in promoting condom use behaviours (Melissa, Farmer & Meston 2006:313).

In the current study, the concept of self-efficacy as it is related to condom use, was used to investigate the sexual behaviours of youth in Nyandeni Local Municipality.

### 2.6.3 Multiple sexual relationships

Many simultaneous affairs relate to people who participate in sexual relationships that involve more than one partner at the same time. Multiple simultaneous partnerships are legitimised through deep-rooted traditions of a polygamous society (Maharaj & Cleland, 2011; USAID, 2013). Multiple sexual partners, particularly if simultaneous, may be the contributing factors to the spread of STIs including HIV (Maharaj & Cleland, 2011; USAID, 2013). When people engage in unprotected sex with many different partners they increase their vulnerability to contract HIV (southern Africa HIV and AIDS Information Dissemination Services, 2014). It is believed that men are more likely than women to have concurrent partnerships (Onaya, Zuma, Zungu, Shisa and Mehlomakhlu, 2014). The Zulu

culture in South Africa encourages men to have more than one-woman lover or a sex partner (Mogotlane et al 2007:40). This practice may impact negatively on the spread of HIV. With regard to the current study, question referring to the number of sex partners were included in the interview questions. It is important to build confidence in the youth such that they are conscious of their sexual rights, responsible for their sexual health, and understand the consequences of unprotected sex. However, youth may be influenced by their peers or environment to practice premarital sexual behaviour at an earlier stage of their development (Eriksson et al., 2013; Stern & Cooper, 2014:121).

### 2.6.4 Age-disparate relationships (Intergenerational sex)

The intergenerational or cross generational sex is between couples where the age difference is more than years older or younger. A study on behavioural and contextual factors driving the epidemic in Namibia by the Ministry of Health and Social Services (2008) revealed that prevalence among men is highest in the age group between 35 to 45. Therefore, under these circumstances, having intercourse with an older person rather than a peer poses an increased risk of HIV infection among younger women.

South African National AIDS Council ( 2015) reported that, 7% of single women and 26% of married women aged 15-24 years had partners 10 years older than them. The phenomenon of sugar daddies and mommies is related with this practice. LeBeau and Mufune (2001) described that such relationships are encouraged by the implied assumption that sex will be swapped for material support. The transactional sex is born out of a system of widespread poverty. This can be contributed by high income inequality in which young men & women have few employment possibilities and access to resources is almost exclusively through wealthier men (LeBeau and Mufune 2001). The concept of intergenerational sex is more common between young female and an older male partner (commonly called sugar daddy syndrome). The phenomenon is reported to be on the increase which may have significant implications for the prevalence of HIV and AIDS (Phaswana-Mafuya et al, 2014:257). Several studies described that young people with exposure to sex are sexually connected with more sexual experienced adults whose HIV prevalence is likely to be high (Muula, 2008, Doherty et al 2006).

### 2.6.5 Coerced or forced sex

South African National AIDS Council (2015) described that child marriage is also a key driver of an early sexual debut. In some settings, up to 45% of adolescent girls reported that their first sexual experience was forced. In South Africa, especially in Mpuma-koloni or in the Eastern Cape Province. There are many cases of forced child marriages. The child can be as young as 13 years, and even though they might have been saved in most cases, they have already been raped by their abductors, which are their husbands who are older men. When these children are saved but might have been already been infected by HIV (South African National AIDS Council, 2015).

### 2.6.6 Absence of access to HIV services

UNAIDS (2017) described that reluctance to acknowledge adolescents' exposure to sex can lead to age restricted laws that govern access to SRHR services. This may include HIV testing and treatment. Girls, as young as 13 years of age, are in sexual relations, yet only parents can grant consent for them to do pregnancy and HIV tests. This is a problem because most of these young girls cannot access services. UNAIDS (2017) highlighted that in 2016, at least 63% of the 108 countries where there was data, required young people to have the consent of parents or legal guardians to access SRHR services. In 71% of the countries, parental consent was needed for young people to take a HIV test (UNAIDS, 2017). The researcher is of the opinion that the age of consent in South Africa should begin from 13 years, looking at these children as young as 13 years, are likely to be involved in sexual relations.

### 2.6.7 Sex workers

Slabbert, et al (2017) described that that certain factors increase HIV risk for South African sex workers. Such factors include poverty, number of dependents they have, and lack of alternative career opportunities. Injecting and drug use, is also common among sex workers.This will also exacerbates their vulnerability to HIV infection (South African National AIDS Council, 2013). Studies have also revealed that understanding of HIV risk is often low among female sex workers. In Durban, it was reported that only 4.6% of

female sex workers could correctly identify HIV transmission risks and they reject the myths (South African National AIDS Council, 2017).

### 2.6.8 Youth and substance abuse

According to Chick & Reyna ( 2012:379) sexual exploration is described as a normal and typically healthy part of an adolescent's development. Therfore certain behaviours increase the likelihood of unwanted outcomes such as pregnancy and sexually transmitted diseases (STD). Researchers have long been interested in describing the relationship between substance use and very common in adolescences. The relationships include sexual risk taking, a relationship that appears to be complex and not always as expected. Across the lifespan, adolescence is the time of greatest risk taking that can also contribute to HIV (Chick & Reyna, 2012:388). While understanding or even over-estimating the likelihood that an action will result in harm, adolescents may place higher value on the benefits that might come from taking a particular risk. By focusing on an individual's decision to take drugs and to have sex. Youth is more likely to become involved in many different risk behaviours when they experience a preponderance of risk factors without the counteracting forces of positive opportunities, relationships, and resources. The risk and protective factors may have different effects on each sexual risk behaviour (Hipwell, Stepp, Chung, Durand, & Keenan, 2012:118), and certain underlying factors may act more strongly on substance use than sexual risk (Jackson, Henderson, Frank, & Haw, 2012:131).

In 2016, it was estimated that 17% of people who inject drugs in South Africa were living with HIV (SANAC, 2017). It is estimated that people who inject drugs, however, only account for 1.3% of new HIV infections in South Africa (Human Sciences Research Council, 2014). People who are using drugs, either by injecting or sniffing, are also associated with other high-risk behaviours such as sex work and unsafe sexual practices to maintain their drug habit. Substance abuse does not end with using drugs. Substance abuse is also consumption of alcohol to the point of being intoxicated. Dependence on alcohol can lead to impaired concentration. The intoxicated person cannot make a decision for her/himself, which can lead to unprotected sexual contact.

## 2.7 SOUTH AFRICAN HIV PREVENTION PROGRAMS FOR THE YOUTH

In countries like South Africa, where the epidemic is driven largely by heterosexual transmission, key behavioural interventions were implemented (Maharaj & Cleland, 2011). These interventions were focused on sexual abstinence, delayed sexual debut, reduced numbers of sexual partners, and correct and consistent use of condoms. This was aimed to prevent or reduce the likelihood of sexual transmission (Maharaj & Cleland, 2011; CDC, 2016). Furthermore, USAID (2013) described that success in reducing HIV incidence will be accomplished by implementing effective HIV prevention strategies. Abstinence from sexual intercourse has been documented as the most reliable way of preventing and avoiding sexual transmission of HIV (CDC, 2016). However, it has been revealed that abstinence campaigns may not reduce high-risk sexual behaviours (Lo, Lowe & Bendavid, 2016). A study conducted by researchers at Stanford University School of Medicine, in which they reviewed records for abstinence-fidelity programs, including data from 1998 through 2013.It was revealed that nearly 500,000 men and women in 14 countries, showed this to be impractical and ineffective in older teenagers (Lo, Lowe & Bendavid, 2016).

The universal ways of controlling the HIV epidemic is prevention. Prevention of HIV and AIDS seeks to reduce the risk of infection by encouraging individuals to avoid risky sexual behaviours. Abstinence, being faithful and condom use (ABC) have been recognised as effective strategies of managing the epidemic (Appiah-Agyekum and Suapim, 2013). A study of adolescent girls revealed that 66.7% of respondents were aware of ‘ABC’ while the remaining 33.3% disagreed that ‘ABC’ helped reduce the risks of acquiring the virus (Appiah-Agyekum and Suapim, 2013).

### 2.7.1 Prevention of mother-to-child transmission

According to the South African National AIDS Council (2014) over the past decade, South Africa has made great progress in reducing mother-to-child transmission of HIV.This was due to largely improvements in the choice of antiretroviral medicines and the widespread

accessibility of the MTCT programme. In 2016, more than 95% of HIV positive pregnant women have received antiretroviral medicine to reduce the risk of MTCT (UNAIDS 2017). As a result MTCT rates have fallen from 3.6% to 1.5% between 2011 and 2016.This program assist achieving the national target for 2015 of a transmission rate below 2% (SANAC, 2016). Almost every health care, or clinic, in South Africa has a policy whereby a person visiting the clinic for health assistance are tested first before being seen by a nurse or by doctor on call. The pregnant women and girls who visit the clinic on monthly basis, or for their checkups, are tested for HIV, and if they test positive, they are given HIV treatment to protect the unborn baby.

### 2.7.2 Dissemination of condoms and condom use

The South African National AIDS Council (2017) described that between 2007 and 2010, South Africa's distribution of male condoms increased by 60%. This was from 308.5 million to 495 million a year. In the most recent National Strategic Plan, the South African National AIDS Council aimed to increase the number of male condoms distributed annually to 850 million by 2018. SANAC (2017); National Department of Health (2017) also indicated that South Africa's female condom programme is also one of the biggest and most established in the world. There was over 26 million female condoms (also known as internal condoms) distributed in 2016. The new strategy will expand condom distribution, making them available at non-traditional outlets such as hair salons, petrol stations, spaza shops, hotels, toll plazas, truck stops and taverns, as well as secondary schools and non-traditional community settings.

### 2.7.3 Voluntary medical male circumcision

Auvert, et al (2005), cited that research emerging from sub-Saharan Africa, suggests that VMMC may reduce the risk of female-to-male HIV transmission by up to 60%. UNAIDS (2017) revealed that this led the South African government to rapidly roll out a national Voluntary medical male circumcision (VMMC) programme. It was aimed to reach 80% of HIV negative men (4.3 million) by 2016. In 2016, it was reported that 50-79% of eligible men had been reached by VMMC programming (UNAIDS, 2017). The National Department of Health (2017) added that, as a result, in 2016, over 491,859 circumcisions were performed in South Africa. Across the country the VMMC programme has mostly

been well received with 78% of women preferring their partner to be circumcised according to the 2011 youth sex survey (NGO Pulse, 2011, 9 June).

### 2.7.4 Pre-exposure Prophylaxis (PrEP)

PrEP Watch (2018) cited that in December 2015, South Africa became the first country in sub-Saharan Africa to fully approve pre-exposure prophylaxis.This was the use of antiretroviral drugs to protect HIV negative people from infection. PrEP Watch (2018) cited that in 2017, it was estimated that between 30,000 and 35,000 individuals were being targeted with PrEP in ongoing and planned projects across South Africa. The 2017-2022 National Strategic Plan aims to expand this, so that PrEP becomes available to all those who are most likely to benefit, including adolescents, sex workers, men who have sex with men, and people who inject drugs (South African National AIDS Council, 2017).

### 2.7.5 HIV prevention programmes for young people

UNICEF (2013) believed that young people have the potential to be tremendous peer educators, and to help in the design of HIV-related services and programs. Technology and social media are consistently being proved as effective ways to engage young people in sharing HIV knowledge (UNICEF, 2013). UNAIDS (2018:12) highlighted that participation and inclusion of youth is a core Human Rights principle. Furthermore, development programmes that focus on young people are most effective when young people participate in decision-making spaces about interventions that affect their lives, and their contributions are meaningfully considered (UNAIDS, 2018:12).

UNAIDS (2016:9) described that that continuous HIV testing and treatment must be accompanied by a primary prevention response. South Africa has built the world's largest condom programme in just a few years. This has double the number of condoms distributed per male, per year, in at least seven of nine provinces (UNAIDS 2016:9). South African National AIDS Council (2017) reported that the South African National AIDS Council intended to increase the number of male condoms distributed annually to 850 million by 2018.

UNAIDS (2016:10), in its prevention gap, reports said that few countries have consistently applied a combination HIV prevention approach. This approach, which provides packages of services including behavioural, biomedical and structural components which had been tailored to priority population groups within their specific local contexts. For example, young people in high prevalence countries need more than condoms and behaviour change communications (UNAIDS,2016:10). They also need CSE and access to effective HIV and sexual and reproductive health services without economic barriers, such as prohibitive costs, or structural barriers, such as parental consent laws (UNAIDS, 2016:10). All programmes need a strong community empowerment element and specific efforts to address legal and policy barriers, as well as the strengthening of health systems, social protection systems, and actions to address gender inequality and stigma and discrimination (UNAIDS, 2016:10).

According to SANAC (2017) Challenges remain in ensuring that condom programmes can serve all groups, particularly those with higher HIV risk. The new strategy will expand condom dissemination, making them accessible at non-traditional outlets such as hair salons, petrol stations, shops, hotels, truck stops and brothels as well as secondary schools and non-traditional community settings.

### 2.7.6 Age-appropriate services

UNICEF (2013) indicated that young people respond much better to HIV and SRHR services that are specific to their age group. ibid mentioned also that research shows that targeted counselling to encourage behaviour change among young people is more effective than only handing out commodities such as condoms. This means that distribution of condoms to the youths must be accompanied by voluntary counselling. UNAIDS (2016), on the other hand, highlighted that in 2015, UNAIDS and the African Union included age-appropriate comprehensive sexual education should be one of the key recommendations for improving the HIV response.

### 2.7.7 Involving schools in the response against HIV and AIDS

Most children and youths are at school; it is therefore imperative that sexual education be taught at schools. Those children do not receive actual sexual education from home, so

school is the best place to at least receive the information on sexual activities. UNICEF (2013) strongly emphasised that schools have the potential to provide comprehensive education on HIV and AIDS and other SRHR issues. More improvement needs to be made to ensure there is equality in access to schools by both girls and boys, and to prevent them from dropping out UNICEF (2013).

## 2.8 CONCLUSION

The literature review focused on previous and current studies.This also indicate how youth participate in risky sexual behaviour.This was regardless of their level of awareness and knowledge of HIV and AIDS. This study explores how the level of knowledge and attitudes to HIV and its influence on sexual risk behaviour among the youth aged 18-25 years in the Nyandeni Local Municipality in Eastern Cape. The literature review also highlighted the effective use of condoms and prevention strategies to avoid risks associated with sexual behaviour.

# CHAPTER THREE

# RESEARCH DESIGN AND METHODOLOGY

## 3.1. Introduction

Discussed in this chapter is the study design, philosophical perspective, study settings, population, data collection methods and ethical considerations. This chapter outlined the methodology used to conduct the research. It addressed processes used to recruit participants and collect data on the level of knowledge and attitudes to HIV and sexual risk behaviour among the youth aged 18-25 years old in the Nyandeni Local Municipality in Eastern Cape. This chapter reviewed the specific strategies employed to collect, analyse and store the data. The specific steps involved in gaining ethical approval from the Ethics Committee (Higher Degrees Committee) of the College of Human Science at UNISA were defined.

## 3.2. Research Approach

The research was conducted using the qualitative enquiry method to collect data. According to Gioia, Corley and Hamilton (2013:1) qualitative researchers demonstrate a common belief. This method can provide a deeper understanding of the social phenomenon that would be obtained from purely quantitative data. The researcher explored the level of knowledge and how attitudes are influenced regarding risky sexual behaviour among the 18-25-year-old youth. Given this goal, a qualitative method approach was called for.

Perez, Holt, Gokert and Chanoi (2015:179) also pointed out that a qualitative design explores attitudes, behaviour and experiences, and through such a method, open-ended, face to face interviews and focus groups is appropriate. In this study, data were collected using interviews conducted with the 18-25-year-old youth. Creswell (2013:191) postulates that qualitative research is any data gathering technique that generates open-ended, narrative data. It tends to be exploratory and descriptive in nature and designed to

develop an understanding of individuals in their natural environment. In this study, the researcher interviewed participants to be able to gain an understanding of the concepts being studied. Qualitative design was preferred because it gave the participants an opportunity to talk and expand more on the topic and questions (Hurley, Cummings & Browner 2013). The aim was not to generalise, but to get the understanding of the issues related to knowledge, attitude and experiences of the participants.

According to Calitz, Strydom and Roux (2014:153), the main goal of exploratory studies is to express a new area of interest to gain an understanding of a concept. In addition, exploratory studies lead to a greater understanding of the concept researched and may not necessarily provide a detailed, accurate and replicable body of data (Babbie 2010:117). In this study, the researcher followed an explorative method to achieve an understanding of a concept researched.

### 3.2.1 Pragmatic philosophical perspective

This study utilised a combination of descriptive research design and exploratory research design. The study followed an interpretivism paradigm, hence using a qualitative approach.

### Ontology and epistemology

The ontology is described as the social reality of a specific situation (De Vos et al 1998:242). In the current study ontological also mean empirical or realistic situation. Ontological commitments are therefore described as assumptions about the essence of the research object and empirics (Mouton 1996:46; Mouton & Marais 1990:147; Polit & Hungler 1999:10-11). In the current study, at the ontological level, it is assumed that:

• The concepts of the HBM was described as the aspects of the reality of the knowledge and attitudes regarding HIV infection and sexual risk behaviours encountered by the lives of the participants. This is referred to the youth between the ages of 18-25 in the Nyandeni Local Municipality at Eastern Cape.

• The social can be described as a reality within the context of the research topic and research questions is suitably specific and generally structured by the HBM.

The development and applications of the research design by qualitative researcher rest on the researchers' beliefs that the research question could be answered truthfully. This will imply that how the assumption reality should be viewed. There is a reality that 18-25-year-old youth at Nyandeni Local Municipality have low or limited knowledge of HIV and AIDS and the risk of their sexual behaviour, and how it is influenced by their negative attitude. The following heading will be discussed under the following:

**Objectivism**

De Vos et al (2011:309) described that objectivism is based on the belief that there is external reality that can be studied objectively. It is described as the ability to know things as they are. There is also a need to check on subjectivity and refrain from personal judgement and emotions. According to Kumar (2014:219) described that authenticity develop in a report when it carries the emotions and tone of participants as they are. In this study, the researcher made sure that she detains from passing personal judgement and emotions.

**Interpretivism**

According to De Vos et al (2011:309) described that the matter of social sciences is fundamentally different from the natural sciences. Different methodologies were used in order to reach an interpretative understanding and explanation that will enable social research understanding in order to appreciate the subjective meaning of social action. In this study, the researcher made sure that the experiences of the participants were not altered or changed in any way, as they were taken as the real truth of the problem. Reality must be socially and personally constructed, and the subject should be actively involved. It can also be a result of a constructive process.

## 3.3 Setting

The investigation was conducted in Nyandeni Local Municipality, the smallest Local Municipality in OR Tambo District Municipality in the Eastern Cape, South Africa. Nyandeni Local Municipality is comprised of two towns, specifically Libode and Ngqeleni.

One NPO, subsidised by the Department of Social Development, from each town was selected. It has been recorded that in 2014, the HIV and AIDS occurrence rate was as high as 50%-60% among tested cases of both young men and women between the ages of 15 to 30. These cases were mainly women who partook in voluntary testing during their regular pregnancy visits, and men who reported symptoms of sexually transmitted infections at the local clinics (Nyandeni Local Municipality IDP of 2015-2016). The researcher is working for the Department of Social Development under OR Tambo District. Due to the extensive HIV and AIDS work she is doing with the Nyandeni Local Municipality, the researcher was interested in discovering the level of knowledge of the youth of Nyandeni, and also if their attitudes influence risky sexual behaviour.

### 3.4 Research Design

Kumar (2014:122) described research design as a blueprint, arrangement and plan of enquiry considered to find answers to a research problem. The researcher has used exploratory and descriptive research design. The choice of research design and data collection method that were utilised in this study was based on the research objectives intended at understanding the level of knowledge about HIV and AIDS. Exploring and describing how the levels of knowledge and attitudes influence risky behaviour among the 18-25-year-old youth. According to Kumar (2014:370), exploratory research is utilised when the objective of the study is aimed at exploring an area where little is known. Hence, the researcher is interested in finding out about the level of information concerning HIV and AIDS amid the 18-25-year-old youth, so the researcher used exploratory research design to explore the phenomenon from which the researcher could gain an understanding of it. Descriptive research was also used in this study. According to De Vos et al (2011:97), descriptive research denotes to more rigorous examination of the phenomenon and their deeper meanings, as a result, leading to thicker description. In this study descriptive research design provided clear description of the level of knowledge, attitudes to HIV and AIDS and sexual risk behaviour among 18-25-year-old youth.

### 3.5 Research Method

In this chapter the researcher outlined the research process, type of data analysis, ethical consideration and measures to ensure trustworthiness.

#### 3.5.1 Population

Babbie (2016:116) described the population for a research as a group (generally people) about whom we want to draw conclusions. The population criteria established the target population. That is, the entire set of cases about which the researcher wanted to make generalisations on, and who met the sampling criteria (Burns & Grove 2005:342). The population of this study are the Nyandeni Local Municipality youth between the ages of 18-25, which were both males and females. The reason for targeting the youth between 18-25 years, is because the researcher is interested in exploring their knowledge, attitudes and sexual risky behaviour as this would be helpful in making recommendations for future education programs to serve as preventive measures.

#### 3.5.2 Sampling

The researcher has used purposive sampling in this study. Vehovar, Toepoel & Steinmetz (2016:21) described purposive sampling as a follow some judgement by the researcher by looking for a kind of 'representative' sample. This will include looking for diversity until some criteria are fully satisfied. Philisa Home Care Based Centre, which is located at Ngqeleni, had a 5-day youth workshop, as the researcher was aware of the workshop, the manager of the Philisa Home Care Based Centre requested that the researcher conduct the interviews during the same time. The interviews were conducted for a period of three days, there were five interviews conducted per day. Five participants were interviewed daily on 5 August 2019 up to 8 August 2019. At Nompilo M U Home Care Based Centre project, located at Libode, 15 participants were interviewed. Five participants were interviewed on 12 August 2019 daily up to 16 August 2019.

**Inclusion criteria that was met for a person to be in a sample**

- The person must be living in Nyandeni Municipality either at Libode or Ngqeleni.
- Female and males between the age of 18 and 25.

- The person must participate voluntarily in the study without compensation.

- The person must give consent to take part in the study, and the interview session will be audio recorded.

**Exclusion criteria was:**

- Female and males below the age of eighteen and above twenty-five years of age.
- Anyone not meeting the above- mentioned inclusion criteria.

A sample size of 30 participants, amid the ages of 18-25 years in Nyandeni Local Municipality were selected for the study using purposive sampling. Ethical considerations regarding each participant and institution were followed. Approval to conduct the study was granted.

### 3.5.3 Sample size

A sample size of 30 participants between the ages of 18-25 in Nyandeni Local Municipality was chosen for the study. The researcher chose the 30 participants by means of approaching two Non-Profit Organisations based at Libode and Ngqeleni area (namely Philisa Home Care Based Centre based at Ngqeleni location, and Nompilo M U Home Care Based Centre project based at Libode location). Fifteen participants (comprised of eight (53%) males and seven (47%) females) were selected from Philisa Home Care Based Centre based at Ngqeleni location, and the other fifteen participants (comprised of eight (53%) males and seven (47%) females) were selected from Nompilo M U Home Care Based Centre project based at Libode location. Collectively, out of the thirty participants, 53% represented male youth and 47% represented female youth. The researcher chose to select more males than females, because only a small number of male youths visited the clinics for testing, and only rarely, except when they have sexually transmitted infections (Nyandeni Local Municipality IDP of 2015-2016). The Non-Governmental Organisations have play a fundamental role. This is especially in country where democracy is in evolution. In a book by Van der Waldt et al. (2014:39), the authors

described that a shift in the focus of NGOs has been noted in that they previously focused more on ensuring that citizens were able to exercise their democratic rights. The focus now is more on bringing government to people as required by RSA Constitution.

### 3.6 Data Collection

**Authorisation**- the researcher was granted permission by the Department of Social Development to conduct the interviews. There is only one Chief of Nyandeni Municipality, and the researcher was given approval by the Chief in charge to conduct the interviews with the NPO beneficiaries which were located in his communities. Thereafter, the researcher was given permission and approval from the NPO directors in charge of Philisa Home Care Based Centre based at Ngqeleni location, and of Nompilo M U Home Care Based Centre project based at Libode to conduct interviews using their beneficiaries, which is the youth.

**Data collection process** -the participants from the identified NPOs were selected by the researcher using purposive sampling. The researcher collected data from 30 participants using semi -structured interviews. The researcher first collected data from fifteen participants at Nompilo M U Home Care Based Centre project based at Libode area, for a period of three days. Thereafter, the researcher collected data from the fifteen participants at Philisa Home Care Based Centre based at Ngqeleni Area for another period of three days. Semi-structured interviews were used to get more opinions and understanding from an individual participant. The researcher utilised in-depth semi-structured interview method of collecting data. An in-depth interview was conducted through the aid of an interview guide. An interview is described as a verbal conversation in which one person, the interviewer, tries to obtain information from, and again an understanding of another person (the interviewee). The interview is described as an effective tool for bringing about rich data on people's views, attitudes and the meanings that support their lives and behaviour (Gray, 2014:382). The researcher used qualitative observation, described as an involvement of taking field notes on the behaviour and non-verbal communication of the participants (Creswell, 2014:191). The researcher used a notebook to take notes of the participants behaviour during the interview.

An interview guide was prepared on time as it controls the interview session. The data collected was written in a note pad by the researcher. A tape recorder was used by the researcher to make sure that she did not omit any information given by the interviewee. Before the interview session began, the interviewee was provided with a consent form to sign. Before signing the consent form, the researcher did explain everything to the interviewee using the language the interviewee understood. This means that the interview session was done in the interviewee's home language.

### 3.7 Data Analysis

Data analysis is described as the process of shaping order, structure and meaning to the bulk of collected data (De Vos et al 2011:397). Data analysis is comprised of reading through your data repeatedly and engaging in activities of breaking the data down (thematising & categorising). This will include building it up again in one novel way (elaborative & interpreting)" (Blanche et al 2006:322). The interviews which were conducted in isiXhosa were translated into English in preparation for data analysis. An inductive approach was used in the study where the themes enclosed in the full data set were identified and analysed without any use of a hypothesis. This permitted the researcher to get a deeper understanding and exploration of knowledge, attitudes to HIV and sexual risk behaviour among the youth aged 18-25 years of age. The researcher used six phases as identified by Braun and Clarks (2006) in Jensen and Laurie (2016:609-610) to analyse data. The following phases were to be addressed:

- **Phase 1:** The researcher acquainted herself with the data. In the comfort of her home office, the researcher familiarise herself with the data collected i.e. listening to the audio recordings and reading the notes captured in the notebook.
- **Phase 2:** The researcher created initial codes. While listening to the audio recordings, the researcher also created codes to name the participants. The names of participants were coded as participant 1 to participant.
- **Phase 3**: The researcher searched for themes. From the information from the interviews, the researcher created themes. These themes were taken directly from the data.

- **Phase 4:** The researcher reviewed the themes. The themes were reviewed using the objectives and research questions.
- **Phase 5:** The researcher well-defined and termed the themes, the researcher termed the themes and sub-themes out of the data.
- **Phase 6:** The researcher produced the report. Then the researcher wrote the report.

### 3.8 The Ethical Considerations

The researcher did not meet any trouble in gaining access to her units of observation (30 youths between the ages of 18-25). The participants were readily available due to the various workshops which were in progress during the two weeks of data collection. The researcher is working for the Department of Social Development and is also accountable for monitoring the NPOs funded by the Department. The attendees of the workshop were youth and elderly, but the researcher only requested to interview the youth. The youth attending the workshop were from different communities under Libode and Ngqeleni locations.

Ethics are described as a set of virtuous principles and values (De Vos et al, 2011:115) Ethical principles regarding protection included:

#### 3.8.1 Authorisation by the institution

Permission to conduct the study was granted by the Ethics Committee (Higher Degrees Committee) of the College of Human Science at UNISA.

#### 3.8.2 Respect of human dignity

- **Right to full disclosure**

The participant may know about the research project he or she is about to participate in. it is therefore the researcher's duty to explain everything about the research project to the participant. The participant has every right to ask questions before agreeing to participate. The researcher must give truthful responses to the participant.

- **Voluntary participation or Informed consent**

Babbie, (2016:64) describes informed consent as the subjects, or participants, voluntary participation in a research project as a full understanding of the potential risks involved. Before the participant interviewing process, the researcher explained the consent form. The researcher further explained to the participant his, or her right, to refuse to participate. As evidence of the participant's willingness to take part in the study, a signed consent form was obtained from the participant.

### 3.8.3 Beneficence

According to Bless, Highson-Smith & Sithole (2013), describe that the important research is not only does no harm, but also potentially contributes to the well-being of others. Beneficence is explained in these terms:

**Right to freedom from harm and discomfort**

Although there were no participants who became emotional and traumatised, the researcher made arrangements with the NPO social worker so that the participant could be referred for counselling. This can be for any other appropriate form as an intervention in case the participant became emotional or traumatised in the interview. In the NPOs identified for data collection, there are already contracted social workers placed by the Department of Social Development who are specifically attached to the NPOs. In this study, no aggressive approaches were used to collect data. and no intimidation was done to the participants. There was no compensation given to the participants by participating in the study.

**Right to protection from exploitation**

In order to maintain the right to protection from exploitation ethical principle, the researcher assured participants that the outcomes of the study would be shared with the local NPOs that are initiated and funded by Department of Social Development during program revisions and implementations, as the personal views of respondents would have been documented on the findings of the final thesis/ dissertation.

### 3.8.3 Anonymity and confidentiality

Babbie, (2016:65) described that anonymity is accomplished in a research project when neither the researcher nor the readers of the findings can find a given response. Confidentiality is when a research project promises confidentiality when the researcher can identify a given person's responses but promises not to do so in public (Babbie, 2016:65). As this is a qualitative research, anonymity cannot be guaranteed, only confidentiality is guaranteed. In this study, the researcher clarified the anonymity and confidentiality part to the participant before their signing of the consent form. As a result of this explanation, some of the participants felt free to not write their names in the consent form, and only wrote their initials. Each participant was not asked their name and surname, the researcher rather assigned a number code while interviewing. The research participant was given a code (such as participant 1 or 2) to protect their identity. The researcher made sure that there was absolute privacy during the interview process. This was done by using a vacant and comfortable office in the NPO site. All transcriptions (audio records, note pad, copies of consent forms), had been anonymised before storage. Furthermore, to protect participants, the principal researcher will retain all raw data. This storage has been done already by the researcher using her computer which is protected by a password. A drop box was created by the researcher on the computer, and the recordings are kept safe without any access except for the principal researcher, researcher supervisor, and Human Sciences Research Ethics Committee working on this project. The researcher decided to keep the data for a period of five (5) years, thereafter it will be permanently erased.

### 3.8.4 Deceiving participants

Babbie (2016:68) recommended that occasionally it is advantageous, and even necessary, to identify yourself as a researcher to those you want to study. Before each interview of every participant, the researcher introduced herself by name and surname, and further informed the participant that the study is for MA Social Behavioural Studies at University of South Africa. The researcher did not deceive the participants in any one way, or the other. The consent form provided all the information needed.

### 3.8.5 Debriefing to the participants

Babbie, (2016:68) stated that debriefing involves interviews to determine any problems generated by the research experience so those problems identified can be rectified. The researcher promised the NPO managers for a follow up session after collection of data. Though the researcher promised to do a follow-up, there was no follow-up visit made by the researcher, the researcher was prepared to make a follow up appointment with the participant to clarify or ask questions which the researcher might have missed.

## 3.9 Measures to Ensure Trustworthy of the Study

Polit & Beck (2011:584) specified that the standard of respectable qualitative research is based on honesty. The trustworthiness is discussed in detail using five constructs, namely; credibility, transferability, dependability and confirmability and authenticity.

### 3.9.1 Credibility

Credibility explains that the findings that the results of qualitative research are credible and believable from the viewpoint of the participants in the research (Kumar, 2014:219). This research study explored the knowledge, attitudes and risk sexual behaviour of the participants to assist in identifying their existing level of knowledge of risky sexual behaviour. This will also determine recommendations for future educational programs as preventive interventions.

The researcher enhanced credibility by:

Creating rapport with the participants- the researcher invested some time in building the rapport with the participants by visiting the NPOs for data collection before collecting the data. The study was explained to the participants and clarified queries about the study before collecting the data.

Member checking- After the researcher had collected data, though there was no follow up visit made by the researcher, the researcher was prepared to make a follow up appointment with the participant to clarify or ask questions which the researcher might have missed.

### 3.9.2 Transferability

According to Kumar (2014:219), transferability is described as a level where the outcomes of qualitative research can be generalised or transferred to other contexts of setting. Filed notes, observation and exploration of non-verbal cues during the interviews were taken into great consideration by the researcher.

### 3.9.3 Dependability

Dependability is well-defined as being whether the same results will be achieved if the same phenomenon is observed twice. The qualitative research encourages flexibility and freedom (Kumar, 2014:219). For dependability to be improved, De Vos at al (2011:421) state that the researcher ought to ask whether the research process is logical, well documented and audited. As a co-coder is very costly to appoint, the researcher could not appoint an independent co-coder. As the supervisor is an experienced qualitative and mix-method researcher, he assisted with co-coding to ensure dependability.

### 3.9.4 Confirmability

According to Kumar (2014:219) confirmability is described as the level where the results can be confirmed or corroborated by other researchers. Confirmability was captured by audio recording the participants, following up on questions, probing and not assuming to understand if the researcher does not understand. The researcher also made sure that her opinions and perceptions regarding subject were withheld.

### 3.9.5 Genuineness or authenticity

Authenticity can be described as a degree to which investigators decently and genuinely demonstrate a variety of realities. Genuineness develops in a report when it carries the emotions and tone of participants as they are. In this study, the researcher made sure that the experiences were not altered or changed as they were taken as the real truth of the problem under study.

## 3.10 Pilot study

The pilot study was conducted in order to find out if the appropriate data could be attained from the participants by means of the interview schedule. Furthermore, the pilot study was used in order to test the interview guide. The pilot study was conducted with three research participants who have met sample inclusion criteria. Thereafter, the research excluded two participants to form part of the research study. The researcher conducted

this pilot study on the 2nd of August 2019 with three participants, two males and one female, aged 23, 18 & 25 respectively. The pilot study aimed at assisting in refinement and checking if the interview guide is trustworthy.

NB: during the conducting of the interview, changes emanated, and were identified during interview of the 1st participant. Question 8 could be added by the researcher regarding the life changes of the participant since HIV was contracted by the participant.

### 3.11 Limitations

The outcomes from the study cannot be generalised to wider communities or population as the small sample was used. If a large sample that covers a large geographical area was utilised, the researcher would have got more diverse opinions and estimations in the research topic.

### 3.12 Conclusion

In this chapter an outline was given of the research approach, research design, population and sample, data collection, data analysis, ethical considerations and measures applied in the study. The researcher will present and discuss the results (findings) in the next chapter.

**CHAPTER FOUR**

# FINDINGS OF THE STUDY

## 4.1. Introduction

This chapter focused on the presentation of the findings from the research. The demographic characteristics are presented. The findings of the study are discussed in the following sequence:

The demographic information of the 30 participants is presented in terms of age, gender, marital status, level of education, place of residence, whether the participants reside in an urban or rural area, their home language, main source of income and finally, employment status. A table format is used to discuss the profile.

The researcher used objectives of the study as key themes and the themes were the basis for the analysis of the obtained data. The themes are classified:

**Theme 1:** HIV and AIDS knowledge and attitudes in youth

**Theme 2:** Sexual risky behaviour among youth

**Theme 3:** HIV prevention strategies

Each theme is introduced briefly, and direct quotes from participants provide the support with clarity on the themes. The intention of this study is two-fold. First, to explore knowledge, attitudes and behaviour of the youth between the ages of 18-25 in the Nyandeni Local Municipality at Eastern Cape Province to identify their existing level of knowledge and risky sexual behaviour. Second, to make recommendations and preventive measure for future education programs.

## 4.2 Participants' Profiles

Table 4.2.1 displays participants by age. It is evident that the largest proportion of participants fall within the ages of 21 which is 17%, and 25 also 17%. Those of 18, 19, 29 and 24 years each account for 13%. Participants 22 years of age account 10%, whereas those who are 23-year-old account 4%. The researcher feels comfortable with the fact that all the ages between 18-25 are represented in the study.

**Table 4.2.1: Age (n=30)**

| **Age** | **Frequency** | **Percentage %** |
|---|---|---|
| 18 years | 04 | 13% |
| 19 years | 04 | 13% |
| 20 years | 04 | 13% |
| 21 years | 05 | 17% |
| 22 years | 03 | 10% |
| 23 years | 01 | 4% |
| 24 years | 04 | 13% |
| 25 years | 05 | 17% |
| **Total** | **30** | **100%** |

Table 4.2.2 demonstrates there were 100% (30) participants, 14 (47%) were females, and 16 (53%) were males. The researcher chose to select more males than females as males rarely visit the clinics for testing, except when they have sexual transmitted infections (Nyandeni Local Municipality IDP of 2015-2016). The researcher is interested in knowing why young males are not frequent in visiting clinics for HIV testing. Maybe some men are afraid to be seen in queues known for HIV testing services, or for people who are there to take their treatment. Another reason could be that some men are afraid that their test results will be positive and prefer not knowing their status. To support the researcher's assumptions Bwambale et al (2008) described that most of the young men fear being stigmatised and therefore they do not visit VCT services in their communities. Bwambale et al (2008) further stated that most men expressed the feeling that they would

go somewhere else other than in their community clinics. The majority preferred VCT sites outside Bukonzo West where the VCT counsellors do not know them. They dreaded that they would be identified and labelled as HIV victims.

**Table 4.2.2: Gender (n=30)**

| Gender | Frequency | Percentage % |
|---|---|---|
| Male | 16 | 53% |
| Female | 14 | 47% |
| Total | 30 | 100% |

Table 4.2.3 shows that 26 (87%) of the participants are single whereas one (3%) is married, two participants (7%) are divorced and one (3%) widowed. The researcher was interested in discovering how many are married (which could result that some might be involved in forced marriages), divorced and separated (are indecisive because of financial dependency to their partner).

**Table 4.2.3: Marital status (n=30)**

| Marital status | Frequency | Percentage % |
|---|---|---|
| Single | 26 | 87% |
| Married | 01 | 3% |
| Divorced | 02 | 7% |
| Widowed | 01 | 3% |
| Total | 30 | 100% |

Table 4.2.4 portrays the level of education amid the study participants. It indicates five (17%) of the participants had a tertiary level of education, twenty (66%) of the participants had high school education, and another five (17%) had only primary school education. The point that the majority of participants had completed high school, and others had tertiary education, even though the number equals those with primary education, might indicate the participants' ability to have knowledge and positive attitudes to HIV and

sexual risk behaviour. The researcher saw it necessary to discover the educational level to see how many had been to school, which would indicate those who had gone to school had been taught about sexual education which is a mandatory by all schools in South Africa from grade 1 to grade 12. All the participants had been to school, and, even better, 66% had been to high school. This is a sign that most youth that formed part of the study knew of sexual education, but, the question might be, was it enough.

**Table 4.2.4: Level of educational (n=30)**

| **Educational level** | **Frequency** | **Percentage %** |
|---|---|---|
| Below-grade5 | Nil | Nil |
| Grade 6- grade 9 | 05 | 17% |
| Grade 10- grade 12 | 20 | 66% |
| Tertiary | 05 | 17% |
| Total | 30 | 100% |

Table 4.2.5 below shows that the participants' place of residence was equally distributed throughout the two villages which cover Nyandeni Local Municipality. The researcher had to make sure that the youth form both Ngqeleni and Libode are part of the study so their views and opinion were heard.

**Table 4.2.5: Place of residence (n=30)**

| **Place of residence** | **Frequency** | **Percentage %** |
|---|---|---|
| Ngqeleni | 15 | 50% |
| Libode | 15 | 50% |
| Total | 30 | 100% |

Table 4.2.6 describes that 27 (90%) of the participants are in a mostly rural area, whereas three (10%) participants live in the semi-urban area of Nyandeni Local Municipality. The study area is mostly rural, and this profile indicates that fact.

**Table 4.2.6: Place of residence whether urban or rural (n=30)**

| Place of residence | Frequency | Percentage % |
|---|---|---|
| Rural | 27 | 90% |
| Urban | 3 | 10% |
| Total | 30 | 100% |

Table 4.2.7 illustrates that 29 (97%) participants are Xhosa speaking, while one (3%) spoke isiZulu. This indicates that the area has mostly isiXhosa speakers. This is one of the reasons that the researcher had to have both an isiXhosa and English interview guide. The researcher made sure that the interviews that were conducted isiXhosa, and the one participant who speaks Zulu, could speak and understand isiXhosa and isiZulu effortlessly. This was imperative for the researcher so that she used the language spoken by the participant, so that in that way, their opinions and views would be expressed in their mother tongue.

**Table 4.2.7: Home language (n=30)**

| Home language | Frequency | Percentage % |
|---|---|---|
| isiXhosa | 29 | 97% |
| IsiZulu | 1 | 3% |
| English | Nil | Nil |
| Other | Nil | Nil |
| Total | 30 | 100% |

Table 4.2.8 demonstrates that fourteen (47%) of the participants are employed, although sixteen (53%) are without a job. Of the fourteen participants employed, the data disclosed there is employed in a full time job, and the remaining thirteen are working contract at the Department of Agriculture learnership, Spar and Boxer supermarket jobs. This employment statistic would help the researcher with information about the economic status. Though not with all youth, it has been common knowledge that the majority of girls

can sometimes be involved in a relationship for economic reasons. This led to them being violated sexually, fearing to ask their partner to use a condom.

**Table 4.2.8: Employment status (n=30)**

| **Employment status** | **Frequency** | **Percentage %** |
|---|---|---|
| Employed | 14 | 47% |
| Not employed | 16 | 53% |
| Total | 30 | 100% |

Table 4.2.9 shows that one participant is earning a permanent salary with benefits. There are five participants which are receiving a stipend (either from contract work or learnership from Agriculture) and a child benefit grant. Excluding those who are benefiting twice, there are six participants who are receiving a stipend, and there are eight participants who are receiving a child grant. Eight participants have no income, eight participants are receiving stipend (as a contract Woolworths store, Spar supermarket, Boxer supermarket, Agriculture learner ship. Furthermore, there are two participants who are receiving an income from domestic work. There are seven participants who have no income at all. In association with the above presented employment status, 53% of the participants are unemployed. Out of this 53%, 27% are receiving only a child grant for their children, which is definitely insufficient for sustainability. The income statistics are relevant for the researcher to know more about the financial stability of the participant. It is clearly shown on the table that their income is insufficient for the survival of the participant and his or her family).

**Table 4.2.9: Source of income (n=30)**

| **PARTICIPANT** | **INCOME BENEFITS** |
|---|---|
| Participant 1 | Social grant |
| Participant 2 | No income |
| Participant 3 | Child grant |
| Participant 4 | No income |
| Participant 5 | Stipend |
| Participant 6 | Child grant |
| Participant 7 | No income |
| Participant 8 | No income |
| Participant 9 | Stipend |
| Participant10 | No income |
| Participant11 | Child grant |
| Participant 12 | Stipend |
| Participant 13 | Stipend |
| Participant 14 | No income |

| | |
|---|---|
| Participant 15 | Child grant |
| Participant 16 | Child grant and domestic work |
| Participant 17 | Child grant and stipend |
| Participant 18 | Stipend |
| Participant 19 | Child grant |
| Participant 20 | Stipend |
| Participant 21 | Stipend |
| Participant 22 | Child grant and stipend |
| Participant 23 | Child grant and stipend |
| Participant 24 | Salary |
| Participant 25 | Child grant |
| Participant 26 | Stipend |
| Participant 27 | No income |
| Participant 28 | Domestic work |
| Participant 29 | No income |
| Participant 30 | Child grant |

### 4.3 Results of the interviews

Data from the interviews was analysed using a thematic analysis method. Codes like participant 3, participant 2 were used by the researcher to identified participants. Highlighted in the analysis are important concerns which were expressed by the participants. It must be noted that the themes identified are connected to each other, and as a result, there is some repetition of key points which could not be avoided.

### 4.4 Key findings

The themes were generated after the process of data analysis. The themes are arranged as per the objectives of the study.

### 4.4.1 Theme 1: HIV and AIDS knowledge and attitudes in youth.

In the perspective of the HBM, knowledge is described as a structural variable which influences risk perception as it enables an individual to recognise the risk of an illness. It further encourages individual take steps to assume healthy behaviour in order to prevent an illness (Dennill et al 1999:157).

**Finding**

**The participants were asked about their understanding of the difference between HIV and AIDS.** Eight participants (participants 3, 11, 12, 27, 28, 29 & 30) reported that HIV is the same as AIDS, meaning that they see no difference between HIV and AIDS. Four participants referred to HIV as a virus, and AIDS as an incurable, as when one is bedridden and very ill. Other participants then expressed different views regarding their understanding of how HIV differs from AIDS, such as HIV being in the blood, whereas AIDS is when you are in stage 4. AIDS is a combination of diseases, while HIV is a virus.

**This is maintained by narrative statements below:**

"*HIV is the virus in the blood. AIDS is when you are in stage four, it is the combination of diseases."* (participant 1)

*"You get HIV from the person who has it. AIDS you get it from the infected blood of a person."* (participant 2)

*"HIV and AIDS are almost the same, when you have HIV you cough non-stop but with AIDS it is when your organs are badly damaged."* (participant 3)

*"HIV is in the blood, not yet changed to AIDS. AIDS is when you are at a last stage, it is a difficult stage".* (participant 4)

*"HIV is a disease in a person contracted by unprotected sex. AIDS, I am not sure what it is exactly but what I know is that it kills and is incurable".* (participant 5)

*"HIV and AIDS, I don't know the difference".* (participant 6)

*"HIV is not yet shown in the body even though it is there, AIDS is when you have signs and symptoms that are visible".* (participant 7)

*“I know AIDS kills and you lose weight, the same goes for HIV, there is no difference because you die in the end”.* (participant 8)

*“HIV are signs and symptoms that you have AIDS, then AIDS is when you are eating treatment daily”.* (participant 9)

*“HIV is the virus in the body, AIDS is a combination of diseases”.* (participant 10)

*“HIV is a virus; AIDS is the same as the virus”.* (participant 11)

*“There is no difference, it is the same, and they are both infectious. HIV is a disease and AIDS is also a disease”.* (participant 12)

*‘AIDS is fully spread in the body and is not curable, HIV is a virus”.* (participant 13)

*“AIDS is a combination of diseases; HIV is a virus passed from sex by an infected person”.* (participant 14)

*“HIV is a disease transmitted by your partner; AIDS is an STI”.* (participant 15)

*“I don’t have an answer to this question”.* (participant 16)

*“AIDS is a disease whereas HIV is a virus from the infected blood”.* (participant 17)

*“HIV is when you are infected with the virus, AIDS is when you have both the Virus and AIDS*”. (participant 18)

*“HIV is a virus of AIDS; AIDS is when you are sick”.* (participant 19)

*“HIV is a virus; AIDS is stage 4 and when you are bedridden”.* (participant 20)

*“HIV attacks the immune system, it is incurable. AIDS is when the virus attacks the immune system and the body cannot save itself.”* (participant 21)

*“HIV is when you know you are positive. AIDS when you are bedridden and in category three.”* (participant 22)

*“HIV is when the virus is starting in your body but has not fully developed in the blood, whereas AIDS is when the virus has spread in the whole body”.* (participant 23)

*"HIV is a virus that enters by blood and sex. AIDS is when you have done sex and is a stage within HIV."* (participant 24)

*"HIV is stage AIDS is stage four and its symptoms are very clear especially when the person is very ill."* (participant 25)

*"HIV is a virus while AIDS is once the person is seriously ill and the virus has changed to AIDS."* (participant 26)

*"According to my understanding, HIV is the same as AIDS"* (participant 27)

*"It is the same, there is nothing more than I can say"* (participant 28)

*"There is not much different, HIV is the same as the AIDS"* (participant29)

*"I do not know the difference; I think they are the same".* (participant30)

**Conclusion**

The responses mentioned above are the participants' own opinions. The authentic measure of their level of awareness might be different. Nonetheless, the acknowledgement of not having appropriate and adequate information on HIV and AIDS. This could serve as a trigger for attending more formal programs on sex education and on HIV and AIDS.

#### 4.4.1.1 Sub-theme 1.1: Modes of HIV transmission

**Finding**

Looking from the views expressed below by the participants, most participants knew the two most ways of transmission of HIV infection i.e. HIV is passed on through sexual intercourse, and when there is cut and when blood meets infected blood. Only two participants, who expressed other ways of transmission, such as mother- to- child transmission. Three participants (participant 1, 3 & 15) further added that HIV can be conveyed by sharing a spoon, from spitted septum which evaporates in the air and has been inhaled by others, who then become HIV positive.

Twenty-nine participants, except participant three (3), reported that HIV is also transferred through contact with infected blood when there is cut and that blood comes into contact with infected blood. Two participants (participant 21 & 25) reported that HIV can be spread from (MTCT).

The participants were probed further to opine how much they are informed about how HIV is transmitted. The participant responses as shown in the table below, 34% of the participants reported to have little information of various methods in which the HIV is transmitted. This is a true reflection of the limited information which they provided on how HIV is transmitted, Hence, many reported that HIV is spreading by having unprotected sex and blood contact with an open cut.

**Table 1.1: Level of Knowledge of HIV transmission**

| Level of Knowledge of HIV transmission | No. of Participant/ frequency | Percentage |
|---|---|---|
| A little | 10 | 34% |
| A bit informed | 01 | 3% |
| Not much | 01 | 3% |
| Not sure | 01 | 3% |
| Well informed | 01 | 3% |
| Very much informed | 04 | 14% |
| Enough information | 09 | 30% |
| More than enough | 01 | 3% |
| A lot | 02 | 7% |
| **TOTAL** | 30 | 100% |

## Conclusion

Sexual transmission may dominate other ways of transmitting HIV and AIDS. This again indicates a limited understanding of other ways of infection on how HIV can be transmitted.

**This is maintained by the narrative statements below:**

*"A little, but I have enough information to avoid being infected by AIDS". "Having sex without a condom, when you have a cut and it gets into contact with infected blood, drinking from a cup used by an HIV infected person, if his or her lips have sores".* (Participant 1)

"*A little, but I know there are many, it's just I know enough to use a condom every time I have sex". "When engaging in unprotected sex. Touch infected blood while having a cut. Eating with an unwashed hand which touched infected blood".* (Participant 2)

*"I am well informed, because the radio is always broadcasting it and its ways of transmission". "other people do not know how they got it, but most of the time you get HIV when you did not use a condom sharing spoon, from spitted septum which evaporates in the air and be inhaled by others which then they become HIV positive".* (Participant 3)

*"I have enough knowledge to look after myself". "Not using protection like a condom, not using gloves when helping in an accident, using other people's toothbrush to brush your teeth".* (Participant 4)

*"I cannot be sure how much know because every day there is something new to know about HIV". "Unprotected sex, and when you have a cut and you touch infected blood".* (Participant 5)

*"I think I know enough to survive and getting infected". "Unprotected sex most of the time, touching HIV infected blood".* (Participant 6)

*"enough information". "Having unprotected sex, not using gloves when in contact with blood".* (Participant 7)

*"a little because it is confusing, one day you hear from the media they have something that can prevent transmission then again you are constantly told to use a condom because there is no cure and you can be easily be infected". So, you can never say you know a lot. "Touching a bleeding person, sex without a condom"*. (Participant 8)

*“I know enough to be able not to be infected”. “When having unprotected sex, blood to infected blood contamination, when you have a cut while helping during an accident”.* (Participant 9)

*“I am very informed, we have been told about HIV spread every from when we were young and we are still being updated almost daily, and it can be boring at times.”. “HIV is transmitted through blood transfusion, when infected blood comes into contact to an open cut in the hand”.* (Participant 10)

*“I am very informed, and I still need more information about it.” “You can get HIV when you have STIs, blood to blood and unprotected sex”.* (Participant 11)

*“not much.” “Using other people’s toothbrush, sex without a condom, and in an accident.* (Participant 12)

*“enough information.” “Sharing toothbrush, having sex without a condom, when you have a cut and you touch blood that could be infected.* (Participant 13)

*“I have enough information to look after myself and to teach my children.” “you can get it when you have unprotected sex, infection by blood to an open cut, toothbrush especially when your gums are bleeding, when you are involved in an accident, cleaning infected sick person without using gloves especially when you touch the stool.* (Participant 14)

*“little.” “Having unprotected sex, touch a bleeding person without gloves, drink with a cup that is used by an infected person”.* (Participant 15)

*“a little.” “When you have a cut and assisting in an accident, unprotected sex”.* (Participant 16)

*“I have enough information to know that HIV is incurable there I must look after myself”. “When you have a cut and assisting in an accident, unprotected sex”.* (Participant 17)

*“I have enough information.” “When you have sex without condom with an infected person, in an accident, using a same sharp tool and the other person is HIV positive”.* (Participant 18)

“I have more than enough.” “Having unprotected sex without a condom, using one toothbrush when one of you is HIV positive, helping a bleeding person in an accident without gloves”. (Participant 19)

*“I am very much informed.” “By sharing the same needle, not wearing gloves when washing the HIV positive person who has sores, unprotected sex”.* (Participant 20)

*“I have enough information.” “If I have sex without a condom, mother-to-child, from blood in an accident”.* (Participant 21)

*“I have information about it, but I cannot tell if it’s enough.” “Sex without a condom, when you have an open wound and get exposed to an infected blood in an accident”.* (Participant 22)

*“A bit informed.” “Sex without a condom, infected blood to uninfected blood”.* (Participant 23)

*“a lot.” “You can get HIV when you are involved in an accident by either exposed cut or wound, sexual intercourse without a condom”.* (Participant 24)

*“A lot”. “Sharing same razor when shaving head or beard, blood to blood infection, mother-to-child infection, through breastfeeding when breast has sores, when having sex without a condom”.* (Participant 25)

*“a little bit.” “When having unprotected sex, in an accident whereby there are open cuts and no gloves are used”.* (Participant 26)

*“a little.” “You get HIV by not using a condom, by not using gloves when helping a person with blood”.* (Participant 27)

*“a little.” “When not using a condom, if you have a cut and don’t use gloves to handling blood”.* (Participant 28)

*“a little.” “You can get HIV when you have a cut and comes into contact with blood, when you have sex with a girl without a condom”.* (Participant 29)

*“A little”. “You get it from touching a person infected blood while helping without gloves, sharing a spoon used by an infected person, unprotected sex”.* (Participant 30)

#### 4.4.1.2 Sub-theme 1.2 Attitudes regarding HIV and AIDS

**Finding**

Apparent from the below mentioned statements by the participants, eighteen participants reported the importance of taking treatment once a person tests HIV positive. Although one participant (participant 28) reported that once a person develops sores in the private area, they must consult a traditional healer. Another participant (participant 10) reported that *HIV is curable, but is not yet confirmed to the public, though he also supportive of taking of HIV treatment and accepting it could lead a person to a normal life.*

**The findings are shown below:**

*"It can be suppressed by medication; you can get help from clinic and hospitals before it destroys you. It is important to find a person you can trust for disclosing and advises".* (Participant 3)

*"If you are HIV positive, you can live long as long as you eat your treatment".* (Participant 4)

*"It is important that you use protection (condom) when having sex because your partner may not tell his/her HIV status.it is important to take ARV treatment immediately".* (Participant 5)

"*HIV is incurable; it can be suppressed by treatment'.* (Participant 6)

*"There must be a change of lifestyle from bad to good behaviour and take your treatment regularly for long live".* (Participant 7)

*"HIV is incurable and can be suppressed by ARV pills".* (Participant 8)

*"I know HIV kills, I wish people could protect themselves, if you are infected then eat treatment to avoid death, if not you can die in no time"*. (Participant 9)

*'HIV is a disease, there are research done but not yet released to the public, it is curable and not yet confirmed to public. If you eat pills you can lead a normal life and accepting it is no.1'.* (Participant 10)

*“HIV cannot be cured though there is a treatment that can suppress it. It cannot kill you either as long as you take the treatment regularly”.* (Participant 11)

*“HIV and AIDS is a transmitted illness, if you do not eat treatment you die”.* (Participant 12)

“*HIV is a disease that does not quickly kill you as long as you take treatment”.* (Participant 13)

*“When you are tested positive you must take ARVs and eat healthy”.* (Participant 15)

*“it is a disease that is found in Humans only, it is incurable, if you contract it stays with you forever till you die, ARVs are taken daily for suppression so that it does not spread quickly in your body”.* (Participant 17)

“*There is HIV whether we like it or not, it can be suppressed by medication, using protection especially when you know you have tested positive prevent it from spreading”.* (Participant 18)

“*Everyone must go for HIV testing when ready, if you test HIV positive eat ARVs immediately, if you don’t eat the treatment you become sick”.* (Participant 19)

*“It is incurable, it can be suppressed by pills, you take the pill at a fixed time for life till they get the cure”.* (Participant 21)

*“There must be counselling before and after testing so that the person does not get depressed when tested positive, the disease affects all people. Once you test positive you must disclose to a person you trust for relief and then eat your treatment and green vegetables not forgetting lots of fruit. Take treatment at the chosen fixed time to avoid defaulting”.* (Participant 24)

*“Government has provided early taking of treatment called Universal Test and Treat (UTT)”. The more you eat your treatment the more the viral load lowers and the CD4 count stays high. eating the treatment when you test positive is a priority now. People hide their HIV status fearing of discrimination especially when the person was "promiscuous”.* (Participant 25)

*"You can live a long-time being HIV positive as long as you are taking treatment and follow the clinic guidelines".* (Participant 26)

"*Eating treatment on time is crucial, avoid defaulting when on treatment, lower alcohol intake and smoking".* (Participant 27)

*"Once you have HIV you develop sores in your private parts, then it destroys your insides like livers and lungs, there are constant discharges". These sores can be removed by a traditional healer (Igqirha) if seen early. If the healer cannot help, the person can try western medicine (uGqirha).* (Participant 28)

**Conclusion**

Most participants reported ART treatment as important, the participants know HIV is not curable and taking the treatment will elongate one's life.

#### 4.4.1.3 Sub-theme 1.3 HIV affects promiscuous people

**Finding**

Participant 29 reported that in his or her community, most youth hide their HIV positive status, fearing of being discriminated against, and be told they deserve to be HIV positive. Participant 30 blames HIV transmission on selling one's body for money.

The findings are shown below:

*"HIV is much in our area, many people especially youth hide it and you would see a person getting thinner day by day, they do not want to talk about it as if they will be known they are positive". Some youth in my community fear they will be reminded of their promiscuous behaviours and be told they deserve the HIV and were looking for it.* (Participant 29)

*"AIDS and HIV are not OK; AIDS can stop if you look after yourself'. Sometimes sleeping around like a prostitute for financial gain can result in being transmitted with it."* (Participant 30)

**Conclusion**

Participant 29 feels there is disgrace and judgement of HIV positive people in his or her community. Participant 30, from her reply, depicts discrimination in his or her statement. This could mean there are communities which need education programs for eradication of stigma and discrimination.

#### 4.4.1.4 Sub-theme 1.4 Youth is not immune to HIV infection

**Finding**

The participants provided various responses. Four participants showed they are not immune to HIV and AIDS; this further revealed their positive attitudes toward HIV stating that it can be suppressed by ARVs.

**The findings are shown below:**

*"I am afraid of HIV, it is not curable, it can be suppressed by ARVs." (*Participant 1)

*"HIV kills but it takes long to kill you, a member from my family had HIV and was eating treatment from the clinic, though he died by car accident."* (Participant 2)

*"The word itself makes smells like death. Once you hear someone you know is HIV positive you think of him/her dying soon."* (Participant 20)

*"If test HIV positive it is not the end of life, when you test positive follow the clinic guidelines for survival."* (Participant 22)

*"HIV does not kill, it is a better disease unlike those which kill you unexpectedly like high blood pressure, Diabetics. If you test positive, it is important to check viral load and CD4 count once in a while."* (Participant 23)

**Conclusion**

The participants know they are not immune to HIV infection.

#### 4.4.1.5 Sub-theme 1.5 Attitude towards testing HIV positive

**Finding**

Twenty-six participants displayed ill-fated but, acceptance and positive attitudes towards testing HIV positive. participant 2 had concerns that people will gossip behind his/her back. Of the twenty-six participants, twelve participants reported that they will take ARV treatment, so they do not get ill from the virus.

**The findings are shown below:**

*"I would wear a condom each time I do sex, to make sure I do not infect anyone."* (Participant 1)

*"I would be very worried of people gossiping about me and my status, but I would learn to ignore and eating treatment as soon as I test positive".* (Participant 2)

*"I would be tormented with fact that I would have avoided this situation, but anyway I would discover a way to accept it and take pills every day."* (Participant 3)

*"I cannot to lie I would be very shocked; I don't know I would react". (Participant 4)*

*"My life would not change; I would eat my treatment and life goes on no matter what".* (Participant 5)

*"I will eat my treatment; I would not see the need to use a condom unless the person I am with wants to use it because now it is not my burden to have to ask for condoms I am already positive anyway".* (Participant 6)

*"It would torture me a great deal but finally I will have to accept and move on"*. (Participant 7)

*"I would be hurt, finally comes to terms with it but that would not stop me from drinking alcohol and smoking with friends because that how I chill and enjoy myself".* (Participant 8)

*"Testing HIV positive would change me a lot, because now I would have to eat pills every day and I really hate pills I prefer liquid medicine".* (Participant 9)

*“I would admit my status and accept it, eat treatment, eat healthy, avoid too much consumption of alcohol and even stop smoking because my lungs will be at ore risk now”.* (Participant 10)

*“It would not change me much; I would accept so that it does not torture me and ending up getting thin and bee seen by other people”.* (Participant 11)

*“It could never change me, because people are living with the virus HIV now in fact the majority is HIV positive, eating treatment will be safest and best option ever”.* (Participant 12)

*“I would have constant dying thoughts, stress, and lack of concentration. I would always thing how do I have to live “.* (Participant 13)

*“I will never accept it, thank you. I would definitely stop dating and lose trust of man who come to me flattering their love which landed me to being HIV.”* (Participant 14)

*“I would have a burden of eating ARVs and changing my eating habits, I am not used to that. It would be difficult for me”.* (Participant 15)

*“My life would not change at all; I would follow the clinic guideline and live my life the way I want positively”.* (Participant 16)

*“I would look after myself more, eat my treatment hence I know when you are positive and taking treatment daily you live long just a HIV negative person”.* (Participant 17)

*“Nothing would change, I would eat my treatment every day, do clinic checkups every six months to make sure my immune system is doing ok”.* (Participant 23)

*“My life would change because now I will have to be a friend to my nearest clinic for survival, I would make sure I stop being careless and take everything cautiously, find a person I trust to share my problems. Eat my treatment everyday”.* (Participant 24)

*“I would definitely tell my partner, take ARVs as soon as I test positive. I would lose trust to opposite sex entirely”.* (Participant 25)

*“I would have a burden of having to eat ARVs every day and I often wonder how they tested like and whether the person’s body reacts in a certain way.” (Participant 19)*

*"since I am already infected with HIV, mine changed because now I have this burden of taking pills every day and missing a day will be bringing closer to death."* (Participant 27)

*"No change would happen as long as I eat my treatment, you are still the same person. HIV positive person is not different from HIV negative person."* (Participant 26)

*"My life would not change, yes I would be shocked for a while, but I would have to make sure I look after of what is left of my health because I am not ready to die soon."* (Participant 28)

*"My life would never be the same again, I would be lonely. I don't who would I trust to disclose my status situation."* (Participant 29)

*"I would strictly and make sure I never run out of HIV pills."* (Participant 30)

Excluding the twenty-six participants, six participants disclosed their HIV status and participant 21 reported that being involved the NGO in her community helped her cope.

**The findings are shown below:**

*"I would involve myself with support groups".* (Participant 20)

*"When I tested positive my life did not change much. What helped to cope after finding out I was HIV positive was the NGO in my community and now I am a contract worker as a caregiver and I have learnt a lot on how to cope with daily struggles of being HIV positive".* (Participant 21)

*"I am HIV positive and my life is still the same even though at first I was devastated when my results cam positive, it was then that I found out who my real friends were. Now I am used to taking treatment every day and I am healthy as a horse."* (Participant 22)

*"I tested HIV positive right after I got married, I was negative when I got married, my only mistake was trusting the person I was marrying to, it changed and I still find it hard to accept my status though I have all the support a person could ask for from family and friends. Since my divorce I have had different partners and I make I use a condom even if a person refuses then if no condom then no sex".* (Participant 18)

**Conclusion**

The participants though they expressed being shocked and hurt if they tested positive for HIV, they displayed positive attitude to live long and positive life. Having NGO's that specifically deal with HIV issues in the communities could be very supportive and caring to people who tested HIV positive.

#### 4.4.1.6 Sub-theme 1.6 Perceptions about condom use

The participants whether the spread of HIV can be reduced by using condoms or protection

**Finding**

**Condoms perceived as prevention from unwanted pregnancies, STIs and HIV**

Twenty-three participants replied on the importance to use a condom, as it not only prevents STIs and HIV, but also unwanted pregnancies. Twenty (70%) participants responded that condoms can reduce the spread of HIV. Eight (27%) participants responded that condoms alone cannot prevent the spread of HIV, stating various reasons such as HIV is not transmitted by sex only, there are many other ways you can get HIV. HIV enters our system in different ways, most people do not want to use it. One (3%) participant responded that she/he doubts it can be reduced by condoms only.

**The findings are shown below:**

*"Condom plays a very important role in lives, it protects us from dreadful diseases, it also helps in preventing pregnancies". "Yes, it can reduce the spread of HIV".* (Participant 1)

*"Condom is vital to us youth, in these days children have children, we cheat all the time". "yes"* (Participant 4)

*"condoms are very important to avoid getting STIs and HIV" "Yes it can be reduced".* (Participant 5)

*“Condom is protection from HIV, Drop, when a person you are sleeping with is dirty inside”. “No, condom alone cannot reduce the spread of HIV, most people prefer ‘inyama enyameni’* (skin to skin). (Participant 7)

*“condoms can save you from contracting HIV.” “Yes, if you use it all the time”.* (Participant 8)

*“All people must use condoms”. “Yes, especially if people listen and accept that HIV is real”.* (Participant 9 )

*“Condoms are protection from HIV”. “No, condoms are everywhere and people know they must use condom but still continue not using them for different reasons known to them and look HIV is spreading”. Statistics shows little evidence in HIV drops. Being permanently curable will reduce its spread, abstinence is useless”.* (Participant 10)

*“You use it to prevent STIs and other STDs not forgetting unwanted pregnancies”.*

*“Yes it can be reduced”.* (Participant 11)

“*To protect yourself from getting this deadly virus”. “I doubt it can be reduced by condoms only”.* (Participant 12)

*“You can avoid getting STIs and HIV if you are using condoms”. “yes”.* (Participant 13)

*“It is right to use condom; it protects you from STDs”. “No, most people do not want to use it, if there could be PrEP injection when you do not have HIV or else provision of a pill lasting three years without contracting HIV”.* (Participant 14)

*“I use condoms to protect myself all times, and I wish all people can do the same.” “Yes, it can if people could start taking use of condoms seriously”.* (Participant 16)

*“Condoms do not prevent HIV alone; it is useful for prevention from falling pregnancy”. “Yes, if all people could use condoms, Department of Health to place condoms in taverns and community shops for easy access, following that they should provide teaching on the right ways of wearing condoms to avoid breakings”.* (Participant 17)

*“It is important for protection against curable and incurable diseases”. “Yes, it can be reduced”.* (Participant 18)

*“Condoms are important in keeping your health safe by preventing STDs”. “Yes, if people could accept it as a precautionary measure”.* (Participant 20)

*“Condoms are useful, they prevent STIs and unplanned child”. “yes”* (Participant 21)

*“a condom plays a very meaningful role in our health.” “Yes, if both partners could commit into using it at all times”.* (Participant 22)

*“Condoms are very important, they prevent STDs, especially HIV”. “Yes, if people could use condos every time they have sex”.* (Participant 23)

*“Condoms are useful in many ways like STI protection not only for HIV”. “No, HIV is not transmitted sexually only there are other ways that you can be can be infected by AIDS’.* (Participant 26)

*“It is important to use a condom for HIV protection”. “Yes, it can be reduced”.* (Participant 27)

*“All I know is that I will use condoms till the last days of my life in this earth. You just cannot put your life at risk by trusting a person you were born in the same womb with”. “No, because there are many other ways you can get HIV.”* (Participant 28)

*“I prefer to wear a condom because I am too young to die and to have a child, trusting someone is hard in these days”. “Yes, I believe it can be reduced”.* (Participant 29)

*“condoms are important for protection against all sexually transmitted diseases” “No, HIV inter our system in different ways”.* (Participant 30).

## Conclusion

The current study showed that most of the youth are aware of how effective it is to use a condom in order to inhibit sexual spreading of HIV and AIDS. However, Information and perceptions on HIV and AIDS do not necessarily brings assurance of anticipated behaviour to using a condom and other safer sex practices.

**Condoms perceived as decreasing pleasure**

**Finding**

One participant (participant 3) responded that condoms are very important, though in some situation's partners become bored in the mention of condom during those heated moments. Participant 6 said that he does not feel good using protection, he prefers 'inyama enyameni' meaning 'skin to skin'.

**Conclusion**

Even though the participants are aware they must use condoms to protect themselves from HIV infection, they still prefer not to use them. The government and non-government agencies must strengthen community campaigns aiming at the entire community, endorsing condoms as sexual diseases preventive measures.

**Condoms perceived as lacking barrier (block) method**

**Finding**

Four participants displayed their dissatisfaction with condoms since they break during sexual intercourse, and one participant (participant 25), called condoms the safest to prevent HIV infection.

**The findings are shown below:**

*"Even though it prevents unwanted pregnancies and disease it has its own disadvantages like when it breaks in the middle of action, a person must sure she/he know the right way of wearing it". "Yes, it can but since our clinic is far, I wish the shops in our area could stop selling us government condoms and gives for free".* (Participant 2)

*"Condoms are ok at the same time not 100% since it can break while having sex". "No it cannot"*. (Participant 15)

*"If I use condoms, I am preventing HIV transmission even though it is not 100% because it can break". "Yes, it can be reduced".* (Participant 19)

*“Condoms do break, they are not 100% safe, and abstaining is the safest option, just like me I do abstain from sexual activities.” “No, besides not being 100% HIV is not transmitted by sex only”.* (Participant 24)

*“condoms are the safest options so far, but they must have accompanied by constant teaching of the right way to wear them like also checking expiry date, women partners should be the one putting them on to their male partners since most men would take it off without a woman partner’s knowledge.” “Yes, there are few chances of being infected by HIV sexually”.* (Participant 25)

**Conclusion**

Participants need to be educated on frequent and correct use of condoms. Condoms need to be used every time there is sexual contact, and in that way, if it is used regularly, the risks of getting HIV are very slim. Condoms need to be put on correctly, in some condoms, there are guidelines on how to put it on correctly.

### 4.4.2 Theme 2: Sexual risky behaviour among youth

The theme describes the sexual risk behaviour amongst the youth. The participants were asked if they see themselves at danger of being infected by HIV and must support their responses.

#### 4.4.2.1 Sub-theme 2.1 Perceived to be at risk of contracting HIV

**Finding**

Twelve (40%) participants reported that they are in danger of contracting HIV. Even though the majority of participants, which is fifty (50%), reported that they are not in danger of contracting HIV. Two (7%) participants responded yes, and yet again no. One (3%) participant reported that he/she does not know whether she is at risk or not.

**No, supporting narrative statements**

Fifteen participants gave various reasons for their NO responses., They reported that they use protection every time they engage in sexual contact, and one other participant

reported that he had no interest in men as she used to be, while the other one participant reported that she has enough information to know how she can be infected by HIV.

**The findings are shown below:**

*"Not at risk because I have one partner".* (Participant 1)

*"No, I use a condom every time I mess around but with my girlfriend, I do not use a condom, I trust her".* (Participant 5)

*"No, I use condoms during sex".* (Participant 6)

*"No, I protect myself with a condom, and I would use gloves when dealing with bloody situations and if it happens that I don't have gloves with I would use plastics to help".* (Participant 7)

*"I am not at risk, I am a condom person, and I don't go around touching blood". (Participant 8)*

*"No. because I use condom with girls who are not my girlfriend, but I trust my girlfriend".* (Participant 9)

*"No, I protect myself and I know that I must wear gloves when handling bloody situation".* (Participant 11)

*"No, when I do sex, I use a condom, unless I am involved in an accident, or the condom breaks though there is little possibility of infection by her".* (Participant 12)

*"No, never, I use condoms always".* (Participant 13)

*"No, my boyfriend and I do use a condom at all times".* (Participant 15)

*"No, I do use protection, I have it in my bag right now".* (Participant 16)

*"No, because I have learnt a lot about AIDS, I am aware of what to do and what not to do to avoid getting it. If you have information you have power".* (Participant 24)

*"No, I no longer have interest in men".* (Participant 28)

*"No, because I test every month and I use condom during sex".* (Participant 29)

*“No, I am always careful especially if something will put me at risk of getting HIV.”* (Participant 30)

**Yes, supporting narratives statements**

Twelve (40%) participants supported their yes statement by mentioning the ways of contracting HIV.

**The findings are shown below:**

*“yes, my girlfriend has twice cheated on me and she loves partying with friends on weekends, so I don’t know if she uses protection when she sleeps around though we sometimes don’t use it when I have with her’.* (Participant 14)

*“Yes, I can get it unintentional by accident and I sometimes drink myself to a state where I do not know what I did a day before”*. (Participant 17)

*“Yes, I do have HIV, and everyone is prone to it”.* (Participant 18)

*“Yes, my partner sometimes does not want to use a condom, but I always refuse sex if there is no condom”.* (Participant 19)

*“Yes, because I work will vulnerable people in my organisation, I once was mistakenly jabbed myself with a needle while I was testing a person”.* (Participant 20)

*“Yes, I already have HIV, though I broke up with my previous boyfriend who infected me, the boyfriend I have now sometimes refuses to use a condom even though I told him my status, he would say HIV is a disease for people. The other boyfriend that I had we only used condom for a week thereafter he did not want it saying he trusts me”.* (Participant 21)

*“Yes, I seldom use a condom because I have been with him for almost three years”.* (Participant 22)

*“Yes, I can get it by accident, and I am on and off from using condom with my boyfriend”.* (Participant 23)

*“Yes, people don’t disclose, if my partner does not want to use a condom and I don’t know his status and I am financially depended on him”.* (Participant 25)

*"Yes, because I can get it from a car accident though I am using a condom".* (Participant 26)

*"Yes, because I am already infected with HIV and I am on treatment. I got it from my boyfriend because he refused to condoms every time, we made love."* (Participant 27)

*"Yes, I sometimes forget to use a condom especially when I am drunk, in fact my girlfriend does not like use using a condom she prefers skin to skin, and I like to feel her insides".* (Participant 4)

One participant reported yes and no.

*"I can say Yes then again I can say No, because there is a situation like blood transfusions were there could be a mistake of window period. By No I mean I protect myself by using a condom".* (participant 10)

One other participant responded to be remained neutral, stating *there are many chances of getting HIV.*

*"I am neutral in this question, there are many chances of getting HIV, and firstly because of the septum spitted by an HIV person it is released in the air and can be breathed by people therefore becoming infected, I might be HIV as I speak to and not knowing it".* (participant 3)

One participant (participant 2) responded not knowing whether is at risk or not.
*"I do not know, I can be at risky or not at risky, I do not want to reply this question, move to another one if there is any".* (participant 2)

**Conclusion**

50% of the participants do not see themselves at risk of HIV infection hence using protection during sexual intercourse while 40% of the participants see themselves to be at risk because of alcohol, rape, being faithful to a partner and yet he or she is not faithful. This demonstrates that the participants are aware that sexual interaction is not the only way you can be infected by HIV. As mentioned previously in the understanding of modes

of HIV transmission, most participants mentioned that sex and HIV infected blood coming into contact with an open cut can lead to HIV infection.

#### 4.4.2.2. Sub-theme 2.2: Sexual risk understanding

Participants were asked about their understanding of sexual risk behaviour.

**Findings**

Seven participants understand risk sexual behaviour as having numerous sexual partners, drinking excessively and one-night stands.

**The findings are shown below:**

*"sleeping around, having sex without a condom."* (Participant 3)

*"Being ignorant of HIV transmission, hooking up for sex in a tavern (one-night stand) no condom".* (Participant 4)

"*Having many partners to please friends or even swinging amongst friends"*. (Participant 5)

*"Having many partners, drinking and ending up 'ulahla' (random sex with a stranger). This usually happens in girls or women when they are too drunk, they lust for sexual contact".* (Participant 10)

*"If you have many sexual partners, if you are drunk you end up 'uwinwa' (first come first serve sexually). Most of times condoms are seldom used under this 'winning' situation".* (Participant 13)

*"Having lots of sex with different men and being love blinded."* (Participant 24)

"*Having more than one boyfriend and even worse not using a condom."* (Participant 26)

Eight (8) participants explained that they understand sexual risk behaviour by having sex without a condom.

**The above narrative statement is supported by the findings shown below:**

*"Sleeping with a person without a condom", sleeping with other people with besides your partner (cheating)".* (Participant 6)

*"Not protecting yourself when doing sex".* (Participant 7)

*"When you do not use a condom".* (Participant 9)

"*Having sex without a condom, you get STIs and HIV".* (Participant 11)

*"Taking risk by doing sex without a protection (condom)."* (Participant 18)

*"Sex without a condom, getting raped".* (Participant 20)

*"Being sexual active and rarely using a condom".* (Participant 23)

*"Nyama enyameni" (Skin to Skin) request by partners especially male partners, people who do not disclose their status and pretend all is well even during sex by not or refusing to use a condom".* (Participant 28)

Seven participants described their understanding of sexual risk behaviour as sleeping with strangers, having no control of your body when drunk, drinking excessively, being raped at night from partying, oral sex, respectively.

**The findings are shown below:**

*"Sleeping with a stranger (one-night stands) in a tavern or party".* (Participant 8)

"*When you are drunk at a party or tavern 'uya winwa' (first come first serve sexually). At this point you have no control of yourself".* (Participant 12)

*"Night gallivanting put you at risk of being raped if you are a woman even man in these days, too much deinking of alcohol or use of substance like dagga and drugs. In this situation you will wake up next to a stranger not knowing whether used a condom or not".* (Participant 14)

*"Drinking too much alcohol, random sex with strangers especially when drunk".* (Participant 19)

*“Alcohol intake you end up not having control of your life”.* (Participant 27)

*“You can be raped at night while walking from work or night fun”.* (Participant 16)

“Oral sex especially private part sucking”. (Participant 30)

Four participants see sexual risk behaviour as infected by sexual transmitted diseases and not knowing your HIV status.

**The findings ate displayed below:**

*“Infection by sexual transmitted diseases like drops, having many sexual partners”.* (Participant 1)

*“Getting HIV, impregnating a girl”.* (Participant 2)

*“Getting pregnant, getting STIs and HIV, alcohol drinking over the limits, walking at night. Too much partying”.* (Participant 17)

*“You get disease when you are afraid to ask for advises. Not knowing your status is putting yourself at risk sexually”.* (Participant 25)

Two participants explained that poverty and peer pressure can lead to sexual risk behaviour by trying to please friends when involved in sexual relations with men who are older than you for luxurious lifestyle in return.

*“poverty, when you are hungry either trying to put bread on the table at home you end up agreeing to demands of no condom during sex”* (participant 21)

*“peer pressure, trying to please friends by having relations or sex with older men for luxurious lifestyle”.* (participant 22)

## Conclusion

when guiding or writing on sex education and general HIV and AIDS well-being programs, there must appropriately state that an autonomous disease which is caused by a virus, the HIvirus as a result there is no known cure of it. These programs must also have course contents pointing out that HIV and AIDS is found simultaneous with other sexual

transmitted disease. In this way the youth will know accurate information on the diseases that are prone when a person put him/herself at risk.

#### 4.4.2.3 Sub-theme 2.3 Factors associated with sexual risk behaviour

The participants were asked what can influence them to participate in sexual risk behaviours.

**Youth and substance abuse**

**Finding**

Eight participants responded that alcohol would be the reason for them and most youth to participate in sexual risk behaviour. One other participant responded about coming from work and being raped, one other participant reported there is no reason he cannot play safe. Some participants supported their reason for putting the blame on alcohol, because when drunk, they turn to lose and need sex immediately, and thus referred 'uyalahla' or 'uwinwe'.

**The findings are displayed below:**

*"drinking alcohol."* (Participant 1)

*"Drinking alcohol way over the limit is my major problem that is one of the reasons I sometimes forget to use protection during sex".* (Participant 4)

*"it would 'uJiki'(Smirnoff), I enjoy alcohol so much."* (Participant 6)

*"Since I do not drink or use any kind of substance, I am always aware and in control so I believe I play safe".* (Participant 8)

*"I tend to have more sex when I am drunk, and girls take advantage of me since I always have money on for buying alcohol."* (Participant 10)

*"My friend are party animals and I just can't break away from them and at times we drink alcohol during weekend till the morning hours".* (Participant 12)

*"When I am drunk 'ndiyalahla' (I end engaging in random sex) but I am trying to break the habit."* (Participant 16)

*“Since I do not drink alcohol or go to parties, I think I can be raped while walking from work since my transport is scarce after 7pm and I knock off work at 8pm in some days’.* (Participant 20)

*“does not drink alcohol so I do not see how I cannot use a condom during sex”.* (Participant 21)

*“Butywala (Alcohol), when I am too drunk, I am ignorant”. “Unprotected sexual intercourse.”* (Participant 27)

Ten participants provided various reasons regarding for using a condom. One participant said that he and his partner sometimes forget to use a condom. Another participant blamed being in a rush fearing that the person about to have sex with him would change her mind. Another participant blamed it to too much on trusting when she has just met a new partner and stop a condom. Four participants reported that they can never have sex without a condom, not. One other participant responded that cohabiting with her partner prevent her from using a condom. Another participant said she is already HIV positive and is now living positively and cannot risk re-infection.

**The narrative statements are shown below:**

*“Even though I use condoms, but there is a thin line between my control and losing it especially when I am at a party and I meet this, we agree to give it to each other (sex), I would be in a rush fearing she would change her mind and even wish I could just penetrate without putting a condom because it will take longer.”* (Participant 7).

*“When I am doing for-playing with my partner we do sometimes forget to put on a condom. yes, I won’t lie I have more than one partner.”* (Participant 14)

*“None, I have learnt my lesson from my previous relationship which gave me HIV, so right now I am trying to live positively”.* (Participant 18)

*“None, I always tell my partner, no CD (condom) no sex ‘mntuwam’ (my love). “I am just as polite as that and I mean business.”* (Participant 19)

*“If I am in too much to that man, I end up trusting him and not using a condom”.* (Participant 23)

*“Nothing, I am always aware of my surroundings. All I can say is that no one can force me to do sex without a condom.”* (Participant 28)

*“Nothing can put me at risk. Most youth being force to doing sex without a condom.”* (Participant 29)

*“when I am under strenuous situation, I end forgetting to use a condom.”* (Participant 30)

*“None for me” having sex at a young age can put an individual at risk of sexual transmitted diseases. At a young age you cannot make wise and safe decisions and old men or even women in these days can take an advantage of your lack of sex knowledge”.* (Participant 17)

*“Vat n’ sit (living with a man for financial gain), not being able to feed your children or family can make cohabit with a man”.* (Participant 24)

**Multiple sexual relationships**

**Findings**

Two participants reported that having more than one partner can influence their risky sexual behaviour.

**These narrative statements are the findings:**

*“having more than one boyfriend can put me at risk.”* (Participant 11)

*“A long-distance relationship, I would cheat because he might be cheating there himself, so why not”.* (Participant 26)

**Conclusion**

The participants know sexual risk behaviours that put youth at risk of contracting HIV. If the participants know having many sexual relationships is sexually risky, it could mean they could avoid it because they would perceive the behaviour as vulnerable to HIV.

**Age-disparate relationships (Intergenerational sex)**

**Finding**

Four participants responded that having relationships and sexual relations with men older than them can put an individual at sexual risk of HIV infection.

**The following statement support the finding:**

*"I cannot think of any reason but to blame the 'sugar dads and mamas'. There is this fashion of young people (both boys and girls) having fake relationships with older man and women."* (Participant 3)

*"There is none for me" but for others I put the blame on old man who take advantage of young girls."* (Participant 5)

*"For me, none". But most youth are taken advantage by older men because of need for survival rather need for food or luxury life at a young age."* (Participant 9).

*"having no money because of 'ukuhlupheka' (having nothing to survive on my own) you end up having different partners like you can have a partner to pay rent and another partner to give you money for food"*. (Participant 22)

**Conclusion**

Relationships where there is a huge age gap, can cause sexual risk. Once the people who are in a relationship live far away from each, there is bound to be a gap that could lead to one or both partners having other sexual relations. This could lead to being infected by the virus and taking it to his or her partner.

**Peer pressure**

**Finding**

Three participants reported that peer pressure is one reason that increases sexual risk behaviour.

**The Finding is displayed below:**

*"Peer pressure, though I always standup for myself, I do not like to be told what to do especially by my friends." (*Participant 2)

*"peer pressure."* (Participant 15)

*"Maybe, If I was a teenager I would say 'peer pressure' but since I am an adult I should say 'Love is blind' (being made to believe the person loves me).*" (Participant 25)

### 4.4.3 Theme 3: HIV prevention strategies

The participants were asked about programmes/strategies they desire to be implemented to lessen the spreading of HIV in Nyandeni Local Municipality. The participants were further asked who should be involved in the programs they wish to be implemented in their communities. Most participants mentioned various types of stakeholder that should be involved, but emphasising that the youths as primary recipients of the programs.

#### 4.4.3.1 Sub-theme 3.1 Education training awareness campaigns

**Finding**

Twelve participants expressed their great need for educational programs in their communities. The participants have highlighted that they want sex and substance education programs, HIV education programs, HIV and AIDS focused NPOs, and counselling youth programs. Participant 6 wants the infected youth or people to be involved. This will help in motivating and warning of HIV infection consequences, and also, this will reduce stigma and discrimination against HIV positive people.

**The findings are shown below:**

*"Just like in my school there should be HIV and substance abuse education in my community because there is youth which is not schooling that needs to be educated". "The youth in my community especially those who are living with HIV so that they could guide and teach us to be more aware".* (Participant 2)

*"Talking to the youth about behaving. Advising to see how HIV does to a person, checking of HIV status, and continuous taking of treatment. Older people must be involved also". "There must be Health Organisations, I am not aware if there is any in my community".* (Participant 3)

*"Wishing for activities that could constantly remind us about the dangers of HIV". "Education and Social Development be involved".* (Participant 4)

*"Motivating youth to use condoms and ways of avoiding HIV infection programs. These must be held at least twice a year. Most of us know HIV is her and it kills but little formal information is shared by professionals. Most of us we share wrong information amongst from each other like if you have unprotected sex you soon wash with Dettol mixed with little 'madubula' to wash your private part so that the HIV does not stick in the private part" "The infected youth or people must be involved. This will help in motivating and waring of HIV infection consequences".* (Participant 6)

*"Alcohol and sex education programs, no sex without marriage programs, NPO programs because there one we have is far because of demarcation". "I would love to be involved, Social Development should be involved also".* (Participant 7)

*"In my community there is a great need that we are taught with advancing knowledge about HIV and AIDS". "You yourself as you are researching can be part by visiting our community and teach us about the new information. There must be workshops targeting youth and community stakeholders".* (Participant 9)

*"Talks and awareness programs, most people are not fully informed about HIV". "The youth and the government departments especially education must be involved".* (Participant 11)

*"Counselling youth programs to teach us on ways of protecting ourselves from HIV infection. "Youth and Social Development social workers".* (Participant 13)

*"Educational programs and awareness campaigns that will allow people of all ages to talk freely". "the youth and parents."* (Participant 18)

*"There must be educations that teach that HIV does not kill, what to do when you test positive and when and how to disclose to a trusted self-chosen person". "The youth must be involved at all times because most of them do not accept their positive status".* (Participant 19)

*"There must be support group programs, HIV and AIDS awareness campaigns for all ages but mostly target youth". "The youth should be the major part, most you are ignorant but these lousy comments like 'inyama enyameni' is more fun and cannot stand plastic. They further say HIV is for people not dogs". "Nurses and other HIV relevant health staff must be involved."* (Participant 20)

*"There must be group educating about HIV and condom relationship, people only hear about it when they visit the clinics once they get home they forget about it and engage in unprotected sex". "This must involve youth and older people".* (Participant 28)

**Conclusion**

There should be youth that must be trained and then be sent to schools to deliver the accurate information about HIV and AIDS not forgetting the behaviours that are sexually risky. Using the youth to be peer educators to other youth will make the youth to listen hence the awareness is from their youth.

### 4.4.3.2 Sub-theme 3.2 Dissemination of condoms and condom use, comprehensive sexual education and HIV prevention programs for youth

The participants were asked on what the can do to lower the risk of contracting HIV. The participants were further probed on whether having one sexual partner can reduce the spread of HIV infection.

**Finding**

Fifteen participants responded to using a condom as a form of prevention, while three participants believe that abstinence is another way of lowering HIV infection.

About 47% participants responded YES, and did not explain their response, while 43% of participants responded NO, and also did not explain their response. Then 7% responded as yes or no, one (3%), of the participants, responded not being sure, *saying that men are cheaters by nature'.*

**The findings are shown below:**

*"For my part I emphases that people should have one sexual partner and still remain condomising at all times". "Yes, being with one sexual partner can decrease the spreading of HIV".* (Participant 1)

*"To make where I go I have a condom even sharing the importance of using a condom with my peers". "No it does not help having one partner because one of you is always a cheater."* (Participant 2)

*"I would distribute condoms hence in my community there aren't any available condoms, you have to go to the clinic to get one, I would place them in taverns where most of sex is initiated, knowing each other's status in a relationship is also helpful," "yes, I would try to influence my partner to be faithful to me."* (Participant 3)

*"There is nothing I can do others except for me to use a condom every chance I get though it is a difficult task for me". "No having one partner is a lot of nonsense, I cannot tell you how much I caught my boyfriend with sleazy women as a result I am cheating too, life is too short for trusting".* (Participant 6)

*"I don't know, except for me to use a condom." "No, women are untrustworthy, the cheat especially when they are drunk."* (Participant 7)

*"Except to use a condom, I cannot think of any other way". "Yes if it was possible, people cheat for different reasons, people are damaged".* (Participant 8)

*“I would use a condom though there is nothing I can do myself, it is up to people to after themselves.” “No, you might be faithful to your partner but is he/she faithful to you”.* (Participant 10)

*“condom use only.” “No, there is no way of knowing if your partner is not cheating on you, you can have that one partner but still you have to use a condom”.* (Participant 12)

*“The government condom we have are very weak, they break easily especially during rough sex, so for me I would make sure condom manufacturing companies make a stronger condom”. “Yes, especially if you are both HIV positive, the disease could remain between the two of you”.* (Participant 15)

*“the use of condoms during sex even though there are times I don’t use it myself, the use of gloves when dealing with blood issues.” “I am not sure because men are cheaters by nature, they never remain to one partner. I may not cheat but how do I know if he is not cheating at me”.* (Participant 16)

*“Since I am already positive, I make sure I always tell my partner to put on a condom”. “No, having one partner cannot reduce the spread of HIV, I learnt the hard way myself, he was my only boyfriend but apparently I was not the only one to him”.* (Participant 18)

*“Wearing a condom each time I have sex, use my own toothbrush, eat treatment everyday so if by mistake the condom breaks are will chances that my partner will not be infected in case I am HIV positive”. “No, faithfulness has long expired in people’s lives, people cheat every day and it’s sickening”.* (Participant 19)

*“Using a condom regularly”. “Yes, but it is impossible in reality, men cannot help but cheat, the same is for women”.* (Participant 21)

“*The most part of HIV infection is through sexual intercourse; there I would advise condom use”. “No, because of this alcohol drink, people find them being unfaithful to their partners”.* (Participant 28)

*“Female condoms must be prioritised, I have no idea what does a female condom looks lie, and maybe if females could use their type of condoms it would be better”. “yes.”* (Participant 29)

*"There is no other way but for me to play my part by being responsible and use condoms every time I have sex". "yes."* (Participant 30)

*Participant 5 "Abstain, if not constant use of condoms, stick to one partner, getting tested with your partner but continue to use a condom". "No, because of trust issues, what if the other one is cheating."* (Participant 5)

*"I believe abstaining is one of the solutions to HIV country." "I can say Yes but then again No, it is hard to trust a woman, women cheat a lot and may get away with it because they are good at hiding cheatings"* (Participant 20)

*"Having programs above abstinence and using condoms. Peer education programs are best instead of involving elders, this way the language will be the same, HIV awareness programs will also be useful". "People from the community who has knowledge about HIV must be prioritised as educators and can be mixed with those coming from outside the community".* (Participant 10)

**Comprehensive safe sex education**

**Finding**

Twelve participants prefer to inform all youth, including the elderly about HIV, and even wishes they could be informed about the new developments about HIV and AIDS.

**Findings are shown below:**

*"I would try by all means to share relevant and useful information with my peers about HIV and new developments". "yes."* (Participant 9)

*"Inform many people about various ways of contracting HIV and also various ways to prevent it". "Yes."* (Participant 11)

*"I would advise people not to stop using protection and have one partner, it the only way to HIV free world." "Yes, provided you still continue to using condom to that one partner."* (Participant 13)

*"I would HIV make sure each and every community especially those deep…deep areas they receive educational information regarding the HIV infection and how to prevent it."*

*“My answer is between yes or no, because for women it is possible to stick to one partner but for men it’s a different issue”.* (Participant 14)

*“I would advise people to continuous condom use and HIV testing every six months.” “Yes sticking to one partner and still using a condom can reduce the spread of HIV”.* (Participant 17)

*“I believe the mass media must to do more coverage on advancement of HIV new developments, maybe people will be interested to listen”. “Yes, especially if my partner knows I am HIV positive so that we continue using a condom”.* (Participant 12)

*“To tell and motivate people to use condoms, and also advise the importance of knowing more about HIV so that people have current information”. “No.”* (Participant 23)

*“Stop having unprotected sex, be informed with up-to-date HIV information”. “No, if it was possible why there are many being infected even today”.* (Participant 24)

*“I would do everyday HIV and AIDS broadcast by YouTube or any other media way that is easily accessible to people especially us the youth” “No, there is guarantee both partners are faithful to one another”.* (Participant 25)

*“I see no better way but to put more emphases the use of condoms, and to learn more about other ways of being infected by HIV”. “yes, I think so.”* (Participant 26)

*“continuous checking of one’s status, especially us men we are always afraid to go for HIV testing.” “yes, you can if you trust one another, there is no need to use a condom.*” (Participant 4)

*“Maintain continuous HIV testing would put more responsibility to all people by trying to avoid HIV infection”. “No, people just cannot help themselves but to cheat”.* (Participant 27)

**Conclusion**

The participant’s responses are evidence that the youth lack knowledge on the fact that even though you have one sexual partner, a condom must be used. Faithfulness cannot be guaranteed in a relationship; it is as if the person is gambling with his or her life. Putting

your life in your partner's hands can be detrimental. Those who responded NO, (43%) have high possibility of using protection with their sexual companions. It is worth noting also there must health services that are youth friendly so that the youth is more interested in those services. Such service must attract the youth to enhance involvement. The distribution of condoms must be made mobile so as to reach many youths especially in the disadvantaged areas in the deep rural areas. There must be mass media campaigns and unlimited nation awareness to deliver all the relevant and accurate HIV information. This awareness must not be regulated on world aids day.

**HIV prevention programs for youth**

**Finding**

Seven participants requested programs that will promote adherence in people taking ARV treatment. Participant 21 wants a traditional practice called 'intonjane' to be brought back. There must be sports activities to lure back the young boys from hanging in taverns and shop corners. Because these are the places where they learn delinquency. Participant 22 wants prep to be introduced in her community for those who are raped, or whose condoms break during sex. She wishes PrEP could start from 13 years. Participant 25 needs initiation educational programs to be implemented in her community as her brother was infected with HIV during sharing of a circumcision blade.

**The findings are shown below:**

*"Department of Health to visit our community with health services like HIV testing". "Education on HIV and testing to know our status instead of visiting the clinic".* (Participant 5)

"*There must be Intonjane Programs (virgininty checks up to 21 years of age done twice a year). There must be sport also which will keep young boys busy instead of hanging in shops and taverns". "The youth, community and community headman must be involved".* (Participant 21)

"*How I wish we could have PrEP for preventing further infections. PrEP offers counselling and some sort of injection that prevent formation of HIV when someone is raped or*

*condom break. It must start from thirteen years. Condom use must not stop also". "youth programs from thirteen years to 24 years must be involved."* (Participant 22)

*"Adherence programs that would provide pills within the community, because most of the youth is infected in our community, those who tested positive and started ARV treatment always defaulted once they see that they are now fine and those who test negative in their monthly visit will think that they are negative whereas the virus is undetectable but still there". "The youth must be involved and form adherence club, to share problems and pains they are experiencing. Adults must be excluded from this club because the youth will not be open during these discussions".* (Participant 23)

*"There must be programs on initiation education, many young boys get infected by the sharing of the circumcision blade, and my brother was a victim also". "Young boys, circumcision leaders and parents".* (Participant 25)

"*There must be programs were there will be distribution of condoms, educational HIV talk, knowing your status, home based care and adherence". "Home based care facilitators"*. (Participant 26)

*"There must be educational programs, Virgin checking by older women. This virginity checks were done in our community, but it stopped because of non-participation". "The youth especially girls who are virgins as young as 8 years must be involved".* (Participant15)

**Conclusion**

Programs must be advanced and be announced to correct socio-cultural norms that inhibit parents from playing an energetic role in the deterrence of HIV and AIDS amongst youth. These programs must comprise of nationwide campaigns to address issues relating to HIV and AIDS, gender inequalities and cultural practices that promote the spread of HIV and AIDS. Activists in UKZN came up with the idea of virginity testing of all young girls from a small age up to 21 years of age. This idea was or is meant for all these young girls to be responsible of their bodies knowing that there comes a day of checking if they were responsible enough. This Contrary to the past, virginity testing today is

conducted as part of public annual celebration(s). The celebrations are conducted in different public venues and not only in the central common space of a village chief.

#### 4.4.3.3 Sub-theme 3.3 Age-appropriate for services

The participants were asked of programs that might be positively influential to the you in their communities and who should be part of those programs.

**Finding**

Eight participants listed various desired programs that might be influential positively to the youths in their communities.

**The findings are displayed below:**

*"In my community I have never heard of any awareness and educational programs done, so I would prefer for us to have HIV awareness programs and form youth clubs which will have different activities for fun while learning". "Social workers and health officials for counselling and HIV testing".* (Participant 1)

*"I am not sure which programs will be relevant hence I have never attended any program in my area, but I would assume you mean programs that teaches people" if so then, I prefer we have activity programs that would occupy our minds with useful things". "Community caregivers and HIV practitioners from the clinics."* (Participant 8)

*"Youth be taught about HIV; most youth are having sex with a condom". "Ward committees can assist".* (Participant 12)

*"Youth programs, educating according to ages on how to manage their lives". "Department of Health and Social Development and not only the Department of Health. Youth always associate nurses with illness so social workers will serve best".* (Participant 17)

*"There must be youth programs which will also create jobs for youth from those programs" "Youth from 18-35 years must be involved".* (Participant 14)

*“Education sessions by organising people to join especially the youth, it must be done quarterly”. “Social Development, nurses from Department of Health and the youth must be involved.”* (Participant 24)

*“there must be frequent at our school to do HIV testing and it will be better because there will be confidentiality unlike at clinics where you are known you are going to do HIV test since they isolate HIV testing Centre from other clinic services.” “They must involve clinic HIV practitioners or hospital nurses”.* (Participant 29)

*“There must be a built place especially for the young where there would HIV educational programs”. “The youth should be involved.”* (Participant 30).

**Conclusion**

The researcher is of the opinion these awareness campaigns could be beneficial to many youths that still have comments of ‘skin to skin’ sex, eradicating the statements that say ‘HIV is for people not for dogs’. More VCT service areas must be placed in all disadvantaged rural and semi-urban areas especially where there is easy access to health services. There is youth that is unemployed or have families that live on a very low monthly income making it difficult to travel with costs to receive health services.

Two participants below reported that they had not seen or heard of programs in their communities. To this point, the researcher is concerned about the effectiveness of the NPOs already operating in Libode and Ngqeleni communities. The participants know there should be a benefit to these programs, but they just do not know how to access them and benefit from them.

**Finding are shown below:**

*“I have not seen heard of anything called programs, maybe they have not yet arrived in my community.” (participant* 16)

*“I have never seen any programs and I don’t know what programs are”.* (participant 27)

## Conclusion

According to the researcher's point of understanding it is evident from the statements that regardless of the accessibility of educational programs in the communities, young people need to be engaged more in these programs. It would also be better for the youth to be educated separately from the adults to cater according to their type of needs for participation and relaxation.

### 4.4.4 Conclusion

Chapter four was presented with information background from the participants, the participant's realities and experiences, were distributed into three themes which were defined and described. The chapter to follow will be discussing the outcomes of the analysis done in chapter four. Chapter 5 will also have recommendations or suggestions for other researchers who might be interested to conduct further research. Also the recommendations might be beneficial to the experts for implementation.

# CHAPTER FIVE

# DISCUSSIONS, LIMITATIONS, RECOMMENDATIONS, AND CONCLUSION

## 5.1. Introduction

Chapter four presented the data and findings of the research study. Chapter five discussed the data, limitations, recommendations and the conclusion for both government, NGO establishments and the next research opportunities. As set out at the beginning, the summary of the results and conclusions are discussed according to the objectives of the study. The researcher also identified strengths and weaknesses of the study.

### 5.1.1 The Health Belief Model: a framework for the discussion

The researcher made use of the HBM as a framework, and the study objectives to organise and discuss the key findings in this study.

## 5.2. Summary of results according to the research objectives

The aim of this study was to explore the knowledge, attitudes and sexual risk behaviour of the youth between the ages of 18-25 in the Nyandeni Local Municipality at Eastern Cape Province. Furthermore, to identify their existing level of knowledge and risk sexual behaviour and provide with recommendations for future education programs and preventive measures. The study objectives were as follows:

- To describe knowledge and attitudes regarding HIV and AIDS among youth 18-25 years at Nyandeni Local Municipality.
- To explore sexual risky behaviour among youth at Nyandeni Local Municipality.
- To discuss prevention approaches that can be utilised to reduce the spreading of HIV amongst the youth at Nyandeni Local Municipality.

### 5.2.1 OBJECTIVE ONE: To describe knowledge and attitude regarding HIV and AIDS among youth 18-25 years

**Participants' level of awareness regarding the difference between HIV and AIDS**

The majority of participants gave different views indicating very little understanding of the difference between HIV and AIDS. They could not specifically distinguish the difference between the two terms, which shows evidence that the participants are not clear about the distinction between HIV and AIDS. Most of participants, according to their educational level dropped out of school. As a result, they missed out on a lot of valuable information from the school programmes. This is supported by the educational level depicted in table 4.2.4, the biographical details of the participants, wherein the 66% of participants who had dropped out of school missed out on educational programmes done by schools. Those who are still at school did benefit by receiving the correct knowledge regarding HIV & AIDS. It is very relevant that the youth have adequate HIV and AIDS information. Therefore, knowledge regarding HIV and AIDS was preferred as the first step in the prevention of HIV infection (UNAIDS/WHO, 2013). In order to mitigate the HIV infection, UNAIDS (2018:7) described that in order to decrease the future HIV infections, therefore is need to consider the youth as primary recipients of prevention strategies.

The researcher used the HBM in order to describe the participants' knowledge regarding differentiation of HIV and AIDS. It explored that a person will turn to take a health related actions if he or she senses an undesirable health condition can be escaped or eluded (Campus, 2005:1). It is therefore important that the individual know that they have the control and command of their lives in order to avoid an illness. This can only realised when a person has a factual or accurate knowledge of the issue.

**Recommendation**

It is therefore recommended that there is a need for the youth to be fully informed more about the HIV and AIDS. This is done in order to provide correct awareness of the disease. The informational sessions should provide frequent updates by the relevant authorities on advanced youth who feel that they do not have adequate knowledge about HIV and AIDS be correctly informed about this disease. There should be proper

estimations of the youth knowledge levels and it must be conducted from time to time. Youth should also be updated on all changes in incidence statistics relating to HIV and AIDS. This should include the changes in the mutation of the virus. The programme providers must guard against the idea that knowledge will necessarily result in expected behaviours.

**Participants' level of knowledge regarding ways of HIV and AIDS transmission**

The majority of the participants knew the two most ways of transmission of HIV infection. This include that HIV is transmitted through sexual intercourse and when there is cut and when blood comes into contact with infected blood. Most participants (34%) reported to know little knowledge about how HIV is transmitted.

The other way HIV transmission include breastfeeding from an HIV positive mother, and sharing of sex toys without sterilising them (Adegoke, 2010). According to Barnett & Whiteside (2006) HIV is described as a concentrated seminal fluid. HIV is may be also transmitted through sharing of an infected needle or syringes by drugs users, needle stick by occupational health workers, patients who have received tainted blood transfusions, blood products, and infected transplanted tissues (WHO, 2006).

**Recommendation**

For the youth to aware of more ways of HIV infection either than unprotected sexual contact, the youth must be taught on exactly all the ways of being infected by HIV.

**Participants' attitudes regarding testing HIV positive**

Even though twenty-six participants reported to be shocked and anxious if they tested HIV positive, eighteen participants reported the importance of taking treatment once a person tests HIV positive. Most participants reported ART treatment as important, the participants know HIV is not curable and taking the treatment will elongate one's life. The majority showed no negative attitude towards people living with HIV instead they insisted that taking ARV treatment at a specified own chosen time will make the individual live longer.

Shame and judgement inflicted by other people weaken and destroy the individuals and communities to defend themselves from HIV. This will affect their ability to remain healthy when they are HIV positive (UNAIDS/WHO, 2013). Such shame and judgement by people can result in people being afraid to visit clinics for antiretroviral treatments and other related services (Maughan-Brown and Nyblade, 2013). Attitude resulting from shame and judgement can be negative or positive depending on the individual. Media has played a huge part in talking about the importance of HIV testing. This has led to more people, especially the youth, to go for HIV testing, or to keep on being aware of their HIV status.

**Recommendation**

As the researcher has noticed in many clinics located in Nyandeni, HIV and AIDS services like picking up of ARV treatment, HIV testing are done in separate areas within the clinic. this makes everyone in the clinic know that those people who are siting there are there for HIV issues meaning that they are HIV positive. The researcher maintains that health services must be suitable for all youth ensuring that even though there are special consulting rooms they must not be separated from other people who has come for help in the clinic.

**Participants' perception regarding condom use**

The different opinions regarding condom use were also communicated by the most of the participants. This has influenced their perceptions regarding condom usage. They the perception that condom use decreases sexual sensation make sex less enjoyable, (one participant). However, there were two participants who reported to seldom use condoms during sexual intercourse. Twenty-three participants replied on the importance to use a condom because can prevents STIs and HIV, as well as unwanted pregnancies. Furthermore, twenty (70%) participants responded that condoms can lessen the spread of HIV. Four participants reported their dissatisfaction with condoms since they break during sexual intercourse. Knowledge and positive attitudes do not actually guarantee probable behaviour with regard to condom use, and it does not provide safer sex practices.

It is believed that inconsistent condom use is less protective than consistent use (CDC, 2011; Crosby et al 2012). Shisana et al (2014) described the consistent condom users are 20 times less likely to be infected by HIV than inconsistent users. According to the HBM, individuals must perceive themselves to be susceptible to HIV and AIDS. They have to believe in the efficacy of condom use in preventing HIV infection. Based on the above discussions, the individuals would be likely use condoms in order to prevent HIV and AIDS.

Perceived benefits regarding condom use with regard to the current study can be described as the belief in the efficacy of condom use to prevent HIV and AIDS (Groenewold et al 2006:4; ReCAPP 2007:4). Self-efficacy in condom use is described as the belief that individual is capable of and be likely to use condoms in sexual situations. This may play a critical role in promoting condom use behaviours (Melissa, Farmer & Meston 2006:313). Youth who lack confidence in their abilities to purchase condoms may not negotiate the use of condoms. They may tend to have a likelihood of engaging in unprotected intercourse. The low self-efficacy of the youth makes them more vulnerable to HIV infection.

**Recommendation**

Therefore, it is vital that all sources available to youth should be offered to them must have clear and truthful information regarding HIV and AIDS. This must include information regarding the use effective use of condoms. Magazines, newspapers, television and radio programmes must be examined in order to make sure that they present factual information that is not contaminated. Condoms need to be put on correctly, in some condoms, there are guidelines on how to put it on correctly.

### 5.2.2 OBJECTIVE TWO: to explore sexual risky behaviour among youth from Nyandeni Local Municipality

**Participants are perceived to be at risk of contracting HIV**

It is about 40% of the participants that have reported to be at risk of HIV infection and whereas 50% of the participants reported not to be in danger of HIV infection. According to Tadesse & Yakob, (2015:3) explained that there are different causes related to risky

sexual behaviours by youth. This are easily influenced by peers, limited support from parents, inappropriate childrearing roles and role models, and living in unfavourable environments. It is also described that youth are more likely to engage on risky sexual activities if they perform poorly at and seek attention from peers and men (Tadesse & Yakob, 2015:3). The youth that have insufficient awareness and knowledge about the risks associated with unprotected sex often acquire sexually transmitted infections as well unwanted pregnancies. According to Tadesse & Yakob (2015:3) this behaviour may also be due to a lack of inadequate information and basic skills to deal with their emotions, and high peer pressure to experiment with sex.

The HBM has an assumption that a person's perception that a health problem is personally relevant will contribute to taking the necessary action. This action is done in order to prevent the health problem including contracting of HIV. In order this to take place, and therefore there must be actions that increase the individual's perception of one's vulnerability to the health condition. The participants had reported their personal reasons as to why they are not in danger of HIV infection. Their responses were based from using a condom during sex and no longer having sex (abstinence). Those participants who reported to be susceptible to HIV infected, responded that, one can get HIV unintentionally, and working with HIV vulnerable people in the organisation, seldom use a condom. This may be as a result of forgetting to use a condom when excessively drunk.

**Recommendation**

The youth perception of their individual risk of contracting HIV and AIDS must be informed of the common risk of contracting HIV and AIDS. This implies that the youth should be informed about the real threat of HIV infection using available statistics. Such knowledge might help the youth to correctly estimate their own risks of contracting HIV. Therefore, all information should be offered in a balanced way without causing fright or a sense that contracting HIV and AIDS is unavoidable, leading to HIV and AIDS weariness and a careless attitude that might undermine healthy sexual practices.

**Participants sexual risk understanding**

About twenty-one (21) participants responded to understand putting one's self at risk of STIs infection including HIV and AIDS. The participants mentioned various ways of being at risk sexually. The participants' responses included the following: sex without a condom, many sexual partners, drinking excessively and losing control of yourself, oral sex, not testing for HIV for status awareness and having sexual relationships with older partners.

Many sexual partners are described as the contributing factor regarding the spread of STIs including HIV (Maharaj & Cleland, 2011; USAID, 2013). It is described that individuals who have many sex partners are considered to be at most risk of contracting HIV infection (Fehringer et al 2013; Maughan-Brown, 2013). People participated in unprotected sex with different partners, they may increase their susceptibility to HIV infection (southern Africa HIV and AIDS Information Dissemination Services, 2014). It is estimated that men are more likely than women to have concurrent partnerships (Onaya, Zuma, Zungu, Shisa & Mehlomakhlu, 2014).

It is reported that among women aged 15-24 years, 7% of single women and 26% of married women reported having a partner 10 years older than them (NSF, 2010). The phenomenon of sugar daddies and mommies has been linked to this practice. LeBeau and Mufune (2001) described that such relationships are motivated by the implied assumption that sex will be swapped for material support or other benefits. This practice of exchanging sex for money or any other goods of value can contribute to HIV infection among youth. The intergenerational sex has common similarities to transactional sex because sex is exchanged for money and/or other materials. The concept Intergenerational sex is more common between young female and an older male partner (commonly referred to as sugar daddy syndrome). Unless something can be done to prevent this, the youth will be trapped to this situation and the final result is to contract HIV.

**Recommendation**

In South Africa there is no fixed age for a person or youth to start sexual education. There is need for sex education and training to be conducted outside the family and household.

Sex education and training programmes must prepare the youth with a self-concept that supports individuals to say “no” to uninvited sexual advances. It must provide facilities where these unwelcome sexual advances could be reported. Life skills training need to form part of sexuality education at all levels of child’s development.

**Participants’ influence to engage in sexual risk behaviour**

Eight participants responded that alcohol would be the reason for them and youth to engage in sexual risk behaviour. One participant blamed cohabiting, being in a rush during sex. Another participant reported peer pressure whereas another participant reported long distance relationship could place him/her in sexual risk.

The participants are aware of the risks associated with risky sexual behaviour. The participants had risk knowledge of being involved in social drinking. They are likely unprepared sexual experiences driven by clouded judgement and peer pressures.

Across the lifespan, adolescence is described as the time of risk taking (Chick & Reyna, 2012:379-428). While the understanding and even over-estimating the likelihood that an action will cause harm, therefore the adolescents may place higher value on the benefits that might come with a particular risk. The youth are more likely to be involved in many risk behaviours when they experience a risk factors without the counteracting forces of positive opportunities, relationships, and resources.

**Recommendation**

Even though there hasn’t been much evidence produced by research studies that showed that alcohol and drug abuse as a cause of youth putting them at risk of HIV infection. It is therefore that there must be more precautionary learning material that should talk against alcohol and drug abuse. The alcohol and drug abuse might affect the one’s reasoning abilities to make the right decisions.

### 5.2.3 OBJECTIVE THREE: To discuss prevention strategies that can be utilized in order to reduce the spread of HIV infection among the youth at Nyandeni Local Municipality

About twenty eighty (28) participants in the study stated various desired programmes and training they wish they could be implemented in their communities and even at their community schools. The participants reported to receive HIV and AIDS education training awareness campaigns, formal sexual health education, adherence programs. The participants have highlighted that they want sex and substance education programs, HIV education programs, HIV and AIDS focused NPOs, and counselling youth programs. The Nyandeni Local Municipality is divided into two Local Municipalities and each Local Municipality has many communities which some are demarcated as far as Port St. Johns Local Municipality. The participants therefore feel that not all youth is reached by the current running NPOs which are funded by the DSD. For the current study to be beneficial to the youth of Nyandeni Local Municipality, the requested programs that could enhance youth knowledge should be implemented.

Most participants mentioned that the youth should be involved in these programs since the youth are the primary recipients of the programs. They further stated that the DoH, DSD and DoE should form part of these programs depending on the program relevance to each department. UNAIDS (2018:12) highlighted that involvement and presence of youth is an essential Human Rights principle.

As previously mentioned in chapter four, the media campaigns to encourage abstinence, delaying sexual debut and regular condom use should be conducted nationwide. This must be done in order to motivate the youth to adopt healthy sexual practices. Abstinence, being faithful and condom use (ABC) were described as the most effective campaigns of handling the HIV epidemic (Appiah-Agyekum and Suapim, 2013).

**Recommendation**

There must be health education of sexual issues which are much more explained in simple terms for the better understanding by all youth irrespective of whether they are literate or illiterate. Throughout these education processes, the youth must be frequently

informed of advanced HIV information so that they are aware of what is new. The health education sessions should consider the psychosocial and socio-cultural issues surrounding the youth irrespective of whether the youth has been exposed to such education at school or from their community. There should be more open communication like drama, debates, community discussions and workshops. These will help motivate a more acceptance of HIV and AIDS in order to lessen the stigma and discrimination against PLWHA.

## 5.3 STRENGTHS AND WEAKNESSES

There were strengths and weaknesses that developed from the findings.

### 5.3.1 Weaknesses of the research study

Already mentioned in 3.2.8 of the study, the outcomes of this study cannot be generalised to wider communities, or population, as a small sample was used. If a larger sample, that covers a large geographical area was utilised, the researcher would have got more diverse opinions and estimations in the research topic.

Had the researcher been able to observe the youth where they frequently hang out to drink alcohol and use substances, more in-depth information on how they (youth) interrelate and escalate their dangerous sexual behaviours would have been revealed.

Using one on one interviews in a qualitative study limits the researcher, as the participants may simply give answers which they think will display a desired good behaviour, trying to impress the researcher.

### 5.3.2. Strengths of the research study

Outlined initially, all the objectives of the study were covered. The objectives were: to explore the knowledge, attitudes and risky behaviour of the youth between the ages of 18-25 in the Nyandeni Local Municipality at Eastern Cape Province, to identify their existing level of knowledge and risky sexual behaviour, and to make recommendations for future education program, as all ages between 18-25 were included and represented

in the study. There were no anticipated potential risks to the participants. The participants finished and left the interview sessions with no serious interruptions, and with peaceful minds.

## 5.4 RESEARCH STUDY LIMITATIONS

The following are the limitation of the research study:

- Only participants between 18-25 years of age participated in the study.
- The research employed qualitative research design, so the findings cannot be generalised to all the youth at Nyandeni Local Municipality.

## 5.5 RECOMMENDATIONS

The researcher is proposing the next recommendations regarding the further research:

- This study was only conducted to youth between the ages of 18-25. The researcher wants to recommend that a study such as this one should also be conducted in youth starting from ages 13-35. Most youth are sexually active from the age of 13, and youth above 25 years to 35 years should be included in a similar study.
- The present research study noticed that most participants had information on HIV and AIDS infection, but it needs to be expanded through informational programs, which they requested, as protective measures to lessen the spreading of HIV infection in their communities.

## 5.6 RECOMMENDATIONS STEMMING FROM THE RESULTS OF THE RESEARCH STUDY

Reported recommendations by participants:

- There is a need for intensive awareness campaigns that will teach young people on the dangers of unsafe sexual behaviour. The strategies to be introduced should involve both youth that have dropped out of school, and youth still in school.

- There is a need for intensive school based and community-based programs for SRH education involving youths that have dropped out of school and youths still in school. These school based and community-based SRH education programs must offer a wide-range of sexual education. Most youths out of school are unemployed and spend most of their time idle in street corners and taverns. The youths in school should be encouraged to stay in school until they finish. The youths who have finished school, or who did not finish school, should be provided with jobs, or income generating projects, to keep them busy so they avoid frequenting clubs too often, and abuse alcohol and drugs. This can succeed by the creation of community projects like NPOs and Cooperatives.
- The establishment of a life skills Centre in the communities of Nyandeni Local Municipality is also recommended. In such a Centre, young people could be trained in various skills that could help them to fight unemployment. The researcher is working for the Department of Social Development under OR Tambo District, meaning she coordinates Departmental Social Services. The researcher will meet with the OR Tambo District Director, and her immediate supervisor, to plan community awareness campaigns, community NPOs and NGOs for 2021-2022 financial year. The focus for these campaigns will be at Nyandeni local municipality which is under the OR Tambo District. The two Non-Profit Organisations, Philisa Home Base Care, and Nompilo M.U Home Base Care Centre, that were part of this study, are not enough to deliver the required services because of demarcation. Many youths in Nyandeni cannot access them. Most youth did not even know there were such NPOs in their Municipality.
- Law enforcement agents should be strengthened and clamp down on people who sell drugs, stop taverns opening into the early hours of morning and organised sex parties in the community, to curb the exposure of young people, especially those less than 18 years, even though they were not part of the study. There is one participant (participant 1) in the pilot study who reported that, in a tavern operating in his community, young women sell sex and are not known by the community members. This could place the young people in danger of contracting HIV.

Adherence programs could help youth who have tested HIV positive, and help them start ARV treatment and remain using it. This is due to most youth in their communities not adhering to ARV treatment which leads to them defaulting and getting sick. These adherence programs could involve youth affected, infected and not infected by HIV. These would keep them busy and occupied, and centres can serve as institutions where the youths can get sex education, access to condoms and other contraceptives. This would prevent youth from having to travel to far away clinics and hospitals, just to get condoms.

- The majority requested that when the programs are implemented, the youth should be involved. The relevant Departments should not be involved without the collaboration of the youth for service delivery. The reason for this request is that most youth associate these departments, especially health as illness, and start avoiding them. Amongst the departmental officials there should be caregivers from the community. The HIV infected youth could form part of awareness campaigns, to dispense a strong message to other youth.

- Some participants recommend the involvement of parents and home caregivers, and they must be provided with intensive sexual education that include HIV and AIDS. Factual information on HIV & AIDS is growing every day. There are new developments that all people from different ages should receive.

- The recommendation, according to the participants, put an emphasis on creating supportive partnerships with families, spiritual groups, schools, media, businesses and community groups, to prevent the spreading of transmission.

- The outcomes from the study revealed that condom use is affected by alcohol consumption. In the study, some participants explained that it is very difficult to think about using condoms when someone is drunk. Young people in these circumstances will have unprotected sex without considering the risks. Health education regarding alcohol consumption by the youth is highly recommended.
  Although there is a widespread HIV and AIDS information awareness, the youths continue putting their lives in danger by engaging in sexual behaviours that are risky, for instance, being involved sexually with several lovers, and engaging in

unprotected sexual contact. Knowledge levels were high among the youths that only stated that the condom is the main source of preventing HIV infection, not taking into account the various ways in which HIV can be infectious.

- The results also revealed an association between various socio-economic factors and risky sexual behaviours, including sexual relationships with different lovers and unprotected sexual interaction. In this study young people who attend parties, or go to clubs, were more likely to be involved in sexual behaviours that are risky.

## 5.7 CONCLUSION

The study aimed at exploring the knowledge, attitudes and sexual risky behaviour of the youth between the ages of 18-25 in the Nyandeni Local Municipality at Eastern Cape Province, and to identify their existing level of knowledge and risky sexual behaviour and to make recommendations for a future education program as preventive measures.

It is nonetheless anticipated that information gained from this study will be beneficial to make recommendations concerning HIV and AIDS that could assist the Nyandeni Local Municipality organisations to implement policies, and programs, to help reduce the occurrence of risky sexual behaviours by the youth. The study will also be beneficial to OR Tambo Municipality as a whole, as it will contribute in fighting against HIV and AIDS. Government organisations will benefit from the study by being able to identify where the problem lies. The government and the existing NGOs will also see whether the current HIV and AIDS interventions are truly working and reaching all communities in the Nyandeni Municipality. The researcher believe that the study may assist in the increased the levels of knowledge regarding HIV by f the youth. The key objective in the study should efficiently be to encourage, promote and influence positive sexual attitudes and risky behaviour amongst youth. Since HIV infection is mainly contracted from sexual intercourse, the researcher believes that the use of condoms is the safest means of controlling STIs, HIV and the AIDS epidemic.

It also emerged that having limited information around HIV and AIDS by the participants contributed to some participants placing themselves at risk to the dangers of HIV infection.

This exploration study demonstrates that the majority of participants interviewed little information about HIV and AIDS infection and prevention, which also agrees with the conclusion that their knowledge is limited. Continuous educational campaigns are mandatory. For instance, the requested implementation of various educational programs in the community could serve this purpose. Recommendations can additionally consist of information on disclosure of HIV and AIDS status, which might lessen stigma and discrimination.

The study therefore concludes that continuous educational campaigns are mandatory, for instance, the requested implementation of various educational programs in the community could serve this purpose.

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## ANNEXURE A: PILOT STUDY

The pilot study is described as a pretesting of a measuring instrument consists of carrying out all aspects of the total data collection on a small scale. The pilot study will be conducted with three research participants who meet sample inclusion criteria. The two participants will be excluded from the research study.

The researcher conducted this pilot study on the 2nd of August 2019 to three participants, two males and one female, aged 23, 18, & 25 respectively. The pilot study aimed at assisting in refinement and checking if the interview guide will deliver trustworthy results. The table below are the questions and answers between the interviewer and the participants.

NB: during the conduction of the interview changes emanated while conduction the interview and fortunately the changes in the interview guide were identified during interview of the 1st participants. Question 8 in the interview guide was added with 'how did your life changed when you contracted HIV?'

### BIOGRAPHICAL DETAILS OF THE PILOTED PARTICIPANTS

**Table research Piloted participants**

| Participant | Ethnicity | Age | Gender | Marital status | Level of educational | Residence | Language | Status of Employment | Main sourc of incon |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Black | 23 | Male | Single | Passed grade 12 | Ngqeleni Rural | IsiXhosa | Not employed | No incon |
| 2 | Black | 18 | Male | Single | Failed grade 9 | Libode Rural | IsiXhosa | Not employed | No incon |
| 3 | Black | 25 | Female | Single | Failed grade 11 | Libode Rural | IsiXhosa | Not employed | Child Gran |

**Objective1: To describe knowledge and attitude regarding HIV and AIDS among youth 18-25 years.**

**1. Understanding of difference between HIV and AIDS**

Participant 1 & 2 (67%) responded to show understanding of difference between HIV and AIDS, whereas participant 2 seems to have little understand of the difference between the two terms.

The participants' responses:

Participant 1: *"HIV is a virus that is transmitted through bodily fluid and HIV positive blood, then AIDS is a combination of diseases that arise when you do not take treatment to suppress the HIV*"

Participant 2: *"You get HIV from the person who has it. AIDS you get it from the infected blood of a person".*

Participant 3: *"AIDS is a disease that attacks the body, leaving it very weak on its own, whereas HIV is a virus that is infection during unprotected sex".*

**2. How well are you informed about HIV can be transmitted?**

One (33%) participant responded to be well informed about HIV transmission and two (67) participants responded to know little about how HIV can be transmitted.

The participants' responses:

Participant 1: *"I am informed enough to avoid HIV transmission"*

Participant 2: *"a little, but I know there are many it's just I know enough for me to protection every time I have sex".*

Participant 3: *"a little"*

**2.1 Probing: Can you share with me how HIV can be transmitted?**

One (33%) participant responded to have mentioned various ways of HIV transmission and two (67%) participants responded with limited knowledge of HIV transmission.

The participants' responses:

Participant 1: *"HIV is conveyed during unprotected sex, HIV positive mother during birth process, infected blood in the cut in the hand or anywhere in the body"*

Participant 2: *"when having unprotected sex i.e. without a condom. Touch infected blood while having a cut. Eating with an unwashed hand which touched infected blood".*

Participant 3: "*You can get HIV when you are careless by not using a condom and also by touching a person whose blood is HIV positive"*

**3. What is your perceptions regarding HIV and AIDS?**

All three (100%) participants responded with relevant information about their opinions on HIV and AIDS. this shows that the participants are not arrogant about HIV and AIDS but have attitudes that are positive. Participant 3 was even concerned about the delay that is taking to find the cure for the disease.

The participants' responses were as follows:

Participant 1: *"you can die from AIDS if you are ignorant, an individual can remain HIV positive for more twenty years in nowadays because of ARV treatment that is available to anyone"*

Participant 2: *"HIV kills but it takes long to kill you, a member from my family had HIV and was eating treatment from the clinic, though he died by car accident".*

Participant 3: *"I think this disease is stubborn, I do not know why it takes this long to come up with the cure, unlike TB even though the cure took some time to be found. There are still people who are cruel and continue to discriminate HIV positive people".*

**Objective 2: To explore sexual risky behaviour among youth from Nyandeni Local Municipality.**

**4. Are you at risk of contracting HIV, If Yes Why? If No, Why?**

One (33%) participant responded **yes** to be at risk stating that he can get HIV infected in other ways besides sex. Another participant (33%) responded to **not knowing** as he can be at risky or not at risky. This refused to dwell further for reason of not being sure.

Participant 3 (33%) responded **No**, explaining that she is afraid of getting it and she uses a condom every time she has sex, there was only one time she did not use a condom was because her partner was abusive and forced her to have sex but she reported him to her family and was threatened by opening a case in the police station and they broke up after that.

The participants' responses:

Participant 1: *"Yes, because I can get HIV infected in other ways besides sex"*

Participant 2: *"I do not know, I might be at risk or not at risk, I do not want to reply to this question, move to another one if there is any".*

Participant 3: *"No, because I am afraid of getting it and I use protection during sexual contact, there was only one time that I did not use protection because my partner was abusive, he forced me to have sex but I reported him to my family and was threatened by opening a case in the police station and we broke up after that"*

**5. What is your understanding of sexual risk?**

All three (100%) participant stated their different understanding of sexual risk, though participant 2 did not explain in deeper understand which leaves the researcher to assume that the participant has little understanding of sexual risk.

The participants' responses:

Participant 1: *"sexual risk behaviour is when you are careless and have sex without a condom, drinking too much to the extent that you can be raped".*

Participant 2: *"getting HIV, impregnating a girl".*

Participant 3: *"When you do things that put you at risk of contracting sexual transmitted diseases".*

**6. What can influence you to engage in sexual risky behaviour?**

The three participant responded with difference explanations, which were:

Participant 1 *"when I am drinking with friends, I turn to have that urge of having sex and in the tavern that I usually go at, there are girls who secretly have sex for money but are unknown by most community members sick they hide it".*

Participant 2 *"peer pressure, though I always standup for myself, I do not like to be told what to do especially by my friends".*

Participant 3 *"if I get raped while partying with my friends because all of us party hard and are hard drinkers but nothing of sort have happened yet".*

**7. What is your perception about condom use?**

Participant 1 responded scarcity of condoms in hi area. Participant 2 expressed concerns of condom break but emphasises right knowledge of putting it on.

Participant 3 stated that using protection all the time is hard to maintain, blaming the duration of the relationship.

The participants responded as follows:

Participant 1: *"Condoms are a life saver, though they are scarce in my area and the clinic is far, I make sure that when I visit the clinic for when I have a fever I take as much as I want buy they always run out fast because of my friends who asked for the".*

Participant 2: *"even though it prevents unwanted pregnancies and disease it has its own disadvantages like when it breaks in the middle of action, a person must sure she/he knows the right way of wearing it".*

Participant 3: *"condoms are safe but sometimes it is hard to maintain condom use when in a long relationship because a man will want to stop once the relationship is more than three months old, that what's usually happens to me, but I try not to give in".*

**7.1 Probing: Do you think the spread of HIV can be lessened by using condoms or protection?**

Two (67%) participants responded **yes** and one (33%) responded **no.** All three participants did not provide reasons for their responses except for participant 2 who explain his response as follows:

Participant 2: "*it can but since our clinic is far I wish the shops in our area could stop selling us government condoms and gives for free"*

**8. How will your life change if you contract HIV or how did your life changed when you contracted HIV?**

Two (67%) participants expressed their emotions as angry and worried and one (33%) participants expressed feelings of acceptance.

The participants responded as follows:

Participant 1: "*I would be angry and feel like God could take me sooner, HIV even AIDS is like a death punishment because people are still dying even though they take the ARV treatment".*

Participant 2: *"I would be very worried of people gossiping about me and my status, but I would learn to ignore and eating treatment as soon as I test positive".*

Participant 3: *"HIV is a disease that we can live with because now there are various treatments and I believe the cure is close to being found, I would keep myself as healthy as possible so that when the cure is found I am ready to take it".*

**Objective 3: To discuss implementation campaigns or strategies that can be used to reduce the spread of HIV among the youth at Nyandeni Local Municipality.**

**9. What is it that you can do to lower the risk of contracting HIV?**

Two (67%) participants responded the priority of condom use and knowledge whereas one (33%) participant's response was to form an educational organisation.

The participants responded as follows:

Participant 1: *"I think I would form an organisation in my community that specifically involve the youth and be taught ways of surviving the disease".*

Participant 2: *"to make where I go I have a condom even sharing the importance of using a condom with my peers".*

Participant 3: *"I wish for distribution of condoms in my community, there should be an organisation that deals with HIV issues so that condoms are taken there instead of having to travel to clinics and hospitals to get them".*

**9.1 Probing: Can having one sexual partner reduce the spread of HIV?**

Two (67%) participants responded **No** and one (33%) responded **yes.** All three participants provided reasons for their responses as follows:

Participant 1: *"No" cheating is a fashion in this era even presidents and people in high places are having scandals on social media and mind you these people are married".*

Participant 2: *"No it does not help having one partner because one of you is always a cheater"*

Participant 3: *"Yes, because I have one partner myself and I trust him".*

**10. Which programs/strategies ought to be implemented to lessen the spreading of HIV in Nyandeni Local Municipality?**

All three (100%) responded to have the need for educational organisations that would teach about HIV and AIDS, substance abuse. Though participant 2 wanted the education on HIV and AIDS to be place to the youth that is not schooling.

Participant 1: *As I have said before I want an organisation that will teach the youth about HIV and AIDS".*

Participant 2: *"Just like in my school there should be HIV and substance abuse education in my community because there is youth which is not schooling that needs to be educated".*

Participant 3: "In our community we as youth need an organisation that will deal with HIV issues".

**9. WHO should be involved in the programs?**

All participants responded that the youth be involved, and participant 3 wanted elders to part of such educational activities.

Participant 1: *"Us the youth should be involve, there must be also professionals from outside our community so that we are able to share our private information with them".*

Participant 2: *"The youth in my community especially those who are living with HIV so that they could guide and teach us to be more aware".*

Participant 3: *"Both the youth and elders should form part of the talks and teaching because the elders can give us hard times at times so must be keep up-to-date of the HIV development".*

**Challenges identified during the interview session piloted participants**

- Question 8 needed to be explained thorough, the researcher to elongate the question for clarity.
- Question 8 before elongation: How will your life change if you contract HIV?
- Question 8 amended: How will your life change if you contract HIV or how did your life changed when you contracted HIV?

The researcher decided to use the isiXhosa interview guide because all participant including piloted participate showed more participation when asked in Xhosa language is their home language. This means that in the thirty (30) participant the English version of the interview guide was not used.

**Successes identified during the interview sessions**

- The interview session was thought to be 45 minutes long for each interview, but all three participants each too between 15 to 20 minutes and almost to the interview session held no interview session took over 20 minutes.
- No interviewer showed bored during the interviews.
- All the participants showed interest during introduction of the interview session, participant three even asked inquisitive question and the researcher gave an honest answer to her question.
- Though all participants showed nervousness in the begin of interview, they became relaxed once question 1 was answered and the researcher made sure to them all that if they prefer, they add in the previous question if anything comes to their mind again.

The pilot study results were fruitful and with the amendment of question 8, the researcher concluded that the interview guide can be utilised for data collection.

**ANNEXURE B LETTER TO NYANDENI COMMUNITY CHIEF**

No. 7 Koyana street

Mbuqe park

Mthatha

5099

Chief Ndamase

Nyandeni Great Place

libode

5160

Dear Sir/Madam

My name is Lorraine Nokuthula Mntonintshi. I have registered for MA (Social Behavioural Studies in HIV/AIDS), Department of Sociology, University of South Africa. I the researcher, hereby cordially apply for permission to conduct my research at your organization, which has been selected as a suitable research site as it meets both sampling profile and the research topics core variables in respect of youth.

The research topic is titled, "Exploration of knowledge, attitudes to HIV and sexual risk behaviour among 18-25-year-old youth at Nyandeni Local Municipality in the Eastern Cape Province". The fieldwork aspect of my study entails the identification and selection of 18-25-year-old youth.

**The criteria for inclusion in a sample will be that the person:**

- Must be living in Nyandeni Municipality either at Libode or Ngqeleni.
- Female and males between the age of 18 and 25.
- Should be willing and available to participate in the study without compensation.

- Should give informed consent to participate in the study and that the interview may be recorded on audio.

**The criteria for exclusion is as follows:**

- Female and males below the age of 18 and above 25 years' old
- Anybody not meeting the above mentioned inclusion criteria

The 30 sampled youth will participate in 45 minutes long face to face interview session. The data collection instrumentation includes an audio recorder and an interview guide. All rights relating to research participants in the study will be thoroughly explained to the participants and strictly maintained by the researcher. The researcher will also provide details of her academic supervisor for reporting of any unprofessional conduct on the part of the researcher.

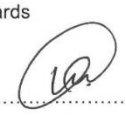
All the findings will be formally documented, and preliminary report will be presented to you; after which a feedback session will be held with the research participants to check whether or not the study results reflects their written or oral input. The researcher will provide one copy to your organization for its institutional memory and appreciation of your client's involvement in this exegetic exercise.

Should you have any questions or concerns regarding the interview process and the study or if any problems arise from this study- please feel free to contact the researcher, Lorraine Nokuthula Mntonintshi at **065 717 4545**, or email me nokuthula. mntonintshi@gmail.com

Your response in the above regard is highly appreciated and any further clarification will be honestly responded to by the researcher.

Thanking you in anticipation

Regards



..... Date: 01/08/2014

Lorraine Nokuthula Mntonintshi

## ANNEXURE C: KING NDAMASE APPROVAL TO CONDUCT RESEARCH

**ANNEXURE C** KING NDAMASE APPROVAL TO CONDUCT RESEARCH

To the Researcher

**RE: EXPLORATION OF KNOWLEDGE, ATTITUDES TO HIV AND SEXUAL RISK BEHAVIOUR AMONG 18-25-YEAR-OLD YOUTH AT NYANDENI LOCAL MUNICIPALITY IN THE EASTERN CAPE PROVINCE**

I Ndamase N.M. Ndamase .....of Nyandeni Municipality (Western Mpondoland) hereby grant permission for Ms. L.N Mntonintshi-Mketo to gain access to my community and conduct her research studies by interviewing the 30 participant desired for her study to be completed.

Kindly be informed that:

- After completion of the study, I request that I be informed of the final outcome of the study which are the finding and recommendations.

**KING NDAMASE NDAMASE**
**NYANDENI MUNICIPALITY**

01/08/2019
**DATE**

.....

STAMP
Western Mpondoland
King N.M. Ndamase Signature
kingndamase@gmail.com

## ANNEXURE D: PARTICIPANT INFORMATION SHEET

UNISA university of south africa

*ANNEXURE D*

**PARTICIPANT INFORMATION SHEET**

Ethics clearance reference number:

Research permission reference number (N/A):

Date : 05/08/2019

**TITLE: EXPLORATION OF KNOWLEDGE, ATTITUDES TO HIV AND SEXUAL RISK BEHAVIOUR AMONG 18-25-YEAR-OLD YOUTH AT NYANDENI LOCAL MUNICIPALITY IN THE EASTERN CAPE PROVINCE**

**Dear Prospective Participant**

My name is Lorraine Nokuthula Mntonintshi I am doing research with Dr. T.R. Netangaheni, a Senior Lecturer in the Department of Sociology towards a MA degree at the University of South Africa. We are inviting you to participate in a study entitled **Exploration of knowledge, attitudes to HIV and sexual risk behaviour among 18-25-year-old youth at Nyandeni Local Municipality in the Eastern Cape Province**

**WHAT IS THE PURPOSE OF THE STUDY?**

The aim of this study is two-fold. Firstly, to explore the knowledge, attitudes and behaviour of the youth between the ages of 18-25 in the OR Tambo Nyandeni Local Municipality at Eastern Cape Province in order to identify their current level of knowledge of risky sexual behaviour. Secondly, to provide recommendations for future education programmes as preventative measure. Furthermore, the findings from the study will assist local NPOs that specifically deal with HIV and AIDS programs during their program revisions and implementations. The expected duration of the interview is 45 minutes.

**WHY AM I BEING INVITED TO PARTICIPATE?**

You have been selected for the study to form part of a sample size of thirty (30) youth from 18-25 years of age from Nyandeni Local Municipality. Before you participate in this study, you will be provided a consent form, which you will have to sign voluntarily before the data collection as proof of your willingness to participate in the study.

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

**WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?**

Your participation will involve an interview, which will be tape-recorded. The reason for recording the interview is that the researcher would be able to transcribe and analyze the data in depth, which will result in more detailed data for the purpose of this study. There will also be follow-up questions during the interviews. The University of South Africa had granted the research ethical approval, which means the study will comply with the code of ethics of scientific research on human participants.

**CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?**

In this study, you have a right to independent decision without any form of coercion whether or not to participate. Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason. You will not be victimized or disadvantaged

from any benefits and activities happening in their community. You have a have a right to withdraw from the study at any time and have a right to ask any questions if you so wish.

**WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?**

There is no reimbursement offered to participate in this study, however there are possible benefits to taking part in this study. Your participation in this research study fully and honestly will assist in making your voice and concerns heard by your local sector systems like Social Development. The researcher will share the findings from the study with you first then go on to share with the Local NPOs that are initiated and funded by the Department of Social Development in the Nyandeni Local Municipality during program revisions and implementations as the personal views of respondents would have been documented on the findings of the final thesis/ dissertation.

**ARE THEIR ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?**

Even though there are, no anticipated risks harm you. The only potential but minor harm will that of discomfort or inconvenience during answering of the questionnaire. If in any way, you feel any discomfort you are allowed to withdraw from the study but be assured that your identity remains anonymous. Your anonymity and confidentiality of the information you provide will remain confidential and anonymous to the researcher and other people. If you feel thirsty and tired, bottled water will be provided to you.

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Preller Street, Muckleneuk Ridge, City of Tshwane
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**WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?**

All the collected information will be kept in a lockable cabinet in either the researcher's home office or work office. The electronic data will be secured by the use of the created password by the researcher and will be known by the researcher and third party such as a trained assistant researcher and the members of the Research Ethics Review Committee. Your identity will not be known with regard to your participation in the research study and the researcher cannot link you to your data. In this study, anonymity will be ensured by using numbers on the data collection instrument instead of respondents' names. This means that the researcher will create coding by numbers, which will be used on the questionnaire. Your anonymous data will be used in the research report only. The research report might then be submitted for publication but you will not be identifiable in it.

**HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?**

The researcher will store your recorded answers from the interview guide for a period of 5 years hence the researcher might be interested in conduction or doing similar research in your Area or community to see if there any changes the findings of the study. Your answers will be securely stored in a locked cabinet in the researcher home office for future research purposes. The electronical information will be stored on a password-protected computer. Furthermore, future use of the stored data will be subject to further Research Ethics Review and approval if applicable. When the five-year period has expired, destroy your answers. Electronic information will be permanently deleted from the hard drive of the computer through the use of a relevant software programme.

**WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?**

There is no compensation offered to participate in this study.

**HAS THE STUDY RECEIVED ETHICS APPROVAL?**

This study has received written approval from the Research Ethics Review Committee of the College of Human Science at UNISA. A copy of the approval letter can be obtained from the researcher if you so wish.

**HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?**

If you would like to be informed of the final research findings, please contact Lorraine Nokuthula Mntonintshi on 084 5287726, E-mail address: Nokuthula.mntonintshi@gmail.com. The findings

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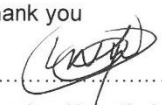
might be accessible by December 2019 or January 2020 but feel free to check the researcher using the contact details provided to check if they are accessible.

Should you require any further information or want to contact the researcher about any aspect of this study, please contact 084 5287726, E-mail address: Nokuthula.mntonintshi@gmail.com

Should you have concerns about the way in which the research has been conducted, you may contact the researchers' supervisor at 0761895087 or 0124296720, E-mail address: robert.netangahe@gmail.com . Contact the research ethics chairperson of the Research Ethics Review Committee of the College of Human Science at UNISA, Tel: +2712 429 2055 Fax: 0866184983, mathama@unisa.ac.za & creccom@unisa.ac.za if you have any ethical concerns.

Thank you for taking time to read this information sheet and for participating in this study.

Thank you



.....

Lorraine Nokuthula Mntonintshi

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

## ANNEXURE E: CONSENT TO PARTICIPATE

Male
21 yrs
Unisa 1st year
Single

Nyakeleni
Xhosa
No children
Not employed

UNISA university of south africa

10

**ANNEXURE E**

**CONSENT TO PARTICIPATE IN THIS STUDY**

I, M (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the answering of the questionnaire.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname M (please print)

Participant Signature ..... Date 05/08/2019

Researcher's Name & Surname L.N MNTONINTSHI (please print)

Researcher's signature ..... Date 05/08/2019

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**ANNEXURE E**

**CONSENT TO PARTICIPATE IN THIS STUDY**

I, _____ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

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I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the answering of the questionnaire.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname..... (please print)

Participant Signature.....Date.....

Researcher's Name & Surname..... (please print)

Researcher's signature..... Date.....

University of South Africa
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# ANNEXURE F: LETTER TO ORGANISATION

**ANNEXURE F** **LETTER TO ORGANISATIONS (Philisa Home Care Based Centre based)**

No. 7 Koyana street

Mbuqe park

Mthatha

5099

NPO Board of Management

Ngqeleni

Dear Sir/Madam

My name is Lorraine Nokuthula Mntonintshi. I have registered for MA (Social Behavioural Studies in HIV/AIDS), Department of Sociology, University of South Africa. I the researcher, hereby cordially apply for permission to conduct my research at your organization, which has been selected as a suitable research site as it meets both sampling profile and the research topics core variables in respect of youth.

The research topic is titled, "Exploration of knowledge, attitudes to HIV and sexual risk behaviour among 18-25-year-old youth at Nyandeni Local Municipality in the Eastern Cape Province". The fieldwork aspect of my study entails the identification and selection of 18-25-year-old youth.

**The criteria for inclusion in a sample will be that the person:**

- Must be living in Nyandeni Municipality either at Libode or Ngqeleni.
- Female and males between the age of 18 and 25.
- Should be willing and available to participate in the study without compensation.

- Should give informed consent to participate in the study and that the interview may be recorded on audio.

**The criteria for exclusion is as follows:**

- Female and males below the age of 18 and above 25 years' old
- Anybody not meeting the above mentioned inclusion criteria

The 30 sampled youth will participate in 45 minutes long face to face interview session. The data collection instrumentation includes an audio recorder and an interview guide. All rights relating to research participants in the study will be thoroughly explained to the participants and strictly maintained by the researcher. The researcher will also provide details of her academic supervisor for reporting of any unprofessional conduct on the part of the researcher.

All the findings will be formally documented, and preliminary report will be presented to you; after which a feedback session will be held with the research participants to check whether or not the study results reflects their written or oral input. The researcher will provide one copy to your organization for its institutional memory and appreciation of your client's involvement in this exegetic exercise.

Should you have any questions or concerns regarding the interview process and the study or if any problems arise from this study- please feel free to contact the researcher, Lorraine Nokuthula Mntonintshi at **065 717 4545**, or email me nokuthula. mntonintshi@gmail.com

Your response in the above regard is highly appreciated and any further clarification will be honestly responded to by the researcher.

Thanking you in anticipation

Regards

.....

Date: 01/08/2019

Lorraine Nokuthula Mntonintshi

## ANNEXURE G: APPROVAL TO CONDUCT RESEARCH

PHILISA HOME CARE BASED CENTRE

**ANNEXURE G**

To whom it may concern

**RE: APPROVAL TO CONDUCT RESEARCH**

Following a consultation by **Ms. Mntonintshi L.N** to the Philisa Home Care Based Centre that was held on the 26/07/2019, I _____ (Board Management chairperson) hereby grant approval for Ms. Mntonintshi to conduct her research interviews to the project beneficiaries.

The Title of her research study is:

**EXPLORATION OF KNOWLEDGE, ATTITUDES TO HIV AND SEXUAL RISK BEHAVIOUR AMONG 18-25-YEAR-OLD YOUTH AT NYANDENI LOCAL MUNICIPALITY IN THE EASTERN CAPE PROVINCE**

Kindly inform the Philisa Home Care Based Centre of any recommendations that mighty be helpful in the smooth running of the project.

**Board Management chairperson**
**Philisa Home Care Based Centre**

07/08/2019
**Date**

Insert Footer Here

*Building a Caring Society. Together.*

## ANNEXURE H: LETTER TO NOMPILO M.U. HOME CARE BASED

**ANNEXURE H LETTER TO ORGANISATIONS (Nompilo M U Home Care Based Centre project)**

No. 7 Koyana street

Mbuqe park

Mthatha

5099

NPO Board of Management

Libode

Dear Sir/Madam

My name is Lorraine Nokuthula Mntonintshi. I have registered for MA (Social Behavioural Studies in HIV/AIDS), Department of Sociology, University of South Africa. I the researcher, hereby cordially apply for permission to conduct my research at your organization, which has been selected as a suitable research site as it meets both sampling profile and the research topics core variables in respect of youth.

The research topic is titled, "Exploration of knowledge, attitudes to HIV and sexual risk behaviour among 18-25-year-old youth at Nyandeni Local Municipality in the Eastern Cape Province". The fieldwork aspect of my study entails the identification and selection of 18-25-year-old youth.

**The criteria for inclusion in a sample will be that the person:**

- Must be living in Nyandeni Municipality either at Libode or Ngqeleni.
- Female and males between the age of 18 and 25.
- Should be willing and available to participate in the study without compensation.

- Should give informed consent to participate in the study and that the interview may be recorded on audio.

**The criteria for exclusion is as follows:**

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The 30 sampled youth will participate in 45 minutes long face to face interview session. The data collection instrumentation includes an audio recorder and an interview guide. All rights relating to research participants in the study will be thoroughly explained to the participants and strictly maintained by the researcher. The researcher will also provide details of her academic supervisor for reporting of any unprofessional conduct on the part of the researcher.

All the findings will be formally documented, and preliminary report will be presented to you; after which a feedback session will be held with the research participants to check whether or not the study results reflects their written or oral input. The researcher will provide one copy to your organization for its institutional memory and appreciation of your client's involvement in this exegetic exercise.

Should you have any questions or concerns regarding the interview process and the study or if any problems arise from this study- please feel free to contact the researcher, Lorraine Nokuthula Mntonintshi at **065 717 4545**, or email me nokuthula. mntonintshi@gmail.com

Your response in the above regard is highly appreciated and any further clarification will be honestly responded to by the researcher.

Thanking you in anticipation

Regards

Date: 01/08/2019

Lorraine Nokuthula Mntonintshi

# NOMPILO M.U HCBC PROJECT

**ANNEXURE I**

Dear Researcher

**RE: APPROVAL TO CONDUCT RESEARCH**

I Phumza Madolo (Board Management chairperson) on behalf of Nompilo M.U HCBC Project hereby grant approval for the researcher to conduct her research interviews to the project beneficiaries.

The Title presented for the research study is as follows:

**EXPLORATION OF KNOWLEDGE, ATTITUDES TO HIV AND SEXUAL RISK BEHAVIOUR AMONG 18-25-YEAR-OLD YOUTH AT NYANDENI LOCAL MUNICIPALITY IN THE EASTERN CAPE PROVINCE**

Furthermore, the NPO or Project would very much appreciate if they could be informed of the results including the recommendations provided.

N.P. Madolo
**Board Management chairperson**
**Nompilo M.U HCBC project**

01/08/2019
Date

NOMPILO M U HCBC
ST. BARNABAS MISSION
P.O. BOX 23
NTLAZA, 5114
SIGN: N.P. Madolo

**ANNEXURE J : LETTER TO DEPARTMENT OF SOCIAL DEVELOPMENT**

No. 7 Koyana street

Mbuqe park

Mthatha

5099

Area Manager

Department of social development

Nyandeni (Libode Area Office)

5160

Dear Sir/Madam

My name is Lorraine Nokuthula Mntonintshi. I have registered for MA (Social Behavioural Studies in HIV/AIDS), Department of Sociology, University of South Africa. I the researcher, hereby cordially apply for permission to conduct my research at your organization, which has been selected as a suitable research site as it meets both sampling profile and the research topics core variables in respect of youth.

The research topic is titled, "Exploration of knowledge, attitudes to HIV and sexual risk behaviour among 18-25-year-old youth at Nyandeni Local Municipality in the Eastern Cape Province". The fieldwork aspect of my study entails the identification and selection of 18-25-year-old youth.

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- Female and males between the age of 18 and 25.
- Should be willing and available to participate in the study without compensation.

- Should give informed consent to participate in the study and that the interview may be recorded on audio.

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The 30 sampled youth will participate in 45 minutes long face to face interview session. The data collection instrumentation includes an audio recorder and an interview guide. All rights relating to research participants in the study will be thoroughly explained to the participants and strictly maintained by the researcher. The researcher will also provide details of her academic supervisor for reporting of any unprofessional conduct on the part of the researcher.

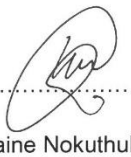
All the findings will be formally documented, and preliminary report will be presented to you; after which a feedback session will be held with the research participants to check whether or not the study results reflects their written or oral input. The researcher will provide one copy to your organization for its institutional memory and appreciation of your client's involvement in this exegetic exercise.

Should you have any questions or concerns regarding the interview process and the study or if any problems arise from this study- please feel free to contact the researcher, Lorraine Nokuthula Mntonintshi at **065 717 4545**, or email me nokuthula. mntonintshi@gmail.com

Your response in the above regard is highly appreciated and any further clarification will be honestly responded to by the researcher.

Thanking you in anticipation

Regards



..... Date: 01/08/2019

Lorraine Nokuthula Mntonintshi

Province of the
EASTERN CAPE
SOCIAL DEVELOPMENT

10th Floor – Botha Sigcau Building – Private Bag X6000 – MTHATHA -5099-REPUBLIC OF SOUTH AFRICA
Tel : (047) 532 6588; Fax : :(047) 532 4554 ; *Website: www.socdev.gov.za

**ANNEXURE K** :: APPROVAL TO CONDUCT RESEARCH

Greetings Principal Researcher

**RE: EXPLORATION OF KNOWLEDGE, ATTITUDES TO HIV AND SEXUAL RISK BEHAVIOUR AMONG 18-25-YEAR-OLD YOUTH AT NYANDENI LOCAL MUNICIPALITY IN THE EASTERN CAPE PROVINCE**

The above matter refers:

1. Permission to conduct the above mentioned study is hereby grant.
2. Kindly be informed that:
   - Further arrangement should be made with the target NPOs.
   - In the course of your study there should be no action that disrupts the NPO services.
   - After completion of the study, a copy should be submitted to the Department to serve as a resource.
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation were possible.

MRS V.N. TITUS
DISTRICT DIRECTOR: OR TAMBO

2019.8.1
DATE

# ANNEXURE I: INTERVIEW GUIDE

**ANNEXURE L: INTERVIEW GUIDE**

BACKGROUND INFORMATION

This section of the interview guide refers to the background or biographical information will allow us to compare groups of participants.

Once again, you are assured that your response will remain anonymous. Your cooperation is appreciated. The researcher will spend plus / minus 45 minutes with the participant during the interview.

Gender.....

Age.....

Ethnicity.....

1. What is your understanding of the difference between HIV and AIDS?
2. In your own opinion, how well are you informed about HIV can be transmitted?
   Probe: Can you share with me how HIV can be transmitted?
3. What is your perceptions regarding HIV and AIDS?
4. Do you consider yourself to be at risk of contracting HIV, If Yes Why? If No, Why?
5. What is your understanding of sexual risk?
6. What can influence you to engage in sexual risky behavior?
7. What is your perception about condom use?
   Probe: Do you think that the spread of HIV can be reduced by using condoms or protection?
8. How will your life change if you contract HIV or how did your life change when you contracted HIV?
9. What is it that you can do to lower the risk of contracting HIV?
   Probe: Can having one sexual partner reduce the spread of HIV?
10. Which programmes/strategies should be implemented to reduce the spread of HIV in Nyandeni Local municipality?
11. . Who should be involved in the programmes?

This is the end of the interview.

Thank you for participating in the study your time is highly appreciated

**ISIHLOMELO L: ISIKHOKHELO SODLIWANO-NDLEBE**

IMVELAPHI

Elicandelo lodliwano-ndlebe lubhekisele kulwazi olungancedisa ukuthelekisa abathathi nxaxheba.

Kwakhona, uyaqinisekiswa ukuba impendulo zakho zohlala ziyimfihlelo. Intsebenziswano yakho ingathakazeleka kakhulu. Umphandilwazi uzothatha imizuzu emane nesihlanu ukuqhuba oludliwanondlebe.

Isini : .....

Ubudala: .....

Ibala .....

1. Wazi kangakanani ngomahluko phakathi kwentsholongwane kaGawulayo nGawulayo?
2. Ngokolwakho uluvo, unolwazi olingakanani nggolosuleleko yintsholongwane kaGawulayo?
   2.1 ungakhe nje undixelele ukuba intsholongwane kaGawulayo isulela kanjani?
3. Zithini ezakho imbono malunga nentsholongwane kaGawulayo noGawulayo?
4. Ingaba uzibona wena usemngci[hekweni wokosuleleka yintsholongwane kaGawulayo, ukuba Ewe kutheni usitsho njalo, ukuba Hayi kutheni usitsho njalo?
5. Wazi ntoni ngokuba sengozini ngokesondo?
6. Yintoni engakuphembelela ukuba uziphathe ngokungaqhelekanga uzifake ebungozini besondo.
7. Zithini imbono zakho ngokusebenzisa ikhondom?
   7.1 xa uzicingela ingaba usasazeko lwentsholongwane kaGawulayo lungehliswa ngokusebenzisa ikhondom xa uzukhusela?
8. Ubom bakho bungatshintsha njani xa unokosuleleka yintsholongwane kaGawulayo okanye ubom bakho batshintsha njani ukufumanisa ukuba unentsholongwane kaGawulayo?
9. Ungenza njani ukunciphisa ulosuleleko lentsholongwane kaGawulayo?
   9.1 ingaba uba neqabane elinye lungehlisa usasazeka lwentsholongwane kaGawulayo?
10. Yeyiphi inkqubo yenguqu engenziwa ukuncedisa ukwehlisa ukusasazeka kwentsholongwane kaGawulayo apha kuMasipala waseNyandeni.
11. Ngubani ocinga ukuba angangenelela abenxalenye kwinkqubo nguqu ozinqwenelayo?

Isiphelo sodliwanindlebe

Umbulelo ongazenzisiyo ngokuthatha inxaxheba nexesha othe walichitha kolodliwanondlebe.

**ANNEXURE M**

UNISA university of south africa

## COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

30 April 2019

NHREC Registration # :
Rec-240816-052
CREC Reference # : 2019-CHS-Depart- 43291589

Dear Lorraine Nokuthula Mtonishi

**Decision:**
**Ethics Approval from 30 April 2019 to 01 May 2023**

**Researcher(s): Lorraine Nokuthula Mtonishi**

**Supervisor(s): Dr T.R.Netangaheni**

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**Exploration of knowledge, attitudes to HIV and sexual risk behaviour among 18-25 year old youth at Nyandeni Local Municipality in the Eastern Cape Province**

**Research Project: Master of Arts in Sociology**

Thank you for the application for research ethics clearance by the Unisa Department of Sociology College of Human Science Ethics Committee. Ethics approval is granted for three years.

The ***High application*** *was* ***reviewed and*** **expedited** by Department of Sociology College of Human Sciences Research Ethics Committee, on the 31 January 2019 in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.

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2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the Department of Psychology Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.
5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
7. No fieldwork activities may continue after the expiry date (**01 May 2023**). Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

*Note:*

*The reference number* **2019-CHS--Depart-43291589** *should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.*

Yours sincerely,

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