Is This Development and Freedom? Managing Sex Risk Behaviour in the Era of HIV and AIDS at a University in South Africa

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This study explored HIV risk perception of university students. A descriptive study design amongst a convenience sample of registered students at the Nelson Mandela Metropolitan University (NMMU), who gave voluntary informed consent to participate, and with access to the student portal was employed. Frequencies and percentages were used to describe categorical data. The Pearson correlation co-efficient (r) and Spearman's rank co-efficient were used to measure the strength or degree of the relationship between variables and identify the significance of the correlation between two variables respectively. Results indicate that males in the sample ($n = 619$) are more likely to acknowledge self-perceived risk than females. This paper concludes that management strategies should be put in place in all universities in order to help the students stay HIV negative. Unless HIV and AIDS are institutionalised, the management of risk behaviour will prove difficult.

Keywords: HIV and AIDS, risk-behaviour, university students, social norms theory, educational management

Introduction

As the future of HIV and AIDS pandemic hangs in the balance, the global efforts to fight the challenges of the disease are unprecedented. To date, there is no known cure for HIV and AIDS. Yet evidence of risk-behaviour practices among the young generation shows no sign of improvement, despite high level of awareness about the dangers of HIV and AIDS. This is a grave revelation when the complexity of the issue is compounded when facts state that HIV infections are particularly high among 15 to 49 years cohorts (Mutinta, Governder, Gow, & George, 2012; Makuwira, Chigwedere, Bisika, & Manyozo, 2014; WHO, UNICEF, and UNAIDS, 2010). Of particular significance is the fact that this is a cohort that constitutes university-going students. For example, the proportion of students who are sexually active at Nelson Mandela Metropolitan University (NMMU) is notably high in comparison with other South African universities, although only a small

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proportion of registered students at the Nelson Mandela Metropolitan University (NMMU) are living with HIV. Reports prior to 2014 indicated that more than 30% of both males and females have had multiple sexual partners. Reports also show that sexually transmitted infections (STIs) among NMMU students are significantly high and this may increase risk of HIV infection (Higher Education HIV and AIDS Programme [HEAIDS], 2010). This trend seems to continue at NMMU as indicated by findings from an online survey (n = 619) during 2014. Of greater concern is the irresponsible behaviour despite the presence of condoms and awareness campaigns. Steenkamp, Dickstein, Salters-Pedneault, Hofmann, and Litz (2012) reported that 50% of the sample have used a condom during the last time of sexual intercourse. Results with regards to multiple sexual partners and inconsistent condom use are similar to reports from other universities in South Africa (Ntata, Muula, Siziya, & Kayambazinthu, 2008) and most western countries (Adefuye, Abiona, Balogun, & Durrell, 2009).

Macintyre, Rusternberg, Brown, and Karim (2004) stated that risk behaviour among students is characterized by the underestimation of personal risk. That is the perception that HIV infection is only a distant possibility. Social-cultural dynamics in South Africa context with students from diverse cultural and social backgrounds on campus are equally drivers of risk behaviour (Reddy & Frantz, 2011). For instance, a study done at the University of the Western Cape by Shefer, Strebel, and Jacobs (2012) among university students revealed normative gender roles and gender inequalities, socio-economic challenges, differences in age, and status as well as HIV and AIDS fatigue as obstacles to behaviour change. Therefore, measures must be put in place for the students who are at risk of being infected with HIV. Many as condoms are supplied to students on campus, it is common knowledge that women have no control over the use of condoms, in our patriarchal communities men do as they please. The individual must also make a conscious decision to use a condom and women should be empowered to make a firm stand on the use of condoms.

Literature Review

Recent representative surveys done in South Africa have found that HIV prevalence is around 15%-16% in woman aged 15-24, compared with less than 5% among man, and among woman aged 20-24, prevalence is between 20%-25%. High risk sexual behaviour increases with age and class is significantly higher among females than males (Human Sciences Research Council, 2014). Condom use together with the general knowledge of STIs is low among adolescents (Fennie & Laas, 2014). In these groups, levels of knowledge about HIV are high, but perceived vulnerability and reported condom use are low (McPhail & Campel, 2001). In South Africa, as in many other less developed countries, the primary method of HIV and AIDS transmission is through heterosexual intercourse. The average infection rate in 2010 was 17.8% among the age group of 15-49. Previous studies suggested that many South African youths know about HIV and AIDS first hand, amongst the age group of 15-24, 26% personally know someone with HIV and AIDS, and 45% personally know of someone who died of AIDS (Fennie & Laas, 2014; Abels & Blignaut, 2011).

Many undergraduate students at university find themselves at residences away from their parental homes when embarking on graduate studies. These young adults fall in the age group which may be categorized as vulnerable to HIV infection. This is especially when first year university students as a group, are exposed to risks, whether it is during the transition period from high school to university or when exposed to risky sexual behaviour. Young adults are particularly vulnerable to HIV infections as they might be at a risk of engaging in risky sexual behaviour, especially if they are under the influence of alcohol, drugs, peer-pressure, or simply lack of maturity (Fennie & Lesso, 2014).

According to Mutinta et al. (2012), while most heterosexual college students know they are at risk for HIV infection, most isolate themselves from any chance of contracting HIV which, in most cases, is the reason for their attitudes towards condom use, as even those who are reported to use condoms may not necessarily reflect actual behaviour. Not using condoms when engaging in sexual intercourse is the main contributor to new HIV infections especially in the African continent. Young women may shy away from discussing condom use in order to prevent confrontation due to their sexual insecurities, and females in abusive relationships may fear threats of violence when they try to negotiate condom use.

Abels and Blignaut (2011) stated that transactional sex among South African youth has been made an exception which is often in terms of gift giving and sharing to reciprocate sexual activities from the youth. This seems to be consistent with earlier studies of McPhail and Campel (2001) in a focus group research which found, unsurprisingly, that gender identity played a key role in high-risk sexual behaviour. Young people's sexual encounters were negotiated within a context where dominant social norms of masculinity portrayed young men as conquering heroes and macho risk-takers in the sexual arena, and where the social construction of femininity predisposed women to use the responses of passivity or fruitless resistance in the face of male advances. Within such a context, sex often took place under conditions of at best, emotional pressure, and at worst, physical coercion of young women.

In a study done by Williams, Campbell, and MacPhail (1999), a conclusion that in the background of the growing HIV epidemic in South Africa, it is increasingly being argued that preventive interventions in this region may be most effective if directed at young people below the age of 16 years. Another survey done in the South African township of Khutsong, indicated that HIV infection was almost non-existent in the 13-16 year age group, followed by a sharp increase in the 16-18 year age group (18.9%), with the peak infection rates of 43.1% for the community as a whole being experienced by the 21-25 year age group (Williams, Macphail, Campell, Taljaard, Gouws, Moema, Mzaidume, & Rasego, 2000). Much of previous research, particularly in developing countries, has concentrated on the phenomenon of sexuality at the level of the individual, while neglecting societal, normative, and cultural contexts (Izugbara & Undie, 2008; Fitzgerald, Collumbien, & Hosegood, 2010; Mills, Beyrer, Birungi, & Dybul, 2012). Focusing on the individual-level assumes that sexual behaviour is the result of rational decision-making based on knowledge. In reality, the complex nature of sexuality means that adolescents conduct their sexual lives through experiences and beliefs that have been generated through their membership of particular societies and communities.

Findings from Hillier, Harrison, and Warr (1998) on their developed countries study on condom use suggested that a high regard for the preservation of reputation means that young women adhere to social definitions of sexual encounters as initiated by men, against female resistance. Women therefore, often do not have condoms available and make few efforts to gain knowledge of their partners' sexual histories, as this would be tantamount to admitting to themselves and society that they plan to engage in sex. In addition, women often avoid carrying condoms due to the negative reputations and labels associated with women who actively seek sex. Furthermore social pressures encourage young women not to engage in sex but those that do are expected to do so in the confines of "serious" and "trusting" relationships. This emphasis on "serious" relationships encourages premature trust of partners and therefore the non-use of condoms. Masculine sexuality is manifest in society's classification of "normal" men as being associated with multiple partners and power over women. Tension develops between the emotional vulnerabilities of young men and the behaviour that they are expected to adopt in order to be accepted as masculine in society the need for men to engage in multiple

sexual relationships combined with internalized negative attitudes towards condoms place their sexual health at risk (McPhail & Campel, 2001).

The Social Norms Theory

The social norms approach is founded upon a set of assumptions that individuals incorrectly perceive that the attitudes or behaviour of others are different from their own; when in reality they are similar (Berkowitz, 2004). This phenomenon is known as Pluralistic Ignorance (Iconis, 2011). It is largely because individuals assume that the most memorable and salient, often extreme behaviour is representative of the behaviour of the majority. This may lead individuals to adjust their behaviour to that of the presumed majority by adhering to the pseudo-norms created by observing such memorable behaviour. These exaggerated perceptions, or rather misperceptions, of peer behaviour will continue to influence the habits of the majority, if they are unchallenged. This means that individuals may be more likely to enact problem behaviours and suppress healthier practices, making support for healthy behaviours much less visible at an aggregate level. This effect has been documented for alcohol, illegal drug use, smoking, unsafe sexual practices and other health risk-behaviours, and attitudes, such as prejudice (Frauenfelder, 2011).

Pluralistic ignorance in social psychology, is a situation in which a majority of group members privately reject a norm, but incorrectly assume that most others accept it, and therefore go along with it. This is also described as “no one believes, but everyone thinks that everyone believes”. In short, pluralistic ignorance is a bias about a social group, held by a social group. Pluralistic ignorance may be able to help us explain the bystander (witness) effect that people are more likely to intervene (help) in an emergency situation when alone than when other persons are near. If people study how others act in a situation, they may notice that people will decide not to help when they see that others are not getting involved. This can result in no one taking action, even though some people privately think that they should do something. Therefore, if one person decides to help, others are more likely to follow and give assistance (Frauenfelder, 2011).

These misperceptions occur in relation to problem or risk behaviours (which are usually overestimated) and in relation to healthy or protective behaviours (which are usually underestimated), and may cause individuals to change their own behaviour to approximate the misperceived norm (Prentice & Miller, 1993). This in turn can cause the expression or rationalization of problem behaviour and the inhibition or suppression of healthy behaviour. This pattern has been well documented for alcohol, with college students almost universally overestimating the frequency and quantity of their peers’ consumption (Perkins, Meilman, Leichliter, Cashin, & Presley, 1999). Such misperceptions can facilitate increased drinking and may be used by problem drinkers to justify their own abuse. Similar misperceptions have been documented for illegal drug use; the same can be said for cigarette smoking and eating disorders. Social norms theory predicts that interventions which correct these misperceptions by revealing the actual, healthier norm will have a beneficial effect on most individuals, who will either reduce their participation in potentially problematic behaviour or be encouraged to engage in protective, healthy behaviours (Frauenfelder, 2011).

Social norms theory can also be extended to situations in which individuals refrain from confronting the problem behaviour of others because they incorrectly believe the behaviour is accepted by their peer group. That is, individuals who underestimate the extent of peer discomfort with problem behaviour may act as “bystanders” by refraining from expressing their own discomfort with that behaviour. However, if the actual discomfort level of peers is revealed, these individuals may be more willing to express their own discomfort to

the perpetrators of the behaviour. Recent research on homophobia, for example, suggests that most college students underestimate the extent to which their peers are tolerant and supportive of gay, lesbian and bisexual students (Frauenfelder, 2011).

We will term this social normalisation theory because it speaks to the “normal” attitude of freedom students feel when they are at the university. They are with their peers most of the time in an “uncontrolled” environment; there are no teachers or parents supervising them all the time. They want to be part of what the others are doing regardless of the dangers involved, their values and even beliefs. Much as they might know the negative outcomes, they get pressurised by the idea that this is “the normal thing to do here” and that “everyone is doing it”. This is done to fit in the “new league”. Being new and lonely in the university institutions are some of the reasons of indulging in risky behaviour. This however impacts negatively on the development they come for.

Educational Management

According to Bush and Glover (2002), educational management is a field of study and practice which is concerned with the operation of educational organizations. The field of management studies is characterized by considerable flexibility of discipline boundaries because it draws on several disciplines such as sociology, political science, economics and general management. Bush (2008) stated that management was an activity involving responsibility for getting things done through other people. In this case, we need the university management teams to put the HIV and AIDS agenda as a priority to ensure that our students graduate without being infected. However, this requires special institutional management that takes into account that HIV and AIDS campaigns are taken seriously by providing access to both male and female condoms places where students can easily access them without being exposed. Management is also perceived as a set of activities directed towards efficient and effective utilization of organizational goals (Sapre, 2002). Therefore, HIV and AIDS prevention must be one of the institutional goals.

Aims and Objectives

The aims and objectives are to assess the prevalence of association between sexual risk behaviour and alcohol use among Nelson Mandela Metropolitan University (NMMU) students.

Sub-objectives included describing the prevalence of behaviour associated with:

- Substance abuse;
- Sexual risk behaviour;
- Determine associations between demographics and health risk behaviour;
- Develop recommendations on holistic approaches to behaviour modification;
- How do we manage the stigmatisation and the tension between safe sex and perceived perception of acquiring female condoms?

Research Methodology

A descriptive study design amongst a convenient sample to determine quantitative data was employed, using an on-line survey. All registered students during 2014, with access to the student portal were invited by e-mail to voluntarily participate in the survey.

Descriptive statistics i.e., frequencies and percentages were used to describe outcome of categorical data. The Pearson co-efficient (r)

$$r = \frac{n(\sum xy) - (\sum x)(\sum y)}{\sqrt{[n(\sum x^2) - (\sum x)^2][n(\sum y^2) - (\sum y)^2]}}$$

and Spearman's rank co-efficient were used to measure the strength or degree of the relationship between variables and to identify the significance of the correlation between variables (Taylor, 1990).

The proposal was approved by the Nelson Mandela Metropolitan University (NMMU) Research Ethics Committee (H13-RTI-HIV-001). Institutional permission for the study was obtained via the Deputy Vice Chancellor (DVC): Research and Engagement (Babbie, 2010). A response rate of at least 300 students was needed to evaluate the outcome as informed by the Department of Mathematical Statistics at the Nelson Mandela Metropolitan University. All students older than 18 years of age who gave consent prior to completing the survey and completed the on-line questionnaire were included in the sample. Demographic data included in the questionnaire were used to determine whether the sample is representative of age, gender, year of study, and race distributions (Babbie, 2010).

Data Analysis

Data were analysed by using the Pearson correlation co-efficient and Spearman's rank co-efficient as indicated above.

Demographics. During the four weeks period, 619 registered students participated in the study of which 66% (409) were female. Approximately, 20% stayed with parents, 25% in the Nelson Mandela Metropolitan hostels, and 30% shared a residence with the other students. An even distribution could be seen between the first three years of study and apart from the faculty of education, more than 10% of students from other faculties participated. The majority (67%) of the sample was black; however, 19% chose not to select a race group and thus the researchers are uncertain about racial representation in the study sample. Results can therefore not be generalised to the rest of the NMMU study population.

Findings

Sexually active. In the first instance the study sought to establish how sexually active university students are.

Figure 1. Sexual active.

Of all the students who participated in the study, as shown in Figure 1, more than 80% of students are sexually active. More than 70% are heterosexual as compared to less than 5% who indicated their homosexuality. About 5% are bisexuals while about 20% are not sexually active.

Sexual behaviour. In order to correlate students' sexual activity and their behaviour, the study further sought to understand whether or not participants had sex in the past year and, also, how many partners they engaged with.

Figure 2. Sexual behaviour.

As shown in Figure 2, 50% of female participants had one partner compared to 30% of male participants who had one partner. Of significance is the fact that of all the participants, 25% of male participants had two partners, 12% of female participants had two partners, more than 10% male participants had three to five partners, and about 6% of female participants had three to five partners. About 8% of male participants had more than six partners and only 2% of female participants had more than six partners. The concern is that in the era of HIV and AIDS, university students are expected to be knowledgeable enough not even to consider two partners but in this study, the percentage of students who had more than six partners is very high.

The use of contraceptives. The use of contraceptives, especially condoms, as a part of HIV prevention measure, has been widely promulgated. However, how it is used both by males and females has been an issue of major debate. Overall, 57% male students and 42% of female students indicated the use of condoms. As to whether the use of condom was dependent on their partners' willingness, the results showed no difference.

Figure 3. Use of contraceptives.

As can be seen in Figure 3, the number of students indicates that they would want to wear a condom but their partner refused is similar for males and females.

HIV testing. Voluntary HIV testing has been a barometer to measure the effectiveness of HIV awareness campaigns. Overall, 75% of the students indicated to have undergone HIV testing, although there was a slight variation between males and females.

Figure 4. Voluntary HIV testing.

As shown in Figure 4, about 70% of the male as compared to almost 80% female participants had engaged in HIV testing.

Alcohol use. The influence of alcohol use on sexual risky behaviour has been well documented. The study sought to understand whether students entering university had already had alcohol. The results show that 56% of the participants had their first time use of alcohol before high school while 13% of the participants had their first time use of alcohol during high school, 3% of the participants had their first time use of alcohol during their first year of university, while 3% of the participants had their first time use of alcohol during their second or third year of university, 10% of the participants had their first time use of alcohol in the later stages of their lives, which would be after the third year of university.

Binge drinking. To further understand how often students use alcohol as a proxy measure of engaging in risky sex behaviour, students were asked to say if they had used alcohol in the past 30 days. It further aggregated the findings in terms of gender.

The results in Figure 5 show that 47% of the participants have made use of alcohol in the past 30 days. However, there was not much difference between males and females; with roughly 35% males as opposed to roughly 29% females, engaging in binge drinking in the past year.

Figure 5. Binge drinking.

High risk alcohol use. As stated earlier, alcohol use has had an impact on the behaviour of partakers. In this study, a further question was asked to find out whether students ever passed out from drinking, regretted having sex after drinking and the frequency with which they had alcohol in a week. About 20% of the participants have passed out from drinking as compared to 75% who did not. Approximately, 17% of the participants do regret having sex after drinking as compared to 52% who did not engage in sexual activities after drinking. In terms of the frequency of alcohol use in a week, about 5% of the participants use alcohol 2-6 times a week; about 18% of the participants use it less than twice a week, while about 41% of the participants use alcohol less than twice a month.

Attitude. To understand students' attitude towards other practices relevant in curbing the HIV infection, the study asked students' attitude questions regarding their belief in birth control and/or contraceptives. The study also attempted to understand whether they believed in wearing a condom when having sex. More importantly, it was vital to understand whether they were worried about getting sexually transmitted infections (STI), at risk of getting HIV, and whether they were tired of HIV awareness campaigns. The findings show a positive correlation between awareness of the dangers of HIV and risky behaviour. Overall, 74% believed in contraceptives with 80% of the participants strongly supporting the use of condoms.

While 50% of students were worried about getting STI, 37% were not worried about getting STI. This is quite significant in the current HIV pandemic not to be worried about getting STIs. This was also consistent with the question of whether or not they believed they were at risk of getting HIV. About 64% believed they were not at risk of getting HIV while 19% did believe. The majority of students (70%) showed positive attitude towards HIV awareness campaigns by indicating that they were not tired with the messages.

Discussion of Findings

University students are expected to have sufficient knowledge about HIV and AIDS transmission, which is expected to translate into behaviour that leads or stops the spread of HIV virus. However, statistics in this study suggests that much as they may have sufficient knowledge about HIV and AIDS, their life style is very risky. Much as they may pretend to perceive risky behaviour as a norm, students themselves know that it is a social acceptance issue. Issues of identity, university loneliness (not knowing anyone on campus for new students), poverty, and the vulnerability thereof become fertile soil for such risky behaviour to flourish.

Male condoms are in every toilet in our NMMU campuses, but female condoms are dispensed on request at the campus clinics. How would students know about that? Why should they be dispensed on request? How many are they given at every request? How do they feel if they are often seen asking for condoms daily? There is gender biasness in this practice and a form of intimidation and forced declaration of indulgence in sex activity, while men can do it secretly. The lack of female condoms makes it difficult to negotiate condom use from their male counter-parts. If females want to use a female condom, they have a better chance of succeeding in doing it because that is what they want; they have a bit of power too in that space to stand ground. But if it is to tell the male partner to use a condom, then it gets complicated, because then they must explain why they are asking their lover to use a condom. It means that the female partner does not trust male partner and he would rather find a woman that will appreciate him better. Issues of mistrust, fear of being rejected weaken the female position. The vulnerable position she is already in makes it difficult to walk away and expect to be freed after being close to reaching the level of penetration. If this man does not force himself on her, it might just be considered in his head that "he is not man enough", so cases of unreported rape in consensual relationships are common under these circumstances.

It is important to understand that condom use is an acquired test, and they “all” long for flesh to flesh intercourse despite the risk involved. It takes a lot of courage to throw away the thrill in sexual intercourse for the sake of what some may still consider being “a myth”. For the students who are in sexual relationships for money due to “poverty”, the fear of losing the relationship is deepened by their helpless socio-economic issues. They fear of rejection by the friendship they have made at the university and the fear of academic failure due to lack of financial support are all challenges that complicates negotiation of the use of condoms.

The risk perception in this particular sub-group of the student population is very low, and one might think that by the time they reach university, they have learnt enough about HIV and AIDS, but that is not the case. By the time they reach university they are already suffering from the HIV and AIDS “fatigue”, they may not want to hear about it anymore. They just become more vulnerable. The freedom they feel by being independent without parental control initiates liberation and indulgence in sexual activities. Much as this study is not representative of all university students in South Africa the sense of freedom from parents is a general and common perspective.

In addition, the relationship between perception of risk and sexual behaviour is complicated and mainly poorly understood. Bearing this in mind, there are implications for HIV and AIDS awareness campaigns on campus with new holistic strategies involving the student leadership and other youth committees as well as the academic fraternity and everyone working in the institution and within the metropolitan, to get involved for better results in taking HIV and AIDS preventative measures seriously. We accept that university students should be mentally astute and be able to draw the connection from “how HIV is transmitted” to “how I can put myself at risk to become HIV infected”.

Does Voluntary HIV Counselling and Testing (VCT) improve risk perception? According to the UNFPA (2002) VCT for HIV allows individuals to know their HIV status and serves as the gateway for HIV prevention for early access to treatment, care, and support. This provides the opportunity for the people to know their HIV status with quality counselling and support to help them cope with a positive or negative test result. Knowing that one is negative is a strong motivator to remain negative. However in a real world, even if the most excellent idea is implemented, contextual and cultural perspectives influence the flow of the operation. In the HIV and AIDS era, stigma is attached to everything that says HIV and AIDS due to the way it is mainly acquired. A student that may be unfortunate enough to be seen by her friends to be testing becomes stigmatised and is considered to be HIV positive and the truth on the results are not required. “Who is she sleeping with?” “Why is she/he sleeping with people like that?” These become the point of departure for the discussions that lead to discrimination and ultimately stigmatisation. Therefore, in advocating for VCT, there must be a deliberate effort to equally understand the context and the culture of the people that are being served. Similarly, appropriate community specific strategies for any HIV and AIDS intervention programmes need to be used. Risk behaviour remains a problem despite awareness and VCT campaigns because students keep on having unprotected sex.

Much as this seems to be the “norm” in campus life, social norms theory predicts that persons express or inhibit behaviour to attempt conformity to perceived norm. This may cause an individual to act in a way that is inconsistent with their own true beliefs and values. All individuals who misperceive the norm contribute to the climate that allows problem behaviour to occur, whether or not they engaged in the behaviour.

Conclusions

Knowing that there are different cultural variations associated with HIV risk perception, the university

students created “norms” about their sexual behaviour, needs to be explored carefully so that created cultural specifics of university life may be recreated into a risk free sexual behaviour. The students must be encouraged to have HIV and AIDS discussion forums to equip them with skills that encourage safer sex or abstinence. Socio-cultural norms and practices are major determinants of sexual risk-taking behaviour. Knowledge about the other sexual partners of the partner does not help with prevention because you may not know who else they are involved with sexually, before and currently, you might not know who else he/she is sleeping with.

In some cultural setting, women must prove their fertility before they get married. That degree of pressure from the male partners and their parents encourages sex outside married; consequently, the relationship may never result in marriage. Thus, the woman would want to try again and again until someone marries her, which by then she may be infected.

Other misconceptions in relation to HIV and AIDS are on the comfort of knowing the number of sexual partners current and past, knowledge of sexual partners’ past sexual behaviour; most of the students think that if they have that knowledge and those people look like they are not HIV positive then they do not need to worry about being infected, they are safe.

The fear of HIV and AIDS seems to diminish as they normalize their risky sexual behaviour, by having discussions about sex, in which they are fully aware that their talks are total misconceptions. They fall in the trap because they want social acceptance, they want “to belong” by doing what everybody seems to be doing to prove themselves worthy of their groups.

Shame associated with having HIV and AIDS makes many students not testify of their HIV positive status, therefore infections occur due to the fact that if they mentioned condoms, then they are declaring that they are HIV positive and nobody wants to be suspected of being HIV positive even when they are.

Community perception of HIV and AIDS risk varies from place to place, and so is the extent of stigma, as the students commune their misconceptions widen even further and conclude by declaring to simply “seize the moment”. Communities that consider HIV and AIDS to be witchcraft have more sympathy to the infected and affected; those who consider it to be out of promiscuity are normally very harsh in attitude. Amongst the students having one sex partner for most male students is not being “man enough” and for poor female students who need money from it, it is not viable (but they do not think that it is prostitution).

Knowing someone with AIDS and being associated with them even by just being a friend is an invitation of stigma. Sex is not discussed in most homes; it is considered a taboo to discuss sex with children. Therefore for many students, any knowledge of sex is picked-up from media or friends or school, sometimes they find it difficult to make the right discussions because they have other needs of belonging, acceptance, and identity. The closeness of parent-child relationships may bring openness to the sex in some cases, but it normally remains a “closed discussion”, questions of sex from children may be considered disrespectful.

Religious affiliation is equally a very serious reason why students do not use condoms or use contraceptives. Some religious understanding is that sex is sacred and the outcomes are children who are a blessing to all humanity. Demonizing sex by mentioning it in line with HIV and AIDS and the use of condoms is considered unnatural and unspiritual.

Normalization of risky sexual behaviour, HIV, and AIDS fatigue and the above mentioned social and religious misconceptions make students who are engaged in unprotected sex, prone to acquiring the HIV and AIDS virus. Management strategies should be put in place in all universities in order to help the students stay

HIV negative. Unless HIV and AIDS are institutionalised, the management of risk behaviour will prove difficult.

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