

Reviewing gender and cultural factors associated with HIV/AIDS among university students in the South African context

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South Africa is in the midst of a catastrophic AIDS epidemic. HIV prevalence statistics in most countries indicate that up to 60% of all new infections occur among 15 to 24 year olds, whilst this group also boasts the highest incidence of sexually transmitted infections (STIs). Statistical findings among South African students predict a 10% increase in the HIV infection rate, highlighting the inability of universities to cope with societies' demands for academically trained workers which, in the near future, will have a detrimental effect on the economy of South Africa. From the literature it is evident that HIV/AIDS is more than a health issue, it is an inter-sectoral challenge to any society. This paper explored the interplay of gender and cultural factors on South African students' sexual behaviour by inter alia discussing the following factors that might put students at risk for HIV infection: male dominance vs. female submissiveness; age of first sexual encounter; gender-based violence; contraception; circumcision; financial status; myths and 'othering'; demonstrating the need for effective strategies, policies and programmes to protect young people, especially females from sexual abuse/rape and its consequences, including HIV. The literature review revealed that South African students, despite adequate HIV/AIDS knowledge, demonstrated high rates of sexual practices that place them at risk for HIV infection, i.e. unprotected sex, multiple partners and 'sugar-daddy practices'. The paper concludes with a discussion on recommendations for future HIV prevention/intervention programmes, highlighting the fact that it acquires an inclusive approach. Such interventions should move beyond the individual level to be effective and target gender-based inequalities, human rights violations, including sexual violence and rape, as well as stigma and poverty reduction, both at community and tertiary educational level.

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Introduction

The Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) pandemic has received overwhelming attention at all levels of social intervention. Michael Gibbons, Secretary-General of the Association of Commonwealth Universities, warned that the HIV and AIDS pandemic would lead to the decimation of higher education structures in South Africa (Bridgraj, 2000:9). This means that universities will not be able to cope with society's demand for academically trained workers (Bridgraj, 2000:9). Looking at the pandemic from this perspective helps us to realise the vulnerability of young adults, as well as the fact that HIV infection is spread through modern sexual behaviour (Marcus, 2002:23).

For many students university life is an opportunity to experiment and be adventurous. Very often experimentation with sex, alcohol and drugs occurs during their university years, lowering students' inhibitions and leading to riskier sexual behaviour and even date rape (Southern African Regional Universities Association, 2009:19). Recent data suggest that up to 60% of all new HIV infections occur among young people in the age group 15 to 24 years, whilst this group also boasts the highest incidence of sexually transmitted infections (STIs) of all age groups (Givaudan, Leenen, van de Vijver, Poortinga & Pick, 2008:98). The existence of HIV has certainly changed the situation from times when the possibility of an unwanted pregnancy was all a student had to worry about after participating in unprotected sexual activity (Thom & Cullinan, 2003:47).

Problem statement and research questions

Several problems currently exist in the battle against HIV and AIDS among students. Abt Associates (in Levine & Ross, 2002:90) estimated that, in the year 2000, the HIV infection rate at university undergraduate level was roughly 22%. Estimates for 2005 rose to about 33%. Tertiary institutions will therefore be confronted with an increasing number of students who will commence their studies as HIV-positive individuals, as well as an increasing number of

students who will be infected with HIV by the time they have completed their studies (Crewe, 2000:11). The negative impact of HIV/AIDS will result in students never reaching senior levels in the economic work sector; thus directly affecting efforts directed at addressing structural problems, including high levels of unemployment, skills shortages and high levels of income inequality (Cornelissen, 2005:1).

Previous educational prevention programmes to combat HIV among students focused on informing the youth about the modes of transmission of HIV (Strydom & Strydom, 2002:216). Knowledge, Attitude, Belief and Practice (KABP) surveys were mainly used to study students' sexual behaviour in relation to HIV. The reason was that researchers believed if the youth could develop the proper skills and had the right information (facts) surrounding HIV and its modes of transition and their beliefs (positive or negative feelings and opinions) were taken into consideration, it might help predict and influence their health-related behaviour, and would they be in the position to change their high-risk sexual behaviour (Badenhorst, Van Staden & Coetsee, 2008:106-120).

After reviewing recent research findings, it became clear that, despite having a sufficient knowledge base with regard to HIV and its modes of transmission to protect themselves, students still put themselves at risk for HIV infection (Southern African African Regional Universities Association, 2009:17-20; Akande, 2001:239). This demonstrates that knowledge alone is not enough to prevent HIV infection and that those factors such as gender and culture should also be researched to help stop the spreading of HIV (Levine & Ross, 2002:90; Eaton & Flisher, 2000:111; Coughlan, Coughlan & Jameson, 1996:255).

Emanating from the above, the following research questions guided this research:

- To what degree do gender and culture influence high-risk sexual behaviour among students at South African universities?
- To what degree do high-risk

sexual practices of students differ on the basis of gender, culture and their awareness of HIV/AIDS?

Purpose

The main purpose of the present study is to review the South African literature on students' sexual practices and high-risk behaviour in order to identify prevailing themes and trends so that new directions may be identified in the research on students and HIV/AIDS prevention. Hence, in the present study the authors set out to:

- Explore the interplay of gender and cultural factors on South African students' sexual behaviour;
- Provide evidence that cultural and gender stereotypes still exist among South African students; and
- Critically discuss other influences relating to gender and sexual behaviour and the possible effect thereof on South African students' high-risk sexual behaviour.

Interplay of gender and cultural factors on South African students' sexual behaviour

Studies by the Department of Health (1994:14) and Trussler and Marchand (1997:51) before 2000, as well as by the World Health Organization (2000:10, 12) highlighted the importance of HIV Prevention Programming within the context of the cultural beliefs of the target society. Moreover, researchers maintain that unsafe heterosexual practices are the most frequently reported risk for HIV/AIDS infection in South Africa (Uys & Alexander, 2002:296; Akande, 2001:239). It is for this reason that sexual practices are a logical starting point for HIV research in South Africa. It is, however, important to focus on understanding sexual behaviour by placing it in a cultural context within the social milieu in which it occurs (Crothers, 2001:13-16). The gender context is determined according to what is culturally defined as being feminine (appropriate female behaviour) or masculine (appropriate male behaviour) in sexual relationships (Ferrante, 2003:314). Research substan-

tiates the importance of gender (for instance, the unequal division of power) as an influence on health behaviour (Finchilescu, 2002:109-131).

The influence of culture and gender on the sexual practices of young adults is also demonstrated by the fact that respondents participating in research studies (Badenhorst *et al.* 2008:106-123; Levine & Ross, 2002:98) admitted that a cultural basis for infection with HIV exists. Arguments revolve around statements that culture shapes both gender and what is considered the ideal form of trust and intimacy in sexual relationships. The following factors have been identified that may place students at risk for HIV infection:

- Multiple partnerships, especially having more than one partner at the same time;
- Big age gaps between sexual partners;
- Not using condom consistently;
- Not knowing you and your partner's HIV status;
- The presence of other sexually transmitted diseases; and
- Excessive alcohol use and 'binge drinking', which increases risk taking behaviour.

(South African Regional Universities Association, 2009:17).

Studying the culture of individuals in relation to their gender and sexual practices will shift the focus from a rational choice based on an individual response to guidelines focusing on cultural differences (Ntlabati, Kelly & Mankayi, 2001:17). Culture and gender influence a lot of aspects surrounding students' high-risk sexual behaviour with regard to HIV infection. These factors play a direct role in an individual's choice to use safe sexual practices to protect himself/herself against HIV. In addition, research findings suggest that gender inequality and gender-based violence are essential determinates of women's HIV risk, worldwide as well as in South Africa (Dunkle, Jewkes, Brown, Gray, McIntyre & Harlow, 2004:1415). Thus, in the next section the influence of gender relations and cultural habits on the sexual practices of female and male students will be discussed by investigating the interplay of factors such as *male dominance vs. submissiveness, age of*

first sexual encounter, gender-based violence, contraception, circumcision, financial status, myths, as well as the concept of 'othering'.

Male dominance vs. female submissiveness

Male and female roles are often shaped by society, culture, the immediate and extended family, communities and individual decisions (Southern African Regional University Association, 2009:19). Research findings overwhelmingly demonstrate how gender inequality may impact negatively on the vulnerability of females. The stereotypical behaviour of some men, together with unfavourable cultural prescriptions such as submissiveness, sexual subordinates, obedience, and willingness, makes women in particular more vulnerable to become HIV infected (Van den Berg & Van Rooyen, 2007:208). Not only does male dominance influence the sexual behaviour of female students and place them at risk, but cultural practices such as male students' view of perceived masculinity, condom use, myths and expectations based on financial status also increase male students' own risk for HIV infection.

According to Le Clerc-Madlala (2002:29), one of the gender factors that place both African and Western male students at higher risk for HIV infection is their striving to be seen as 'masculine' by their peer groups. Masculinity can be placed on a continuum between what is considered masculine and 'macho', and what is seen as refined and being a 'sissy'. Thus, from an early age, 'to be a real man among boys', is in the majority of South African cultures associated with "power, virility and domination of women in sexual relationships" (Chikore, 2000:39). Consequently, male students who believe that risk-taking is an expression of masculinity may be more likely to engage in high-risk sexual and drug-using behaviour, because they have to meet certain expectations to attain the status of 'masculine and macho'. The risk lies in these expectations, which may include having several sexual partners, engaging in casual sex, unprotected sex, demonstrating negative attitudes toward condom use, having control over women, and owning expensive acces-

sories (Selikow, Zulu & Cedras, 2002:24). 'Macho' male students from an African cultural background regularly distinguish between their female partners as belonging to one of two groups, i.e. as 'girlfriends' they are seen as long-term sexual partners (with whom condoms are often not used); whilst those in the second group are seen as casual sexual partners (with whom condoms are preferably used). This might add to the fact that research among female students demonstrates that they frequently regard not using condoms during sex as a way of enhancing their social status. They might believe that this choice will make male students see them as permanent girlfriends, rather than 'casual partners'.

Focusing on female students, several cultural customs seem to influence a female student's view of protecting herself against HIV infection. As seen in the Western and African cultures in South Africa and discussed above, male dominance in society plays a major role in the behaviour of female students. A female is expected to be submissive to her male partner, to raise their children and not to speak openly about their sexual concerns and interests (Ferrante, 2003:342). By contrast, a man is expected to be the leader in the community and in family life (Taylor, Peplau & Sears, 2000:274). The literature makes it clear that most gender-based power, both in marriage and courtship, is given to males through social conventions. The problem is that male students control the most easily accessible barrier against HIV infection, the male condom. Female students are more at risk of HIV infection, as they may feel powerless to insist on condom use (Finchilescu, 2002:109-131).

Age of first sexual encounter

Gender stereotypes, combined with age differences between partners in a sexual relationship, may constitute a risk factor for women (UNAIDS, 2005). Many women, especially younger females, cannot refuse unwanted sex or negotiate protection from pregnancy and STIs, including HIV, because they fear retaliation – resulting in multiple adverse physical, social and emotional outcomes (Dunkle *et al.*, 2004:1415-1421).

Age influences the vulnerability of female students in two ways. Firstly, female students – notwithstanding their cultural background – often prefer to have sexual relationships with older men. These men, in view of their sexual behaviour (the possibility of having had multiple sexual partners), carry a higher risk of infecting their current female partner(s) with HIV. Secondly, younger female students' risk of HIV infection is further increased due to their inexperience in negotiating for safer sex. Furthermore, in situations of forced sex or coercion, whether by strangers, acquaintances, family members, boyfriends or 'sugar daddies', negotiating condom use is virtually impossible (UNAIDS, 2005; Marcus, 2002:27). Contributing to the escalation of this risk factor is the unique South African phenomenon that female submissiveness, barricaded beliefs regarding male dominance, high levels of sexual crime and the fear of HIV infection propel men towards seeking increasingly younger groups of females for sexual relationships (Le Clerc-Madlala, 2002:23). This has direct implications for younger females because of their biological, immunological and/or virological susceptibility, which changes in age, making them more vulnerable to infections in their teens and early twenties (Van den Berg & Van Rooyen, 2007:209). Younger females' reproductive tract is not fully developed and the skin is more likely to rip or tear during sexual intercourse, which increases the risk of HIV infection (Van den Berg, 2004:83). In addition, research findings have demonstrated that women who began their sexual activity before the age of 17 are more prone to herpes simplex infections, which cause cellular changes and may result in cervical cancer. Moreover, research findings have demonstrated that 33% of girls between the ages of 12 and 17 years have already had sexual intercourse; that girls even as young as 8 years are sexually active; and that 4% of girls between the ages of 12 and 17 years have already been pregnant (Henry Kaiser Family Foundation, 2001:23).

Gender-based violence

Researchers postulate that gender-based violence and gender inequality are important determinants that place

women at greater risk of contracting the HIV/AIDS virus (UNAIDS, 2005; Garcia-Moreno & Watts, 2000:253-265). Gender-based violence refers to a range of harmful custom behaviours against girls and women, including intimate partner violence, domestic violence and assaults, child sexual abuse and rape (Auerbach, Byram & Kandathil, 2005:1). Forced sex is not the only cause of HIV infection; in addition, the attitudes and mindset that underlie the act of forced sex, the disrespect for the rights of others, including the failure to disclose one's HIV status, all contribute to spreading the HIV virus (Anderson, Ho-Foster, Matthis, Marokoane, Mashiane, Mhatre, Mitchell, Mokoena, Monasta, Ngxowa, Salcedo & Sonnekus, 2004:952-954). According to Chinkdanda (as cited in Van den Berg & Van Rooyen, 2007:206), women become victims to men's abusive behaviour and sexual violence because of women's perceived traditional role in society as 'the weaker sex' and in some cases women are even 'relegated to the same status as children'. Prevalence estimates for gender-based violence vary widely as a result of differing definitions of violence, but current estimates indicate that between 8% and 70% of women worldwide have been physically or sexually assaulted by a male partner at least once in their lives (Auerbach *et al.* 2005). Moreover, it is reported that one of the driving forces behind the HIV/AIDS epidemic in South Africa, is rape. By estimate there are more than one and a half million rapes in this country each year (Meel, 2005:207-208). Many times this can be ascribed to stereotypical male behaviour, which associates masculinity with having easy access to women and in an attempt to emphasise male control women are being forced to have sexual intercourse (Van den Berg & Van Rooyen, 2007:207; UNAIDS, 2005); Evidence also exists that gangs regard girls in their area as their 'property' with a view that they 'must be available for sexual intercourse' – thus increasing the risk for gang rapes and HIV infection (Le Roux, 1994:269). Moreover, results from other South African studies inter alia demonstrated that 25% of sexually active females admitted that they had been forced to have sexual intercourse; that child sexual assault, forced first intercourse and adult sexual assault by non-partners were signifi-

cantly correlated with increased sexually risky behaviour (Dunkle *et al.* 2004:1419). Although those suffering from forced sexual intercourse believe that there is a good possibility that they are HIV positive, they are less willing to go for testing. Despite the fact that there is a visible association between the increase in sexual violence against women and the increased incidence of HIV infection in South Africa, HIV infection as a result of sexual assault has merited much less attention in this country (Meel, 2005:268). Focusing on the development and implementation of future HIV/AIDS prevention programmes, the government and NGOs have to take cognisance of how sexual abuse affects the way 'survivors' interpret HIV risk awareness initiatives, understanding both their impact on individual risk reduction and how a history of abuse might further affect the spreading of HIV/AIDS (Anderson *et al.* 2004:952-954).

Contraception

There is a growing body of literature bearing testimony to cultural risk factors for HIV infection of female students, including assault, coercion, poor interpersonal communication and high levels of risk-taking. According to the 'International Women's Health Coalition' (2008:3), the imbalance of power between male and female partners in heterosexual relationships, greatly reduces the ability of young women to either refuse or negotiate the use of condoms. Research among students from a Western cultural background found that both male and female students see contraception as the responsibility of the female (Marcus, 2002:26). In addition, female students from an African cultural background often believe that not using a condom will enhance their social status with their male counterparts (Seloilwe, Jack, Letshabo, Bainame, Veskov, Mokoto, Kobue & Muzila, 2001:204). They may even be expected to demonstrate their fertility by having children before they can get married (Preston-Whyte & Zondi, in LeClerc-Madlala, 2002:28). The choices made by female students regarding whether or not to use contraception, what type of contraception to use and whether it will prevent HIV infection, affect their vulnerability. Factors contributing to female students not choos-

ing contraception that also serves as a barrier against HIV infection, include the reality that female students are more concerned about an unplanned pregnancy than HIV, and that condoms are often seen in a negative light (Marcus, 2002:8-9; Skidmore & Heyter, 2000:31; Serlo & Aavarinne, 1999:469).

In both African and Western cultures, gender may influence male students' use of the male condom as a barrier method against HIV and unwanted pregnancy. As mentioned above, a male paradigm is recognised in condom use (Harrison, Xaba, Kunene & Ntuli, 2001:67-69). Research findings reported the following reasons why men do not always use condoms during sexual encounters, i.e. they 'dislike condoms because they are unromantic; condoms are uncomfortable and caused loss of erection/decreased sexual performance; or the unavailability of condoms' (Badenhorst *et al.* 2008:106-123; UNAIDS, 2005). In addition, in some cases male students will use insincere 'expressions of love' in order to have unprotected sex with female students – thus fear of rejection may cause female students to engage in unsafe sexual practices. Furthermore, both male and female students indicated feeling uncomfortable in talking with their partner about issues related to HIV risk (Thompson-Robinson, Richter, Shegog, Weaver, Trahan, Sellers & Brown, 2005:27). According to Levine and Ross (2002:94), the associations made by students between love, passion and trust combine in such a way that asking questions about previous sexual relationships and requesting condom use during sex are deemed inappropriate. Despite the fact that students have a sufficient knowledge base with regard to HIV and its modes of transmission to make them more aware and more careful to avoid being infected with the HIV virus and STIs (Levine & Ross, 2002:89-108; Uys, 2002:295-311; Eaton & Flisher, 2000:97-124; Coughlan *et al.* 1996:255-261), many of them still do not use any form of contraception. Recent research findings conducted at South African universities confirm this trend among students, for example, 44% of sampled students at the University of the Free State, comprising students from African and Western cultures, indicated having had sex with between two and

five sexual partners since their registration at this tertiary institution, whilst nearly 20% of UFS students admitted to using not any form of contraception. In practice, this implies that a fifth of these participating students are currently at risk of infection or being infected by their partner (Badenhorst *et al.* 2008:106-123).

Circumcision

Unprofessionally performed, circumcision provides a cultural, gender-related risk factor for HIV infection among male students. The circumcision of young males is practised in several cultures, and may be performed for medical, cultural or religious reasons. In South Africa, male circumcision is seen as an important part of African cultures' initiation process, symbolically leading the young male into adulthood. Traditionally, it is believed that the male's masculinity is tested during this procedure. However, major problems have emerged as far as traditional male circumcision in South Africa is concerned. Several health risks are associated with the procedure. If it is not done by a medically qualified person – this may include among others unhealthy surroundings, incorrectly performed circumcisions – it may lead to infection of circumcision wounds, gangrene of the penis, or even death (Peltzer, Nqeketo, Petros & Kanta, 2008:1024). During group circumcision procedures unsterilized tools (such as a razor or a piece of glass) are sometimes used (Louw, 1998:480), resulting in participants infecting one another with HIV. In stark contrast to the negative perceptions associated with unprofessionally performed circumcision procedures, some health professionals are in favour of medically performed male circumcision procedures and *inter alia* postulate that male circumcision can be an additional important intervention to reduce the risk of heterosexually acquired HIV (Peltzer *et al.* 2008:1024-1025). The theory that male circumcision may provide protection against HIV infection originated and developed in North America and is based on the following assumptions, namely keratinisation of the glans when not protected by the foreskin; quick drying after sexual contact, reducing the life expectancy of HIV on the penis after sexual contact with an HIV positive partner; and the reduc-

tion of numerous target cells on the foreskin. In addition, it is postulated that male circumcision may also cause a reduction in STIs, which in turn will reduce the acquisition of HIV (Auvert *et al.* 2005:1120). However, despite numerous observational studies that were carried out in Africa, insufficient evidence was found to suggest that male circumcision intervention prevented HIV infection.

Pervasive gender inequalities mean that females in particular face numerous violations to their sexual and reproductive health and rights, including sexual initiation ceremonies and female circumcision procedures that have a detrimental effect on their physical and emotional well-being (Jejeebhoy, Shah & Thapa, 2005:171-185). Female circumcision is undoubtedly one of the gravest forms of gender-based human rights' violations committed against women. The most severe form of female circumcision, also known as female genital mutilation, is called 'pharaonic' circumcision and involves the removal of the 'clitoris, labia minora and parts of the labia majora'. The two sides of the 'vulva' is stitched together, leaving only a small opening for urination and menstruation (Van den Berg & Van Rooyen, 2007:210). Direct consequences of female circumcision are the contraction of infections and risk of HIV infection due to unsterilized instruments and the performance thereof by ignorant people and laymen; chronic urinary tract infections; incomplete healing; and excessive scar tissue that can cause vaginal obstruction. Young females sometimes bleed to death or they become infertile (Van den Berg & Van Rooyen, 2007:210; Brady, 1999:209-211). Thus, it is imperative that health-care providers fulfil an important role in the eradication of this cultural practice, acting as advocates by increasing professional and public awareness about such practices, and explaining the dangers and lifelong disabilities it imposes (Brady, 1999:714-716).

Financial status

Social and economic realities have a direct impact on HIV/AIDS as well as the quality of life and potential success of university students. Many students are forced to migrate to bigger towns to attend university, which affects their

financial security and makes them more vulnerable to HIV. Students who are economically and socially disadvantaged in particular, are at the highest risk for HIV infection because of the impoverished living conditions they are exposed to (Van den Berg & Van Rooyen, 2007:213). In addition, many students' bursaries are not dispersed until well into the academic year, creating an unstable economic situation (Southern African Regional Universities Association, 2009:19). South African literature of the last five years makes it abundantly clear that financial status is a major HIV risk factor, often influenced by gender. A lower economic status adds to the problem of females having unwanted sexual relationships (Evian, 2003:204). It was found that 'sugar daddy' practices and prostitution occur in South African student communities (Kelly, 2001:30-31). Money often plays a role in young women bargaining with older men for sexual favours. A regular practice in African and Western cultures is that of males presenting female sexual partners with gifts. These partners are seen as 'girlfriends' and not as 'prostitutes' (Delius & Walker, 2002:7).

Female students sometimes regard sexual practices and their gender as a source from which to gain material and financial advantages. Sexual favours may vary on a continuum from rewards for meeting basic needs to sex for expensive items. The tendency of younger women to form relationships with men five to ten years their senior and to accept money or favours in return for sex increase the likelihood that they will be exposed to HIV (Chikore, 2000:39). The literature also points to the fact that young women are even becoming greedier in their financial expectations when bargaining for sexual favours (Le Clerc-Madlala, 2002:30-31). Female students might also see sex with older men as a means to increase their social status. The financial position gained by these practices compensates for their lack of social and sexual power. Levine and Ross (2002:102-103) warn that females' submissiveness and sexual liaisons should not only be linked to students from an African cultural background, but are applicable to Western gender roles as well.

Male students' financial status be-

comes a risk factor when they do not have the financial resources to buy expensive accessories (Selikow *et al.* 2002:24). South Africa's high unemployment rate may be seen as a contributing factor in pressurising male students to prove their masculinity in other ways than their financial means (Barnes, 2000:19). Uncertainty about their financial future as a result of limited job opportunities could lead to male students being more aggressive towards their female partners in sexual relationships. This supports the findings by Strydom and Strydom (2002:262) that HIV prevention among students is hampered by social and economic factors that are beyond their personal control. Since male students see themselves as initiators of sex, based on their gender norms, they can pursue several sexual relationships as an alternative route in order to gain macho status (Le Clerc-Madlala, 2002:30, 33). Moreover, Levine and Ross (2002:101-102) warn against linking male licentiousness and female submissiveness only to African cultures, since they may also be found in other cultural groups. It is highly likely that this phenomenon, in view of intercultural relations on campus and the patriarchal basis of Western culture, will also be found among male students from a Western cultural background.

Myths

Misconceptions about HIV/AIDS amongst South Africans are often linked to cultural beliefs and convictions, such as "individuals that have been bewitched because ancestral spirits have been disobeyed and aggravated; ancestral spirits purportedly punishing individuals to fall ill; that diseases that were initiated by ancestors is seldom fatal and can be overcome by offering sacrifices to restore the positive relationship between the individual and the ancestor" (Van den Berg & Van Rooyen, 2007:201). Culture and gender may be linked to myths surrounding HIV that make women more vulnerable to HIV/AIDS infection. These factors are entwined with one another, and must be viewed as universal to females, with individual effects and influences on their behaviour and how members of the opposite sex and the community see them. Research

suggests that widely believed myths still exist amongst many cultures, thus reinforcing negative attitudes about safer sex, one of the most prominent of these myths being the virgin-cleansing myth, i.e. the belief that sex with a virgin will cure HIV infection and AIDS (Jewkens, 2002:13; Levine & Ross, 2002:89). If these myths are believed in specific cultural groups, there is a possibility that many female students, in view of their gender, are the 'victims' of gender-based sexual violence and rape by HIV-positive men in their communities believing them to be virgins. In contrast, female students may take part in these 'sugar daddy' practices and prostitution, not only because of the possible enhancement of financial and social status, but due to the myth that HIV is only found among young people, and that unprotected sex with older men is therefore seen as 'safe' (Levine & Ross, 2002:104).

The myth that HIV does not cause AIDS, and that it is only a method used by Western cultural groups to restrict their population growth, might lead to students (both male and female) from African cultural backgrounds not considering the risk of HIV infection being a reality (Le Clerc-Madlala, 2002:39). Myths that condoms have microscopic holes in them, which can let the HIV virus through, might improve the chances of male students not using condoms (which are already viewed in a negative light) (Coetsee, 2007:15).

'Othering'

People's attitudes towards HIV/AIDS may also affect their own sexual behaviours. Several researchers have found a general inclination among students of different cultural groups (who see their peers as part of their 'in-group') to associate the risk of HIV infection with specific groups (identified as people outside their peer group, and seen as the 'out-group'). Since students are not part of the identified stereotypical out-groups in which HIV infection is perceivably found, they see themselves as 'safe' during sexual encounters with a person belonging to their in-group, resulting in high levels of sexual activity with a lower level of safer sex practices (Badenhorst *et al.* 2008:119-121). This 'othering' of the disease leads to the possibility that female

students, in view of their gender, cultural group and social habits, might not see themselves as at risk of being infected with HIV. Female students from both African and Western cultures have stigmatised the following groups' cultural backgrounds as carriers of HIV: poor rural women, gay men, prostitutes and drug addicts (Levine & Ross, 2002:93; Shaw, 2002:92; Uys, 2002:388).

Male students, like females, are also inclined to 'othering'. This issue causes male students to regard HIV as something that only happens to 'other people' belonging to stereotypical out-groups. Students perceive their social circle to be closed to people of the out-groups, and therefore see their in-group as 'safe'. Their belief that their social networks are not promiscuous is confused with the notion that "birds of a feather flock together" (Marcus, 2002:32). Myths and stories about out-groups ('they') being infected with HIV may quickly reach levels of conviction and influence how they are treated by the rest of the student community. Poor individuals without scholastic or tertiary education, gay men, and heterosexual students may be included in these stigmatised groups. Cultural stigmatisations also exist among students; and students from a Western cultural background see students from African cultural backgrounds as the carriers of the disease. Students, notwithstanding their cultural backgrounds, stigmatise poor black people with a lack of education as being responsible for spreading HIV (Badenhorst *et al.* 2008:106-123; Levine & Ross, 2002:100).

Marcus (2002:27) affirms that background, education and culture combine to form a sense of individual or collective safety. HIV infection is also seen as an abstract fear by students, and the groups identified as the carriers of HIV (by an in-group) are seen as distant from the students themselves, either through age, race, cultural or social associations. Even though students may admit that the risk of HIV infection is closer and greater than they want to believe, it does not mean that they will stop looking for ways to reassure themselves. All these factors contribute to students not seeing themselves as being at serious risk of contracting HIV (Akande, 2001:248; Kelly,

2001:19; Heunis, 1994:149).

Conclusion

Tertiary education represents a time for sexual exploration and freedom for many young people. Many students become sexually more active as they move to urban settings away from their homes and enter a developmental phase during which experimentation and risk-taking with a variety of sexual practices seem appealing. Unfortunately this sexual exploration and freedom can result in students contracting HIV (Thompson-Robinson *et al.* 2005:26). Statistical findings among students predicting a 10% increase in the HIV infection rate of universities' undergraduates in only five years (Levine & Ross, 2002:90), as well as the possible inability of universities to cope with societies' demands for academically trained workers due to the effect of HIV and AIDS on students (Bridgraj, 2000:9), draw attention to new high-risk behavioural patterns among students who are normally seldom targeted in HIV/AIDS prevention programmes.

According to Gordon (2008:7) negative outcomes associated with sexual behaviour are the result of both risk (at the personal level) and vulnerability (the socio-economic and cultural factors that put people at risk in the first place). In this literature review a myriad of factors that might influence students' HIV risk behaviours were discussed, for example, male dominance vs. female submissiveness; age of the first sexual encounter; gender-based violence; contraception; circumcision; financial status; myths; as well as the concept of 'othering'.

Most of the current issues and debate evolving around HIV education focus on addressing specific measurable outcomes such as HIV/AIDS awareness, HIV/AIDS knowledge and the effect of preventative measures such as condom use, whilst other programmes emphasise the importance of abstinence only. However, despite South African students' HIV/AIDS knowledge base, research findings suggest that they still engage in high-risk sexual behaviour (Badenhorst *et al.* 2008:106-123; Levine & Ross, 2002:89-108; Uys, 2002:382-402; Ichharam & Martin, 2002:363-381; Marcus, 2001:23-33; Eaton & Flisher,

2000:97-124; Coughlan *et al.* 1996:255-261) and that abstinence-only programmes did not decrease risky sexual behaviour, incidence of STIs or pregnancy (Gordon, 2008:23).

The ever-increasing statistical records of HIV/AIDS prevalence, especially in South Africa and other sub-Saharan countries, further bear testimony of the fact that current HIV/AIDS intervention programmes have failed to address the underlying concepts of masculinity and high-risk violent practices of sexuality. What is warranted is a new and inclusive understanding of the HIV/AIDS crisis, recognising that it not just a health issue, but also a developmental, gender, social and economic issue that should be regarded inclusively. Moreover, in a country such as South Africa, deeply rooted AIDS-related stigmas and fear of abandonment (especially women), create a barrier to HIV testing and have negative consequences for AIDS prevention and treatment (Meiberg, Bos, Onya & Schaalma, 2008:49, 53). Thus it is imperative that future HIV/AIDS educational programmes, both at school and tertiary educational levels, should also address issues such as poverty reduction, gender inequality, stigmatisation and discrimination, which place people at greater risk for HIV, STIs and unwanted pregnancy. In practice this implies the coordination of HIV prevention activities with strategies that address the poor economic conditions and unequal gender norms that encourage young people, including students, to engage in risky sexual relationships (Gordon, 2008:10). Any national policy should be inclusive, involving all stakeholders in the process, including students. Furthermore, greater pressure must be placed on government and tertiary education institutions to implement programmes to contend with and educate growing numbers of tertiary education students who may be receiving no or inadequate sexual health education. In conclusion, we would like to make the following recommendations to address the issue of HIV/AIDS infection in general, as well as the high risk sexual behaviour of university students specifically:

- The culture of 'silence' that surrounds human sexuality, which provides fertile ground for the undetected spread of HIV and

STIs, needs to be broken (Shisana, 2004:8);

- A priority of government and organisations working in HIV prevention must, firstly, be to strengthen women's ability to protect themselves, including the provision of appropriate and accurate AIDS information (Chikore, 2000:41);
- Whilst the empowerment of women is the first step; in addition, we must also target men, engaging them to seriously reflect on their sexuality and responsibility to prevent the spread of HIV – they must be encouraged to become actively involved in debates focusing on the development and implementation of preventative health-care programmes in society; and
- Finally, focusing on the increased prevalence of HIV/AIDS among tertiary education students, it is incumbent that the South African government, in collaboration with tertiary institutions and students, should put intervention programmes in place that do not only increase HIV/AIDS awareness of a theoretical/informational level/stance, but create opportunities (workshops, forums, reciprocal discourse, etc.) where HIV-related issues could be fiercely debated so that HIV/AIDS knowledge will ultimately lead to behavioural changes in the sexual attitudes of many students currently still at risk of contracting the HIV virus. Prevention campaigns must not only focus on the basic facts of the disease, but also emphasise the dangers of alcohol and drug abuse; safe vs. risky sexual behaviours; and barrier methods to prevent HIV transmission ('International Women's Health Coalition', 2008:1-4; Pithey & Morojele, 2002:25-28). Focusing on gender issues specifically, will open up discussions to address date rape; freedom of choice to use contraceptives and negotiate safe sex; and decrease the vulnerability to HIV infection for many South African students.

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