PROMOTING STUDENTS' SEXUAL AND REPRODUCTIVE HEALTH IN PEER-LED PROGRAMMES AT TWO SOUTH AFRICAN UNIVERSITIES: EMERGENT TENSIONS AND DILEMMAS

M. van der Riet
School of Applied Human Sciences
University of KwaZulu-Natal
Durban, South Africa
e-mail: vanderriet@ukzn.ac.za

J. Akhurst*
e-mail: j.akhurst@ru.ac.za

L. Wilbraham*
e-mail: l.wilbraham@ru.ac.za

*Psychology Department
Rhodes University
Grahamstown, South Africa

ABSTRACT

Sexual and reproductive health programmes with students in higher education in South Africa, are a neglected area of intervention. We report on piloting the peer-facilitated *Auntie Stella* intervention material at two South African universities. This participatory methodology encourages critical thinking by opening discussion on managing relationships, sexual decision-making, gender-based violence and risk-safety. The format involves cards featuring a letter, a facilitated discussion, an answer-response and possible action points. Six focus groups of participants were facilitated by postgraduate students over four months. Using thematic analysis four tensions were identified in the student discussions: HIV awareness was in tension with relationship practices; awareness of risk was in tension with denial of vulnerability; awareness of individuals' rights was in tension with claims on these rights; and HIV knowledge was in tension with HIV stigma. The *Auntie Stella* material has the potential to open up discursive spaces amongst students, and to develop agency in sexual decision-making.

Keywords: sexual and reproductive health, students, South Africa, participatory groups, Auntie Stella

INTRODUCTION

With South Africa having the highest number of people living with HIV globally, the university

context raises particular challenges (Hoffman et al. 2017), as young people experience more independence and an accompanying increase in sexual exploration (Hindin and Fatusi 2009). A 2008–2009 Higher Education HIV/AIDS Programme study found that the mean prevalence of HIV at universities in South Africa was 3.4 per cent (HEAIDS 2010a). University campuses are "sexualised spaces where peer pressure to be sexually active is evident" (Shefer, Strebel and Jacobs 2012, 113). At school level, young people will have experienced Life Orientation curricular content and some may have had parental guidance in matters related to sexual health and the management of relationships. However, at university level many young people may have inadequate information and skills to cope in the new, more complex context, with few structured programmes seeming to address sexual and reproductive health (SRH). Drawing from a more comprehensive survey study, Hoffman et al. (2017, 6) highlight the risk factors, finding "inconsistent condom use, overlapping partnerships, and possibly partnerships with non-students" that "suggest a substantial potential for exposure to HIV" amongst students who are sexually active.

In response to the challenge of HIV and AIDS, various prevention and treatment programmes at universities have been developed (HEAIDS 2010b). These programmes may provide HIV and AIDS resources and information, counselling and testing, anti-retroviral prophylaxis, treatment of sexually transmitted infections (STIs) and opportunistic infections, and male and female condoms. For those students who are HIV positive, wellness management, ARV treatment and psychosocial support may also be provided. HIV and AIDS education and prevention programmes have also been implemented (e.g. peer training). More recently, the focus has been on integrating HIV and AIDS education into the curriculum (De Lange 2014; Gill and Di Monte-Miller 2017; Verhoef 2016; Volks, Reddy and Saptouw 2016; Wilbraham 2016; Wood, Soudien and Reddy 2016), but students' exposure to this will depend on subject choice. There seem to be relatively few studies of peer-led interventions and integration of the risks of STIs into broader programmes related to SRH.

Lessons from interventions

Evaluations of HIV and AIDS interventions highlight the complexity of sexual activity, and related vulnerabilities. The drivers of the pandemic are considered to be a complex range of interweaving factors such as gender-based violence, women's poverty, alcohol use, intimate partner violence and economic risk (Harrison et al. 2010). The most effective interventions have focused on these social influences that underlie risk, seen as causal pathways of HIV infection. HIV and AIDS cannot be adequately addressed through a focus on abstinence, partner reduction and "Just say no!" (Aggleton, Yankah and Crewe 2011). It needs to be addressed in relation to

sexuality, sexual diversity, personhood and rights. This recognition of sexual activity as complex, situated and conditional, goes far beyond giving individuals information and assuming they will appropriately assess a health risk, as was expected in earlier sexual health programmes.

Focussing on social and cultural processes (e.g. forms of masculinity and femininity that shape sexual behaviour) is also seen as critical in changing social norms related to sexual relationships and vulnerability (Bhana and Anderson 2013; Reddy and Dunne 2007). Some participatory youth programmes have effectively altered beliefs about gender and HIV risk through providing viable alternative normative behaviours. Jewkes (2010) argues that these programmes focus on building critical thinking and communication skills, and on gender beliefs and values, and it is through this that they may impact on the structural context of risk (Jewkes 2010).

Accepting the complexity of sexual activities and the associated risks highlights the need for the integration of HIV prevention with SRH (Parker and Scott 2013), including the elements of contraception, pregnancy-related care, STIs, and broader issues of sexual violence and cervical cancer (Stevens 2009). An investment in SRH services and education has far-reaching benefits including social and gender equality, and better education outcomes (Singh, Darroch and Ashford 2014). Unplanned pregnancies and STIs (including HIV) limit educational opportunities for youth. There are thus many reasons to focus on the development of students' SRH management skills.

Providing discursive spaces

In a context of high HIV risk, it is critical to develop abilities to gather information and discuss risk and vulnerability within sexual relationships (MacPhail, Pettifor and Rees 2007). Sathiparsad and Taylor (2006) argue that this can make young people aware of their rights and responsibilities, as well as build their agency to manage decision-making in sexual relationships. SRH is usually provided by university health services through information, counselling, treatment and referral for contraception, STI and pregnancy testing. Nevertheless, students have "substantial unmet sexual and reproductive health needs" (Hoffman et al. 2017, 9). For students to become agentic in the management of their SRH it is necessary to build on health-centred provision, by providing discussion spaces about the context of sexual activity and risk. This might address the "AIDS fatigue" experience for students when presented with didactic educational information about HIV and risk (Shefer et al. 2012). Stigma also still prevents HIV education (Aggleton et al. 2011), and these forums might counter prevalent silencing and facilitate engagement with SRH. Small-group participatory learning processes are

useful to develop critical consciousness about how gendered roles and norms create contexts for sexual health risk (Petersen et al. 2009). Group-based delivery facilitates exploring social norms, especially if led by older mentors (Harrison et al. 2010).

This article reports on a SRH programme piloted at two South African universities. It is not a formal evaluation study. We present a thematic analysis of findings with respect to students' dominant SRH concerns and their responses to sexual activity and related vulnerabilities, and we comment on the utility of this kind of intervention process.

Auntie Stella programme

The Auntie Stella programme is SRH intervention material developed in Zimbabwe by the Training and Research Support Centre (TARSC 2006). The material has been trialled with adolescents in a number of African countries (Gwadara 2009; Kaim and Ndlovu 2000) and was thus seen as relevant to the Southern African context, although it would need some adaptation for university-level students as young adults. The material promotes discussions about SRH through addressing topics such as relationships, peer pressure, unplanned pregnancy, gender-based violence, STIs (including HIV) and transactional sex (see TARSC website: http://tarsc.org/auntiestella/). An example of the material (Card 14 *I may be HIV positive*, of 42 such cards) can be seen in Figure 1. The Auntie Stella (AS) material was devised to be used in a peer-led, participatory process. The "agony aunt" format on each card allows the participants to discuss a "question" posed in a narrative that sets out an issue or problem, as a letter, and then to engage with a proposed "answer" and a set of activities to guide group discussion, facilitated by a trained peer. The activities draw on the knowledge and experiences of young people on SRH issues.

METHODOLOGY

In this study we used the Auntie Stella material which emerged out of a participatory research process in which young people's discussions about sex and relationships formed the basis of the cards which were developed. Our methodology echoed the participatory elements in TARSC's research process in that group discussions were facilitated by slightly older students (older "peers"), and group members took an active role in responding to the stimuli and determining the direction of and the level of detail in discussions. Whilst participants did not determine the research methods, they actively contributed to the content and their interests directed the choice of further materials to be used. Gilbert and Sliep (2009) have found that critical thinking and reflexivity are promoted in dialogical contexts, because the informality

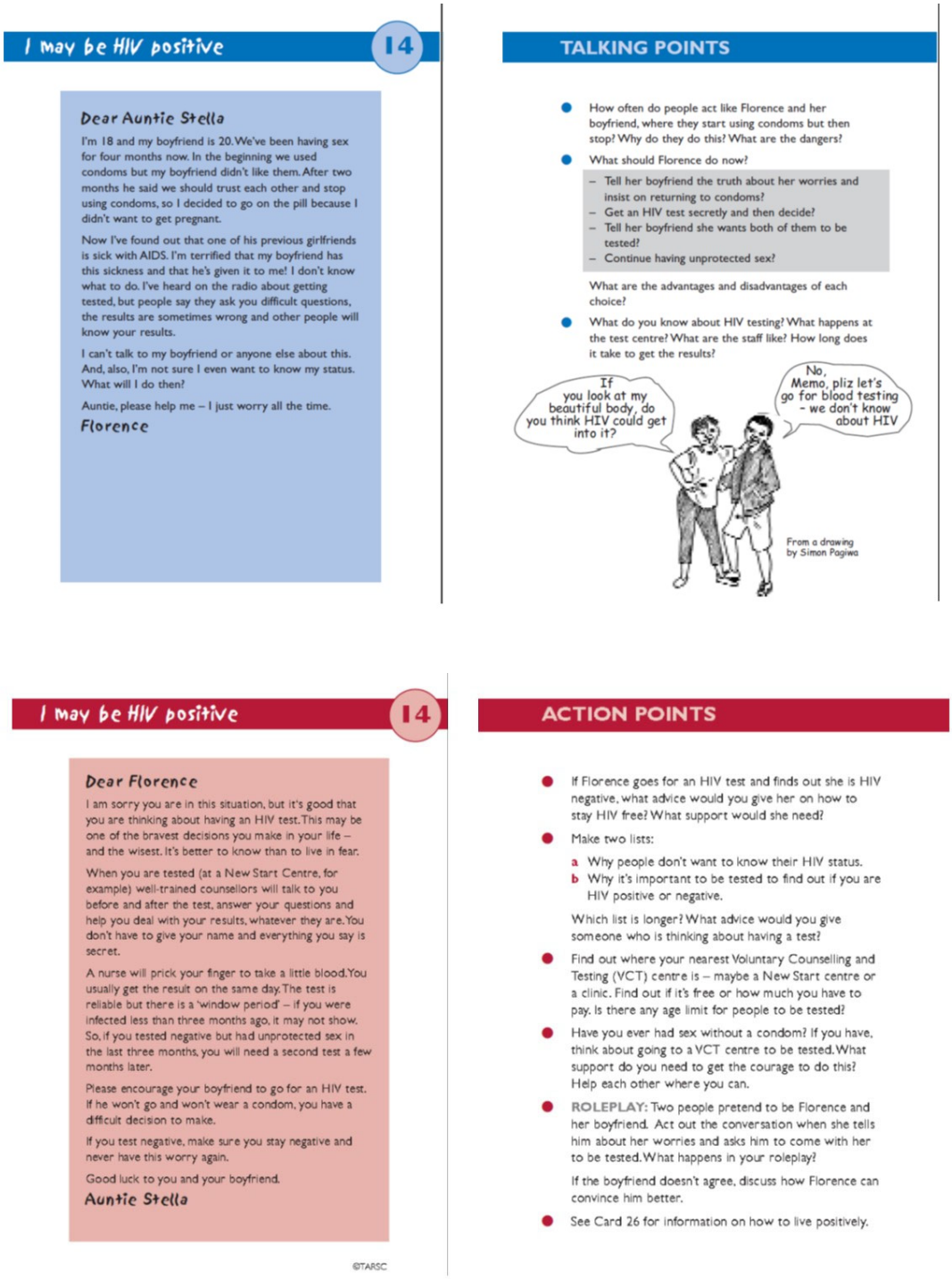

Figure 1 Card 14: I may be HIV positive

and relational interactions enable more open and frank discussions. A systematic review by Harrison et al. (2010) also found that group-based approaches were most successful in shifting norms regarding risky sexual behaviours. In this research process, the group discussions facilitated students hearing alternate views, challenging, and learning from, each other. In this way the methodology encouraged critical thinking.

For this study, participants were recruited across two urban university campuses through advertising on social media and notice boards, addressing university classes and snowball

sampling. Registered students who responded, and were over 18 years old, were invited to participate in a series of group discussions. Participants were encouraged to attend more than one session, in an attempt to construct a process of engagement with SRH matters. Across the two campuses, 42 undergraduate and postgraduate participants between 18 and 26 years of age were involved. Most identified themselves as male or female with some providing alternative identities. Ethical approval for the pilot study was obtained from the two institutions where the study was conducted (HSS/0445/017 and PSY2016/02).

A series of focus group discussions (some female only and one male only) took place in 2016/7, using cards selected by facilitators as appropriate for a university-level student group. This selection included cards featuring communication in heterosexual relationships, safer sex negotiation, peer pressure, HIV testing and disclosure, and gender-based violence; and excluded cards featuring biological aspects of puberty, sex and pregnancy, homosexuality and household caring arrangements. The AS material was used as the basis for the discussions with the postgraduate student facilitators prompting the participants to clarify or expand issues. The facilitators received basic training in the content of the AS cards. The discussions occurred in English, with some code-switching to isiZulu and isiXhosa (the first languages of some of the participants). Discussions were audio-recorded for transcription purposes and translated where necessary. The qualitative analysis of this data used a thematic analysis framework (Braun and Clarke 2006). The themes that were identified are presented as a set of tensions that became evident in the students' discussions, highlighting the need for ongoing engagement around these SRH issues and the AS materials.

EMERGING THEMES

The findings depict a series of tensions or contradictions that characterise the participants' responses to dilemmas relating to sexual activity. Overall it is clear that these university students are knowledgeable about HIV transmission, as well as about some other SRH-related issues. They appear to know what kinds of sexual interactions create greater risk (e.g. not using a condom, having multiple partners). Many of them have relatives living with HIV and using anti-retroviral treatment. There were some issues that students presented as needing more clarification, for example, the possibility of being re-infected through unprotected sex, the trustworthiness of condoms, and child-bearing among partners living with HIV.

The tensions seemed to constellate in four main areas. Firstly, participants' awareness of HIV and knowledge about transmission contrasted sharply with their reports of their own and other students' relationship practices. Secondly, their awareness of risks in sexual activity and of HIV prevalence was in tension with their denial of vulnerabilities. Thirdly, they seemed

aware of people's rights, but identified limitations on people claiming these rights. Finally, their knowledge about HIV contrasted with their stigmatisation of HIV and their awkwardness in discussions about disclosure. In the presentation of these findings the researcher is referred to as 'R', and participants as 'P', the universities are referred to as "UniX" and "UniY", the relevant focus group discussions are numbered, and card numbers and topics are noted.

HIV awareness vs practices

Across the two universities and various focus groups, penetrative sex in relationships (between women and men) happened to establish, or to prove, love of/for a person, or to indicate the seriousness of the relationship. Abstinence was mentioned only in the early stages of a relationship, or as a strategy to avoid the distractions, demands and risks of sex interfering with their studies. Condoms were used mostly in casual relationships and were not used consistently; condom use might take place initially and then diminish as the relationship became more established, as illustrated below:

> "Sometimes you find that okay, we trust each other. But maybe one time while you are about to have sex, you discover that there is no condom. And you decide to have sex without it. It then happens again a few weeks later and soon you discover that it is a habit, you guys are having sex without a condom more often than not." (UniX2, Card 14 I may be HIV positive, Card 16 I was raped).

Most students did not know the HIV status of their partners, and therefore unprotected sex represented a risk. Practices like having multiple partners and having sex when under the influence of alcohol were reported as common, increasing the risks. This illustrates contradictions between knowledge and actions:

> "... almost everyone in my area engages in sexual activities without knowing their partner's status and they have multiple sexual partners or temporary relationships, and no one encourages another to get tested before engaging in sexual activity. It's more risky, mostly when you're under influence of alcohol and under pressure of having many friends who are also doing it. You find yourself doing it also. When you know that you do not know your sexual partner's status, you should use condom." (UniX2, Card 22 Should I tell him I'm HIV positive?).

Transactional relationships, or transactions in relationships, were seen as common. In discussions about Card 12 *I pay for lunch, don't I deserve sex*?, one participant commented:

> "The majority of guys pay for things in the hope that you will have sex or hook up with them, buying you drinks and getting you a bit more drunk. Even presents and stuff. It makes you more susceptible for you to be nice to them ... they think he deserves it. They always say 'he's so sweet and he always pays for everything'." (UniX1).

In the men's discussion (UniY2) of Card 12 *I pay for lunch, don't I deserve sex?*, young men resisted the construction of the young woman being at risk. Their commentary focused on how not achieving sex in this interaction would embarrass the man, illustrating a complex set of identity positionings in relationships:

> "... I think this girl takes this guy for an isdididi [fool], because once you do everything for a girl she just takes you for granted. You think that she's using you at the end; she ends up not loving you but using you. I think this lomjita [guy] is not loved but is being used because if he's loved, ngabe bayamgcabisa [she would be having sex with him]."

The facilitator in this group (UniY2) then engaged the participants about their construction of the materiality of love. The participants seem insistent that "nothing is for free", framing sexual relationships as contracts with material exchanges:

> Researcher (R): "So, spending means that he loves her?"
>
> P: "Yeah, you wouldn't waste your money on something you don't love; you wouldn't take your money and buy a car if you don't like it. You take your money to buy something you like not something you don't want."
>
> R: "So, if you love/like something, you should force it to love you back or give you something you want?"
>
> P: "You not forcing it, brother, but you show that you need it, you pay for this thing."
>
> R: "So basically, you're buying it?"
>
> P: "You pay for it; you don't want it for free."

The discussion amongst these men centred on the exchange implicit in such relationships. The only resolution they offered was that "he" should not buy things and "she" should not take them, because her acceptance implied agreement to the terms:

> "It's like a contract and she accepts the offer, but she doesn't want to perform in terms of the offer .... The girl should stop taking Themba's things if she doesn't want to sleep with him, straight."

In a discussion of Card 36 *My sugar daddy treats me badly*, in which a young woman who is in a relationship with a much older man recounts her abuse, participants showed an awareness of the power differential and the reduced agency of the woman:

> "... Going back to the card where he hurts her intentionally because she didn't want to have sex without a condom, that just shows the power he thinks he has over her. That's wrong, because that just shows you that he doesn't see you as a person but like as this object for his personal use." (UniX1, Card 36)

Participants also demonstrated awareness of the limited options available to a young woman in such circumstances. Participants highlighted how social disapproval of the intergenerational relationship could restrict the girl's options if she tried to leave the relationship:

> "Awuh! ... the guy will get her [laughs] ... what can she do because you can't even go the police especially here in South Africa because they will ask you what were you doing with an old guy." (UniX1 Card 17 Should I have sex for money?, and Card 19 What are antiretrovirals?)

However, participants also commented on the material advantages of relationships with older men, and the potential of offers of marriage:

> P1: "A good thing about dating old people is that you get things such as jewellery or accessories."
>
> P3: "Also, young women date old people because they want to fit in and be able to dress with nice clothes among you friends ...."
>
> P2: "It is a good thing though to want old guys."
>
> P3: "[agrees] ... because old guys want to get married of which people at our age group, they don't talk about marriage." (UniX2, Card 17 Should I have sex for money?, Card 19 What are antiretrovirals?)

The above discussion highlights the complexities of sexual decision-making in relationships, where, especially in resource-constrained contexts, women become subject to power imbalances that limit their agency. They thus become vulnerable and unable to insist on safer sex.

Awareness vs denial of vulnerability

Despite acknowledging these practices that set up vulnerability, and despite their awareness of the inherent risks, students displayed a casual response to HIV, denying their own vulnerabilities.

> "And also with HIV, people they are no longer scared of HIV because nowadays, few people die from HIV but majority of them die from these small diseases that people don't take concern of them. So the girl must just relax; she won't die anytime soon" (participants laugh). (UniX2, Card 17 Should I have sex for money?, Card 19 What are antiretrovirals?)

In another group:

> P1: "Another thing is that, we tend to distance HIV and AIDS from ourselves. We have that mentality that 'Ugh, HIV. I will never get that. Where would I even get it from'?"

R: "Do you guys not think that also, the fact that we as the youth somehow do not fear HIV and AIDS?"

P1: "Indeed. I believe majority of us fear cancer more that HIV." (UniX2, Card 14 I may be HIV positive, Card 16 I was raped)

Assessments of HIV risk exposure were based on the degree of closeness to a sexual partner, and physical appearance. This denial of vulnerability (in spite of knowledge) seems interwoven with a stigmatisation of HIV, as is evident in this extract:

> "... we have that mentality of when someone is close to you, we think they do not have HIV. We conclude on that based on their appearance and we do not think that we are at risk. Even though we are taught that HIV has nothing to do with appearance, but we still behave as if it does. We distance it from ourselves, even when you know your status but you do not know your partner's, we still do it because when we look at them, we say that they are handsome and where could they possibly get HIV? Then we engage in sexual activity without using a condom." (UniX2, Card 22 Should I tell him I'm HIV positive?)

Being in love with and trusting one's partner were seen as a form of protection against risk:

> "... in some relationships once they hear the words 'I love you', they automatically think love is equal trust; he/she is healthy; he/she will protect me; he/she is free from diseases. If my partner was not, he/she was going to tell me because she/he loves me; our love means we are open to each other and we protect each other." (UniX2, Card 22 Should I tell him I'm HIV positive?)

The prejudice related to HIV and AIDS is evident in the participants' association of the diseases with lower educational level, outside of the university setting. This discussion also shows their awareness of the disconnection between knowledge and activity:

> "We attach [associate] HIV and AIDS with uneducated people. For example, in a university setting, we get shocked when people say they are HIV because we think that educated people are less like to get HIV. I do not know why this is a case because we have psycho-education around HIV and AIDS, but we still believe what we want to believe." (UniX2, Card 22 Should I tell him I'm HIV positive?)

This denial of vulnerability has also been found by other researchers working with student participants (Shefer et al. 2012; Petersen et al. 2009).

Rights vs taking action

On one of the campuses the study was conducted at a time when there was a heightened sensitivity to women's experiences of rape and sexual violence, and a strong rights discourse

was evident:

> "Even if I come to your house or room and we agreed to have sex, if I say no and I am not feeling it anymore then he must stop. If not, he is raping me. Regardless of whether I had come there initially to have sex with you." (UniX2, Card 14 I may be HIV positive, Card 16 I was raped)

Protests at this university had highlighted students' frustration with official responses and students' awareness of the systemic gender inequities, illustrating both women's vulnerability and an increased agency in calling out men who had used their power over women. Participants also noted the gendered social organisation in institutional settings that might play a role in some people's passivity in taking self-protective steps:

> "The law does not protect us. We as females in this room talking about something painful such as rape, if we find ourselves in such a situation, we doubt that we will report. So clearly we are not safe." (UniX2, Card 14 I may be HIV positive, Card 16 I was raped)

This awareness of rights and systemic constraints did not necessarily enable students' agency. Negotiation about sexual practices and assertion of one's rights may also be inhibited by fear of intimate partner violence:

> "So maybe this boy beats you up once. Then you make an excuse for him that 'He was drunk' and 'He apologised; he will not do it again' or 'He was angry because I did not want to have sex', and still you make excuses for him. ... The next time, he beats you up because ... a guy from church ... walked you home and you are not having an affair ... he will accuse you of being a slut and beat you up and rape you still. ... For me, when it is a boyfriend [who raped you or used coercion], it will not be easy. You will ask yourself questions like 'Oh, but what did I do?', 'If I don't give him sex, then where will he get it?'" (UniX2, Card 14 I may be HIV positive, Card 16 I was raped).

The above comments illustrate the social contexts of students' SRH decision-making, and the participants' keen awareness of the constraints on open communication in relationships. Their seemingly casual references to physical violence resonate with research that has highlighted intimate partner violence as a significant driver of HIV risk (Jewkes et al. 2006).

HIV awareness vs stigmatisation

Having an experience of HIV through a relative or community member, whom they know is HIV positive, could make students sympathetic and aware of the risks. However, this awareness seemed to be in tension with their moral judgement of those who were HIV positive. This was evident in discussion of Card 22 *Should I tell him I am HIV positive?*, in which a young woman was constructed as "evil" if she did not reveal her status to her partner:

> "No, she must not be evil; she cannot sleep with Thando knowing that she is HIV. She must tell him and if Thando is willing to risk his life, they can use a condom. But she must tell him." (UniX2, Card 22).

This rather extreme labelling might be based on participants' own fears of not knowing their sexual partners' HIV status. However, it also shows prejudice. Some of the students argued that the "right way" was to tell him first, and prioritise protection. Later in this group, a participant comments that "... they can have sex but they must also protect themselves" (UniX2, Card 22). This supports Auntie Stella's answer in Card 22 that tries to balance the responsibility of the individual (to disclose their status) and their rights (to have sex), with the rights of people without HIV. In the AS card, the letter-writer is praised for being conscious about not "passing on HIV", and asked to take the responsible steps of abstaining or using a condom during sex so as not to risk infecting her partner.

However, the tensions between doing the right thing, disclosure and self-protection, became more evident in discussions related to their own disclosure. A discussion of Card 14 *I may be HIV positive,* illustrates participants' fears of the repercussions of disclosure to a sexual partner, with a focus on physical violence or public outing and shaming via social media or gossip as forms of retribution, for example: "No. No. She should not tell her boyfriend anything! He may want to harm her or even accuse her of cheating on him." (UniX1). Participants in this group suggested that the young person's course of action should be to find out her status, rather than rely on the relationship: "She should rather go get tested alone, find out where she stands and only then should she talk to her boyfriend" (UniX1). This suggests that students do not experience relationships as places of support and safety.

Participants in another group (UniX2, Card 22 *Should I tell him I'm HIV positive*?) also commented on the risks of disclosure and people's right to keep their HIV status confidential (i.e. "it's not an obligation to reveal your status"). The discussion swung between comments on how disclosure may risk the relationship (e.g. "He could leave you"), how disclosure could be personally damaging (e.g. "He could reveal it to others"), and how it was deceptive and unfair if one did not disclose (e.g. "one could be seen as a liar, and *playing him*").

In these discussions, participants seemed to be trying to find ways to retain the relationship, be self-protective in terms of sexual risk, protect the innocent and unaware partner, and also to hold on to their rights to confidentiality. In discussing Card 38 *My mother has HIV and says so*, which addresses the imperative to disclose and the fear of the repercussions, participants also supported the need to disclose, but expressed fears about stigmatisation. Interestingly, at the end of the discussion one of the participants prioritises the individual's right

to protect her reputation and identity, and to think of herself:

P2: "But sometimes it is not good to tell people about your status because sometimes people can spread or gossip about other people's lives or business. For instance, if I tell one my friend that I'm HIV positive then do something that upsets her/him, then she/he can decide to backchat me with my status."

P3: "... But if you reveal your status, people will also start treating her [you] differently now that she is [you are] HIV positive."

P2: "I would not tell my friends ... then next thing they start fearing and even scared to mention the name HIV and even scared to criticise people who are sleeping around because they will think maybe I was sleeping around. I think a person should start thinking about yourself rather than thinking about other people, because people will feel awkward if you tell them you are positive." (UniX2, Card 38)

However, another group discussion about Card 38 *My mother has HIV and says so* reveals more stigmatising attitudes, and participants' concerns about being infected with HIV. The participants said they would leave a partner if he revealed his status. The researcher challenges the participants about this prejudice, as follows:

R: "Why the concept of leaving because of HIV?"

P3 and P5: "Because we are scared of getting infected."

R: "Why are you leaving? You will meet other people and they will not disclose their status, then what? This is a stigma attached to HIV. Wanting a relationship with you does not mean I want to infect you."

P5: "Come on, I am negative and you positive; do you see your future with me? Participants: Haibooooooooo. [NO] ...."

R: "So, people with HIV do not deserve to be with people who are negative? ..."

P3: "It's not to say they don't deserve to be loved. Personally, is that I expect at some point in our relationship I will expect to have sex with you without a condom. What will happen?" (UniY1)

Such stigmatising statements reveal gaps in existing SRH campaigning, and students' knowledge, around challenging the assumptions of heteronormative sex – that, even in contexts of high HIV prevalence, "real sex" remains penetrative, HIV-free and condom-free (Wilbraham 2016). This resists engagement with other sexualised practices and biomedical advances in antiretroviral treatment, and how safer sex might be normatively performed between sero-concordant and sero-discordant partners.

The usefulness of AS material

The AS material, particularly the cards selected as appropriate for university-level young adults,

seemed to open discursive spaces around students' experiences in sexual relationships and their concerns about sexual health. Their awareness of risks and vulnerability were in tension with actual sexual practices. The precarious balancing of personal protection with expectation to disclose, the fraughtness of sexual negotiation in relationships, and their stigmatisation of those with HIV, illustrate the complicated context of SRH decision-making for young people at university. For the most part, the selected AS material reflected students' concerns and realities. Students seemed to identify with the issues on some of the cards, as is suggested here:

> "... it makes you reflect on the fact that, by the way, I am not the only one who experiences what I am going through; there are many others with similar challenges" (UniY1, Card 1 Should I sleep with him?).

Participants in a male focus group argued that students need to be more prepared when coming to university, hinting at the need to understand the social and cultural context of sexual activity, rather than just the activity of sex:

> "You should be told that when you get to 'varsity', you should do this and that and know what to expect, not to be told about umkhuba [sex] but what even leads to umkhuba so you can distance yourself from it." (UniY2, Card 1 Should I sleep with him?)

Participants commented on the value of the AS process, and the robust style of Auntie Stella's commentary and guidance, viz.

> "Auntie Stella is very clever, look at the 'You have a very difficult decision to make' – she is low-key suggesting that she should dump should he refuse to use a condom again." (UniX2, Card 14 I may be HIV positive; Card 16 I was raped)

However, participants also commented that some of these issues were common amongst "children", meaning those younger than them, suggesting that they were using the cards as a distancing device. This highlights the need to adapt the material to depict student-age-related situations to avoid participants' othering of the problems and issues. On the other hand, for some participants the advice that Auntie Stella provided was perceived as not relating to young people's realities:

> "I think it's easy for an adult to say, like, don't do this and that, don't care about what everyone says, but when you're in an environment where they're not gonna stop teasing you and stuff ... [everyone laughs] ... it's still not easy to fix, and for him it's still gonna be hard to say to himself 'Well, I'm just gonna stop listening to them and stuff'." (UniX1, Card 12 I pay for lunch, don't I deserve sex?, Card 6 I want to have sex like all my friends!)

In another example that opened up useful resistance from students, Auntie Stella suggests joint testing in Card 14 *I may be HIV positive*. However, in a university context that includes unequal heterosexual relationships, along with fears of blame, public shaming on social media and violence around disclosure of HIV-status, joint testing for HIV was not seen as a realistic or well-researched option, viz.

> "... Stella should look at both sides and look at the pros and cons of all the suggestions that she gives." (UniX2, Card 14 I may be HIV positive, Card 16 I was raped)

Participants in the discussion of Card 16 *I was raped* were also very critical of Auntie Stella's response. In response to Sibongile's letter describing how her uncle raped her when she went outside, Auntie Stella responds in Card 16:

> "Rape is never the victim's fault but there are ways for women to try to avoid it. Never walk alone (if you do, look confident and walk fast). Never, at any age, drink too much alcohol or smoke mbanje (marijuana). If you like a boy, tell him firmly how far you want to go before you start romancing. If you are attacked, scream, kick, bite, hit or knee him between the legs – and try to get away. Sibongile, I do hope you find the help you need."

The participants reacted strongly to the content and attitude of this response, commenting that it was judgemental and unfairly placed the responsibility in the hands of women:

> P2: "Auntie Stella is being ridiculous. Somehow she says that when girls or women drink, getting raped at the end of the day or night is their fault because they went out drinking or were smoking in the first place."
>
> P1: "At some point she does say that rape is not the survivor's fault, but she has a BUT. She says because you did not fight or bite, then it's your fault and she is somehow making excuses for the uncle. Stella is talking rubbish." (UniX, Card 16 I was raped)

These comments highlight the importance of further adaptation of the material to tertiary level students, with careful attention being paid to gender, and to age – without entirely removing the possibilities for students' discursive engagement with didactic or overly simplistic messaging.

DISCUSSION

The AS material, particularly in the form of an ongoing focus group process, could be argued to be an "effective teaching" of HIV and AIDS (Gill and Di Monte-Miller 2017). Its participatory style and opening up of a space for dialogue is in sharp contrast to didactic health education processes. The material in the selected cards had a particular focus on HIV and AIDS,

however there was relatively little discussion about the (shifting) facts related to HIV and AIDS in an advanced epidemic, suggesting the need to regularly update the material. Discussion centred on sexual diversity, personhood and rights, types of femininity, the ways in which men and women act in relationships, and issues of power and exchange. It is clear that the material has the potential to move beyond issues of abstinence and partner reduction (Aggleton et al. 2011), with the social context of relationships and decision-making being evident throughout the discussions. This hold promise for further development of the AS material, to move beyond the transfer of knowledge and develop young people's agency in SRH decision-making (Harrison et al. 2010).

It is clear that these young people in university settings valued the discussions about SRH using the AS material. Although these groups did not specifically develop abilities to gather information (cf. MacPhail et al. 2007), nor were they designed for a specific focus on skills development, the participants spoke out about a range of issues related to student SRH practices, at times referring directly to their own SRH practices. Several researchers have identified the need to engage with young people's experiences, in order to inform the development of sexual decision-making and relationship management skills (e.g. Aggleton et al. 2011).

However, the findings illustrate disjunctures between students' espoused attitudes and knowledge and their responses and reported actions. Their discourse and positioning illustrate tensions and contradictions within their practices, and in their understandings of risk, rights and HIV-related information. It seems that their level of education and their access to resources did not guarantee that they would engage in self-care and protection. The implication of this is that interventions need to create spaces to challenge social norms related to SRH, and provide spaces for students to engage in collective critical thinking. Working on these disjunctures through group discussions could potentially impact on protective behaviour.

Although facilitation of these processes is key, our task was not to provide evidence of the efficacy of peer facilitation, which would need a bigger study and possibly a longitudinal design. However, it might be that having a slightly older peer facilitator initiate the discussion, probing and prompting debate, helps to break the silence young people experience around issues of sexuality and risky practices. This has implications for the training of facilitators to promote the development of participants' agency to manage decision-making in relationships; and to develop participants' critical consciousness about how gendered roles and norms create contexts for sexual health risks.

CONCLUSION

Whilst in SRH research, there has been a focus on poverty-affected contexts of risk, specifically

with younger adolescents, there is little research related to non-curricular programmes in university settings. In sum, the data indicates that this methodology and the nature of the material stimulated energetic discussions about SRH in the university context. This peer-led, participatory and interactive process articulated students' knowledge, experience and concerns about sexual relationships, health and risk. It also provided a window onto students' lives and the social contexts of their SRH decision-making. The AS material, if customised for the HE context holds promise as the basis for developing such interventions further. Adaptations of the AS material could be used to create a sex-positive discourse, fostering young people's agency in sexual decision-making. This study illustrates the need to understand other contexts of risk, which are crucial for the population in HE and the experiences of young people who are managing sex, intimacy and relationships. Broader student services divisions, their managers and counsellors need to be more actively be involved in designing and supporting interventions such as this.

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