EXPLORING THE REASONS FOR THE LACK OF KNOWLEDGE ON HIV TO PREVENT HIV INFECTIONS AMONG FORMER SECONDARY SCHOOL-GOING YOUNG WOMEN IN TOWNSHIP COMMUNITIES, KWAZULU-NATAL

by

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DECLARATION

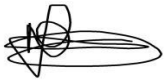
I declare that the above dissertation is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I declare that this study was conducted in strict adherence to the Unisa Research Ethics Policy and that ethical approval was obtained prior to data gathering.

I declare that I submitted the dissertation to originality checking software and that it falls within the accepted requirements for originality.

AI tools were used solely to assist with language editing and improving the academic writing, generating ideas and clarifying concepts, organising and structuring the content, and improving the clarity, grammar, and overall presentation of the work. The AI tools were not used to summarise or explain existing literature or to perform data analysis. The final submission reflects my own understanding, critical thinking and original input and I take full responsibility for its content.

I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other higher education institution.



2026-02-06

SIGNATURE DATE

DEDICATION

I dedicate this dissertation to my two lovely children

Ntokomalo and LuThingo.

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I wish to express my outmost gratitude to both the seen and unseen. To God be the glory for guiding me through this process as well as phase in my life, for always being there through the toughest times and always lighting up the path to my journey. I do not stop there but I also give thanks to my ancestors for always looking out for me and making it possible to achieve my dreams.

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ABSTRACT

The study explored reasons for limited HIV-related (human immunodeficiency virus) knowledge amongst former secondary school-going young women aged 19 to 24 years in the Umlazi township community, KwaZulu-Natal, and how these factors may undermine HIV prevention efforts. Given their disproportionate vulnerability to HIV infection, the study examined factors contributing to limited awareness, barriers to prevention initiatives, and educational approaches that could reduce risk.

A qualitative research design employing purposive sampling was utilised. Data were collected through semi-structured interviews with 15 young women who had completed secondary school and were analysed using thematic analysis.

Participants reported receiving HIV education at school; however, they perceived it as outdated, judgemental, and limited in scope, with insufficient coverage of sexuality, gender relations, safe sexual practices, and HIV-related stigma. Additional barriers included social stigma, inadequately trained educators, and limited support systems.

The study recommends the wider implementation of peer-led interventions and enhanced educator training to promote informed decision-making regarding sexual and reproductive health and HIV risk reduction.

The findings highlight the need to strengthen school-based HIV education to improve HIV-related knowledge, reduce vulnerability and support long-term HIV prevention efforts in township communities.

KEYWORDS: 19-24 years, HIV, Insufficient/Lack of Knowledge, KwaZulu-Natal, Preventive Measures, Secondary Schools, Young Women

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LIST OF ACRONYMS AND ABBREVIATIONS

ACRONYM / ABBREVIATION	DESCRIPTION
AGYW	adolescent girls and young women
AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARVs	antiretrovirals
ASRHR	adolescent sexual and reproductive health and rights
COVID-19	coronavirus disease 2019
CSE	comprehensive sexuality education
DBE	Department of Basic Education
GBV	gender-based violence
HBM	Health Belief Model
HCC	HIV care continuum
HIV	human immunodeficiency virus
HIVST	HIV self-testing
HSRC	Human Sciences Research Council
HTC	HIV testing and counselling
IPV	intimate partner violence
KZN	KwaZulu-Natal province
LO	Life Orientation
PEP	post-exposure prophylaxis
PrEP	pre-exposure prophylaxis
PLWHA	people living with HIV/AIDS
PTSD	post-traumatic stress disorder
QoL	quality of life

RDP	Reconstruction and Development Programme
SA	South Africa
SADAG	South African Depression and Anxiety Group
SCT	Social Cognitive Theory
SLT	Social Learning Theory
SRH	sexual and reproductive health
STI	sexually transmitted infection
TasP	treatment as prevention
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational Scientific and Cultural Organisation
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Introduction

The province of KwaZulu-Natal (KZN) in South Africa continues to exhibit second highest prevalence of HIV (human immunodeficiency virus), particularly amongst young women, 19 to 24 years old. Although the general population's HIV prevalence was estimated to have decreased by 44% in 2012, recent data suggest that the burden of HIV continues to be disproportionately greater amongst young women compared with young men (UNICEF, 2023; Naidoo, Takashana, Sewpaul, Jooste, Siyanai, Maseko, et al., 2024:74). According to Statistics South Africa (Stats SA) (2022) and UNAIDS (2023), in 2022, an estimated 7.8 million South Africans, or 12.7% of the country's total population, were predicted to be HIV-positive across all age groups. While formal education is important in spreading HIV-related information, many young women who have completed secondary school still have a poor awareness of HIV transmission, prevention and socio-behavioural factors that influence risk. This is especially evident in township and other underserved communities, where structural disparities, societal norms, and restricted access to youth-friendly healthcare exacerbate risk. Recent South African studies have shown that adolescents continue to face barriers to accessing sexual and reproductive health information and services, including stigma, inadequate implementation of adolescent and youth friendly services, healthcare system constraints and social norms that discourage help-seeking behaviour (Holtman, Bimerew & Mthimunye, 2024:1-2; Malahlela, Muthelo, Mbombi, Ntho, Phukubye, Ntshayintshayi & Ramalata, 2024:2; Rammela & Makhado, 2024:1-2).The transition from secondary school to early adulthood is a hazardous age in which many young women are exposed to more HIV risk factors, frequently without appropriate tools or support to protect themselves.

Despite the continuous efforts to implement and promote HIV prevention and support programmes to young women about practicing safe sexual behaviours, young women still lack the fundamental knowledge and attitudes about HIV, which increases their risk and vulnerability of HIV infections (UNAIDS, 2020). Therefore, HIV infections are likely to keep spreading because of the insufficient awareness and understanding of the virus (Nqabeni, 2018:61-62). In reference to the above-mentioned, unfavourable views and perceptions of HIV-infected individuals and the bias that findings from classifying a person as a member of a group that is seen to be socially unacceptable strongly influences the beliefs that people have. Beliefs such as thinking that HIV can only affect a specific subset of the population, passing moral judgement on individuals who take action to stop the spread of HIV and believing that some are deserving of HIV infections because of their decisions. Young women and future generations should be taught adequate and correct information about HIV and AIDS to prevent infection and re-infection which will lessen the vulnerability of women to HIV.

The implementation of various channels to educate and promote knowledge about HIV to young women in secondary schools and in their communities should empower them to be more cautious when engaging in sexual activities, increasing their awareness on infections and about safe practices in order to prevent HIV infections and lower the transmission rates (Obiezu-Umeh, Nwaozuru, Mason, Gbaja-Biamila, Oladele, Ezechi, et al., 2021:2). It is, therefore, important that HIV awareness programmes implemented in township communities are designed in a manner to educate young women on the various levels of care and treatment available to them if they are living with HIV or when caring for someone with it.

Wachinger, Kibuuka, Oldenburg, Bärnighausen, Ortblad and McMahon (2021:443-444) highlight that young women with awareness of their HIV status are also empowered to better control HIV-related behaviours and establish a new sense of self through access and the utilisation of HIV self-testing services such as HIV self-testing (HIVST), reduces the imbalance of testing between patient and doctor and

the drawing of blood but empowers one to take control over their life and how they test for HIV.

This study sought to explore the underlying reasons for the lack of knowledge on HIV to prevent HIV infections amongst former secondary school-going young women in township communities in KZN province in South Africa. Understanding these factors is critical for developing more effective, tailored treatment that can bridge the knowledge gap and minimise new HIV infections amongst this high-risk population.

1.2 Background

In KZN, the young women in the age group of 19 to 24 years of age have been categorised as a high-risk group and are at the centre of the HIV epidemic across South Africa, accounting for about half of all new infections, with young women being the most vulnerable population in the province. This gender gap is caused by a number of variables, including age-disparate relationships, transactional sex and sex work, gender-based violence (GBV), high-risk behaviours like many sexual partners, inconsistent condom usage, early sexual debuts and socio-economic considerations such as poverty and poor education levels. Research indicates that young women become involved in these kinds of relationships primarily for financial gain, often motivated by socio-economic factors (Milovanovic, Jewks, Matuludi, Dunkle, Hlongwane, Vanleeuw, et al., 2023:555-556; Jonas, Beattie, Crutzen & Mathews, 2023:2998).

The inclusion of HIV education in the Life Orientation curriculum in secondary schools, particularly in the township communities of KZN, has shown to be an effective strategy in preventing HIV. This subject offers vital information on HIV and related health issues, aimed at making HIV education compulsory in secondary schools (Ryan, Hahn, Mwinnya, Maharaj, Mvandaba, Nyanisa, et al., 2020:2). Limited understanding of HIV and its prevention strategies within school curricula, particularly in marginalised communities, reflects broader systemic weaknesses in

the implementation of sexuality education, resulting in persistent gaps in educators' knowledge (Siqwavu & Ngobeni, 2025). This limitation is not merely an individual shortcoming but also indicates inadequate training, inconsistent curriculum support, and unequal access to professional development opportunities. Consequently, the delivery of comprehensive HIV education is weakened, which undermines the effectiveness of school-based prevention programmes and perpetuates vulnerability amongst learners. Despite policy recognition of the importance of HIV education, implementation gaps continue to constrain educators' ability to translate knowledge into effective classroom practice. Strengthening educator training and ensuring sustained, context-sensitive professional development are, therefore, critical to improving instructional quality and programme effectiveness (UNESCO, 2024; UNESCO IICBA, 2025). In this regard, this study critically examined the role of HIV knowledge in preventing infections amongst young women and explores how school systems can more effectively support HIV education delivery.

Young women are more susceptible to infection because they are less inclined to take necessary precautions and engage in risky behaviours, which raises the infection rate. Sullivan, Rosen, Allen, Benbella, Camacho, Cortopassi, et al. (2020:358-360) argue that although young women seem to be more open when it comes to HIV testing than men, they also confront numerous prevention challenges including the lack of HIV education, prejudice and stigmatisation, all of which can lead to late testing, diagnosis and the reluctance to seek medical help. Although insufficient knowledge on HIV preventive measures act as barriers in reducing transmission rates amongst young women, susceptibility to infection is heightened by the lack of knowledge about HIV transmission and prevention. This also then leaves them as being recognised as the key contributors to the ability to halt the spread of infections.

Young women encounter various obstacles in gaining sufficient understanding about HIV, which impedes their ability to prevent infection. These obstacles can be classified into social, cultural, economic and systemic categories. Social barriers such as stigma, gender inequality and limited sexual health communication prevent

young women from receiving needed information and support (UNAIDS, 2023; Ngcobo & Zhandire, 2025:743). Cultural factors, including traditional beliefs (such as HIV as ancestral punishment), sexuality norms (such as stigma against condom use or myths like virgin cleansing) and social taboos that forbid talking about sexual health, discourage open dialogue and reinforce misinformation about HIV risk and prevention (Ngcobo & Zhandire, 2025:743). Economic (financial) barriers such as lack of money, unemployment, reliance on transactional sex for resources frequently prevent HIV awareness from leading to more secure actions (Haffejee, Ducray, Basdav & Kell, 2023:2). Systemic challenges where young women's capacity to acquire knowledge about and use HIV prevention methods is further hampered by insufficient health resources designed for young people, inadequate education systems and lack of female participation in HIV prevention efforts (Ngoma-Hazemba, Chavula, Sichula, Silumbwe, Mweemba, Mweemba, et al., 2024:2191).

This can, therefore, be overcome by promoting awareness about the importance of HIV testing and the prevention of sexually transmitted infections (STIs) through Life Orientation programmes implemented in the school's curriculum with an effort to encourage more young women to be open-minded to the idea of testing, diagnosis and in seeking medical attention or help (Ryan et al., 2020:2).

The Life Orientation sexuality programmes have been recognised as crucial venues for integrating education aimed at confronting detrimental ideas on HIV and AIDS (acquired immunodeficiency syndrome), GBV, unintended pregnancies as well as promoting safer and non-violent sexual practices. To effectively prevent HIV and reduce stigma and discrimination, the current level of knowledge amongst young women must be strengthened through accurate and comprehensive information (George, Beckett, Reddy, Govender, Cawood, Khanyile & Kharsany, 2022b:271; Mandiwa, Namondwe & Munthali, 2021). This will ensure better understanding and prevention of the virus.

Alternative methods can be used to enhance knowledge about HIV control and to reduce transmission. Students can be taught in languages and through methods that they are most comfortable with, making the information more relatable. Additionally, HIV education should evolve from traditional teaching to more interactive approaches, such as role-playing, which can help students to actively engage and reduce the likelihood of HIV infections in the future (UNAIDS, 2020).

If young women are properly educated about HIV prevention, their awareness will increase. They will better understand the significance of utilising condoms during sexual intercourse and have increased confidence in negotiating this with their partners. As a result, HIV transmission could decrease because of reduced exposure to the virus. Furthermore, programmes like abstinence education, PrEP (pre-exposure prophylaxis), and ART (antiretroviral therapy) are also important tools in lowering the risk of HIV transmission (Fonner, Ntogwisangu, Hamidu, Joseph, Fields, Evans, et al., 2021:3; Kumar, Haderxhanaj & Spicknall, 2021:1810). These approaches, combined with accurate information, are essential for empowering young women to protect themselves against HIV.

1.3 Problem Statement of the Research

Despite decades of global efforts to curb HIV transmission, young women aged 19 to 24 years of age in South Africa continue to be disproportionately impacted by the epidemic. Research indicates that both biological vulnerabilities and an intricate interaction of social, behavioural and cultural elements significantly increase their heightened risk of infection (Gutierrez, 2014; Butts, Kayukwa, Langlie, Rodriguez, Alcaide, Chitalu Weiss, et al., 2018:2; Tarkang, Pencille, Amu Komesour & Lutala, 2019:77-78). Restricted access to comprehensive HIV education, prevailing gender inequalities, poverty, stigma and limited open communication within families continue to undermine prevention efforts. This is particularly evident amongst young women with former secondary school education who frequently partake in risky sexual behaviours without sufficient knowledge and guidance or abilities to safeguard themselves.

This knowledge gap is further compounded by weak parental involvement in sexual health education, cultural taboos surrounding sexuality and inadequate youth-centred health services. These factors not only increase individual vulnerability but also sustain cycles of HIV transmission within families and communities, placing an ongoing burden on public health systems and hindering national progress in HIV control (Fauk, Hawke, Mwanri & Ward, 2021; HSRC, 2018).

Although existing studies have extensively documented the social and structural drivers of HIV risk amongst young women, less attention has been given to how former secondary school-going young women specifically interpret and apply HIV prevention knowledge after leaving school. In particular, limited research has explored how school-based HIV education, parental communication, cultural dynamics, and access to prevention resources collectively shape their post-school HIV-related knowledge and risk perceptions.

To address this gap, this study employed a qualitative approach to explore the experiences and perspectives of former secondary school-going young women in Umlazi Township, KZN. By examining how participants interpret and apply HIV-related knowledge within their social, cultural and family contexts, the study provides insight into the factors that facilitate or hinder HIV prevention after leaving school. In doing so, the study contributes context-specific evidence on the interaction between educational, familial, cultural and structural influences on HIV-related knowledge and behaviour. The findings may inform the development of more targeted, culturally responsive and youth-centred HIV prevention interventions, policies and educational strategies aimed at reducing HIV vulnerability amongst young women in high-risk communities.

1.4 Rationale and Significance of the Study

According to Alhasawi, Grover, Sadek, Ashoor, Alkabbaaz and Almasri *(*2019:471), one of the primary tactics used in the prevention and control of HIV and AIDS around

the world is spreading as much knowledge and awareness about the virus as possible. Inadequate comprehension and harmful practices are key roadblocks to HIV knowledge and prevention. With that being said, the promotion of HIV knowledge and prevention on young women will be beneficial in raising awareness of and about the virus and will result in the decrease in transmissions.

Despite ongoing HIV prevention initiatives, many young women (19 to 24 years old) continue to lack the necessary HIV education (transmission and protection) and how its implementation in secondary schools can be improved. To address this concern, the study investigated the underlying factors that hinder effective learning and identifying opportunities such as improving health education interventions on HIV knowledge by introducing new methods and strategies of upskilling young women in ways that they would not feel discriminated against, safe and important, which would encourage them to participate and engage more in other forms of implementing HIV knowledge such as interacting in activities, and teaching others about HIV and preventive measures as well as by encouraging as much parental involvement where parents also open up to their children and teaching them about HIV and prevention.

The study sought to highlight the significance of the lack of knowledge about HIV and AIDS and the prevention strategies that could be implemented to address it in the future. It emphasised the need for alternative approaches, either in the school curriculum or through public education, to inform young women. The aim is to reduce transmission and infection rates amongst sexually active girls and young women (UK Department for Education, 2025; Cabecinha & Saunders, 2022).

This study will contribute to the existing body of knowledge by equipping young women with information on HIV prevention and by recommending enhancing existing educational awareness programmes and strategies aimed at reducing the risk of transmission.

Therefore, the envisioned significance of the study is that it will assist in the reduction of HIV transmissions in future as it aims to discover what causes the lack of knowledge on HIV to prevent infections in young women and by educating young women of and about the virus and implementing strategies to teach and learn about it. The findings of this research study are essential in suggesting not only to young women but also the future generation of young women and by diminishing and combating the spread of this epidemic.

1.5 Aim of the Study

The aim of this qualitative study was to explore the reasons for limited HIV-related knowledge amongst former secondary school-going young women aged 19 to 24 years in township communities of KZN, to examine how these factors may undermine HIV prevention efforts and to identify improvements to school-based HIV education and other evidence-based initiatives that could strengthen HIV prevention and support informed sexual and reproductive health decision-making.. Additionally, to identify means by which better support for young women can be achieved through better delivery and access of HIV-related information; therefore, strengthening the educational system.

1.6 Research Purpose

The purpose of this qualitative exploratory study was to explore the reasons for limited HIV-related knowledge amongst former secondary school-going young women aged 19 to 24 years in township communities of KZN and to gain an in-depth understanding of how these factors may undermine HIV prevention efforts and contribute to their continued vulnerability to HIV infection. The study further explored participants' experiences and perceptions of school-based HIV education to identify gaps and generate evidence-based recommendations for strengthening HIV

education programmes and improving HIV prevention amongst young women in township communities.

1.7 Research Objectives

In addition to examining how to best address the lack of information on HIV impact to prevent HIV infections in young women who attended secondary schools, the following objectives were identified:

- To explore the impact of inadequate HIV knowledge, stigma, and risky sexual behaviours on the vulnerability of young women to HIV infection and the prevention of HIV infections amongst them.
- To examine young women's awareness of HIV control and prevention strategies, including condom use, HIV testing, PrEP, post-exposure prophylaxis (PEP), and treatment adherence.
- To explore the forms and nature, accessibility and effectiveness of HIV education interventions offered in secondary schools in KZN township communities.
- To identify educational and community-based interventions that may raise HIV awareness, eliminate stigma and improve HIV prevention efforts amongst young women.
- To study the influence of stigma, cultural beliefs, gender norms and GBV in determining young women's HIV preventive behaviours and their access to support services.

1.8 Research Questions

1.8.1 Main research question

What are the underlying factors influencing HIV-related knowledge, prevention practices and vulnerability to HIV infection amongst young women aged 19 to 24 in Umlazi Township, KZN?

1.8.2 Sub-question(s)

a) How does inadequate HIV knowledge contribute to the vulnerability of young women in township communities of KZN to HIV infection despite having completed secondary education?
b) What is the level of awareness amongst young women regarding HIV prevention and control strategies such as condom use, HIV testing, PrEP, PEP, and treatment adherence?
c) What educational barriers within secondary schools hinder the effective delivery and understanding of HIV education amongst young women in township communities of KZN?
d) What educational and community-based interventions can be integrated into the educational system to improve HIV knowledge, reduce stigma, and support HIV prevention amongst young women in township communities of KZN?
e) How do stigma, cultural beliefs, gender norms, and GBV influence young women's HIV prevention behaviours and access to HIV-related support services?

1.9 Definitions of Key Concepts

- Infections: The invasion and growth of bacteria, viruses, fungi or parasites that are not typically present in the body and cause infections. It is a condition brought on by bacteria that enters the tissue. Within the context of HIV, infection refers to the spread of the virus (Obeagu, Obeagu, Ede, Odo & Buhari, 2023).
- Prevention or preventive: Measures performed to prevent an undesirable event from happening are referred to as prevention. It is an act of stopping or hindering someone or something, in this case by the use of condoms, abstinence, treatment, contraceptives and so on (Cabecinha & Saunders, 2022). In the medical field, measures to prevent the onset of harm or disease include immunisations, responsible sexual behaviour and education (Obeagu & Obeagu, 2024).

- Young women: Ladies and females are terms designated to describe young women between the ages of 19 and 24 years of age. Because of a combination of biological, financial and socioeconomic reasons, this group is viewed as being especially susceptible to HIV infection in many nations (Musa, Othman, Fadele, Ahmed, Okesanya, Ibrahim, et al., 2025).
- HIV education: Initiatives or informational campaigns aimed at increasing knowledge and comprehension of HIV, including its effects, prevention, treatment and transmission. Reducing stigma and promoting safer practices are the objectives (Keyes, Turfe & Das, 2025).
- Township community: A township community is a more dispersed or smaller-scale settlement than a city. It is usually a South African residential area that was historically underdeveloped and separated during apartheid. This South African residential area is frequently found on the outskirts of cities. These populations may have issues like increased HIV prevalence, significant unemployment and restricted access to healthcare (Moghayedi, Mehmood, Michell & Ekpo, 2023:8542).

1.10 Operational Definitions Based on the Lack of HIV Knowledge to Prevent HIV Infections Amongst Former Secondary School-Going Young Women (19-24) in Township Communities, KZN

- **Young Women Who are Completing Secondary School:** Females aged 19 to 24 years residing in township communities of KZN who have attended and also completed Grade 12 at a registered secondary school. This was verified through self-reporting during interviews.
- **HIV Infection:** A general comprehension about HIV infection as discussed in the context of personal experiences, peer stories or community knowledge (Swinkels, Nguyen & Gulick, 2024). A self-reported or disclosed positive HIV status by participants without requiring medical verification.
- **Educational System:** Refers to the schooling environment and experiences that the participants experienced during their middle-school years. This

includes the curriculum, the teachers, health education programmes, and in general, school climate, especially how and where HIV-related information was missed or falsely taught, as recalled by witnesses. It is what participants remember of their formal schooling experience during secondary education, including teachers, curriculum, health education efforts as well as the general atmosphere in school (Säljö, 2023:18). In particular, the researcher wanted to examine how information on HIV was delivered or not delivered. Therefore, they then elicited from recalled and pictured descriptions in the participants' narrations.

- **Educational System: Knowledge (About HIV):** According to the study that was conducted, it referred to what participants said in interviews about their understanding of views and feelings on HIV prevention (such as condoms, abstinence) therapy. It also included both the correct answers and wrong information arising from a participant's present level of knowledge (Qashqari, Alsafi, Kabrah, AlGary, Naeem, Alsulami, et al., 2022; Sallam, Alabbadi, Abdel-Razeq, Battah, Malkawi, Al-Abbad, et al., 2022:745).
- **Susceptibility (to HIV infection):** How participants' idiomatic expressions of the possibility that they or a friend could become infected with HIV; if it is not oneself, then who? (Manby, Aicken, Delgrange & Bailey, 2022:459; Fu, Tian, Wang, Lu, Bian, Zhang, et al., 2024). Incidentally, this also refers to the way in which subjects conceive their own or companions' vulnerability to the virus.
- **Support (for HIV prevention and care):** Support includes emotional, informational and social assistance that the participants in this study received from their families, peers, partners, schools or health services in relation to HIV prevention, testing or living with HIV. It is compiled according to their (participants') own accounts (Ntuli & Madiba, 2021).
- **HIV-related information:** This refers to information that participants can recall hearing or accessing; for example, prevention methods, HIV tests, how to take the medicine, what is happening in one's body regardless of whether this information came from formal or informal media both in and out of school (Bilon, 2025).

1.11 Summary of the Research Process

The study design employed a four-month explorative qualitative research. In the first stage, the researcher was involved in preparing for data collection including identifying the research location of the study, selecting the sample size of fifteen young women of ages between 19 and 24 who had finished secondary school education through a purposive sampling technique and obtaining ethical approval from the University of South Africa (Unisa) before commencing data collection.

Data were collected over a three-month period through semi-structured interviews to explore participants' perceptions and experiences of HIV education and HIV prevention.

The final month was devoted to organising and processing the data collected by transcription, coding, categorising, as well as thematising the data to identify major themes related to the research objectives and questions.

The entire process of conducting the research was sequential in nature, starting from preparation to data collection and ending up with data analysis.

A more detailed explanation is captured in Chapter 3.

1.12 Ethical Considerations

Ethical issues were strictly observed throughout the study to respect the rights, dignity and well-being of participants. These included informed consent, voluntary participation, confidentiality, anonymity, privacy, debriefing, and the safety and security of research data. Prior to data collection, ethical clearance was acquired from the Unisa College of Human Sciences Research Ethics Committee 57115354_CREC_CHS_2023 and permission to participate was received from all participants. Participants were informed about the goal of the study, their role in the research and their freedom to withdraw at any moment without any negative effects. To maintain secrecy and anonymity, pseudonyms were employed and all identifying information was deleted from the data. Furthermore, all data were securely stored

and safeguarded against unauthorised access. The ethical precautions were implemented to protect the integrity of the research process and respect participants' rights. A more comprehensive discussion of the ethical considerations is offered in Chapter 3.

1.13 Chapter Conclusion

This chapter presented an overview of the study titled "Exploring the reasons for the lack of knowledge on HIV to prevent HIV infections among former secondary school-going young women in township communities, KwaZulu-Natal." It provided the background to the study and outlined the problem that motivated the researcher to undertake the investigation highlighting the persistent prevalence of HIV infections amongst young women in township communities, despite the existence of various awareness and prevention initiatives. The chapter emphasised the significance of examining the underlying factors contributing to inadequate HIV knowledge and the need for targeted, sustainable interventions to strengthen HIV education and reduce vulnerability amongst young women, particularly within socially and economically disadvantaged communities.

In addition, the chapter emphasised the potential contribution of the study towards informing future HIV prevention programmes, educational initiatives, and community-based interventions aimed at improving HIV-related knowledge and awareness amongst young women in KZN. Ethical considerations including informed consent, privacy, anonymity, voluntary participation, non-maleficence, safety, autonomy, and justice were strictly adhered to, ensuring the protection and dignity of all participants throughout the study. The subsequent chapter will present a review of relevant literature and theoretical frameworks related to HIV knowledge, HIV prevention, and the experiences of young women within similar socio-economic and community contexts.

1.14 Outline of the Study

The chapters of this dissertation consist of the following components:

Chapter 1: Is the orientation of the study and it briefly outlines the rationale of the study, research problem, significance of the study, problem statement, the aim of the study, research purpose and objectives, as well as the meanings of concepts.

Chapter 2: The Literature review analyses the existing literature regarding the factors contributing to insufficient HIV awareness for preventing HIV infections amongst 15 young women aged 19 to 24 years old. It explores the consequences of insufficient information, including increased vulnerability, personal challenges, and societal attitudes. The review also identifies and discusses potential strategies for improving HIV awareness in this group. In fulfilling its methodological role, it addresses the research problem, assesses theories, and provides a conceptual framework adopted for this study.

Chapter 3: Details the research design and methodology that was utilised to gain insight into the reasons for the knowledge gap concerning young women 19 to 24 years of age infected with HIV. It further outlines sampling, study population and the types of sampling methods employed, data gathering instruments and approaches, as well as ethical aspects that the researcher utilised during the research process.

Chapter 4: Focuses on the data analysis, presentation and description of the research findings where the findings of the study are based on the examination of the interview transcripts and researcher's field notes on the lack of knowledge on HIV to prevent HIV infections amongst former secondary school-going young women in township communities in KZN.

Chapter 5: Presents the researcher's observations and reflections on the fieldwork process, including experiences and insights gained during data collection. The chapter also discusses the main findings of the study in relation to findings from previous studies and the existing literature.

Chapter 6: Provides a summary of the key findings in relation to the study's research objectives and research questions. The chapter further discusses the study's contribution, limitations, and recommendations, including recommendations for future research.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter focuses on existing research and literature to explore the lack of HIV knowledge to prevent HIV infections amongst 15 young women aged 19 to 24 years old. A literature review provides a synthesis of existing research, identifies gaps and situates the study within the broader academic discussions on HIV prevention and young women's vulnerability (Ebidor & Ikhide, 2024:180; Galvan & Galvan, 2025:3; Luft, Jeong, Idasardi & Gardner, 2022:2-3; Moulaison-Sandy, Castaño-Muñoz Ridenour & Adkins, 2025:1244). Furthermore, the chapter explores suggested strategies that could be implemented to improve HIV knowledge and strengthen HIV prevention efforts amongst young women to further validate the research findings. The Umlazi district records the highest HIV prevalence rate in the country and has a lower matric pass rate compared to other districts in the province (Jimmyns & Meyer-Weitz, 2019a:385-386).

2.2 Insufficient Comprehensive Sexual Education

Adesina and Olufadewa (2020:2542) define comprehensive sexuality education (CSE) in South Africa as a curriculum-based approach aimed at equipping young women with cognitive, emotional, physical and social knowledge regarding sexuality.

The ongoing frequency of HIV infections amongst young women indicates that current educational interventions may not be adequately effective in underprivileged township areas, even though CSE is widely acknowledged as a key tool for improving sexual and reproductive health. Although many low- and middle-income nations have integrated CSE into their school systems to promote adolescent sexual and reproductive health rights, Chavula, Zulu and Hurtig (2022:197) argue that major obstacles still stand in the way of successful implementation. These barriers include

inadequate teacher training, insufficient resources, socio-cultural resistance, weak monitoring systems, and limited collaboration between the education and health sectors, all of which reduce the effectiveness of CSE programmes. This raises important questions about whether existing educational interventions adequately address the lived realities, socioeconomic circumstances, and vulnerabilities experienced by young women aged 19 to 24 living in KZN township communities. Evidence from KZN indicates that, despite supportive policies, adolescents and young women continue to face challenges such as limited access to youth-friendly sexual and reproductive health services, parental and community resistance to sexuality education, inadequate psychosocial support, and persistent cultural norms that undermine the implementation of comprehensive sexual and reproductive health (SRH) programmes (Nota, Crankshaw & George, 2025). Furthermore, Adekola and Mavhandu-Mudzusi (2022) found that sexuality education in KZN often fails to influence learners' sexual decision-making because it does not sufficiently consider the social and economic contexts in which young people live, including poverty, gender inequality, and unequal power relations.

Furthermore, the inadequate understanding of factors that facilitate or hinder the application and effectiveness of CSE reveals a crucial gap within the reviewed literature. Although the United Nations Educational Scientific and Cultural Organisation (UNESCO) (2018) advocates for age-appropriate, evidence-based and culturally sensitive sexuality education, the continued lack of HIV knowledge amongst young women suggests that access to information alone may be insufficient without effective meaningful community engagement and contextualised intervention strategies

According to Daugherty and Frabotta (2018:81-90), the lack of CSE around the world poses a serious public health issue because it leads to high risks of becoming vulnerable to the threat of HIV, STIs, unintended pregnancy, and unhealthy or abusive relationships. It can be stated that if the youth is deprived of proper information on the matter, then the individual would have lower chances of making reasonable decisions concerning their sexual health. This point of view correlates

with UNESCO (2018), where it is claimed that CSE goes beyond providing biological information and should include such skills as healthy relationships, communication, consent, and so on, as well as gender equality and human rights. Although Daugherty and Frabotta (2018) and UNESCO (2018) share similar views on the significance of CSE, it should be noted that UNESCO (2018) states that the efficiency of sexuality education largely depends on social and cultural context. Hence, adding CSE to the curriculum would not necessarily lead to good sexual and reproductive health outcomes. This argument is supported by Adekola and Mavhandu-Mudzusi (2022), who found that sexuality education in KZN has had limited influence on learners' sexual decision-making because it often fails to address the realities of poverty, gender inequality, unequal power relations, and cultural norms that shape young people's experiences. Collectively, these studies suggest that effective HIV prevention requires not only comprehensive sexuality education but also contextually relevant, culturally responsive, and community-supported interventions that address the structural factors influencing young women's vulnerability to HIV.

2.3 Exploring the Impact of Inadequate Knowledge and Risky Behaviours on Preventing HIV Amongst Young Women

In South Africa, the HIV epidemic continues to disproportionately affect young women, a reality shaped not only by biological vulnerability but also by persistent gaps in comprehensive prevention knowledge and entrenched socio-economic inequalities. Although general awareness of HIV remains relatively high, substantive understanding of effective prevention strategies such as consistent condom use, oral PrEP, and emerging long-acting prevention methods remains uneven amongst adolescent girls and young women (Jackson-Gibson, Ezema, Orero, Were, Ohiomoba, Mbullo & Hirschhorn, 2021; UNAIDS, 2024a). Importantly, this challenge cannot be attributed solely to a lack of information. Rather, it is deeply embedded within structural conditions including poverty, GBV, economic dependency, and intergenerational sexual relationships, all of which significantly constrain young women’s agency in sexual decision-making (UNAIDS, 2024b). Consequently, limited

prevention knowledge interacts with reduced social and economic power to heighten vulnerability, creating conditions that normalise risky sexual practices and increase the likelihood of HIV acquisition.

This interaction between inadequate knowledge and constrained agency is reflected in the continued prevalence of behaviours such as inconsistent condom use, multiple concurrent partnerships, and age-disparate relationships amongst young women in South Africa (Bergh, Toska, Duby, Govindasamy, Mathews, Reddy & Jonas, 2024:1137-1138; Jonas et al., 2023:2998). Within contexts shaped by patriarchal social norms and male-dominated sexual decision-making, many young women encounter substantial barriers to negotiating safer sex practices or accessing HIV prevention services (Mudzingwa, de Vos, Atujuna, Fynn, Mugore, Mabandla, Hosek, Celum, Bekker, Daniels & Medina-Marino, 2024:321). As a result, insufficient prevention knowledge weakens risk perception, while structural inequalities reinforce the acceptance of unsafe practices, sustaining a cycle of heightened HIV transmission. However, knowledge alone is insufficient to achieve sustained behavioural change.

According to Mahomed, Bukusi, Sikazwe, Musoke and Karim (2024:913), HIV prevention initiatives for adolescent girls and young women (AGYW) need to take a risk- and need-based approach that entails the use of biological, behavioural, and structural methods instead of using awareness programmes alone. This paradigm considers the fact that preventive measures are influenced not only by personal knowledge but also by how accessible, acceptable and available these services are within social surroundings. In addition, Chen-Charles, Joseph Davey, Toska, Seeley and Bekker (2025:1876) indicate that while there has been an increase in the awareness of PrEP amongst AGYW in sub-Saharan Africa, this awareness has not necessarily translated into taking the PrEP. The factors of stigma, issues of disclosure, accessibility, and other health system limitations have remained barriers to the implementation of this preventive measure.

Consequently, the World Health Organization (WHO) (2024) emphasises the need for an effective combination of HIV prevention programmes that involve the use of biomedical methods along with behavioural and structural methods in order to register significant reductions in the rate of HIV infection amongst youths. Such programmes should also cater to various social and structural barriers to the utilisation of HIV prevention programmes, especially in vulnerable groups. It is evident from these facts that HIV prevention programmes based only on awareness raising will not be effective for AGYW. Therefore, effective HIV prevention strategies must extend beyond surface-level awareness campaigns to address the broader structural and behavioural drivers of risk, equipping young women not only with accurate prevention knowledge but also with the social, economic, and healthcare resources necessary to translate that knowledge into protective action (UNAIDS, 2024a).

2.3.1 Inadequate school programmes and lack of support hinder the focus and quality of education

Numerous educational systems either exclude or insufficiently address HIV prevention and comprehensive sexual health. In certain areas, particularly within conservative or religious communities, sexuality education is restricted to promoting abstinence, overlooking essential information about condoms, STIs and HIV transmission (Ramathebane, Maja, Molungoa & Sayed, 2021:2). According to the WHO, the CSE is a key component in reducing rates of sexually transmitted infections and unintended pregnancies. Yet, despite strong data backing comprehensive sexuality education, some education policies still seem to prioritise belief systems over public health (WHO, 2023a).

From a research-informed perspective, these experiences are at the centre of a framework for CSE, developed by UNESCO, which emphasises that CSE must be grounded in the best available evidence, including that which is medically accurate and peer-reviewed. Abstinence can certainly be part of the conversation, but it should not be the entire message. Correct programmes should be used to empower

students, educating them with information about their bodies, relationships and health. Making condoms available, teaching young people how to use them, educating them about consent, preventing HIV and reproductive health are not only integral to public health but they protect human rights as well (WHO, 2023a; UNESCO, 2018).

2.3.2 Exploring the role of treatment as prevention in addressing the impact of inadequate HIV knowledge and risky sexual behaviours amongst young women

Although HIV remains incurable, the use of antiretroviral therapy (ART) demonstrates that the virus can be effectively controlled when individuals have access to the correct medication and follow treatment schedules as directed by healthcare professionals. Consistent adherence to ART reduces the viral load in the blood, improves overall health, and lowers the risk of HIV transmission. Therefore, access to appropriate medical care is essential in enabling people living with HIV to lead healthy lives and maintain safe relationships (WHO, 2023b; WHO, 2025; UNAIDS, 2023).

HIV prevention, treatment methods and service delivery paradigms are rapidly evolving. To maximise the potential impact of these novel treatments and methods, it is critical that they are designed and implemented in ways that are acceptable to individuals for whom they are meant to reach and/or involve in order to have the greatest impact (Ortblad, Sekhon, Wang, Roth, van der Straten, Simoni, et al., 2023:601).

According to Gibas, Kelly, Arribas, Cahn, Orkin, Daar, et al. (2022:869-870), there is no fixed number of HIV drug regimens, however, different classes and combinations of antiretroviral drugs used in treatments provide effective viral suppression and prevention of its spread. A combination antiretroviral treatment with three drugs has been used since 1996 as the preferred method of treatment of HIV-1 because of high efficacy of viral replication inhibition. Nonetheless, even with considerable

advancements in the safety of antiretroviral treatment, the use of the medication during the prolonged period of time can be accompanied by certain problems connected with side effects. Therefore, the emergence of two-drug regimens can be viewed as an attempt to balance between the effectiveness of viral suppression and decrease of the burden of medication. Importantly, the described tendency shows that HIV treatment approaches have been developing constantly and change according to the need in effective and safe methods for lifetime treatment. Nonetheless, while the creation of simplified regimens is important to overcome treatment-associated barriers, it is important to mention that such strategy will be successful only with appropriate patient selection, high adherence, and access to healthcare services.

Callander, McManus, Gray, Grulich, Carr, Hoy, et al. (2023:1) add that HIV treatment leading to viral suppression can effectively lower an individual's risk of transmitting the virus to zero, with universal treatment currently serving as the cornerstone of treatment-as-prevention (TasP) as an international approach to public health (Callander et al., 2023:1-3).

2.3.3 How age-disparate relationships contribute to HIV risk and hinder the uptake of HIV prevention and treatment amongst young women

Numerous global studies demonstrate that the uptake of HIV interventions is significantly hindered by factors such as low perceived HIV risk, reluctance to disclose HIV status, fear of stigma, and concerns about the side effects of treatment (Chimoyi, Chikovore, Musenge, Mabuto, Chetty-Makkan, Munyai, et al., 2022:2). These barriers indicate that HIV prevention and treatment efforts cannot succeed without directly addressing social and psychological constraints that influence individual behaviour. In addition, economic instability contributes to increased vulnerability amongst young women, as it can drive engagement in relationships with older men who are more likely to be HIV-positive caused by higher levels of prior exposure and financial power imbalances (Mabaso, Maseko, Sewpaul, Naidoo Jooste, Takatshana, et al., 2021:97; George, Beckett, Reddy, Govender, Cawood, Khanyile, et al., 2022a:973). Taken together, these findings highlight that effective

HIV interventions must address both structural inequalities and behavioural barriers in order to reduce infection risk.

Chimoyi et al. (2022) posit that the reduced involvement in caregiving amongst women has been observed as a result of real or predicted violent responses from male partners. Mabaso et al. (2021) support this by adding that sexual relationships where there is a significant age difference can place young women at a higher risk of contracting HIV. This is because older male partners are more likely to be HIV-positive and these relationships often involve sex without protection and coercion, emphasising that it is unfortunate that these young women are more inclined to do this because they frequently enter into these kinds of relationships for financial or other material reasons. Chimoyi et al. (2022) back up Mabaso et al. (2021) by criticising how men have poor health outcomes related to HIV and that this is often linked to lower rates of HIV testing, reduced engagement with and adherence to treatment potentially because of underutilisation of healthcare services.

2.3.4 How restricted access to media, technology and youth-friendly health services limits HIV awareness and prevention amongst young women

The provision and utilisation of healthcare services appropriate for young women in South Africa, particularly in high-HIV-prevalent settings such as KZN are sub-optimal. In South Africa, public clinics may seem hostile with the long hours that young women have to wait for services as well as pre-judgemental attitudes, which include limited operating hours that would discourage them in pursuing much-needed HIV prevention services such as PrEP, testing and counselling (Mudzingwa, de Vos, Atujuna, Fynn, Mugore, Mabandla, Hosek, Celum, Bekker, Daniels & Medina-Marino, 2024:321; Pillay, Stinson, Adams & Maharaj, 2021:5). Furthermore, many healthcare providers may not receive the required training to cater adequately for the distinct requirements of young women, which can result in negative experiences that deter these services from being utilised. Consequently, according to Obiezu-Umeh, Nwaozuru, Mason, Gbaja-Biamila, Oladele, Ezechi et al. (2021:2), these barriers become a part of the insufficient utilisation of essential sexual

reproductive health services amongst one of the populations that is highly vulnerable to new HIV infections (Folayan, Sam-Agudu & Harrison, 2022:1199; Govender, Naidoo & Taylor, 2020:367-368).

2.4 Exploring Young Women's Awareness of HIV Control and Prevention

The Human Sciences Research Council (HSRC) (2018) states that young women in South Africa demonstrate high general awareness of HIV, a testament to the country's extensive public health campaigns and widespread availability of ART. National surveys indicate that nearly all young women are aware of HIV's existence and its primary transmission routes (HSRC, 2018). However, this awareness often does not translate into a comprehensive or strong understanding of prevention and control mechanisms. Critical knowledge gaps persist regarding the biological efficacy of PrEP, the significance of undetectable or untransmutable, as well as the proper and regular use of condoms (Zuma, Wight, Rochat & Moshabela, 2022). This superficial awareness is frequently undermined by pervasive misinformation, stigma, and deep-seated socio-cultural norms that hinder the practical application of knowledge, leaving a dangerous chasm between knowing about HIV and knowing how to effectively control and prevent it.

Consequently, the limitations in depth of awareness directly impact young women's agency and ability to engage in effective prevention behaviours. While they may be aware of condoms, negotiating their use within power-imbalanced or age-disparate relationships remains a significant challenge, often influenced by economic dependency and the threat of GBV (Baruwa, 2025:1041). Furthermore, awareness of biomedical controls like PrEP is often low, and where it exists, access remains hindered by structural barriers including healthcare provider bias, logistical challenges, and a lack of youth-friendly services (Duby, Fong-Jaen, Brown, Scheibe & Bukusi, 2022). Therefore, enhancing awareness requires moving beyond basic information dissemination towards transformative education that addresses structural

drivers, promotes gender equality, and integrates clear, accurate information on all available prevention tools to empower informed decision-making (UNAIDS, 2022a).

2.5 Sociocultural Barriers to HIV Knowledge Amongst Young Women: Examining the Impact of Stigma, Prejudice and Gender Norms on Prevention Efforts

The persistence of HIV-related stigma in KZN appears to continue to obstruct open discussions about sexual health as societal attitudes continue to often lead to the marginalisation of individuals living with HIV, potentially deterring young women from seeking information and support (Nice, Thurman, Luckett & Zano, 2024:4158-4159; Williams, van Heerden, Friedman, Chibi, Rodrguez & Memela, 2024). Misconceptions about HIV and its modes of transmission may also influence behavioural intentions regarding HIV testing. It can be argued that comprehending a person's level of HIV knowledge or awareness is crucial to determining how much danger that they perceive when engaging in actions that could result in viral transmission such as unprotected sexual intercourse (Nall, Chenneville, Rodriguez & O'Brien, 2019:2).

2.5.1 Exploring the various forms of HIV-related stigma and their effects on access to care

Stigma is the term used to describe unfavourable thoughts, emotions and behaviours towards those who are HIV-positive or who are perceived to have the virus. Furthermore, stigma fosters social removal. Labels like "stigma" are detrimental to society that gives the disadvantaged individual or group a sense of distance from the general public (Kumar, 2023:21).

Discriminatory practices that limit people from the ability to access healthcare, employment, education and freedom of expression, amongst other things, are frequently motivated by stigma. It manifests as stigmatising words and actions,

including avoiding social interactions, verbal abuse and physical assault. According to Gilmore and Somerville (1994), discrimination refers to when someone is treated unfairly and unjustly because of their actual or imagined HIV status. It involves placing blame and evoking unfavourable feelings towards a particular group or people and claiming that they or their principles are to blame for their illness (Kumar, 2023:21; Pantelic, Casale, Cluver, Toska & Moshabela, 2020:1-2). According to Pantelic et al., 2020:2), those who are stigmatised may also interpret stigma in the form of worthlessness, guilt or humiliation. Stigma can personally result in loneliness, violence, ostracism, hunger, abandonment and demise (Kumar, 2023:20). According to Ke, Yang, Yang, Qiu, Qiao, Song, et al. (2020:1), there are risk factors linked to the route of transmission such as using injectable drugs or engaging in sex work as well as other personal traits such as ethnicity, education, religion, gender, job or disability, PLWHA (people living with HIV/AIDS) are also stigmatised (Ebrahimi Kalan, Han, Ben Taleb, Fennie, et al., 2019:287).

2.5.2 Factors contributing to HIV-related stigma

Even though there have been many efforts both globally and locally to reduce the adverse impacts of HIV-associated stigma, it is still a common and ongoing problem for young women and PLWHA across multiple settings, such as the workplace, family, community and healthcare. HIV-related stigma remains a significant barrier to optimal health outcomes, psychosocial well-being, treatment engagement, and quality of life for people living with HIV (Fauk et al., 2021:5424; Robinson, Cooney, Fassbender & McGovern, 2023:3133; Powell, Mills, Tennant, Young & Langdon, 2024:2).

Hall, Davis, Ohrnberger, Pickles, Gregson, Thomas, et al. (2024:12836) stress that it is important to know what affects quality of life (QoL) and how HIV-related stigma affects people in general in order to plan and carry out effective national and worldwide HIV programmes. Numerous studies have demonstrated that stigma associated with HIV has a significant negative impact on the quality-of-life concerning health for individuals diagnosed and living with HIV (Hoang, Pham,

Nguyen, Tran & Le-Thi, 2024:1; Kanyemba, Richter, Cloete & Anova Health Institute, 2022; Fauk et al., 2021).

It has been recognised that stigma around HIV impedes attempts to prevent, treat and test for the virus (Dessie & Zewotir, 2024). Amunyela and Magesa (2021:43) support this by adding that it has been evident that cultural beliefs and norms continue to influence health-seeking behaviours and because of insufficient knowledge about HIV, some people still believe that the infection is witchcraft. Endalamaw, Gilks, Ambaw and Shibabaw Shiferaw (2024) posit that for the HIV epidemic to be effectively addressed, comprehensive services are necessary. Members of the community should be equally knowledgeable about HIV and have tolerant views of individuals who are affected by the virus. Furthermore, they should have access to HIV testing and ART (Endalamaw et al., 2024). Jehooni, Arameshfard, Hatami, Mansourian, Kashfi, Rastegarimehr, et al. (2018:7292) highlight that education measures to enhance HIV knowledge and prevention should be provided to young women through media, interactions between students and instructors as well as through parental involvement from homes.

Moreover, in order to achieve this and given the insufficient or low levels of HIV knowledge and awareness amongst young women, the importance of knowledge about the virus in the community, the need for more attention to it at school level and the negative effects of ignorance on the HIV epidemic, it is suggested that some HIV information be included in the school's curriculum through Life Orientation sexuality programmes, which will educate young women of and about HIV and that such information be included in students' textbooks (Ryan et al., 2020:2-3).

2.5.3 The role of GBV, and cultural norms hindering HIV prevention amongst young women

Violence, fear, gender discrimination, stigma and harmful cultural beliefs substantially impact young women's deficit in HIV-related understanding and

perpetuate the HIV epidemic. These interlocking barriers restrict free communication about sexual health and limit access to accurate information (Kumar, 2023:20; Mthembu, Mabaso, Reis, Zuma & Zungu, 2021). According to South African data, intimate partner violence (IPV) is very common amongst young women. It is associated with a decrease in sexual autonomy, thereby hindering their ability to access HIV testing and prevention services, negotiate the use of condoms or disclose their status to partners, family or medical professionals (Mthembu et al., 2021:1160; Shamu, Machisa & Pego, 2021:1927195).

Mthembu et al. (2021) support this and place emphasis on fear, especially fear of violence, rejection or stigma that fuels a culture of disempowerment and silence, perpetuating false information and undermining trust in one's ability to make wise health decisions (Mthembu et al., 2021; Gibbs Dunkle, William, Jama-Shai, Washington & Jewkes, 2021:667-668).

2.5.4 Cultural beliefs as barriers to HIV education and prevention for young women

Sexuality discussions are considered taboo in many countries and amongst many cultures, and it is also believed that HIV infections are only transmitted through sexual acts. These social taboos, therefore, suppress awareness on HIV and prevention, preventing young women, particularly those aged 19 to 24, access to the information that they need to negotiate safe sex. As a result, in Africa, health communication for HIV cannot be effective unless cultural norms and values are taken into account (Thurman, Nice, Visser & Luckett, 2020:2), although it was later discovered that high-risk HIV-positive women were discovered to possess a strong level of awareness on HIV acquisition and transmission prevention, which suggested that information-gathering activities had reached women who require it. Still, about one in every two people living with HIV continue to be unaware of their status (Gumede & Sibiya, 2018:103). HIV remains a serious public health concern across Africa, with cultural and religious beliefs influencing testing and prevention (Ngcobo & Zhandire, 2025:743).

2.6 Challenges to Acquiring Sufficient Knowledge for HIV Prevention Amongst Young Women

Young women in KZN face several interconnected obstacles hindering their access to sufficient HIV prevention education. Recent evidence shows that structural and programmatic barriers continue to limit the reach of HIV prevention interventions across South Africa, particularly amongst young women, who are disproportionately affected by HIV (UNAIDS, 2024; Human Sciences Research Council, 2023; Mavhandu-Mudzusi, 2021:1542). Low participation rates, socioeconomic marginalisation, and inadequate programme targeting continue to prevent structured prevention initiatives from effectively reaching many young women, despite ongoing national prevention efforts (UNAIDS, 2024).

In addition, evidence from South African and global studies highlights that HIV knowledge gaps are not only the result of limited access to information but are also deeply shaped by structural inequalities and the lived realities of young women, including gender inequality, poverty, and unequal access to health services (Govender et al., 2018:56; Obeagu et al., 2024:1–2; WHO, 2023). These conditions interact to reduce the effectiveness of prevention messaging and limit meaningful engagement with HIV education.

Furthermore, national data indicate that despite expanded HIV prevention strategies, significant disparities remain in awareness and uptake of services amongst young women, particularly those in socioeconomically disadvantaged communities (HSRC, 2023; South African Department of Health, 2023–2028). This suggests that knowledge gaps persist not merely due to lack of information dissemination, but because of broader systemic inequalities that shape how young women access, interpret, and act on HIV-related knowledge (UNAIDS, 2023(a); WHO, 2023).

2.6.1 The impact of cultural taboos on young women's access to HIV prevention knowledge and reproductive health decision-making

Embedded sexual taboos really hamper young women's pursuit of health and place them at substantial risk of contracting HIV. Such traditional views are inflexible but still present a huge restriction. They obviously influence all young women's decisions about HIV and largely determine whether or not young women receive any information at all on this issue. Therefore, talking about sexual and reproductive health is generally taboo and proper information is not available. Consequently, exposure to all the facts is limited or non-existent. As a result, young women lacking this open discussion platform find it difficult to make knowledgeable choices on and about their own bodies and lives, which, in turn, increases their susceptibility to HIV (Mavhandu-Mudzusi, Mudau, Shandu & Ndou, 2021:1542; Tohit & Haque, 2024).

2.7 Weak Link Between Health Services and Schools

A persistent gap between health services and educational institutions in KZN undermines the delivery of comprehensive sexual and reproductive health (SRH) services to young women. This deficient connection leads to lost potential for HIV mitigation, given that schools often lack referral systems to youth-friendly health facilities, and healthcare programmes are not sufficiently incorporated into educational initiatives (Arije, Hlungwani & Madan, 2022:1494; Busang, Zuma, Herbst, Okesola, Chimbindi, Dreyer, et al., 2023:1553; UNAIDS, 2018).

2.7.1 Motivation and low morale.

The quality-of-service delivery is often compromised by low employee morale, which can lead to diminished performance and workforce attrition. According to George et al. (2022a:410) and UNAIDS (2018), providing healthcare providers with relevant education and encouragement improves their ability to offer good, youth-focused services and promotes clearer conversations about ways to avoid HIV. When these professionals are well-informed and driven, they can share correct information more effectively, leading to better overall health for the population. George et al. (2022a)

highlight the importance of building on what has been already instilled by providing accurate, age-appropriate information to young women and its significance in preventing the spread of HIV.

2.7.2 Lack of co-ordination between schools and health services

In KZN, there is frequently a lack of co-ordination between educational institutions and healthcare services, which restricts young women's access to HIV prevention resources. This disparity highlights the necessity for more integrated strategies in sexual and reproductive health education with accessible, youth-friendly healthcare services (Busang et al., 2023:1553; UNAIDS, 2018). Schools often function as independent institutions, with limited mechanisms for sharing student health data or coordinating referrals with local clinics, thereby missing critical opportunities for early intervention (Vergnani, Mason, Taole, Fynn & Saville, 2018). This disconnection is especially detrimental for young women, who may require accessible, confidential health services such as contraception or HIV testing that are not reliably available or promoted within the school environment (Vergnani et al., 2018).

Consequently, this systemic failure perpetuates health disparities and undermines public health initiatives. Without structured pathways for referral and follow-up, health education delivered in schools frequently lacks direct links to practical service provision, leaving young people aware of health risks but unable to act on that knowledge (James, Pisa, Imrie, Beery, Martin, Skosana, et al., 2021). For example, while Life Orientation curricula may cover HIV prevention, learners are seldom systematically guided to clinics for PrEP or regular testing. Effective models, such as school-based health clubs or mobile clinics visiting schools, have demonstrated success in improving service uptake; however, these remain pilot projects rather than nationally integrated programmes (James et al., 2021; Khuzwayo, Taylor & Naidoo, 2020). Sustained improvement, therefore, requires stronger political will, inter-departmental budgeting, and clearly defined roles to ensure that schools and health services work synergistically rather than in parallel.

2.8 Secondary School Education Interventions to Enhance HIV Knowledge and Prevention to Assist Young Women After Secondary School Completion

Secondary school education interventions in South Africa are critically positioned to enhance HIV knowledge and equip young women with prevention tools that remain relevant after they leave the formal schooling system. The national Life Orientation curriculum serves as the primary vehicle for this education, aiming to provide comprehensive knowledge on HIV transmission, prevention, and debunk stigma (DBE, 2014; Cabecinha & Saunders, 2022). However, the effectiveness of these interventions in ensuring long-term preparedness is often hampered by their theoretical nature, inconsistent implementation, and a frequent neglect of the profound socio-structural factors and economic inequality that continue to dictate vulnerability post-schooling. To be truly effective, interventions must, therefore, move beyond the standard curriculum to incorporate practical, skills-based components (James et al., 2021). This includes building agency for negotiation in sexual relationships, facilitating direct linkages to health services for PrEP or contraception, and fostering critical thinking to challenge harmful gender norms, thereby empowering young women to utilise their knowledge and access preventive tools long after their secondary education is complete (James et al., 2021; Khuzwayo et al., 2020).

2.8.1 Prevention strategies

As Cabecinha and Saunders (2022:229) suggest, HIV is a chronic medical condition when it is managed with the right care and treatment. Through time, and if not treated, the virus weakens the immune system, increasing individual risks and susceptance for serious infections. However, Cabecinha and Saunders (2022) argue that prevention modalities are necessary to curb the impact of HIV on a population. These tactics fall under the three categories which are primary, secondary, and tertiary prevention.

2.8.2 Primary preventive strategies

The overriding purpose of these prevention strategies targeting HIV is to stop new infections and, thereby, halt transmission. This is achieved using a mix of educational, psychological and biomedical approaches. A particular focus must be directed towards the millions of young women, especially those in township communities in KZN who have completed secondary education, amongst whom comprehensive HIV knowledge has barely increased and challenges to accessing services remain, because not knowing can have a hugely deleterious effect on preventive efforts (Cabecinha & Saunders, 2022; Frieslar, 2020).

Preventing new HIV infections means advocating for safe sex (such as consistent condom use) and improving access to the sexual health education.

Strategies for interventions to control engagement are activities with targeted behavioural changes including community intervention, school-based health programmes and advertisements for high-risk groups. According to Zuma, Seeley, Sibiya, Chimbindi, Birdthistle, Sherr, et al. (2019:336), HIV epidemic control is also supported by health care interventions like PrEP, PEP and TasP.

Much work exists around these issues, such as how to find common ground in religious communities, put aside conventions for young women to do the same and build awareness campaigns through mass media that directly address their experience and concerns. However, if we do not also address such underlying issues as general attitudes towards sex in society at large and gender discrimination in its many forms, none of this will work (de Oliveira, Kharsany, Gräf, Cawood, Khanyile, Grobler, et al., 2017). Hence, reducing infection rates amongst this vulnerable group of people demands a comprehensive strategy that includes both preventive education and empowerment and access to healthcare (Cabecinha & Saunders, 2022; Psaros, Milford, Smit, Greener, Mosery, Matthews, et al., 2017:165).

2.8.3 Biological interventions

Three fundamental biomedical strategies form a cornerstone of modern HIV prevention: PrEP, which involves a daily oral tablet that significantly reduces the risk of HIV acquisition for HIV-negative individuals; TasP, a strategy which guarantees that individuals living with HIV are on effective ART to suppress their viral load, thereby reducing the likelihood of virus transmission to others; and PEP, an emergency medication regimen that must be initiated within 72 hours following a potential exposure to HIV to prevent the virus from establishing infection (Cabecinha & Saunders, 2022:231; UNAIDS, 2022b; WHO, 2022).

2.8.4 Education and awareness

School subjects like Life Orientation are essential in equipping young people, especially young women, regarding sexual health and HIV information methods for transmission and prevention. Students learn about bodily autonomy, consent, the significance of frequent examinations and methods to access reproductive health services.

2.8.4.1 Promotion of safe sexual practices

The “Promotion of Safe Sexual Practices” is a foundational pillar of HIV prevention strategies. This multifaceted approach extends beyond mere awareness to promote the consistent adoption of specific protective behaviours (UNAIDS, 2022c; WHO, 2022). Its core components include the proper application and consistent use of condoms, which act as a physical barrier against HIV and various other sexually transmitted diseases, and the decrease of the number of sexual partners, which directly decreases the potential network of exposure (Stover & Teng, 2022:3). In the South African educational system, this crucial information is primarily disseminated through Life Orientation (LO) classes (UNAIDS, 2022c; WHO, 2022; DBE, 2014;

Cabecinha & Saunders, 2022). These curricula are designed to empower young people by moving beyond biological facts to foster critical thinking and decision-making skills. As noted by Cabecinha and Saunders (2022), these classes emphasise making informed sexual decisions, aiming to translate knowledge into tangible, healthy behaviours. This involves teaching negotiation skills for condom use within relationships, addressing gendered power dynamics that can be a barrier to protection, and promoting a broader understanding of sexual health that includes respect, consent, and well-being. Therefore, the aim is to prepare students equipped with the necessary resources and self-efficacy to navigate their sexual lives safely during their school years and long after they have graduated (Cabecinha & Saunders, 2022).

2.8.5 Secondary preventive strategies

Secondary prevention measures for HIV aim to quickly identify those who have become infected with the virus and provide them with treatment to avoid negative health outcomes while decreasing the likelihood of transmission. This ensures that a positive result from HIV testing and counselling (HTC) leads to prompt linkage to care; that is, support to be placed on ART and deal with medical aspects of disease, management and onward transmission, partner notification and contact tracing; that is, identification of those who may have been exposed via the index case and regular HTCs (Cabecinha & Saunders, 2022; Venketsamy & Kinear, 2020:1-3).

Like most other people in the township communities in KZN, former secondary school-going young women run a particularly high risk of becoming HIV-positive because of a combination of social and economic complexities, combined with poor knowledge around HIV. One of the biggest reasons for ongoing transmission amongst this group is because of inadequate comprehensive knowledge about the virus. This includes limited understanding of the importance of regular screening, early treatment benefits, and virus transmission and prevention mechanisms.

The LO programmes at school closes these differentials in a sentence or two by, on the one hand, calling for an affirmative action approach, and on the other, bidding HIV testing to be made more meaningful for students and it also seeks to reduce stigmas attached to being HIV infected (Reddy, James, McCauley, Denison, Dwane, Mathews, et al., 2019:49-50).

It is unfortunate that these messages may not reach young women who have dropped out of school. However, community-based LO concepts can push forwards efforts for secondary prevention in such situations as peer education, public health campaigns and youth outreach support. Such moves may help young women to become tested, to find out their status so that they know who is at risk of needing treatment and by breaking the conspiracy of silence, which will ultimately assist in the reduction of new HIV infections in these communities (Sibanda, d'Elbée, Maringwa, Ruhode, Tumushime, Madanhire, et al., 2021; Galárraga, Kuo, Mtukushe, Maughan-Brown, Harrison & Hoare, 2020).

2.8.6 Tertiary preventive strategies

Tertiary preventive efforts are essential for young women living with HIV in KZN township communities to strengthen the management of the illness and promote their overall well-being. These are lifesaving tools in light of the significant barriers that these women have encountered with health information and care. Their health can be improved, and the virus can be managed to reduce further transmissions with appropriate balance between anti-retroviral treatment, mental and emotional support as well as interventions that reduce stigma (Cabecinha & Saunders, 2022:232).

However, Luthuli and John-Langba (2024) indicate that decreased understanding of HIV as a result of inadequate sexual education, poverty and the continuing social attitudes may impede their attempts in accessing these services or remaining on treatment. Low participation in higher-level prevention activities is related to fear of being judged in the township communities, few places to seek young women-friendly

healthcare and misperceptions regarding treatment. Community peer group-based and mental health services have the potential to improve treatment effectiveness and reduce stigma, particularly if adapted to the comfort of the circumstances amongst young women in situations of greatest social disadvantage (Nakimuli-Mpungu, Musisi, Smith, Von Isenburg, Akimana, Shakarishvili, et al., 2021). Targeted learning and outreach need to go hand-in-hand with these approaches in order to adequately support HIV-positive young women and address the on-going gaps in the understanding of HIV.

2.9 The Impact of COVID-19 on HIV Service Disruptions and the Role of Inadequate HIV Knowledge in Increasing Vulnerability Amongst Young Women in South Africa

The global coronavirus disease 2019 (COVID-19) pandemic has severely impacted the social cohesion, economics and public health of numerous nations while upsetting many facets of human existence (Sukmaningrum, Levy, Negara, Devika, Wulandari & Januraga, 2024: 775). Ayers, Zhu, Harrigian, Wightman, Dredze, Strathdee, et al. (2024:1166-1167) posit that, despite frequent assertions in opinion pieces, the COVID-19 pandemic has had a greater effect on susceptible demographics, notably those who are affected by HIV but there has been little factual support for these allegations.

According to Sukmaningrum et al. (2024), numerous studies have examined how the pandemic has impacted the health and wellness of young women living with HIV. Alsulaiman and Rentner (2021:2) state that the COVID-19 pandemic resulted in substantial disruptions across numerous sectors, resulting in young women, especially those infected with HIV, being nervous and fearful. Several factors contributed to fear and anxiety, including worries about health and fear of contracting an infection from a visit to the clinic (Seretlo, Ramavhoya, Mulaudzi, Gundo, Nesengani, Kgatla, et al., 2024:274).

Ojukwu, Pashaei, Maia, Omobhude, Tawfik and Nguyen (2025:350) support Alsulaiman and Rentner (2021) by adding that these pandemic disruptions posed numerous challenges for the HIV care continuum (HCC), including outpatient care and treatment services, supply chain disruptions, resource relocation and strained healthcare systems which hindered public health efforts and negatively affected existing programmes (Ojukwu et al., 2025:350; Alsulaiman & Rentner, 2021). As a result, the pandemic forced life to be confined outside the normal whilst communities, leaders, health officials, businesses and educators took drastic measures caused by this profoundly lethal virus (Alsulaiman & Rentner, 2021:2). The impact on the monitoring of HIV, adherence to antiretroviral medications and access to those amongst people living with HIV was even more catastrophic by the COVID-19 pandemic. There was a decreased use of HIV services like ART and PrEP in 2020 because the priority shifted from the virus that causes HIV to the one that caused COVID-19 (Seretlo et al., 2024:273).

2.10 Theoretical Framework Applied in This Study

This study was guided by a conceptual framework structured to explore the gap between HIV education and prevention outcomes amongst young women 19 to 24 years old in KZN townships. The framework enabled the researcher to interrogate the cycle of risk through four integrated proportions, primarily utilising Social Learning Theory (SLT) to study social and observational influences, and then the Health Belief Model (HBM) to understand individual perceptual factors. First, it employed SLT to study how risky behaviours were learned and reinforced through modelling, social norms, and environmental influences, establishing them as fundamental drivers of HIV incidence. Second, it applied HBM to assess the state of young women's awareness and perceptions including their perceived vulnerability, severity, advantages, and obstacles associated with HIV management and prevention. Third, it mapped the existing educational landscape by exploring previous school interventions, evaluating their design through the lens of SLT's principles of observational learning and HBM's focus on motivating factors. Finally, this theoretically grounded framework was forwards-looking, designed to identify actionable initiatives that made use of SLT to create supportive social environments

and employed HBM to address individual perceptions, thereby strengthening prevention efforts to disrupt the transmission cycle. These proportions provided the foundational framework for conceptualising the research processes, procedures, and protocols (Ngulube, 2018:5).

2.11 Discussion of Theories Chosen to Inform the Study

According to Bandura's Social Cognitive Theory (SCT), individuals' behaviours are determined by the interplay between personal experience, the environment, and observational learning (Bandura, 1986). As per the theory, prior experiences determine one's expectations, reinforcements and self-efficacy, all of which affect behavioural choices. The findings of this study confirm this theoretical assumption, in the sense that the risk of contracting HIV amongst the young women in the study was determined not just by their own lack of awareness, but also by peer effects, social interactions, gender issues and socio-economic context. It was evident from the accounts of participants that decisions regarding HIV issues were made in response to their observation of other people. These findings support SCT's proposition that learning occurs through observation and interaction with the social environment rather than solely through direct personal experience. Consistent with Bandura's (1986) argument, the findings further indicate that young women often model behaviours observed within their peer groups and communities, where peer pressure, transactional relationships and social expectations contribute to risky sexual practices. This interpretation is supported by Mthembu, Maharaj and Rademeyer (2019:247), who identify peer influence as an important driver of risky sexual behaviour, and by Millanzi, Osaki and Kibusi (2023:2), who found that young women may engage in risky sexual relationships because of economic vulnerability and material needs. Collectively, these findings demonstrate that HIV prevention behaviours are shaped by the interaction of personal, behavioural and environmental influences, consistent with the central principles of SCT.

2.11.1 Social Learning / Cognitive Theory

Albert Bandura's SCT, derived from Social Learning Theory, suggests that behaviour emerges because of the dynamic interplay between individual factors, behaviour, and the environment (Bandura, 1986). Four constructs serve as the theoretical foundation of SCT, namely self-efficacy, observational learning, outcome expectations, and environmental influences. Together, they form the basis on which it can be understood why knowledge of HIV prevention is not being translated into actual protective behaviours amongst former secondary school-going young women from township communities in KZN.

The findings of this research study are explained by SCT and the constructs involved in HIV prevention behaviour. Specifically, self-efficacy denotes one's perception of their capability of executing a certain behaviour successfully. When considering HIV prevention behaviour, self-efficacy means an ability to practice condom use correctly, negotiate safe sex, and have easy access to preventive measures like PrEP (UNAIDS, 2023; WHO, 2022).

Such findings indicate that limited knowledge about HIV coupled with insufficient skills contribute to low self-confidence on how to execute these actions, which, in turn hinders the consistency of these preventive behaviours.

Observational learning is yet another factor contributing to behavioural development through the influence of social models. The behaviours of participants are affected by those actions that they observe amongst their peers, partners, or within their community. In cases where there is normalisation of risky sexual practices and few positive examples for prevention behaviours in terms of HIV, there is a high chance for these actions to be practiced and increased vulnerability to HIV. Similarly, the importance of outcome expectations should be emphasised because participants can refrain from engaging in preventive behaviours such as condom usage because of possible negative repercussions, including stigma, rejection, and disputes with one's partner (Gutin, Harper, Moshashane, Ramontshonyana, Stephenenson, Shade, et al., 2021; Muhanga, Jesse & Allan, 2024:1).

In addition, personal determinants of behaviours are affected by the environment in which individuals live; they include such aspects as poverty, gender disparities,

cultural norms, stigma associated with HIV, and lack of youth-oriented healthcare providers (Haffejee et al., 2023; Govender & Reddy, 2020).

Overall, SCT demonstrates that limited HIV prevention behaviour amongst participants is not solely caused by inadequate knowledge, but rather the combined effect of low self-efficacy, social modelling, negative outcome expectations, and structural constraints.

The theory is, therefore, applied in this study as an analytical framework to interpret findings and to guide the discussion and conclusion by explaining how these interconnected factors contribute to HIV vulnerability amongst former secondary school-going young women in Umlazi Township communities.

2.11.2 Application of the Health Belief Model

The HBM is one of the useful theoretical frameworks for studying the HIV prevention behaviours amongst young women in KZN township communities. According to the HBM theory, people who have high perceived susceptibility to health problems or conditions, perceive the negative consequences of these conditions, realise the positive outcomes of preventive measures, and feel confident enough to take such measures are more likely to adopt preventive behaviour (Champion & Skinner, 2008; Rosenstock, 1974).

It should be emphasised that the cues to action are also highlighted as an important element in the HBM. Cues to action can be both internal and external stimuli that motivate people to change their lifestyle and adopt preventive measures.

Research conducted in South Africa indicates that a considerable number of young women are under the impression that they are not at risk of becoming infected with HIV even though the communities they belong to have a high level of HIV prevalence rates (Ndlovu, Dlamini & Shezi, 2025). Furthermore, the prevalence and availability of ART may contribute to the perception that HIV has been considered a manageable disease for many years now. This factor may lead people to underestimate the severity of the disease and, hence, fail to take the necessary preventive steps (HSRC, 2024). Despite young women knowing the benefits of using

prevention measures such as condom use, HIV screening, and PrEP, they still have barriers that include stigma, gender inequality, lack of accessibility of HIV prevention tools and strategies, and negotiating safer sexual behaviour (Haffejee et al., 2023; Molelekwa, 2024).

The HBM further highlights the role of cues to action and self-efficacy in determining health-related behaviours. The majority of young women may not have received adequate HIV prevention messages after leaving school because of insufficient community programmes raising awareness and on-going health promotion initiatives. As a result, the chances of encouraging them to test for HIV regularly and partake in other preventive measures may be reduced. Moreover, many young women might not feel confident about negotiating condom use and discussing HIV testing and treatment because of societal pressures and the consequences associated with such behaviours. This study employed the HBM as an analytical framework for analysing the findings in this study because it allows examining participants' experiences and perceptions of HIV prevention activities. This model makes it possible to study the experience of participants and their perception of HIV prevention activities. Specifically, such notions as perceived susceptibility and severity, perceived benefits and barriers, cues to action, and self-efficacy were used for the interpretation of the results and identification of the factors that may help to promote or prevent HIV prevention behaviour. For instance, participants' narratives demonstrated that perceived susceptibility influenced preventive behaviours. Some participants such as Khanyo reflected that limited sexuality education and inadequate HIV knowledge during adolescence reduced their awareness of personal HIV risk, contributing to behaviours that increased vulnerability to infection. Similarly, participants who grew up in families affected by HIV, including Nuh and Zama, described how limited age-appropriate communication about HIV delayed their understanding of HIV transmission and prevention, illustrating how low perceived susceptibility may develop despite living in high-risk environments. The findings also reflected perceived barriers, as participants described HIV-related stigma, cultural expectations and difficulties discussing sexuality as obstacles to accessing HIV information and engaging in preventive practices For example, while Philie's narrative indicated that cultural values were barriers to open communication on sexual issues, Nolwazi's experiences revealed how community stigma and fears of

being judged created barriers to open discussion of HIV-related issues. In contrast, the study results also emphasised the role of cues to action and self-efficacy. While Fikile explained how pregnancy served as a catalyst for her motivation to take medications and seek HIV-related help, Enhle's involvement in support classes improved her sense of self-efficacy. Moreover, Samke's disclosure at an early stage of infection, as well as the availability of HIV education, increased her level of self-efficacy in protecting not only herself but also other people. These examples demonstrate how the HBM provided a valuable framework for explaining how individual perceptions, social influences, and lived experiences shaped HIV prevention behaviours amongst the participants.

2.12 An Integrated Conceptual Framework Based on the HBM and SCT for Exploring the Reasons for the Lack of HIV Knowledge to Prevent HIV Infections

This study is premised on a conceptual framework which incorporates the HBM and SCT as a way of understanding why there is a lack of HIV prevention knowledge amongst former secondary school-going young women in the townships of KZN. Despite having HIV prevention programmes and sexuality education being offered in schools, previous studies show that such measures may not lead to adequate HIV knowledge and preventive behaviour in the young women (Jimmyns & Meyer-Weitz, 2019a:384). Such issues are particularly prevalent in KZN, whereby young women aged between 19 and 24 have continued to be disproportionately affected by HIV infections compared to other groups in South Africa (UNICEF, 2023; UNAIDS, 2023). The literature shows that young women in such settings face problems like lack of access to factual information about their sexual health, stigma related to HIV infections and sex, and negotiating safer sexual activities (Dellar, Dlamini & Abdool Karim, 2015; Pettifor, Bekker, Hosek, DiClemente, Rosenberg, Bull, et al., 2013).

This research is guided by the HBM as it explains how the perceptions and beliefs of young women can affect their interaction with the information on HIV prevention. Perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy will help to understand how the participants perceive

HIV, the importance of the information and the obstacles in obtaining or using the information (Tarkang & Zotor, 2015:1). For instance, the change in the perception about the severity of HIV because of improved treatments and antiretroviral drugs can affect the way in which young women perceive their vulnerability to the disease (HSRC, 2024; Machemedze, 2023). Self-efficacy is also important to understand the confidence of participants in obtaining information and practicing preventive measures.

Whereas the HBM focuses on individual perceptions, the SCT expands on this understanding by acknowledging the role of social contexts and experiences in the acquisition and application of knowledge. This is especially significant in the context of township communities where family interaction, peer interaction, social dynamics in the community, and availability of reliable information can play a part in the development of knowledge about HIV prevention amongst young women (Gatheru, Wao, Alamdo, Kwarteng, Kwashie, Kabiru, Ogum, Torpey & Manu, 2024). It is, therefore, appropriate to use the HBM and the SCT in this qualitative study, as these frameworks provide a lens for exploring and interpreting lived experiences of former secondary school-going young women and the factors shaping their HIV prevention knowledge.

2.13 Chapter Conclusion

In conclusion, the reviewed literature consistently demonstrates that despite high general awareness, significant gaps persist in the depth and practical application of HIV knowledge amongst young women in South Africa. These inadequacies, compounded by socio-structural barriers, gender inequality, and a frequent lack of coordination between educational and health systems, severely limit the long-term effectiveness of secondary school HIV education. The COVID-19 pandemic further exacerbated these existing vulnerabilities, disrupting vital health services and adherence support, thereby highlighting the fragility of current prevention interventions. Ultimately, the literature reveals a critical need for stronger, integrated,

and theory-informed interventions that extend beyond knowledge dissemination to empower young women and address the systemic drivers of their vulnerability. The next chapter will present the research methodology that was applied in this study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the research methodology for a study exploring the reasons for the lack of knowledge on HIV to prevent HIV infections amongst former secondary school-going young women in township communities of KZN. Utilising a qualitative explorative design, this chapter elaborates on the approach, sampling strategy, data collection instruments, and analytical techniques used to explore the roots of this issue. Ethical protocols guiding the research are also discussed (Afzal, Khalil & Saleem, 2024:120-121; Berman, Jones, Udry & National Longitudinal Study of Adolescent Health, 2020).

3.2 Research Approach Applied

This study employed a qualitative, exploratory research approach to explore the reasons for the lack of knowledge on HIV to prevent HIV infections amongst former secondary school-going young women in township communities of KZN. An exploratory design is particularly suited to under-researched areas, as it facilitates the discovery of new insights and emergent perspectives (Firdaus, Zulfadilla & Caniago, 2021:3; Olawale, Chinagozi & Joe, 2023:1386). This methodology was considered essential for exploring the multifaceted reasons behind poor HIV knowledge retention and application, a subject where cultural, social, and educational factors are not yet fully understood (Saarijärvi & Bratt, 2021:2; Butts et al., 2018; Tarkang et al., 2019).

This approach is important, as it provides the necessary flexibility to engage with participants' findings and lived experiences in depth, permitting for the emergence of unexpected themes and rich, context-specific data that quantitative methods might overlook (Fellows & Liu, 2021:11-12; Saarijärvi & Bratt, 2021:2). By prioritising depth

of understanding over generalisable data, this approach is uniquely suited to uncovering the complex social, cultural, and educational factors that support the central issue of this research (Fellows & Liu, 2021:11-12).

3.2.1 Constructivist paradigm

In this study, a qualitative exploratory research design was adopted within a constructivist paradigm to gain insight into the experiences, behaviours, emotions, values and beliefs of participants in relation to HIV-related knowledge, prevention practices and vulnerability to HIV infection. The constructivist paradigm recognises that individuals construct their understanding of reality through lived experiences and reflection and that knowledge is developed through interaction between the participant and the researcher (Adom, Yeboah & Ankrah, 2016). Therefore, meaning is not simply discovered but constructed through engagement with participants' interpretations of their experiences.

To operationalise this paradigm, a qualitative exploratory methodology was adopted using face-to-face interviews as the data collection method. This approach was appropriate as it enabled the researcher to gain a deeper understanding of participants' perceptions, beliefs, experiences and challenges related to HIV prevention. The study was conducted in township areas of Durban, KZN, and focused on young women aged 19 to 24 who had completed secondary school.

The qualitative exploratory design was aligned with the research objectives and questions relating to HIV-related knowledge, prevention practices, and vulnerability amongst young women in township communities. Specifically, the study explored the impact of inadequate HIV knowledge, stigma and risky sexual behaviours on vulnerability to HIV infection, awareness of HIV prevention and control strategies, including condom use, HIV testing, PrEP, PEP, and treatment adherence; and the nature, accessibility, and effectiveness of HIV education interventions within secondary school and community settings. It also examined how stigma, cultural

beliefs, gender norms, and GBV influence HIV preventive behaviours and access to support services.

Face-to-face interviews provided participants with an opportunity to openly share their experiences, thoughts, and emotions without fear of judgement (Osborne & Grant-Smith, 2021:110). This method enabled the researcher to obtain contextual information and ask relevant follow-up questions related to the research objectives and areas of investigation. Qualitative procedures are valuable because they provide a level of understanding that is difficult to obtain through closed-ended questionnaires (Bruna, 2021). Therefore, this qualitative exploratory approach assisted in developing a deeper understanding of factors influencing HIV knowledge, prevention behaviours, and vulnerability amongst young women, while identifying possible educational and community-based interventions to strengthen HIV awareness and prevention efforts.

3.3 Research Design

In this study, a qualitative exploratory design approach was utilised to identify the reasons for the lack of knowledge on HIV to prevent HIV infections amongst former secondary school-going young women aged 19 to 24 years living in Umlazi Township communities in Durban, KZN.

The qualitative design was ideal because it allowed for the gaining of rich insights about participants' experiences and beliefs concerning the phenomenon under investigation (Creswell & Poth, 2018). The exploratory design was chosen because of the lack of research conducted on the factors causing insufficient HIV knowledge amongst former secondary school-going young women in townships. Exploratory research design is recommended when studying phenomena that are not yet understood and need further exploration of participants' perspectives and experiences (Cloutier, 2024:359; Busetto, Wick & Gumbinger, 2020).

Semi-structured interviews were used to gather information from the participants. The use of semi-structured interviews enabled the researcher to obtain detailed information about participants' personal experiences and perceptions while allowing flexibility for follow-up and clarification questions related to the research problem (DeJonckheere & Vaughn, 2019). Direct observation was conducted during the interviews with field notes used to document participants' emotional reactions, non-verbal cues, and behaviours that provided contextual information for interpreting data.

The study was conducted amongst former secondary school-going young women residing in Umlazi Township. Participants needed to be between 19 and 24 years of age, having gone through secondary school education, living in Umlazi Township, and able to provide informed consent in order to take part in the research. Those who were outside the stated age range, had not been in secondary school education, were not living in Umlazi Township, and those unable to provide informed consent were excluded from the research.

A total of 15 participants met the inclusion criteria and were recruited for the study. All 15 participants provided informed consent and completed the interview process, therefore, there were no participant withdrawals or incomplete interviews. A detailed description of the sampling strategy, participant recruitment process and justification for the sample size is presented in the subsequent section of this chapter.

Overall, the qualitative exploratory research design enabled the researcher to systematically explore participants’ experiences and perceptions regarding HIV knowledge and prevention. The design generated rich, descriptive data that provided insight into the individual, social and contextual factors influencing HIV knowledge amongst former secondary school-going young women in Umlazi Township.

3.4 Research Design and Implementation of the Exploratory Qualitative Approach

This study employed an exploratory qualitative research design to gain an in-depth understanding of young women's experiences, perceptions and social realities regarding HIV knowledge and awareness within KZN township communities. This research approach was appropriate for this study because it allowed the researcher to examine social problems which were complex and where there was little or no knowledge of the phenomenon under study (Hammersley & Atkinson, 2019). The design provided the researcher with an opportunity to explore how young women understood HIV prevention and how they accessed HIV information. It also provided an opportunity to find out how social and socio-economic factors impacted on their participation in HIV prevention practices

The exploratory nature of the study gave the participants the opportunity to describe their experience in detail without being confined to pre-defined categories. The researcher used qualitative interviewing to explore how the participants viewed HIV-related knowledge, awareness, stigmatisation, decision-making about sexual health and barriers preventing them from accessing prevention services. It was important because HIV susceptibility of young women is affected by a number of different variables such as education, community environment, family, gender relations and socioeconomic circumstances.

The implementation of the exploratory research design followed a systematic process. The first stage involved identifying the research problem and developing research questions that focused on understanding the factors contributing to limited HIV knowledge and prevention challenges amongst young women who had completed secondary education in township communities. A review of existing literature was then conducted to identify gaps in current knowledge and to guide the development of the research objectives and data collection approach.

After formulating the research framework, it became necessary to identify the research setting and participants who could provide relevant information for the research objectives. The selected township community was a suitable setting for studying the experiences of the young women, as it represented the social and structural environment affecting HIV prevention through availability of information, healthcare facilities, education and supportive community systems. Participants meeting the inclusion criteria were identified and recruited for participation in the research study.

Prior to data collection, ethical clearance was received as well as all necessary permissions. The participants were made aware of the purpose of the research and their rights as participants, measures of confidentiality and right to withdrawal were discussed with them. It was very important to establish trust between the researcher and participants, especially when conducting HIV research where stigmatisation and sexual experiences can be part of the discussion.

The data were collected through face-to-face semi-structured interviews which enabled the participants to provide information regarding themselves in their own language, while at the same time, allowing the researcher to ask probing questions of the interviewees for additional information. Interviews were conducted with the focus being on the participants' perception of HIV/AIDS, HIV information sources, HIV education experience, views on prevention and the social-cultural context within which HIV behaviours are influenced.

A pilot study was subsequently conducted to assess and refine the clarity, relevance, and suitability of the research questions and data collection procedures. Feedback from the pilot study proved valuable in strengthening the interview process and enhancing the overall quality and credibility of the research design and processes.

Through this exploratory qualitative approach, the study was able to generate a contextual understanding of young women's experiences of HIV knowledge and prevention within township communities. The design provided insight into not only the challenges faced by young women but also their agency, coping strategies and perspectives on improving HIV education and prevention interventions.

3.5 Sampling

The research study utilised a purposive non-probability sampling method. This was to purposefully sample the young women in the age range 19 to 24 years residing in the township community of KZN, who had received secondary school education. Purposive sampling was used with the goal of concentrating on those who are most susceptible to contracting HIV and who could offer rich, relevant insights based on their educational experiences and context.

3.5.1 Sample size and sample population

This study adopted an exploratory qualitative research design. A non-probability purposive sampling technique was employed to recruit participants who met the predetermined inclusion criteria and were able to provide rich, relevant, and detailed information on the reasons for the lack of knowledge regarding HIV prevention amongst young women.

The participant recruitment process took place in the Umlazi Township community. The researcher made contact with the community members and assessed their suitability to participate in the research. In making contact with the community members, the researcher introduced themselves, outlined the purpose and objectives of the research, outlined the requirements of participation, which included the amount of time that the interview will take, and told them that their participation is strictly voluntary. The community members were also told that they had the option

not to participate or could withdraw from participation at any point during the research without facing any form of punishment.

In order for participants to qualify, they should have been females, aged between 19 and 24 years, residing in the Umlazi Township, and having completed secondary school. The young females who were either below 19 years, above 24 years, and those who had not attended secondary schools were disqualified from the research. After the selection, the participants were given the participant information form containing details about the study and then asked to sign the informed consent prior to the start of data collection. The process of recruiting participants was performed in line with the accepted ethical guidelines, which stated that purposive sampling should be used as the method of recruitment. Although snowball sampling is recognised as a useful approach in qualitative research for identifying additional eligible participants through participant referrals, it was not employed in this study to ensure adherence to the approved recruitment procedures.

The total of 15 young women were recruited for the study. This was because the sample size was deemed appropriate, because qualitative research is concerned more with the generation of in-depth data as opposed to statistical representation. Data collection and preliminary analysis were undertaken concurrently. After each interview, the researcher reviewed the interview transcript, compared participants' responses, and identified emerging codes and themes. As the interviews progressed, participants consistently reported similar experiences regarding HIV prevention knowledge, and no substantially new codes or themes emerged during the final interviews. The last interviews served to confirm the existing findings rather than generate new insights. Recruitment, therefore, ceased after 15 participants because data saturation had been achieved (Golzar, Noor & Tajik, 2022:72).

3.5.2 Eligibility criteria

A set of predetermined guidelines or standards known as the eligibility criteria establishes a person's eligibility to take part in a research study. These criteria are necessary to guarantee that the study's findings are appropriate to the target group, are ethically sound and are applicable to the intended population (Hossan, Dato'Mansor & Jaharuddin, 2023:211-212; Majid, 2018:3).

3.5.3 Inclusion criteria

The use of clearly defined inclusion criteria facilitated the selection of 15 young women from the Umlazi Township community who possessed the characteristics necessary to address the research objectives. The participants selected by the researcher were female, aged between 19 and 24 years, living in Umlazi and having attained secondary level education. This was crucial because the research intended to explore the reasons responsible for lack of knowledge about HIV prevention methods amongst young women. Participants with such characteristics were capable of providing information about their experiences, source of HIV information and factors that affect their knowledge of HIV prevention measures.

Through this process, the researcher was able to collect contextually specific information about how young women in the Umlazi Township community acquire, understand and relate with information concerning HIV prevention. Hence, the inclusion criteria assisted in collecting data that were relevant to the research question. In addition, the participants gave information about the social, educational, and community factors affecting their knowledge and awareness of HIV prevention measures.

3.5.4 Exclusion criteria

The exclusion criteria specify the traits that make an individual ineligible to participate in the study, and these characteristics include the inability to comply with the study procedures, comorbidities or medication use. The exclusion criteria are frequently employed to safeguard participants' safety, lower confounding variables and improve the study's internal validity (McKenzie et al., 2019:33; Patino & Ferreira, 2018:84).

According to the exclusion criteria used in the current study, males were not recruited because the study was interested in interviewing young women living in the township communities. In addition, the age criterion of participation was set at females aged between 19 and 24. It meant that women below or above the specified range were excluded, to provide consistency in terms of development stage, education, and exposure to HIV information sources.

It was important not only for ethical reasons related to the safety of participants but also for achieving greater accuracy, reliability, and internal validity of findings achieved.

Ultimately, this strengthens the applicability and repeatability of the findings within similar township-based contexts (McKenzie et al., 2019:33).

3.6 Data Collection

The main tool for collecting data in this study was semi-structured interviews. A semi-structured interview guide was formulated from the research questions and objectives of this study. The guide had open-ended questions, which were meant to enquire about participants' knowledge, experiences, and perceptions concerning HIV prevention amongst young women. The semi-structured interviews gave the researcher an opportunity to ask more questions, which sought to clarify participants' answers and explore other emerging issues in the process of interviewing the participants (Adams, 2015). This strategy was helpful in obtaining specific

information about the factors influencing HIV prevention knowledge amongst young women in the Umlazi Township community.

Prior to data collection, ethical approval was secured (see Annexure E) and the foundational principles of informed consent were diligently followed (see Annexure B). Each prospective participant was formally contacted and provided with a detailed information sheet outlining the study's purpose, procedures, potential risks, and their rights (see Annexure C). Written consent was obtained from all individuals before their inclusion in the study. To safeguard participant well-being, a protocol was established whereby any individual experiencing psychological anguish was offered immediate consultation with a medical professional. Furthermore, all participants were furnished with a list of counselling organisation contacts, enabling them to access support discreetly at their own discretion.

The semi-structured format was helpful in facilitating a rich comprehension of the viewpoints and lived experiences of the participants. By allowing for asking probing follow-up questions, the method moves beyond insincere verbal responses to uncover deeper meanings, contextual factors, and personal interpretations (Bryman, 2016). This aligns perfectly with the exploratory aim of the study which was to understand the intricate reasons behind HIV knowledge gaps. Furthermore, to triangulate the information and offer crucial contextual understanding, the observational method was employed (Firdaus, Zulfadilla & Caniago, 2021:4-5).

As DeWalt and DeWalt (2011:1) assert, "participant observation is a method in which a researcher takes part in the daily activities, rituals, interactions, and events of a group of people." In this study, observational notes were kept recording non-verbal signals, interactions, and environmental factors that could illuminate the participants' stated experiences. This combination of semi-structured interviews and observation ensured a comprehensive data collection process, capturing both what participants said and the context in which it was said, thereby improving the validity and depth of the findings (Bryman, 2016). This approach ensures that all key thematic areas are

systematically addressed while granting the researcher autonomy to pursue unexpected yet valuable lines of enquiry that arise during the conversation.

3.7 Data Analysis

Thematic analysis was selected as the primary method for data analysis in this study. This approach was particularly appropriate for the exploratory qualitative design of this study as it provided a systematic yet flexible framework for identifying, analysing and reporting patterns (themes) within the dataset (Braun & Clarke, 2006:81–82; Wiltshire & Ronkainen, 2021:161). Its applicability was suitable for this research, which sought to understand the reasons for the lack of knowledge regarding HIV prevention amongst former secondary school-going young women in township communities of KZN. The method enabled the researcher to move beyond surface-level responses and identify significant, recurring patterns within the interview data, thereby capturing the collective experiences and perspectives of participants.

The data analysis process followed the six phases of thematic analysis proposed by Braun and Clarke (2006). Firstly, the researcher familiarised themselves with the data by repeatedly reading the interview transcripts to gain a comprehensive understanding of participants' responses and the overall content of the dataset. During this stage, initial observations and potential patterns relevant to HIV prevention knowledge were noted.

Secondly, the researcher generated initial codes by systematically reviewing the transcripts and identifying meaningful sections of data related to the research objectives. Codes were assigned to relevant statements that reflected participants' experiences, perceptions, sources of HIV-related information, and factors influencing their knowledge of HIV prevention.

Thirdly, the researcher examined the initial codes and grouped related codes together to develop potential themes. These emerging themes represented broader patterns within participants' accounts and reflected common experiences shared across the interviews. Fourthly, the researcher reviewed and refined the identified themes by comparing them against the coded extracts and the entire dataset to ensure that they accurately represented participants' experiences.

The final step was naming and defining the themes by explaining what they meant in relation to the research question posed. Subsequently, these themes were arranged in such a way that they would illustrate the factors affecting HIV prevention knowledge for young women in the Umlazi Township community. Lastly, the report was written using the themes and the quotes from the participants to prove the interpretations made from the data gathered.

By thoroughly coding data and organising them into themes, the researcher was able to figuratively "see through the eyes of their participants". This process offers a strong platform for interpreting the underlying meanings, social contexts, and personal realities conveyed in the findings (Naeem, Ozuem, Howell & Ranfagni, 2023:2; Braun & Clarke, 2006:85; Nowell, Norris, White & Moules, 2017). Consequently, the method moves beyond simple observation to enable a richer engagement with the data, enabling the researcher to obtain insights into the participants' perspectives at a more profound and personal level, which is central to achieving the exploratory aims of this study (Braun & Clarke, 2006:93; Nowell et al., 2017).

3.8 Trustworthiness, Credibility and Validity of the Qualitative Study

In qualitative research, the concepts of validity and reliability are reframed as **trustworthiness**, which ensures that the study's findings are credible, rigorous, and sound (Noble & Smith, 2015). This study was guided by this principle, employing specific strategies to uphold its integrity.

Credibility: This pertains to the assurance that the findings are accurate and congruent with reality. To ensure credibility, this study employed techniques such as **prolonged engagement** with the field to build rapport and **persistent observation** to identify crucial characteristics. The researcher consciously reflected on and bracketed personal biases throughout the process to ensure that the views presented were those of the participants, not the researcher (Noble & Smith, 2015).

Reliability: This concerns the consistency and reproducibility of the research process. To achieve dependability, this study maintained a detailed **audit trail**, including comprehensive records of interview notes, audio recordings, and methodological decisions, allowing the research process to be transparent and accountable (Korstjens & Moser, 2018).

Transferability**:** This denotes the degree to which findings can be applied to other contexts. While qualitative research does not seek statistical generalisation, this study provides ***rich, thick descriptions*** of the participants, setting, and phenomena. This enables readers to evaluate the importance and potential transferability of the findings to their own situations (Korstjens & Moser, 2018).

Confirmability: This ensures that the findings are shaped by the participants and the data, not by researcher bias. Confirmability was achieved by triangulating data collection methods (such as interviews and observation) and maintaining a clear audit trail that links the findings directly back to the raw data, demonstrating that the interpretations are grounded in the evidence collected.

Prior to data collection, informed consent was secured, and participants were guaranteed confidentiality and anonymity to create a safe environment conducive to open and honest dialogue, further strengthening the trustworthiness of the data.

3.9 Ethical Considerations

Ethical considerations in qualitative research form a fundamental framework that guides the entire research process, prioritising the dignity, rights, and welfare of participants. Core principles include obtaining **informed consent**, which clearly explains the study's purpose, procedures, potential risks, and benefits to participants before they voluntarily agree to take part (Unisa, 2017; Unisa, 2016).

3.9.1 Main description

Given the delicate nature of the research, which focused on HIV knowledge and experiences amongst young women aged 19 to 24 in township communities of KZN, the research was classified as medium- and high-risk study and it involved human participants directly. Support measures included offering immediate access to professionals for participants experiencing distress. Additionally, participants received contact details for counselling organisations to facilitate private and convenient follow-up support. Given the intimate and potentially distressing nature of discussing HIV, sexuality and associated experiences, the researcher was aware of how to conduct research of this nature and would apply active listening and ethical sensitivity techniques. During interviews, the researcher would closely observe emotional health. Whenever any participant displayed signs of distress, the interview was either paused or discontinued. In the event that participants required any psycho-social support, the researcher would help them to connect with SADAG (South African Depression and Anxiety Group), provide them with their contact details and/or help them in scheduling their first session.

To safeguard the rights, security and dignity of participants, these were protected through ethical clearance from the University of South Africa, which was obtained from the College of Human Sciences Research Ethics Committee at the University of South Africa prior to the commencement of the study (Unisa, 2016; Unisa, 2024). Ethical approval was granted under the reference number 57115354_CREC_CHS_2023 (Annexure E), the research complied with ethical

standards including confidentiality, voluntary participation and informed consent (Unisa, 2020).

3.9.2 Informed consent

Informed consent is an agreement. It is when people give permission or authorisation to participate in something (Villamañán, Ruano, Fernández-de Uzquiano, Lavilla, González, Freire, et al., 2016:209; Unisa, 2016; Unisa, 2024). The researcher held the responsibility of ensuring that all participants fully comprehended the study's aims and procedures prior to any data collection. Prior to each interview, the researcher provided a detailed verbal explanation of the study's objectives, the interview process, and what would be expected of them. A copy of the consent form provided either electronically via email or as a physical hard copy was then given for review.

Crucially, it was emphasised that participation was entirely voluntary; individuals were under no obligation to sign the consent form and could decline without penalty. Furthermore, informed consent was treated as an ongoing, iterative process rather than a single event. The researcher periodically revisited the terms of consent throughout the study to renegotiate participation and reaffirm the participants' right to withdraw at any time without consequence. This approach was fundamental to building a foundation of trust and ensuring ethical integrity (See Annexure B).

3.9.3 Protection of privacy

The researcher assured the participants that whatever they discussed will remain private and will remain between both parties. Only should the participant be of harm to themselves should a third party be notified and involved (Unisa, 2017).

Should the participant also have required anonymity and remain unknown throughout the whole study, the researcher would respect their wishes and assure

them that their true identity would not be revealed no matter the circumstances, unless decided otherwise by the participant (Unisa, 2016; Unisa, 2017; Unisa, 2024).

All participant data were treated with strict confidentiality. Interviews were conducted in private, safe spaces to protect participants' identities. Names or any identifying information were not recorded; instead, pseudonyms were used. All information gathered such as audio files, and research notes were locked away and kept safe. Only the researcher and the supervisor had access (Unisa, 2017).

3.9.4 Confidentiality

The interviewer always reassured the participants that confidentiality was adhered to throughout the whole study, not once, but reminded their participants all the time Unisa, 2017; Unisa, 2024). It was, therefore, of utmost importance that the interviewer clearly explained and ensured confidentiality to the participants and that all rules and regulations were made clear. Before every session, the participant(s) were also made aware by the researcher that confidentiality would only be breached should they be of threat to themselves or others. The researcher explained to the participants that their rights were respected and protected and that they were not forced to participate against their will (Jones, 2019:5-6; Unisa, 2017).

3.9.5 Anonymity

The researcher ensured participants that anonymity is of choice and because they were partaking in face-to-face interviews, they, therefore, had the choice to remain anonymous and not disclose their names should they wish, yet still participate. Should they wish to withdraw, their wish should be respected (Unisa, 2017; Unisa, 2024). After the gathering of all information required for the study, the data collected were then handed over to the University so that further analysis was conducted. This was also explained to the participants. They were most definitely assured that this was only conducted under their given permission and that their identity would continue to remain hidden (Unisa, 2017; Unisa, 2024). It was crucial that the

participants in this study were made aware that their data would be stored for a period of one to two years before being destroyed but would be kept safely where only the researcher would have access to them.

3.9.6 Debriefing

Debriefing is a crucial step following a research study, particularly those involving human participants. Researchers use it to give participants complete details about the study's goals, methods and any misleading information that may have been included. This is an essential ethical practice especially in psychology and behavioural research (Oates, Carpenter, Fisher, Goodson, Hannah, Kwiatowski, et al., 2021; Unisa, 2016).

According to Gardner (2013:166), debriefing involves reflecting on an event or situation, examining and incorporating the knowledge gained into one's understanding and awareness. This process allows for analysing what occurred, discussing success and determining areas of modification, enhancement or alternative approaches for future situations. Crookall (2023:117-118) supports this by stating that debriefing is an episode within a simulation where participants reflect on and discuss their experiences with one another aimed at facilitating learning.

3.9.7 Voluntary participation

Prior to each interview, the researcher explicitly communicated to all participants that their participation was entirely voluntary and uncompensated. It was clearly stated that participants retained the right to withdraw from the study at any point, for any reason, without incurring penalties or loss of benefits. Furthermore, participants were informed of their right to decline to answer any question and to request the withdrawal and destruction of their data at any time, a request that the researcher committed to honouring immediately (Unisa, 2016).

Throughout the study, the researcher upheld a participant-centred approach, prioritising the rights and welfare of those who were involved. This included continuously reaffirming the voluntary nature of participation and ensuring that participants did not feel coerced, threatened, or uncomfortable (Unisa, 2017).

3.9.8 Respect for dignity and cultural sensitivity

The study was fundamentally guided by the ethical principle of **respect for human dignity**, which necessitated a deep and culturally sensitive approach to engaging with the Umlazi Township community. This commitment was operationalised by meticulously designing the research to align with the participants' daily lived realities and cultural norms (Unisa, 2017). For instance, all communication and research instruments were linguistically and contextually adapted; interviews were conducted in the participants' preferred language (such as isiZulu) by a researcher fluent in local vernacular and cultural cues to ensure clarity, comfort, and authentic expression.

The methodology was intentionally crafted to avoid any form of stigmatisation or moral judgement regarding the participants' knowledge or behaviours related to HIV. This non-judgemental stance was paramount to building genuine trust and mitigating the power dynamics often inherent in research (Unisa, 2016). Ethnographic design was instrumental in this process, as it allowed for immersive and empathetic engagement. By spending time within the community and observing social contexts, the researcher was able to create a secure, empowering environment where participants felt safe to share their perspectives openly and honestly, thereby ensuring that the findings are an authentic reflection of their experiences.

3.9.9 Data protection, management and retention

In strict adherence to the research ethics policy of the University of South Africa, stringent protocols for data protection and retention were implemented to ensure the

confidentiality and security of all participant information. All collected data, including audio recordings, transcripts, and observational notes, were securely stored in password-protected digital files and locked in physical storage for a mandatory period of five years. Following this retention period of five years, all data will be permanently and irreversibly destroyed through the secure deletion of digital files and shredding of any physical documents (Unisa, 2017).

Furthermore, the ethical principle of specific informed consent was rigorously upheld. No data or information obtained from participants will be used for any purposes beyond the explicit objectives outlined in this study. Should any future use of these data be proposed, a new, separate process of informed consent will be sought and obtained from each participant, clearly explaining the new purpose and securing their voluntary agreement (Unisa, 2017).

3.9.10 Safety and security of researcher and participants

To ensure the physical well-being of all participants during the data collection period, stringent COVID-19-specific safety protocols were rigorously implemented in accordance with national lockdown regulations. Prior to commencing fieldwork, the researcher established clear contingency plans for managing potential health incidents, including procedures for reporting and responding if any individual displayed COVID-19 symptoms. Preparation was essential for conducting interviews safely and ethically (Unisa, 2020).

During the sessions, these protocols were strictly enforced. Every participant was required to sanitise their hands and undergo temperature screening before entering the premises (Unisa, 2020).

Beyond these physical health measures, the researcher’s paramount concern was to cultivate a psychologically safe and supportive environment. This was achieved by

proactively building a foundation of trust and rapport, ensuring that participants felt secure, respected, and free from any sense of threat or danger throughout the research process. The creation of this safe space was a prerequisite for facilitating open and honest dialogue (Unisa, 2020; Unisa, 2016; Unisa, 2017)

3.9.11 Pilot Study

Lowe (2019:117) describes a pilot research as a brief feasibility study intended to evaluate several facets of the procedures intended for a more extensive, exacting or corroborated enquiry, where the primary purpose is to stop researchers from starting a large-scale study without sufficient understanding of the methods proposed, in essence, it (pilot study) is carried out to avoid the occurrence of a fatal flaw in a study that is expensive in terms of both time and money (Deming, 1966:8; Dzwigol, 2022:83). According to Polit and Beck (2017), pilot studies are used by researchers to assess the suitability of their proposed techniques and protocols.

Van Teijlingen and Hundley (2002:1) state that the phrase “pilot study” describes both the precise pre-testing of a specific research instrument, such as a questionnaire or interview schedule as well as miniature copies of a full-scale study (also known as “feasibility study”), further adding that large-scale studies may include several pilot studies prior to the main survey being conducted and can be based on quantitative or qualitative methodologies (Deming, 1966:8).

3.10 Conclusion

This chapter has outlined the methodological framework employed in this study, detailing the specific procedures undertaken to ensure a severe and ethically sound study. Grounded in a qualitative research paradigm, the study adopted an exploratory descriptive design utilising explorative qualitative methods. A non-probability, purposive sampling strategy was employed to recruit participants, and data were collected primarily through face-to-face interviews, which were audio-recorded to ensure accuracy and completeness. The collected data were subjected

to thematic analysis, following the systematic six-phase approach proposed by Braun and Clarke (2006), to identify, analyse, and report key patterns and themes. To uphold the trustworthiness and rigour of the study, reliability was verified using Lincoln and Guba's (1985) model of trustworthiness, which emphasises credibility, dependability, confirmability, and transferability.

The next chapter will present and interpret the research findings that emerged from this methodological approach, providing an in-depth discussion of the themes identified and their implications for understanding the central research problem.

CHAPTER 4

THE STUDY FINDINGS

4.1 Introduction

This chapter presents a detailed analysis and synthesis of the data gathered for this study, moving from raw data to emergent meaning. The purpose of this research was to investigate the persistent lack of HIV prevention knowledge amongst young women (aged 19 to 24) in KZN who have completed secondary education, and to identify pathways for improvement in HIV prevention within the educational system.

Building upon the qualitative methodological framework outlined in the previous chapter, this analysis is grounded in the rich, explorative information gathered through semi-structured interviews with participants and field observations. The chapter is structured around the key themes and patterns that emerged organically from analyses of the interview transcripts. The interview questions were designed to address the study's research questions (Section 1.8) by exploring participants' experiences, knowledge and perceptions related to HIV prevention, HIV education and the social and contextual factors influencing prevention practices. The responses were analysed thematically to generate the findings presented in this chapter.

In addition, insights from the researcher's observation protocol are incorporated to provide contextual understanding of the social and environmental factors influencing participants' experiences. These observations contribute to interpreting not only what participants shared, but also the broader community conditions, resource limitations and cultural contexts that shape their perspectives.

By integrating participant experiences with contextual observations, this chapter provides a comprehensive understanding of the challenges influencing HIV

prevention knowledge and practices amongst young women. Relevant literature is incorporated throughout the presentation and discussion of findings to contextualise the results, demonstrate their relationship with existing knowledge and highlight the contribution of this research to the broader field of HIV education.

4.2 Demographic Profile of the Participants

Fifteen participants participated in this study; all were former secondary school-going young women between the ages of 19 and 24 years, living in township communities of KZN. Table 4.1 is a summary of each participant's biographical details. In order to safeguard their identities, participants were assigned pseudonyms.

Table 4.1: PARTICIPANTS' DEMOGRAPHIC INFORMATION

PARTICIPANT	GENDER	AGE	EDUCATIONAL LEVEL	EMPLOYED YES/NO
P1	Female	19	Dropped out in Grade 12	No
P2	Female	22	Completed matric	Yes
P3	Female	21	Completed matric	Yes
P4	Female	23	Completed matric	Yes
P5	Female	20	Dropped out in Grade 10	Yes
P6	Female	19	Completed matric	Yes
P7	Female	21	Completed matric	No
P8	Female	19	Completed matric	No
P9	Female	23	Dropped out in Grade 11	Yes
P10	Female	21	Dropped out in Grade 10	Yes
P11	Female	20	Completed matric	No
P12	Female	23	Completed matric	Yes
P13	Female	19	Completed matric	Yes
P14	Female	21	Completed matric	Yes
P15	Female	19	Completed matric	Yes

Source: Researcher's conceptualisation

4.3 Addressing the Research Questions and Discussion of the Findings

4.3.1 Social and environmental factors in which these young women live

The research conducted in Umlazi revealed a community operating within a complex tapestry of socio-environmental challenges and resilient adaptations. The physical landscape is defined by spatial inequality, marked by a mix of formal, state-provided RDP (Reconstruction and Development Programme) housing and informal, self-built shacks. This patchwork urban fabric is further characterised by a deficit in essential infrastructure, with many areas lacking adequate drainage systems and paved roads, exacerbating vulnerabilities to weather and access.

This physical environment is mirrored by significant social challenges. Persistent unemployment, particularly amongst the youth, serves as a persistent stressor, with idleness and limited opportunity contributing to visibly high levels of crime. These factors collectively create a context of substantial adversity.

However, to view Umlazi solely through the lens of its challenges would be to overlook its dynamic spirit. In direct response to the formal economy's limitations, a vibrant informal sector has emerged as the community's lifeblood. The streets are lined with the entrepreneurial endeavours of local residents, who have created a self-sustaining economic ecosystem. From street food vendors and informal retail spaza shops to a bustling transport economy centred around cars, buses, and taxis, this informal sector demonstrates remarkable resourcefulness.

Ultimately, the defining characteristic of Umlazi is not its hardship, but the profound resilience and strong social cohesion that flourishes in spite of it. Residents maintain an unwavering cultural pride and a strong sense of community, using collective resourcefulness to navigate daily obstacles. This complicated interplay between a challenging environment and a determined human spirit forms the essential backdrop against which the lives of the young women in this study must be understood.

It addresses the critical principle of reciprocal determinism in SCT, which posits that behaviour is shaped by the continuous interaction between personal factors and the environment (Bandura, 1986; Haffejee et al., 2023). This indicates that in the townships of KZN, this dynamic is decisively skewed by powerful socio-structural barriers**.** Even when young women possess high self-efficacy and the knowledge to practice prevention, adverse conditions such as financial precarity, housing instability, and restrictive gender norms create an environment that actively constrains their agency. A moving example is a woman who, despite knowing how, and intending to demand, condom use, may be prevented from doing so by economic dependence on her partner or the threat of becoming homeless. Therefore, these environmental factors interact reciprocally with personal factors, often overriding individual intention and rendering the consistent practice of preventive behaviours profoundly challenging, regardless of personal awareness or motivation.

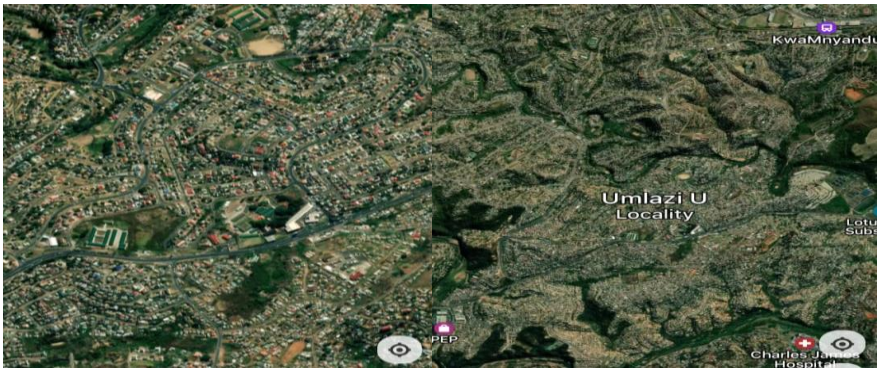

Image 4.1: Aerial view of Umlazi

Source: Mapquest (2025)

4.3.2 Underlying factors influencing HIV-related knowledge, prevention practices and vulnerability to HIV infection amongst young women

The findings presented in this chapter are based on data generated from the semi-structured interviews conducted with former secondary school-going young women. The interview questions were designed to address the study's research questions

(Section 1.8) by exploring participants' HIV-related knowledge, prevention practices, and perceived vulnerability to HIV infection. In addition, the interviews examined participants' experiences of HIV education during secondary school, their perceptions of the effectiveness of the Life Orientation curriculum, their awareness of HIV prevention and control strategies, including condom use, HIV testing, PrEP, PEP, and treatment adherence, the educational barriers that hinder effective HIV education, and their recommendations for strengthening HIV education and prevention initiatives within schools and communities. The interviews also explored participants' perspectives on the influence of stigma, cultural beliefs, gender norms, and GBV on HIV prevention behaviours and access to HIV-related support services. The responses to these questions were analysed thematically, resulting in the five key themes presented in this chapter, (1) inadequate HIV-related knowledge and challenges in acquiring sufficient information for HIV prevention amongst young women; (2) inadequate school programmes and limited institutional support hindering the effectiveness of HIV education; (3) cultural beliefs as barriers to HIV education and prevention amongst young women; (4) the role of GBV and cultural norms hindering HIV prevention amongst young women; and (5) strategies for promoting safe sexual practices, strengthening educational programmes, and addressing HIV-related stigma amongst young women. Collectively, these themes provide a comprehensive understanding of the multiple and interconnected factors contributing to HIV knowledge gaps and the continued vulnerability of young women aged 19 to 24 in Umlazi Township, KZN, to HIV infection.

4.3.3 Findings

4.3.3.1 Theme 1: Inadequate, or challenges in acquiring sufficient, knowledge for HIV prevention amongst young women and Theme 2: Inadequate school programmes and lack of support hindering the quality of HIV educational programmes

The findings revealed that young women in township communities of KZN are still ill-equipped and continue to face significant challenges in acquiring adequate HIV

prevention knowledge despite having completed secondary education. These challenges were highlighted by two interrelated themes: *inadequate access to sufficient HIV knowledge for HIV prevention amongst young women and inadequate school programmes characterised by poor sexuality education and lack of practical HIV prevention guidance.*

The majority of the participants faced challenges in coming to terms with the virus after they had found out that they had contracted it, attributable to a number of reasons, mainly having little to no knowledge of and about it. They also faced difficulties internally in accepting that they have HIV and how society will perceive them.

Participants' findings revealed that HIV knowledge was often acquired through illness, trauma, or personal diagnosis rather than through preventive educational processes.

> *"I was diagnosed with pneumonia when I was little, my health has always been challenging. I remember spending two nights in hospital with pneumonia, and I guess it wasn't the only thing that I had. Although I didn't know at a young age about my status, but I suppose I've had HIV for quite a long time if not my entire life. My siblings and I are all on treatment, which serves as a red flag that we all got the virus from our mother during birth". (Nuh)*

Nuh reflected how she always struggled with poor health and recurrent illness while she was young before eventually realising that she was also HIV-positive. Her story illustrated how HIV is often normalised in township communities, where treatment use and chronic illness became everyday occurrences.

Participants discussed how they also observed other households with people who were on treatment, yet discussions of HIV transmission and prevention remained

absent. This silence served as an example of how HIV can be clearly present in communities while remaining poorly understood.

Similarly, Zama explained that after both her parents died from HIV-related illness, she only thought it was just a sickness until she grew older.

> *"When my parents passed away from HIV, I had little knowledge of what it was as I was still very young. I didn't even know that it was a deadly virus that would also shape my life in future as I only thought it was just a sickness up until I grew older and got to learn what it was". (Zama)*

Such findings suggest that many children in township communities grow up witnessing illnesses, funerals and usage of therapy without receiving comprehensive explanations regarding HIV.

The study revealed that educational institutions inadequately prepared young women regarding sexual relationships and HIV prevention. Khanyo recounted becoming sexually active early in life, with limited awareness of the diseases associated with intimacy.

> *"I live with the guilt of rushing into adulthood with little knowledge of it. I became sexually active at a young age not knowing much about the diseases of being intimate with your partner". (Khanyo)*

Her experience emphasises a deficit not only in factual HIV knowledge but also in practical sexual health guidance.

Philie similarly noted that:

> *"My school did not teach us much about sex, and every other thing related to sex which then made me develop interest as I grew older in studying about health related issues such as the dangers of being sexually active". (Philie}*

This perspective reveals how young women frequently acquire sexual information from their peers, by observing others or through their own experiences instead of through structured education. This aligns well with the Social Cognitive Theory, which suggests that young people often learn by imitating the behaviours of those around them, be they parents, peers, or the community and without adequate HIV knowledge, they may unconsciously replicate risky actions that they have observed, putting their health in danger (Jonas, Duby, Maruping, Dietrich, Slingers, Harries, Kuo & Mathews, 2020:3-4; Bandura, 1986).

The experiences shared by participants also revealed that crucial HIV prevention practices such as discussing condoms, being tested for HIV, and consistently following treatment plans were not regularly observed within their communities. Conversations about PrEP, PEP, or routine HIV testing seldom happened amongst friends, family, or in schools. Instead, discussions about HIV typically arose only after someone fell ill or received a diagnosis. The SCT posits that this absence of visible role models and consistent prevention efforts can diminish young women's self-assurance in embracing safer health behaviours (Biderman, Doria, Sinno, Rand, Hackett, Miller, et al., 2021:387). This directly relates to research question b (1.8.2), as it reflects limited comprehensive awareness of HIV prevention strategies such as PrEP, PEP, and consistent condom use.

The findings also showed that HIV knowledge was often acquired reactively rather than proactively.

> *"I was very traumatised by what had happened to me and I had blocked every thought of it from my brain up until I had a health scare. I didn't even think much about the possibility of having contracted the virus up until I tested positive and all memories came flashing back". (Thando)*

Thando stated that she had “blocked every thought” of her trauma until a health scare led to HIV testing, after which “all memories came flashing back”. This illustrates delayed risk recognition and highlights the absence of preventive education and psychosocial support systems that could encourage early testing and awareness.

The challenging circumstances in these townships further exacerbated the difficulties already present. Participants described communities characterised by unemployment, overcrowding, gender inequality, and limited opportunities for young people. Within these environments, emotional relationships, financial dependence, and social belonging often took priority over HIV prevention.

> *“Little did I also know about HIV as we were never taught about sex at school and I had to learn the hard way when my ex-boyfriend infected me and now we are not even together anymore. I wish I never engaged in sexual activities so young as this would’ve been prevented”. (Khanyo)*

Khanyo illustrated how prevention knowledge became secondary to immediate social realities.

The research brought to light the significant emotional toll of acquiring HIV, particularly for individuals who contracted the virus at or around the time of their birth. Nokubonga, for instance, voiced deep bitterness towards her parents, feeling that they had robbed her of her youth:

> *“Although finding out about my status when I had undergone testing for TB, I was in disbelief and in denial as I had never heard that anyone at home had HIV, even though we had a history of TB. Coming to terms and accepting very quickly was mainly due to having a very supportive family system and not only that, but I also felt that it was never my fault. After finding out that everyone at home was aware of my status, I also learnt that my parents had HIV and I had*

got the disease from them when I was born. Yes, I have accepted it as I cannot change it but I am still struggling to allow myself to forgive them as I feel that they had robbed me of my youth and could've avoided me from getting infected". (Nokubonga)

Similarly, Smah held both her mother and medical staff responsible for her infection:

"I have always struggled to accept that I am HIV positive and that it was because of the nurses negligence. I sometimes blame my mother and ask questions like why she allowed another woman to breastfeed me, why did she not at least give me formula instead". (Smah)

Such findings highlighted profound feelings of anger, accusation, and lingering trauma, all intensified by the enduring social disapproval associated with HIV in township settings.

Cultural norms also shaped the participants experiences. Philie noted:

"My culture is very strict when it comes to sex before marriage and as someone who has a partner and have seen / witnessed most of my friends and age mates being sexually active, I know one day that I will be too, as I also wish to have my own family and have children". (Philie)

Despite being intended to encourage abstinence, this absence of communication restricted access to dependable sexual health information and lowered young women's confidence in discussing protective sexual practices.

4.3.3.2 Theme 1: Inadequate, or challenges in acquiring sufficient, knowledge for HIV prevention amongst young women

This theme addresses the study objective: *To explore the impact of inadequate HIV knowledge, stigma, and risky sexual behaviours on the vulnerability of young women to HIV infection and the prevention of HIV infections amongst them.* The findings revealed that inadequate HIV knowledge, limited practical prevention skills, and persistent stigma significantly contributed to the vulnerability of young women to HIV infection. Participants described how insufficient access to relatable and practical HIV information undermined their ability to make informed decisions regarding HIV prevention and treatment.

4.3.3.2.1 Lack of accessible and practical information

A significant finding that surfaced from the data was the participants' emphasis on limited access to accessible and practical HIV information as a barrier to prevention. This finding extended beyond a lack of factual knowledge as participants highlighted challenges in obtaining information that could be applied to their everyday realities. As one participant explained, being aware of one's HIV status provides "valuable information that can assist guide your actions" to maintain personal and partner health (Samke). Similarly, Nokwanda's experience of having to "do more research and teach myself of the virus" to provide support to her sister illustrated how HIV knowledge was often acquired through personal initiative rather than consistent access to structured information.

These accounts demonstrate that participants valued HIV knowledge but also revealed gaps in how information was accessed, understood, and applied. Therefore, the finding does not suggest that young women lacked awareness of HIV altogether, but rather that available information was not always sufficient to develop the practical skills and confidence required to navigate prevention decisions within complex social contexts.

4.3.3.2.2 HIV as a lived and traumatic community reality

During the interviews, participants frequently spoke with emotional intensity when recounting experiences of illness, loss, and fear associated with HIV within their families and communities. Several participants paused, became visibly distressed, or lowered their voices when discussing the deaths of parents or caregivers, suggesting that HIV was not simply understood as a health condition but as a lived and traumatic social reality embedded within their households and communities. The surrounding community context appeared to shape their perceptions significantly, as HIV was often associated with suffering, secrecy, and loss rather than prevention, support, or empowerment. These observations highlighted how participants' understanding of HIV was deeply influenced by personal experiences and community findings rather than by formal educational interventions.

One participant reflected on the emotional burden of caring for her mother who was ill with HIV-related complications:

> *"I witnessed my mother falling very ill and I had to take care of her. Leading up to her death, I wasn't OK, I could sense that she wasn't going to make it judging from how sickly she was and that alone imposed a lot of fear in me, as to what if the same happens to me and my siblings since we are also in the same predicament". (Nuh)*

As Nuh narrated her experience, she appeared emotionally overwhelmed and spoke cautiously about the fear that HIV had created within her family. Her account reflected not only grief and trauma but also the intergenerational anxiety surrounding HIV within communities where illness and death remain highly visible.

Similarly, another participant associated the deaths of her parents with a lack of HIV awareness and education:

“I lost my parents because of HIV and I believe that if only they knew more about it, they would still be alive”. (Nokubonga)

This statement revealed a keen understanding that lack of HIV knowledge continues to result in negative outcomes in the lives of families and communities. In her statement, Nokubonga revealed that participants saw HIV information as an important tool in relation to survival, making decisions and well-being. This idea aligns with the notion of health literacy that highlights the need for people to have access to information, understand it and use it in order to make health-related decisions (Nutbeam, 2000: 259-261). Thus, lack of sufficient knowledge in relation to HIV infection can make it difficult for young women to recognise risks and use HIV prevention methods. In this regard, recent research into the problem of HIV infection provides additional confirmation. According to UNAIDS, adolescent girls and young women continue to be disproportionately infected with HIV and proper access to information, supportive environment and HIV prevention services is required in order to protect them from HIV infection (UNAIDS, 2024a). Thus, perception of HIV knowledge as protection is based on the understanding of the role of information in preventing HIV infection.

Furthermore, the Health Belief Model suggests that individuals’ engagement in preventive behaviours is influenced by their perceptions of health risks, the seriousness of consequences, and the benefits of preventive action (Rosenstock, Strecher & Becker, 1988:178). Nokubonga’s account demonstrates that participants recognised HIV knowledge as an important factor in understanding risk and protecting themselves and their communities.

“I was lucky that I did not get infected but what happened to me showed me how vulnerable young women can be when they do not have control over what happens to their bodies. It made me realise that HIV is not only about choices people make, sometimes it is connected to experiences of violence and situations that are beyond a person’s control”. (Xoli)

She further added:

> *“What happened to me when I was young does not define who I am today. I went through something painful, but I have learned to accept myself and live my life honestly. I know who I am, and I am not ashamed to speak about my HIV status or my experiences because keeping silent does not help anyone”. (Xoli)*

For Xoli, HIV became meaningful through a different form of trauma. While reflecting on her life experiences, she shared that her sexual identity had been shaped, in part, by being sexually abused by a family member at the age of five. However, she was lucky because she did not become infected with the virus as a result of the abuse. While Xoli is not living with HIV, her story shows how HIV can be an effect of the violation of someone's integrity, therefore, emphasising the place of this virus in people's traumatic experiences. Living in a large extended family with her mother, her aunt, her grandmother, two uncles and her sister, she calls herself emotionally tough and open despite her traumatic history, deciding to accept her identity and live her life freely. Therefore, it shows that for some young women, HIV is not only about seeing their family members being ill and dying from this disease but also about their vulnerable experiences when they become infected with this virus during these traumatic events.

Overall, the stories of the participants show that HIV is not just a medical condition for the participants but a part of personal experiences related to bereavement, care, abuse and vulnerability. All these aspects determine the participants' perception of HIV as a traumatic experience that happens to the community and which is closely connected to the pain and grief of the community members.

4.3.3.2.3 Behavioural change through increased awareness and responsibility

Although many participants experiences were marked by a general feeling of fear, uncertainty and disengagement from healthcare services, some viewpoints

highlighted the ability of personal experiences to positively impact attitudes regarding HIV prevention and treatment consistency.

One participant explained how her pregnancy became a turning point in taking responsibility for her health after previously disengaging from care:

> *"Ever since I found out about my status, I have never been to hospital because of defaulting on medication, my pregnancy made me take a sharp U-turn in life and I make sure I make my health a priority". (Fikile)*

Fikile's reflection demonstrated how life events such as pregnancy can reshape attitudes towards HIV treatment and prevention. During the interview, she spoke with a sense of renewed determination, suggesting that support and practical guidance can positively influence behavioural change when individuals feel personally responsible for protecting themselves and their children.

4.3.3.2.4 The need for comprehensive and relatable HIV education

Consequently, they articulated a strong desire for educational interventions that move beyond biological mechanisms to address the nuanced socio-cultural factors influencing their risk, such as GBV, negotiation for condom use, and understanding PrEP and PEP as prevention tools. In their view, bridging this information chasm through comprehensive, relatable, and stigma-free education is not just beneficial but essential to empowering them to make informed decisions and ultimately reduce infection rates.

4.3.3.3 Theme 2: Inadequate school programmes and lack of support hindering the quality of HIV educational programmes

Interventions or treatments can be included in the educational system to enhance HIV knowledge and support young women.

When participants were asked to elaborate on the potential efficacy of diverse educational interventions for HIV prevention, they responded affirmatively. A prevailing sentiment was that the educational system had failed both them and their parents' generation. Their narratives reflected that, had their parents possessed adequate knowledge and access to information and treatment, several outcomes might have been possible. This was evident in Nokubonga's reflection that "if only they knew more about it" that greater HIV knowledge amongst previous generations may have changed the outcomes experienced within her family, particularly in relation to HIV-related loss. Similarly, Smah's account, in which she stated that "I have always struggled to accept that I am HIV positive", highlighted the emotional consequences of limited understanding of HIV transmission, as she reflected on the unanswered questions and feelings of blame associated with how she acquired HIV.

These accounts suggest that participants viewed HIV education as extending beyond the provision of biomedical information. Their reflections indicated that comprehensive HIV education could have strengthened family communication, improved understanding of prevention and transmission, and supported more informed decision-making amongst both caregivers and young people. The findings further highlighted the importance of accessible and age-appropriate HIV education within schools and communities to provide foundational knowledge from adolescence into adulthood. These findings align with Dadzie, Gebremedhin, Salihu, Ahinkorah and Yaya (2024:2), who highlight the importance of parental knowledge, access to HIV information, and early prevention education in reducing transmission risks and improving health outcomes.

4.3.3.3.1 Intergenerational silence and retrospective HIV knowledge

Zama reflected on the emotional trauma of losing both parents without fully understanding the illness that caused their deaths:

“My parents passing left a huge gap in my life, I remember crying so much and not knowing how my life would turn out. I never understood what kind of illness it was that took them so close apart in such a short period of time, but when I got to learn about my own health, I knew for sure what it was, even though no-one had told me, but the symptoms and everything they went through are what I know now from what I’ve learnt”. (Zama)

Her account demonstrates how HIV knowledge was acquired retrospectively through personal experience, observation, and later education rather than through direct familial communication. Within many communities where HIV remains highly stigmatised, silence surrounding illness and death often leaves young people to make sense of HIV independently.

4.3.3.3.2 Fear, shame and educational disruption

Similarly, Nothando associated her delayed treatment-seeking behaviour and school dropout with fear, shame, and inadequate knowledge about HIV:

“mmmh….. (sigh) If only I had the courage, of which I believe I would have if I knew more about the virus, I would’ve never dropped out of school. I wouldn’t also have been ashamed and I would’ve seeked professional assistance and started treatment immediately”. (Nothando)

Her narrative illustrates how limited HIV literacy within the community can reinforce stigma, self-isolation, and educational disruption amongst young women living with HIV. The participant’s reflection also demonstrates how increased awareness and psychosocial support could encourage confidence, help-seeking behaviour, and retention in educational spaces.

4.3.3.3.3 Positive impact of educational and support programmes

> *"I was able to feel safe and secure in my own space, health and mental state. The classes I started when I found out about my status assisted me a lot in feeling like I do fit in with the society and I am not an outcast. My status and what the society thinks does not define who I am". (Enhle)*

In contrast, Enhle described the positive impact of educational and support classes after learning about her HIV status.

Her experience highlights the transformative role of supportive educational interventions in reducing internalised stigma and strengthening self-acceptance. Enhle's reflection that the classes helped her feel that she could "fit in with the society" and that "my status and what the society thinks does not define who I am" demonstrates how supportive interventions can challenge feelings of exclusion and promote a more positive sense of identity. Beyond merely transferring knowledge, these programmes created a sense of belonging and social inclusion. This was further reflected in Nokwanda's account of seeking information in order to "support" her sister and avoid discrimination "without any knowledge" of HIV (Nokwanda), highlighting how education can contribute to more compassionate and supportive social environments. Within communities where HIV-positive individuals are frequently marginalised, support groups and educational workshops appear to function as protective spaces that rebuild confidence and social identity.

4.3.3.3.4 Family support as part of HIV education and coping

Participants also reflected on the influence of family support within the broader HIV education process. Nokubonga explained that her family protected her from experiences of social isolation:

> *"I think my family took that decision for me, I've never experienced how it felt like being isolated". (Nokubonga)*

This demonstrates how family environments can shape the lived experiences of young women living with HIV. In communities where stigma remains prevalent, supportive families may act as buffers against discrimination and emotional distress.

4.3.3.3.5 Community learning and self-education

Likewise, Nokwanda described actively educating herself after learning of her sister's HIV status:

> *"When I learnt of my sisters status, I made it my mission to do more research and teach myself of the virus so that I know how to support her as well as not to discriminate those who have it especially without any knowledge on how they might have contracted it". (Nokwanda)*

Her response reflects how HIV knowledge within communities is socially constructed through lived experiences, caregiving responsibilities, and interpersonal relationships. Rather than relying solely on formal schooling, participants and their families actively sought information to challenge stigma and improve support systems. This demonstrates the agency exercised by community members in contexts where formal HIV education may be insufficient.

4.3.3.4 Theme 3: Cultural beliefs as barriers to HIV education and prevention for young women.

A significant number of participants identified deeply entrenched cultural beliefs as a formidable barrier to effective HIV education and prevention for young women. Participants described a social environment where open discussions about sexuality, condom use, and prevention methods are heavily stigmatised, deemed inappropriate, or directly contravene traditional norms that prioritise abstinence-only approaches. Within many families and communities, conversations about sexual and

reproductive health remained largely silenced, as traditional norms continued to prioritise abstinence-only expectations and discourage open engagement with topics related to sex and HIV (Aliyu & Aransiola, 2023:2-3; Knight, Humphries, Van der Pol, Ngcobo, Essack, Rochat & van Rooyen, 2023:1726).

During the interviews, participants frequently lowered their voices, paused before discussing sexuality, or laughed nervously when referring to condom use or HIV testing. These responses reflected not only personal discomfort but also the broader social conditioning that framed such discussions as taboo. The hesitancy observed in the interviews mirrored the wider community context where young women are expected to remain silent about sexual matters in order to preserve respectability and avoid social judgement.

4.3.3.4.1 Silence, stigma and fear of social judgement

Participants explained that this culture of silence created an environment of secrecy and shame that prevented young women from seeking information, accessing healthcare services, or openly discussing HIV prevention without fear of being judged. The stigma associated with HIV remained deeply rooted in community perceptions, where testing or openly associating with someone living with HIV often invited suspicion, gossip, or social exclusion.

Nolwazi reflected on her experience of dating a partner who was HIV positive:

> *"I have never been a judgemental person therefore dating someone who was HIV positive wasn't much of a big deal for me. I honestly think I was able to proceed with the relationship because he was very open and honest with me from the get-go". (Nolwazi)*

While narrating her experience, Nolwazi appeared calm and reflective, yet her account revealed the emotional burden imposed by community attitudes. She further explained:

> *“It was quite of a challenge as people would also ask me personal intimate questions out of curiosity that I might also be infected or get infected”. (Nolwazi)*

Her experience illustrated how community curiosity often became intrusive surveillance, where women associated with HIV-positive individuals were subjected to suspicion and moral scrutiny. The social environment appeared to reinforce the idea that HIV was not merely a health condition but also a marker of social shame.

Similarly, Nothando described the intense fear associated with HIV testing and disclosure:

> *“For me it wasn’t just the fear of getting tested and the findings, but what the findings would mean in the eyes of others. What if someone sees me? What if I test positive and the word spreads before I felt ready to disclose it?” (Nothando)*

As Nothando recounted this experience, she repeatedly referred to “others” and “people,” highlighting the extent to which community perceptions shaped her understanding of HIV testing. Her concern was not solely about the medical outcome, but about the anticipated social consequences attached to being seen accessing HIV-related services. This reflected a broader community context in which visibility at clinics or testing centres could lead to gossip, labelling, or reputational damage.

4.3.3.4.2 Cultural taboos and limited access to information

Participants further emphasised that cultural taboos around sexuality prevented young women from accessing accurate HIV-related information. Questions about sex, relationships, or HIV prevention were often interpreted as signs of promiscuity, discouraging young women from openly seeking knowledge. Nothando expressed frustration with this contradiction within her cultural environment:

> *"In our culture, you do not talk about these things openly, you can't just ask questions about sex or HIV without people looking at you funny or assuming things about you. You are supposed to know, but how are we supposed to know when no one is teaching us?" (Nothando)*

This statement captured the tension between cultural expectations and the realities faced by young women. Participants highlighted how they were expected to make responsible decisions about their sexual health while simultaneously being denied safe spaces to learn, ask questions, or access guidance. During the interviews, several participants appeared visibly frustrated when discussing the lack of open communication within families and communities. This frustration reflected the broader structural silence surrounding sexual and reproductive health education.

Embedded sexual taboos really hamper young women's pursuit of health and place them at substantial risk of contracting HIV. Such traditional views remain present and continue to create restrictions that influence young women's access to HIV-related information and their ability to engage in open discussions about sexual and reproductive health. Participants' experiences reflected how limited communication about HIV and sexuality may affect understanding and decision-making. This was evident in Zama's reflection that she initially understood HIV as "just a sickness," demonstrating how limited early conversations about HIV may shape young people's knowledge and interpretation of the condition. Similarly, Nokubonga's experience of discovering her HIV status later in life, despite her family's awareness of her

condition, highlighted the consequences that may arise when HIV-related communication is not openly addressed.

Therefore, when talking about sexual and reproductive health remains taboo, access to accurate and comprehensive information may be restricted. Consequently, exposure to all the facts is limited or non-existent. As a result, young women lacking this open discussion platform find it difficult to make knowledgeable choices regarding their bodies and health, which, in turn, increases their vulnerability to HIV. These findings support previous research indicating that sexual taboos and cultural restrictions may limit young women's access to sexual and reproductive health information (Reddy et al., 2021:1171; Mavhandu-Mudzusi et al., 2021:1542; Tohit & Haque, 2024).

4.3.3.4.3 Patriarchal norms and restricted sexual agency

Furthermore, participants highlighted how certain patriarchal norms exacerbate this vulnerability by limiting a woman's agency to negotiate safe sex practices, often placing her health at the mercy of a partner's decisions.

Some participants described how cultural expectations positioned men as primary decision-makers in relationships, particularly regarding sexual matters. This dynamic often discouraged women from insisting on condom use for fear of conflict, accusations of mistrust, or even abandonment. Philie's observations of relationships within her community illustrate these unequal power dynamics, noting that young women often remain in "unstable relationships where they are not respected or treated well" because "they think it's normal," while "older guys are promising things just in exchange for their own satisfaction". These accounts suggest that unequal relationship dynamics may limit young women's ability to negotiate safer sexual practices, despite recognising the importance of HIV prevention.

4.3.3.4.4 Traditional healing practices and delayed medical care

Some participants acknowledged the important role of traditional healing practices within their communities, noting that these practices were culturally respected and trusted. At the same time, a few participants reflected that reliance on traditional remedies occasionally delayed engagement with conventional HIV testing and treatment services as individuals sometimes consulted traditional healers before accessing medical care. These accounts suggest that cultural beliefs may influence healthcare-seeking behaviour and, in some instances, affect the timing of HIV diagnosis and treatment initiation.

Rather than dismissing traditional healing practices, participants' experiences highlighted the importance of HIV prevention programmes engaging more meaningfully with local cultural beliefs and practices. Their accounts suggest that culturally responsive approaches may strengthen HIV prevention efforts by recognising the realities within which healthcare decisions are made.

The findings further indicate that, for many participants, cultural beliefs were not simply background influences but formed part of the broader social context within which young women understood and responded to HIV-related risks. Participants' narratives further suggest that conversations about HIV and sexual and reproductive health remained sensitive, highlighting the influence of cultural expectations on communication, help-seeking, and HIV prevention.

Consequently, these findings suggest that understanding HIV prevention is best understood within the broader social and cultural contexts that shape young women's experiences and health-related decision-making.

4.3.3.5 Theme 4: The role of GBV and cultural norms hindering HIV prevention amongst young women

A critical discovery from the data was the interconnected influence of GBV, restrictive cultural norms and unequal gender relations as barriers to HIV prevention amongst young women. Participants described how patriarchal structures and limited sexual education often reduced young women's ability to make informed decisions and protect themselves. Philie explained, "Most of us are just figuring things out on our own as we aren't taught about such in school nor at home".

Cultural expectations around sexuality were also identified as contributing to vulnerability. Philie shared, "My culture is very strict when it comes to sex before marriage, but I know one day that I will be too, as I also wish to have my own family and have children," highlighting the tension between cultural expectations and young women's lived realities.

Participants further emphasised that HIV risk is shaped by unequal power relations and experiences beyond individual control. Khanyo reflected, "Little did I also know about HIV as we were never taught about sex at school and I had to learn the hard way when my ex-boyfriend infected me". Similarly, Xoli noted, "HIV is not only about choices people make, sometimes it is connected to experiences of violence and situations that are beyond a person's control". These accounts demonstrate that HIV prevention requires addressing broader social factors, including gender inequality, GBV, and limited agency amongst young women. This environment severely limits their autonomy to negotiate safe sex practices, refuse unwanted sexual activity, or insist on condom use, often out of fear of triggering abuse.

Participants described communities where early sexual relationships, particularly with older men, had become normalised despite the risks attached to them.

In many cases, young women remained in unhealthy relationships because dependence, fear, or community expectations made leaving difficult. Participants also highlighted how violence or the threat of violence often silenced young women and prevented them from negotiating condom use or refusing unsafe sexual practices.

One participant explained:

> *"I have seen so many girls even younger than me becoming sexually active so early. Some of them end up in these unstable relationships where they are not respected or treated well but they stay because they think it's normal. We grow up watching this and think it is love but in actual fact, it's survival. Most of the time it's older guys are promising things just in exchange for their own satisfaction". (Philie)*

Philie's account reflects the broader social context in which unequal power dynamics and transactional relationships become normalised within communities. During interviews, it was evident that participants viewed these experiences as deeply embedded in the social fabric of their environments, where young women are socialised to tolerate emotional neglect, control, and even abuse within relationships. Such conditions increase vulnerability to HIV infection because young women may prioritise survival and relationship stability over sexual protection.

Participants also described how cultural norms surrounding sexuality created silence and discomfort around discussions of sex, HIV prevention, and reproductive health. Several participants explained that conversations about sex were often considered inappropriate before marriage, resulting in limited sexual health education both at home and in school settings. This lack of open communication appeared to contribute to curiosity, misinformation, and unpreparedness amongst young women entering sexual relationships.

As Enhle shared:

> *"My culture is very strict when it comes to sex before marriage and as someone who has a partner and have seen/ witnessed most of my friends and age mates being sexually active". (Enhle)*

She further adds:

> *"I know one day that I will be too, as I also wish to have my own family and have children". (Enhle)*

Enhle's findings demonstrate the tension between cultural expectations of abstinence and the lived realities of young women who are exposed to sexual relationships within their communities.

4.3.3.5.1 Fear of judgement and limited access to HIV prevention services

Participants further reflected on how fear of judgement, stigma, and family disapproval discouraged young women from accessing HIV prevention services such as testing, contraception, or condoms. In some communities, seeking sexual health information was interpreted as evidence of sexual activity, which reinforced secrecy and silence around HIV prevention. As a result, young women were often left vulnerable to misinformation and risky sexual behaviours.

4.3.3.6 Theme 5: Promotion of safe sexual practices, educational programmes, and HIV-related stigma amongst women

This theme addresses the study objectives: *to examine young women's awareness of HIV control and preventive strategies including condom use, HIV testing, PrEP, PEP, and treatment adherence* and *to identify educational and community-based activities that may raise HIV awareness, eliminate stigma and improve HIV prevention efforts amongst young women*.

It also answers the following research questions*: what educational and community-based interventions can be integrated into the educational system to improve HIV knowledge, reduce stigma and support HIV prevention amongst young women in township communities of KZN* as well as *how do stigma, cultural beliefs, gender norms and gender-based violence influence young women's HIV prevention behaviours and access to HIV-related support services*

A central recommendation that emerged from the participants was the urgent need to increase HIV awareness and lower infection rates amongst this vulnerable group. However, this call to action extended far beyond a simple request for additional information; rather, participants advocated for a transformative, multi-faceted approach to public health education. Participants envisioned awareness campaigns that are not only widespread but also culturally identifiable and informative, actively working to dismantle the stigma that silences discussion and prevents help-seeking behaviour (Murewanhema, Musuka, Moyo, Moyo & Dzinamarira, 2022:31).

4.3.3.6.1 Emotional and psychological burden of HIV stigma

Throughout the interviews, participants often expressed their experiences with HIV in emotionally charged ways, reflecting the profound psychological burden associated with both the diagnosis itself and the surrounding stigma within their communities. Several participants paused, sighed deeply, or became visibly emotional when discussing their status or family experiences, indicating that HIV continues to carry strong emotional and social meanings beyond its medical implications.

It became evident that many participants had internalised feelings of shame, anger, guilt, and isolation because of the way in which HIV is discussed or concealed within their communities and families.

One participant reflected on the emotional pain that she experienced after discovering her HIV status. Initially she struggled with feelings of anger and sought to make sense of what had happened, directing blame towards her mother.

“Knowing that I had HIV hurt me more than having the virus itself. I blamed everyone around me, especially my mother”. (Smah)

As Smah narrated her story, she appeared deeply reflective and emotionally conflicted, suggesting that her journey towards acceptance involved confronting feelings of blame, confusion, and grief. Her account demonstrated how inadequate communication and limited HIV awareness within healthcare and family contexts can contribute to emotional trauma and misunderstanding.

Another participant described the emotional turmoil which she experienced following her diagnosis:

“I blamed myself; I hated myself, I couldn’t cry because I didn’t want my friends to know, I……(sigh), I had mixed emotions”. (Nothando)

Nothando’s hesitation and audible sigh during the interview reflected the emotional weight of stigma and fear of social rejection. Her statement illustrated how concerns about community judgement and disclosure can intensify feelings of self-hatred and emotional isolation amongst young women living with HIV.

Similarly, another participant expressed feelings of loss associated with living with HIV:

“I feel robbed of my youth, of my health”. (Thando)

Thando’s brief but powerful statement reflected a perception that HIV had altered the trajectory of her life and identity as a young woman. During the interview, her tone suggested frustration and sadness, revealing how HIV can shape young women’s perceptions of their future opportunities, well-being, and social experiences.

Another participant explained how discovering that her family had known about her HIV status before she did created feelings of betrayal and confusion:

“I was hurt, mostly because when I found out, everyone in my family had known and I started seeing things, such as Oh, so this is why I was everyone’s favourite, why I got so many passes for my wrongdoings, for being so spoilt”. (Nokubonga)

Nokubonga’s account highlighted the silence and secrecy that often surround HIV within families and communities.

4.3.3.6.2 Practical HIV awareness as a tool for prevention

Crucially, participants linked heightened awareness directly to the goal of lowering infection rates by advocating for programmes that are grounded in practical, real-world application. They advocated for initiatives that provide straightforward information access to and clear education about prevention methods such as PrEP and condoms, teaching negotiation skills for safe sex within often complex power dynamics in relationships, and fostering community-wide conversations that normalise sexual health.

In essence, the participants suggested that self-awareness is an important initial step for giving young women the ability and knowledge to make appropriate decisions and decrease their chances of being infected with HIV. It was stated that a lack of access to education concerning HIV could lead to fear, confusion and denial of the infection. Khanyo reflected, “I live with the guilt of rushing into adulthood with little knowledge of it. I became sexually active at a young age not knowing much about the diseases of being intimate with your partner”.

Participants also described stigma and anticipated judgement from families, peers, and communities as significant barriers to disclosure, acceptance, and seeking support. The emotional impact of an HIV diagnosis was often accompanied by feelings of shame and self-blame. Nothando shared, “I blamed myself; I hated myself, I couldn’t cry because I didn’t want my friends to know… I had mixed

emotions." Similarly, Smah explained, "Knowing that I had HIV hurt me more than having the virus itself. I blamed everyone around me, especially my mother".

At the same time, participants also indicated that supportive environments could assist with acceptance and coping. Nokubonga described how support from her family helped her to process her diagnosis, stating, "Coming to terms and accepting very quickly was mainly due to having a very supportive family system… I felt that it was never my fault." These findings suggest that practical HIV awareness must extend beyond providing biomedical information to include stigma reduction, emotional support, and the creation of safe spaces where young women can disclose, access care, and adhere to treatment without fear of judgement.

4.3.3.6.3 HIV prevention and the social reality of stigma amongst young women

Participants powerfully emphasised the inextricable link between HIV prevention and stigma**,** identifying the latter as a critical social barrier that paralyses prevention efforts amongst young women. They described a pervasive culture of silence and shame surrounding HIV, where the fear of being labelled, gossiped about, or ostracised is often greater than the fear of the virus itself. This stigma, they argued, manifests in multiple damaging ways: it discourages open conversations about sexual health, making it difficult to seek or share accurate information; it deters individuals from becoming tested, as an HIV-positive result is viewed as a social death sentence rather than a manageable health condition; and it prevents those who are positive from disclosing their status or adhering to treatment, for fear of violence or abandonment.

Nothando shared:

> *"At first I was in shock as I did not know how to process the findings I had received. I kept imagining the whispers, the stares, the pity. It became too much to carry so I eventually decided to drop out of school. Not that I wanted to but I felt like I was cornered by my feelings and had no choice. I was*

terrified of being judged and treated differently, the fear of stigma attached to HIV and being stigmatized once other people found out about my status and as the fear slowly took over me, I started to also feel like I just didn't belong anymore". (Nothando)

Nothando's narrative reflects the extent to which stigma influences educational participation, social belonging, and emotional well-being. Participants explained that young women often internalise the fear of community reactions, causing them to withdraw from spaces where they once felt accepted. It was observed that participants viewed stigma as something deeply rooted within everyday community interactions, where gossip and judgement become powerful forms of social control.

4.3.3.6.4 Silence, delayed disclosure and limited prevention awareness

Another issue strongly highlighted by participants was delayed disclosure within families and communities. Participants explained that family members often avoided discussing HIV status openly, believing that they were protecting young people from emotional pain or social discrimination. However, participants reflected that this silence frequently delayed their understanding of HIV prevention, treatment, and self-protection.

Nokubonga explained:

"I was really surprised when I found out that everyone in my family knew about my status and looking back, it made sense but the truth is, not knowing held me back. I missed out on a chance to fully understand my own health and how to protect myself from others. I now see delayed disclosure a major social barrier. Although it might've came from a place of love and protection, it also prevented me from being part of my own prevention journey and acquiring tools and information needed early to protect myself". (Nokubonga)

Participants described how delayed disclosure prevented them from asking questions, understanding medication, or fully participating in decisions concerning their health. It became clear that silence within families often reinforced feelings of exclusion and confusion. In many cases, young women only became active participants in their own healthcare much later, after years of limited communication and uncertainty surrounding their status.

Participants also observed that communities often avoid open discussions about HIV because of the fear associated with being linked to the virus. This silence contributes to misinformation and limits opportunities for education and support.

Thando reflected:

> *"I realised that silence and delay in support are huge barriers in HIV prevention. We often think we are protecting someone by not speaking up; by avoiding hard conversations but it's the silence that does the most damage. If I had known from the beginning maybe things would've been different. This whole experience made me see how stigma, fear and lack of communication can paralyze prevention efforts. People suffer in silence because they do not feel safe or speak out". (Thando)*

Thando's account illustrates how silence functions as a barrier to prevention within families and communities.

4.3.3.6.5 Internalised stigma and self-blame

Beyond fear of external judgement, participants also described experiences of internalised stigma. Some participants blamed themselves after testing positive and experienced feelings of guilt, shame, disappointment, and hopelessness. These emotions often affected their willingness to seek support, disclose their status, or engage confidently with healthcare services.

Fikile explained:

> *“I was disappointed at myself when the nurses told me, but I had already suspected that I might have contracted the virus judging from how ill I was and the kind of lifestyle I led. I just still did not want my suspicions to be realistic”. (Fikile)*

It became apparent that many participants had absorbed negative societal attitudes surrounding HIV, leading them to associate the diagnosis with personal failure or moral wrongdoing. Participants described how community findings around HIV often reinforce shame and blame, making it difficult for young women to view HIV as a manageable health condition.

4.3.3.6.6 Stigma as a barrier to prevention behaviour

Participants further explained that stigma directly affects HIV prevention behaviours. Although condoms, testing services, and prevention methods such as PrEP may be available, participants described these resources as socially inaccessible because accessing them publicly often attracts judgement or suspicion. Young women feared being labelled sexually active, irresponsible, or HIV-positive simply for seeking prevention services.

Consequently, participants highlighted that without targeted interventions to dismantle this deeply embedded stigma through education that normalises discussion, community-led initiatives that foster empathy, and policies that protect confidentiality, even the most robust biomedical prevention strategies will fail to reach their full potential, as the social environment continues to punish young women for engaging in the very behaviours that could protect them.

A strongly advocated solution amongst participants was the urgent need for the widespread promotion of safe sexual practices through dedicated educational programmes aimed at empowering young women with practical knowledge and life skills related to HIV prevention**.** They emphasised that existing efforts often fall short by focusing solely on abstinence or theoretical knowledge, failing to provide practical, actionable skills tailored to the complex realities that young women face. Participants called for comprehensive, age-appropriate, and culturally sensitive programmes that move beyond biology to address critical life skills, such as how to confidently negotiate condom use with a partner, access and properly use prevention tools like PrEP and PEP, and understand the critical importance of regular testing.

4.3.3.6.7 Limited sexual health education in schools

> *“To be honest, at school they don’t really teach us much about sex and the dangers that come with it. We only hear small things in Life Orientation but it’s not deep enough”. (Nothando)*

Similarly, Philie reflected on the absence of both school-based and familial guidance regarding sexual health:

> *“Most of us are just figuring things out on our own as we aren’t taught about such in school nor at home”. (Philie)*

These findings reveal how young women within their communities are often left to independently navigate issues related to sexuality, HIV prevention, and relationships without adequate support or guidance.

Participants argued that educational programmes should move beyond biological explanations of HIV and, instead, equip young women with practical skills such as

negotiating condom use, accessing prevention services like PrEP and PEP, understanding consent, and recognising the importance of routine HIV testing. Their responses suggest that effective HIV prevention programmes should empower young women with confidence, communication skills, and agency within intimate relationships.

For some participants, early disclosure and access to HIV-related knowledge positively shaped their understanding of health and self-care. Samke explained:

> *"Being aware of your HIV status provides you with valuable information that can assist guide your actions to maintain the health of both you and your partner". "I knew that I was HIV positive at the age of 11 when my parents told me". (Samke)*

Likewise, Smah reflected on the benefits of early treatment initiation and HIV education:

> *"Having contracted the virus at birth and starting treatment very early assisted me a lot in staying healthy. I also learnt very early about the virus and I grew up feeling like I can fit in anywhere and everywhere as I did not bring it on myself to have it".(Smah)*

4.3.3.6.8 HIV testing as an empowering preventive practice

Participants also stressed the importance of regular HIV testing as a preventive and empowering practice.

Zama shared how testing enabled her to take control of her health after suspecting that she may have contracted HIV because of her parents' status.

> *"Testing at an early age as well as after every 3 to 6 months is beneficial for one's own health, and I will make an example with me. When I suspected that*

“what if, what if I have the virus since my parents did” and going to test, assisted me so much so, that I immediately started ART treatment and joined the local team support group and I would encourage everyone else to go find out their status and learn more about the virus even if you do not have it as it is a health related issue”. (Zama)

Her narrative illustrates how knowledge of one’s HIV status can facilitate early treatment initiation, access to support systems, and healthier coping mechanisms. It also highlights the active role that participants take within their communities by encouraging others to test and educate themselves about HIV. This demonstrates that young women are not merely passive recipients of health information but can become advocates for awareness, support, and prevention within their social environments.

CHAPTER 5

RESEARCHER REFLECTIONS, FIELDWORK OBSERVATIONS AND DISCUSSION OF FINDINGS

5.1 Researcher Observations and Reflections on the Fieldwork Process

Observation was an important component throughout this study, requiring continuous reflection on the researcher's role, their interactions with participants, and the social context within which the research was conducted. This was particularly important given that the study explored the reasons for the lack of knowledge on HIV to prevent HIV infections amongst former secondary school-going young women in township communities of KZN. Engaging with young women affected by HIV involved discussions of highly sensitive experiences related to sexuality, HIV education, diagnosis, stigma, relationships, family experiences, and personal trauma.

Throughout the data collection process, the researcher remained aware that participants were sharing deeply personal experiences that were shaped by educational, social, cultural, and economic circumstances. The researcher continuously reflected on how their interactions with participants, their emotional responses, and the interview environment influenced their understanding of the participants' experiences. However, the researcher remained mindful that these observations were not research findings but reflexive insights that assisted them in understanding the broader context within which participants' narratives were situated.

The interview process provided an opportunity to engage with participants' experiences while reflecting on emotions, hesitations, and meanings associated with discussing HIV-related experiences. These observations highlighted that HIV

knowledge is not acquired solely through formal education but is also shaped by family communication, community conversations, cultural expectations, and personal experiences. Critical engagement enabled the researcher to appreciate how stigma, silence, gender relations, socioeconomic conditions, and limited access to comprehensive sexuality education influenced participants' understanding of HIV prevention and their experiences of being affected by HIV.

When interacting with Nuh, the researcher realised the calmness with which she talked about being chronically ill and then finding out later that she was infected with HIV as a result of mother-to-child infection. Even though she spoke of being sick all her life as something common, the researcher considered the issue of how families might normalise poor health without necessarily talking about the issue of HIV infection and how to live with it. Through this interaction, the researcher learned more about how one grows up around issues related to HIV without having any age-appropriate conversations regarding it.

While interviewing Zama, the researcher noticed that she became more reflective when discussing the loss of her parents because of HIV-related illness. Although she explained that she initially understood HIV as "just a sickness," her emotional response highlighted how limited information during childhood may influence how young people later interpret illness, loss, and their own health experiences. This prompted reflection on the importance of supportive communication within families when discussing HIV and related experiences.

During Fikile's interview, the researcher observed a sense of determination and personal growth as she reflected on how her pregnancy became a turning point in prioritising her health. Although she acknowledged previous challenges with medication adherence, her account was expressed with acceptance and a focus on transformation rather than regret. This interaction highlighted how significant life experiences may influence health-related decisions and strengthen commitment to

HIV care. It also reinforced the researcher's understanding that experiences of living with HIV are dynamic and shaped by changing personal circumstances.

Enhle's interview provided insight into the transformative role of supportive educational interventions. As she reflected on attending classes after learning about her HIV status, the researcher observed increased confidence and self-acceptance in the way in which she described no longer viewing herself as an outsider. Her experience highlighted how supportive spaces can assist young women in challenging internalised stigma, developing a positive sense of identity, and recognising that their HIV status does not define their worth.

Nokwanda's account reflected empathy, responsibility, and a willingness to challenge HIV-related misconceptions. As she narrated how she sought information once she knew that her sister was living with HIV, the researcher realised that family relations and caring for someone can motivate an individual to obtain information and be more supportive towards people living with HIV. This conversation made the researcher understand that not only do people obtain information about HIV through formal schooling, but HIV knowledge is socially constructed too.

While interviewing Khanyo, the researcher became aware of the emotional consequences associated with limited sexuality education. As she reflected on becoming sexually active at a young age, Khanyo's reflections conveyed feelings of regret and self-blame, which prompted the researcher to consider the emotional consequences of limited sexuality education. This experience reinforced the importance of approaching participants' narratives with sensitivity and without judgement, while recognising that HIV vulnerability is influenced by broader educational and social environments rather than individual decisions alone.

Philie's reflections further prompted consideration of how cultural expectations and social norms may influence young women's willingness to discuss sexuality and HIV

prevention. Her account highlighted the importance of understanding participants' experiences within their cultural contexts while recognising how certain expectations may restrict open conversations about sexual health.

While interviewing Thando, the researcher became aware of some extended pauses and visible emotional distress when she reflected on her trauma and HIV diagnosis. This interaction reminded the researcher of the emotional weight associated with discussing HIV experiences and reinforced the importance of allowing participants sufficient time and space to share their stories. It also strengthened the researcher's commitment to conducting interviews in a manner that prioritised participants' dignity, emotional safety, and wellbeing.

The researcher's interview with Nokubonga was particularly significant in shaping their reflexive understanding. Although Nokubonga expressed acceptance of her HIV status, the researcher observed a noticeable emotional shift when she discussed her parents and the circumstances surrounding her HIV acquisition. This reminded the researcher that acceptance of an HIV diagnosis does not necessarily eliminate feelings of grief, anger, or unresolved loss. It also highlighted the importance of supportive family relationships in assisting young women to cope with HIV-related experiences.

Through the interview with Xoli, the researcher was particularly impressed by the way in which Xoli handled the issues of childhood sexual abuse and the impact of such experiences on her life. Despite having been through a very traumatising experience, Xoli spoke with confidence and focused on her strength rather than seeing herself as someone who is traumatised. Through her mentioning that she felt lucky for being free from HIV despite the sexual abuse, the researcher came to understand that HIV is not just a diagnosis; it can be a constant threat for victims of sexual violence. This led the researcher to understand the complexities of how trauma, sexual identity, and HIV interact in the lives of young women. The researcher

understood that the participants' perspectives about HIV were informed by their experiences of vulnerability, whether or not they actually had HIV.

Similarly, during the interview with Smah, the researcher observed emotional responses when Smah discussed her mother and the circumstances surrounding her HIV acquisition. Her reflections demonstrated that experiences of HIV extend beyond the biomedical aspects of infection and are connected to family relationships, identity, trust, and unresolved emotional experiences.

Samke's interview demonstrated maturity and clarity in her understanding of HIV and health management. As she reflected on learning her HIV status at the age of 11 and the importance of knowing one's status, the researcher observed a strong awareness of the relationship between HIV knowledge, personal responsibility, and protecting both individual and partner health. Her account highlighted the potential value of early, supportive disclosure and access to appropriate information in strengthening health literacy and decision-making amongst young people living with HIV.

The researcher's engagement with Nothando further strengthened their understanding of the relationship between HIV, education, and psychosocial wellbeing. Nothando's reflections on the influence of HIV on her educational experiences and personal confidence highlighted the importance of supportive school environments and psychosocial interventions for young women living with HIV.

Although Nolwazi told her story in a composed manner, it was evident from her story that there was an emotional strain involved in community perceptions and stigmatisation because of HIV. The question she was asked regarding whether she had been infected with HIV because of her connection with a person with HIV made the researcher see how community curiosity can turn into a form of social

surveillance. It became clear from this discussion that stigmatisation because of HIV is not necessarily limited to those infected with HIV.

Across the interviews, the researcher became increasingly aware of recurring patterns in the research environment. Discussions about sexuality, disclosure, and HIV diagnosis were often accompanied by hesitation, emotional responses, or careful consideration of words. Many participants described communities where HIV was present and widely known, yet conversations about HIV prevention, testing, and sexual health remained limited. These reflections enhanced the researcher's understanding of how stigma and silence may influence the availability and accessibility of HIV-related knowledge.

The fieldwork further highlighted the broader social realities influencing participants' experiences. Poverty, unemployment, unequal gender relations, cultural expectations, and limited educational opportunities emerged as important contextual factors shaping how young women accessed HIV information, negotiated relationships, and engaged with prevention practices. These reflections encouraged the researcher to interpret participants' experiences within their wider social and structural contexts rather than viewing HIV vulnerability solely as a consequence of individual knowledge or behaviour.

Throughout the research process, the researcher remained conscious of their responsibility to distinguish between participants' lived experiences and their own interpretations. The researcher, therefore, used these observations to enhance their understanding of the research process rather than empirical evidence. Maintaining observational awareness enabled them to remain aware of how their own perspectives, assumptions, and interactions could influence the research process while ensuring that participants' voices remained central to the analysis.

Ultimately, the researcher's observations throughout the research process strengthened the credibility, trustworthiness, and ethical integrity of the study. They enabled them to understand that inadequate HIV knowledge amongst former secondary school-going young women in township communities of KZN was not simply a result of individual information gaps, but emerged from interconnected educational, social, cultural, and structural factors. These observations were, therefore, essential in ensuring that the findings accurately represented participants' experiences while acknowledging the complex realities influencing HIV prevention and vulnerability.

5.2 Main Findings Linked to Other Studies

The findings of this study relate to Theme 1 and Theme 2, indicating that inadequate HIV prevention knowledge amongst young women in KZN township communities is not merely an individual limitation, but reflects broader challenges within educational, family, cultural, and social systems. Participants' experiences revealed that limited exposure to HIV information from an early age, inadequate school-based programmes, lack of parental communication, persistent stigma, and restrictive cultural norms collectively influence young women's ability to make informed decisions regarding HIV prevention.

These findings align with the HBM, which suggests that health decisions are shaped by individuals' perceived susceptibility to illness, perceived severity, perceived benefits of preventive action, and perceived barriers (Rosenstock, 1974; Champion & Skinner, 2008). Because many participants lacked sufficient HIV information during childhood and adolescence, some did not perceive themselves as personally vulnerable to HIV despite living in communities where HIV prevalence remains high. This illustrates that awareness of HIV within a community does not automatically translate into individual risk perception or preventive action.

The findings are also supported by the SCT, which proposes that young people develop behaviours through observation, social interaction, and modelling from parents, peers, and communities (Bandura, 1986). In contexts where HIV discussions remain limited and prevention behaviours are not openly demonstrated, young women may lack opportunities to observe positive health practices. In relation to Theme 2, the absence of visible role models promoting condom use, HIV testing, PrEP, PEP, and open sexual health discussions may weaken confidence and self-efficacy in adopting safer behaviours. Therefore, insufficient HIV knowledge is shaped not only by individual factors but also by the social environments in which young women learn and make health decisions.

Furthermore, the findings indicate that HIV prevention requires more than awareness; it requires practical skills that enable young women to act upon their knowledge. According to SCT, self-efficacy is central to behavioural change because individuals must believe that they have the ability to perform preventive behaviours effectively (Bandura, 1986). Participants demonstrated uncertainty regarding condom negotiation, accessing prevention services, and communicating about sexual health within relationships. This suggests that HIV education often provides information without adequately developing the interpersonal and practical skills required in real-life situations.

UNAIDS (2023) and WHO (2022) emphasise that effective HIV prevention requires technical knowledge, communication skills, and access to prevention services. However, this study indicates that educational campaigns alone are insufficient when social barriers prevent young women from acting upon their knowledge. When young women lack confidence in performing preventive behaviours, self-efficacy becomes weakened, creating a cycle where limited confidence contributes to avoidance of prevention measures, particularly in high-pressure situations.

Luthuli and John-Langba (2024) support this argument by highlighting that limited comprehensive sexual education, poverty, and HIV-related stigma contribute to poor

understanding of HIV and create barriers to accessing essential services. Therefore, bridging these knowledge gaps requires comprehensive, relatable, and stigma-free education that empowers young women to make informed decisions and reduce HIV vulnerability (Chimbindi, Birdthistle, Floyd, Mthiyane, McGrath, Zuma, et al., 2020:4; Chimbindi, Mthiyane, Zuma, Baisley, Pillay, McGrath, et al., 2022:233).

The findings to Theme 2 further highlight that HIV knowledge is socially and contextually constructed rather than limited to formal education settings. Although schools remain important spaces for HIV education, participants' experiences suggest that school programmes are often fragmented and insufficiently supported. Ahmed (2015:12) argues that sexuality education within schools often becomes a response to limited communication within the home environment. However, when both family and educational systems fail to provide adequate guidance, young women may enter adulthood without the knowledge and confidence required to navigate HIV prevention.

Dadzie et al. (2024:2) similarly demonstrate that parental knowledge and access to HIV information could contribute to improved outcomes through earlier prevention education, reduced transmission risks, and stronger decision-making abilities. Conversely, Aliyu and Aransiola (2023:1–2) argue that failures in parental communication and support structures may contribute to continued vulnerability amongst young people. Therefore, effective HIV prevention requires collaboration between schools, families, healthcare systems, and communities.

Although inadequate knowledge was identified as a key challenge, the findings demonstrate that knowledge gaps cannot be separated from the cultural and social environments in which young women make health decisions.

Beyond educational limitations, the findings related to Theme 3 and theme 4 demonstrate that cultural beliefs and social expectations continue to influence HIV prevention behaviours. Aliyu and Aransiola (2023:2–3) support these findings by

explaining that traditional norms may promote abstinence-focused expectations while restricting open discussions about sexuality and HIV. Similarly, Reddy et al. (2021:1171), Mavhandu-Mudzusi et al. (2021:1542), and Tohit and Haque (2024) argue that sexual taboos and cultural restrictions may prevent young women from obtaining accurate sexual and reproductive health information.

Participants' experiences suggest that sexuality remains a sensitive topic within some communities, where open discussion may be associated with shame or viewed as encouraging sexual behaviour. These cultural restrictions limit young women's ability to seek information, negotiate safer practices, or access healthcare services. Although traditional healing practices remain culturally significant, dependence on these approaches may sometimes delay HIV testing and medical care.

Theme 4 further highlights that HIV vulnerability is influenced by gender inequality and gender-based violence further demonstrate that HIV prevention cannot be separated from broader social inequalities. Although participants understood the importance of condoms and HIV prevention methods, their ability to negotiate safer sexual practices was frequently influenced by unequal relationship dynamics, financial dependence, age disparities, and fear of violence.

These findings align with Gomez, Arteaga, Villeda and Gutmann (2021), who argue that limited awareness and reduced access to prevention knowledge undermine young women's agency. Similarly, Duby, Bergh, Jonas, Reddy, Bunce, Fowler and Mathews (2023:2015–2016) found that young women often encounter social and cultural barriers that restrict condom negotiation. Govender and Bhana (2021) and Mihretie, Kassa, Ayele, Liyeh, Belay, Miskr, Munye, Azanaw and Worke (2023) further emphasise that transactional relationships and financial vulnerability may reduce women's ability to prioritise HIV prevention.

Mthembu et al. (2021) highlight that intimate partner violence reduces women's sexual autonomy and affects their ability to negotiate condom use, access HIV services, and disclose HIV status. Abebe, Alie, Adugna, Shifera, Agegnehu, Yosef, et al. (2025:2) argue that HIV prevention strategies cannot be fully effective unless structural issues such as gender inequality and intimate partner violence are addressed. Therefore, participants' accounts from Themes 3 and 4 illustrate that HIV vulnerability is not produced by isolated behaviours but through interconnected systems of inequality, gender expectations, and social disadvantage.

These educational, cultural, and gender-related barriers collectively contribute to the stigma and fear surrounding HIV prevention identified in Theme 5.

Theme 5 highlights the importance of HIV prevention approaches that move beyond information dissemination towards empowerment, stigma reduction, and social support. Participants' recommendations align with Murewanhema, Musuka, Moyo, Moyo and Dzinamarira (2022:31), who argue that HIV awareness campaigns should be culturally relevant and designed to challenge misinformation and silence surrounding HIV.

Similarly, Cabecinha and Saunders (2022) and Psaros et al. (2017) emphasise that comprehensive prevention strategies require both improved healthcare access and broader social interventions.

According to the HBM, individuals are more likely to engage in preventive health behaviours when they perceive themselves to be vulnerable to a health condition and believe that preventive actions can effectively reduce that risk (Tarkang & Zotor, 2015:1-2). However, this study indicates that educational campaigns alone are insufficient when social barriers prevent young women from acting upon their knowledge.

Participants demonstrated that prevention tools such as condoms, HIV testing, PrEP, and PEP were not necessarily inaccessible because of availability but because of the social meanings attached to accessing them. Being seen seeking prevention services could imply promiscuity or HIV infection, creating fear and discouraging health-seeking behaviour. Hartmann, Nyblade, Otticha, Marton, Agot and Roberts (2024) similarly demonstrate that stigma influences HIV prevention and treatment engagement by creating social consequences associated with accessing services.

These findings align with Kumar (2023:20) and Robinson et al. (2023:3134), who explain that stigma may result in discrimination, social rejection, isolation, and internalised shame. Furthermore, stigma intersects with gender, socioeconomic status, and other vulnerabilities, creating multiple layers of disadvantage for people living with HIV (Gilmore & Somerville, 1994; Robinson et al., 2023:3134).

Through SCT, these findings further demonstrate the importance of positive social modelling and supportive environments. Participants' accounts suggest that HIV prevention is influenced not only by access to information but by whether prevention behaviours are socially accepted and visible within their communities. This observation reinforces SCT's emphasis on modelling and demonstrates that supportive social environments may increase young women's confidence to engage in preventive behaviours. Conversely, environments characterised by secrecy and judgement reinforced fear and avoidance.

Overall, the integration of HBM and SCT provides insight into the complex factors influencing HIV prevention amongst young women. While HBM explains how perceived risk, benefits, and barriers influence health decisions, SCT highlights the importance of social environments, role models, and self-efficacy in sustaining behavioural change (Rosenstock, 1974; Champion & Skinner, 2008; Bandura, 1986).

Therefore, the findings across all five themes demonstrate that HIV prevention cannot rely solely on increasing awareness amongst young women; effective

prevention requires collaborative approaches involving supportive educational systems, family involvement, community engagement, and structural interventions that strengthen young women's ability to protect their sexual and reproductive health.

5.3 Conclusion

This chapter has provided a detailed analysis of the complex factors perpetuating the HIV knowledge gap amongst young women in KZN. By applying the lenses of the HBM and the SCT at the individual level, this includes low perceived risk and misconceptions about prevention. Socially, it is driven by pervasive stigma, a critical lack of positive role models, and restrictive gender norms that limit personal agency. Systemically, these issues are compounded by an educational curriculum that fails to adequately address the lived realities of learners. The evidence confirms that these personal, social, and structural factors interact reciprocally, creating an environment where even educated young women remain vulnerable.

This comprehensive thematic analysis establishes a critical foundation for the final phase of this research. Having identified and examined the root causes and systemic obstacles, the stage is now set for the development of targeted, evidence-based solutions. Therefore, Chapter 6 will build directly upon these findings to present a consolidated set of key conclusions and actionable recommendations. These will be strategically designed to guide the improvement of HIV prevention initiatives within the educational system and the wider community, aiming to translate the insights from this analysis into a practical road map for change.

CHAPTER 6

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

6.1 Introduction

The purpose of the study was to explore the lack of knowledge on HIV to prevent HIV infections amongst young women who are most susceptible to HIV and how to support them through the educational system by improving efficient strategies to reduce vulnerability to HIV. Additionally, it aimed to examine the underlying reasons why many young women still do not receive adequate HIV education and how secondary schools can improve its delivery specifically by implementing inclusive, non-discriminatory and safe health education approaches that promote informed and responsible sexual behaviour. To achieve the purpose, the following objectives (see Section 1.7) were formulated:

The study sought to explore the impact of inadequate HIV knowledge, stigma, and risky sexual behaviours on young women's vulnerability to HIV infection and their ability to engage in effective HIV prevention practices. It further aimed to examine young women's awareness and understanding of HIV control and prevention strategies, including condom use, HIV testing, PrEP, PEP, and treatment adherence. The study also explored the nature, availability, accessibility, and perceived effectiveness of HIV education interventions provided in secondary schools within township communities of KZN. In addition, it aimed to identify educational and community-based interventions that could contribute to increasing HIV awareness, reducing stigma, and strengthening HIV prevention efforts amongst young women. Furthermore, the study examined the influence of stigma, cultural beliefs, gender norms, and gender-based violence on young women's HIV preventive behaviours and their ability to access HIV-related support services.

This chapter will be structured into three main sections. The first section will provide a summary and discussion of the study findings in relation to the research objectives

and research questions. It will highlight the key insights emerging from participants' experiences regarding HIV prevention knowledge, access to HIV-related information, stigma, social and cultural influences, and factors affecting young women's engagement with HIV prevention strategies within township communities in KZN.

The second section will discuss the limitations of the study, including methodological and contextual factors that may have influenced the findings and the extent to which the results can be applied beyond the study setting.

The final section will present recommendations informed by the study findings. These recommendations will focus on potential improvements to HIV education programmes, community-based interventions, and areas requiring further research. As this was a qualitative study, the recommendations will be aimed at enhancing understanding of young women's experiences and informing the development and improvement of interventions that address HIV prevention knowledge, stigma reduction, and access to support services.

6.2 Summary of Key Findings in Relation to Research Objectives and Research Questions

This section gives an analysis of the important findings of the research in connection with the research questions. It synthesises the important themes emerging from the findings, such as lack of knowledge on HIV, risky sexual practices, effectiveness of school-based HIV education programmes, community-based HIV prevention programmes, and the effects of stigma, cultural beliefs, gender stereotypes and gender-based violence on the susceptibility of young women to HIV infection in KZN township communities. Instead of analysing each of the research objectives separately, findings will be analysed as interrelated themes that show the ways that these factors interact with each other to affect HIV prevention knowledge and behaviour of young women.

In addition, the importance of the research will be illustrated by providing the contextualised evidence that would contribute to the body of the existing knowledge on HIV prevention amongst young women. The findings indicate that the susceptibility to HIV infection amongst young women is influenced not only by their knowledge and behaviour but also by the factors that interact with each other. Through highlighting the underlying factors causing lack of knowledge about HIV and the factors impeding successful HIV prevention education, this research generates data that can be used in developing more comprehensive HIV prevention programmes. Hence, this research contributes to the current body of knowledge while providing practical guidance for people involved in HIV prevention programmes aimed at young women.

6.2.1 Discussion of the key findings in relation to research objectives and research questions

According to the findings of this study, it can be seen that HIV vulnerability in terms of young women being susceptible to HIV infection in the KZN township communities depends on how HIV knowledge deficits, stigmatisation, risky sexual practices and social and structural context interact. These do not work in isolation but work together to determine young women's capacity to acquire information and make decisions about their sexuality. While there has been increased awareness over time, the findings suggest that awareness alone does not translate into prevention practices amongst young women.

In respect of the inadequacy of knowledge about HIV, the results highlight the role of the insufficient exposure of young women to full information about the virus as one of the factors affecting their vulnerability to the HIV infection. As mentioned by Dellar et al. (2015:1453), fewer than half of adolescent girls have sufficient knowledge regarding the methods of protecting themselves from HIV, which proves that there are still young women who lack knowledge about the virus despite higher awareness about it. Similarly, Ngcobo, Ndhlovu and Mchunu (2023:25) indicate that while young women might have general knowledge about the ways of spreading the disease,

such knowledge does not always result in preventive behaviours within township contexts where poverty, unemployment and gender inequalities influence health-related choices.

The findings further suggest that HIV knowledge inadequacies influence young women's ability to make informed decisions regarding HIV prevention and sexual health practices. According to the HBM, poor knowledge can have an effect on perceptions of vulnerability to HIV infection, the perceived seriousness of the infection and the perceived benefits of adopting preventive behaviours. Therefore, young women who do not have adequate information about HIV can face difficulties in evaluating their level of vulnerability and adopting preventive measures. Additionally, the SCT can be used to explain how social context, learning processes and self-efficacy impact behaviours related to HIV prevention. It is evident from the results that misconceptions and misinformation shared by the peers and the community can decrease the self-efficacy of young women in applying information about HIV prevention. The results are supported by research studies that indicate the impact of inadequate comprehensive sexuality education on young people's access to HIV-related information (UNAIDS, 2023; UNESCO, 2024).

In addition, the findings further suggest that risky sexual behaviour amongst young women should be considered in light of poor understanding of the virus amongst young women, their social vulnerability and imbalances in gender power relations. Sexual risk behaviour is not necessarily a consequence of personal choice, because it is shaped by young women's inability to negotiate in their relationships, their fears of talking about AIDS prevention with their partners, and difficult financial situations that can make young women prone to transactional sex.

However, the findings indicate that knowledge gaps amongst young women should not be understood only as individual limitations. Instead, these gaps are connected to wider socio-economic and structural inequalities that influence access to health information and prevention services. Young women who come from deprived families

might face a variety of obstacles that limit their access to healthcare facilities, exclude them from the Internet and reduce their level of health literacy skills, influencing their access to and use of HIV-related information (WHO, 2020). Hence, knowledge gaps found in the current study are not limited to personal ignorance and are related to wider social issues affecting access to health-related resources (Leddy, Selin, Lippman, Kimaru, Twine, Gómez-Olivé, et al., 2022:1863; Zhang, Luo, Rong, Meng, Du & Tan, 2022:2).

Because schools represent one of the primary settings through which young people receive HIV-related information, these structural challenges were also evident in relation to the forms, accessibility and effectiveness of HIV education interventions offered in secondary schools within KZN township communities. The findings suggest that although HIV education is included within school curricula, its implementation remains inconsistent and does not always respond to the realities experienced by learners. Limited learner engagement, insufficient practical application and inadequate follow-up support mechanisms were identified as factors that reduce the effectiveness of school-based HIV education. Furthermore, discussions regarding sexual health and HIV prevention were sometimes restricted because of cultural expectations and educator discomfort when addressing issues related to sexuality. As a result, some young women continue to leave school with misconceptions regarding HIV transmission, prevention and treatment, including beliefs that HIV can be cured through healthy diets or antiretroviral medication adherence (Chauke, van der Heever & Hoque, 2021:42–50).

Drawing on Bandura's SCT (1986), the findings demonstrate that effective HIV education requires more than the provision of information. Learners require supportive environments where they can observe positive prevention behaviours develop confidence and acquire skills necessary for HIV prevention practices. The absence of such environments may limit opportunities for observational learning, self-regulation and the development of preventive behaviours. The findings further indicate that many young women rely on peers and informal youth networks for HIV-related information because of limited access to comprehensive school-based

education. However, peer-based knowledge may reinforce misconceptions and myths surrounding sexuality and HIV prevention rather than correcting them (Francis, 2022; Makhoba & Ntombela, 2021:1–3). Therefore, the effectiveness of HIV education interventions should not only be assessed by whether HIV content exists within the curriculum but also by whether such interventions empower young women with practical knowledge, confidence and skills to negotiate safer sexual practices.

These findings show that efforts to improve education regarding HIV should not just be confined to the contents of the curriculum. It should be able to help young women to gain enough self-confidence and competence to implement the information regarding HIV in their social environment outside of school.

Given the limitations associated with school-based HIV education programmes, the findings demonstrate the importance of strengthening community-based interventions that complement formal school-based HIV education. Because young women's decisions regarding HIV prevention are influenced by their families, peers and communities, community-based interventions remain essential in reinforcing HIV prevention messages and addressing barriers that extend beyond the school environment. As the study indicates, HIV prevention needs more than increasing the knowledge of the youth. It requires strategies that aim at addressing issues of stigma, promoting gender norms that encourage supportive environments for young women who seek HIV prevention and treatment services. Cultural norms, which discourage open dialogue regarding sexuality in domestic and community settings, can result in educational silencing and make it difficult for young women to comfortably discuss issues related to using condoms and being tested for HIV infection (Frimpong, Budu, Mohammed, Tetteh, Seidu & Ahinkorah, 2022:991-992; Baruwa, 2025).

Moreover, socio-economic issues like poverty and unemployment have continued to shape HIV prevention practices by constraining the options of young women and making them more vulnerable to factors such as transactional sex and neglect of

health concerns (Mabaso, Makola, Naidoo & Jooste, 2018:1245). These findings demonstrate that HIV prevention interventions must address not only individual knowledge and behaviour but also the social and economic conditions that shape young women's ability to practise safer behaviours.

The findings also highlight the significant influence that stigmatisation, cultural views, gender roles, and gender-based violence exert upon the preventive actions against HIV and service usage taken by young women. The stigmatisation related to HIV testing, disclosure and treatment can discourage young women from using preventive services because of embarrassment and fear of being discriminated against (Nyblade, Ndirangu, Speizer, Browne, Bonner, Minnis, et al., 2022:2). Similarly, the cultural views about sexuality and gender roles can lead to gender inequality and thus impede young women from making decisions about condom usage, testing for HIV and other preventive measures (Jewkes, Dunkle, Nduna & Shai, 2010; Govender, Naidoo, Taylor & Reddy, 2020:475). GBV is yet another reason why women become vulnerable to the HIV infection because they are not able to make decisions about their sexual behaviour.

Taken together, the findings demonstrate that HIV prevention amongst young women requires interventions operating at multiple levels. While comprehensive sexuality education addresses knowledge gaps, community-based interventions, stigma reduction initiatives and strategies that promote gender equality are equally important in creating supportive environments where young women can make informed decisions regarding HIV prevention and access available support services.

Overall, the findings demonstrate that HIV vulnerability amongst young women in KZN township communities cannot be viewed solely as the outcome of individual behaviour. Instead, it reflects interconnected educational, socioeconomic, cultural and structural inequalities that influence access to information, prevention services and supportive environments. Addressing HIV prevention amongst young women, therefore, requires comprehensive and context-specific interventions that combine

effective sexuality education, stigma reduction, community engagement, gender-transformative approaches and improved access to HIV prevention services. Such interventions should be responsive to the lived experiences of young women and aim not only to increase awareness but also to strengthen agency, confidence and sustained engagement in HIV prevention.

6.2.2 Contributions of the study in relation to the key findings

The findings obtained from this study contribute to the existing literature because they offer specific information on the factors that influence vulnerability to HIV amongst young women in KZN townships. By summarising the results for each of the research questions, the study shows that vulnerability to HIV is not caused by one element only but rather is caused by the relationship between inadequate HIV knowledge, risky sexual behaviours, shortcomings in HIV education, stigmatisation, culture beliefs, gender norms, GBV and broader socioeconomic conditions.

The findings relating to HIV knowledge inadequacies show that increasing awareness alone is insufficient to reduce HIV vulnerability. On the contrary, young women's capacity to form a sound judgement will depend upon the quality of their HIV education as well as on the conditions under which they can acquire reliable information about their health. The conclusions drawn from the findings are relevant to the HBM and the SCT.

Findings concerning HIV education at schools further contribute to what has already been studied because the research results indicate that the success of HIV education is not determined by the educational content alone, but it is also determined by how the information is communicated. Inconsistencies in communicating the information, lack of learner involvement, cultural obstacles and discomfort felt by educators have reduced the efficiency of HIV prevention education, thus confirming the necessity of culturally sensitive sex education at secondary schools.

The findings also demonstrate the importance of strengthening community-based HIV prevention interventions. By showing how family influences, peer networks, community norms and socioeconomic conditions shape HIV prevention behaviours, the study extends existing knowledge beyond school-based education and emphasises the importance of community-centred approaches that reinforce HIV prevention messages, reduce stigma and improve access to prevention and support services.

In addition to this, the findings related to stigma, cultural beliefs, gender and GBV help in gaining a better perspective on the structural determinants which are still contributing towards the vulnerability of young women to HIV infection. The study highlights the fact that gender disparities, the fear of stigma and cultural pressures tend to prevent young women from negotiating safer sex, HIV testing and accessing other related services.

Overall, this research makes an important contribution to the body of knowledge available on the topic in question because of the contextual evidence available from the lives of young females in KZN township communities. In contrast to the current approaches to analysing vulnerability to HIV amongst individuals in terms of their personal behaviours and actions, the research suggests that there are a number of interconnected educational, cultural, socio-economic and structural factors influencing vulnerability to the disease.

6.3 Limitations

1. Time limitations

The study was conducted within a limited timeframe, which restricted the duration of data collection and did not allow for follow-up interviews or the exploration of changes in participants' experiences and HIV knowledge over time.

2. Access to participants

The sample for the study comprised only those eligible young women who agreed to participate in the study. The young women who opted not to participate may have had different experiences, which may have influenced the range of views and experiences that were gathered.

3. Number of participants and sampling strategy

A purposive sample of 15 participants was selected to obtain detailed accounts of participants' lived experiences. While this sampling strategy was appropriate for the exploratory qualitative design, the limited sample size restricted the diversity of perspectives captured and the findings cannot be statistically generalised to all former secondary school-going young women in township communities of KZN or South Africa.

4. Settings of the interviews

The interviews were conducted in settings where the participants' confidentiality and privacy were guaranteed. Nevertheless, the participants might still have felt uncomfortable talking about some sensitive issues including their HIV status and sexual violence and trauma experiences. This may have resulted in information being withheld or socially acceptable answers being given.

5. Use of a qualitative research design

The qualitative design enabled an understanding of participants' lived experiences within township communities of KZN. However, the findings are context-specific and were not intended to produce statistically generalisable results amongst all former secondary school-going young women or young women living with HIV in South Africa.

6. Gender-specific focus

This study was focused exclusively on former secondary school-going young women. The perspectives of young men, their sexual partners, parents, caretakers, health workers, and other people from the communities were not explored, therefore, limiting understanding of the broader social and gender dynamics influencing HIV knowledge, prevention behaviours and HIV-related information and support..

7. Sensitivity of the research topic

Conversations regarding HIV knowledge, sexual behaviour and abuse and trauma could have been emotionally stressful for the participants. As a result, some participants may have avoided discussing certain experiences, minimised sensitive information, or withheld details that could have contributed to a more comprehensive understanding of factors influencing HIV prevention knowledge.

8. Limited psychosocial support services

The limited availability of counselling and psychosocial support services within the study setting may have reduced opportunities for participants to access ongoing support after the interviews, despite appropriate referral procedures being followed.

6.4 Recommendations

The research was conducted with the hope of improving efficient and effective methods to minimise the vulnerability of HIV amongst young women to cope after they complete secondary school, as well as to examine the causes of why young women still lack the necessary knowledge on HIV, particularly within the context of township communities in KZN.

Based on the findings of this study, the following recommendations are proposed to strengthen existing HIV prevention programmes and improve HIV knowledge

amongst former secondary school-going young women in township communities of KZN.

1. Community-based HIV education programmes

The findings revealed that participants were no longer attending school and, therefore, had limited access to school-based HIV education. Thus, it would be important for programme managers to organise community-based sessions on HIV education in places that are conveniently accessible to the participants, such as community centres, youth centres, churches and NGOs. These sessions must be made accessible at convenient times and must be conducted in a language that can be easily comprehended by former secondary school-going young women.

2. Strengthen community outreach services

The findings indicated that participants had limited opportunities to receive HIV prevention information outside of the formal school setting. Therefore, existing community outreach programmes should be expanded to include HIV education specifically for former secondary school-going young women. Community health workers and peer educators should provide information on HIV prevention, demonstrate correct condom use, promote HIV testing and facilitate referrals to youth-friendly health services. Community outreach programmes should also be geared towards engaging with young women who are more vulnerable to acquiring HIV infections such as school dropouts, teenage pregnancies, and those facing volatile family situations. Apart from providing education regarding HIV prevention, community outreach services should also be instrumental in providing information on sexuality, life skills training, and other psycho-social issues.

3. Integrate HIV education into existing community programmes

The findings showed that young women who had left school were not consistently reached by existing HIV education initiatives. Therefore, organisations already providing services to young women, such as youth development initiatives, skills development programmes, and support groups, should integrate short HIV prevention education sessions into their routine activities. This approach would strengthen existing programmes without the need to establish new services while increasing access to HIV information amongst young women who are no longer reached through school-based education. The young women need to be actively engaged in the process of developing educational messages about HIV prevention because this will make sure that the preventive strategy is realistic, culturally sensitive, and based on their real-life experiences.

4. Improve communication by healthcare practitioners

The findings suggested that some participants experienced barriers when accessing HIV information and support from healthcare services, particularly those who had experienced abuse or other traumatic experiences. Healthcare facilities should, therefore, provide regular in-service training for healthcare practitioners on youth-friendly and trauma-informed communication approaches to ensure that HIV prevention information is delivered in a respectful, supportive and sensitive manner. Furthermore, the healthcare services need to improve the provision of youth-friendly clinics through conducting HIV tests and counselling, offering family planning services and reproductive healthcare to young women in times when they are accessible.

5. Strengthen peer education initiatives

Increase the use of peer educators within township communities, as findings revealed that many participants relied on peers for information about HIV. Programme managers should recruit and train young women from the local community to serve as peer educators. Peer-led discussions, small group sessions and community awareness activities may improve the acceptability of HIV prevention messages and encourage young women to seek HIV testing and other prevention services.

6. Strengthen family communication about HIV

The findings indicated that communication about HIV and sexual health within families was limited, leaving many participants without reliable guidance at home. Community programmes should, therefore, promote early, accurate, and age-appropriate communication about HIV throughout families and communities, include parent and caregiver information sessions that equip families with skills and resources to discuss HIV prevention and sexual health openly with young women.

7. Strengthen existing community-based awareness initiatives targeted at eliminating HIV-related stigma and misinformation. The findings showed that HIV-related stigma and misinformation continued to influence participants' knowledge and understanding of HIV prevention. Existing community awareness initiatives should, therefore, be strengthened by involving healthcare facilities, community leaders, cultural organisations, religious groups and local media in delivering accurate HIV prevention messages and reducing HIV-related stigma within township communities.

8. Strengthen youth leadership and participation in HIV prevention programmes

The findings brought out the need to enable the young women to be more active partners in the process of HIV prevention in their communities. The programme managers should create youth leadership programmes aimed at enabling former secondary school-going young women, especially those who are HIV-positive or have increased chances of contracting HIV to be effective advocates, communicators, leaders, and mobilisers within their communities. Such programmes should encourage youth involvement in the planning, implementation and monitoring of the HIV education and awareness programmes.

Moreover, it is recommended that further research be conducted to evaluate the effectiveness of community-based HIV education programmes targeting young women who are not in school. Longitudinal studies could be conducted to look at the trends in knowledge and practices of HIV prevention before and after engaging in community-based HIV education and intervention programmes. It is further recommended that research be conducted to explore the views of healthcare providers, community leaders, family members, and young women on barriers to HIV education and prevention. This will give a more holistic view on factors affecting HIV vulnerability.

6.5 Recommendations for Future Research

Based on the findings of this study, the following recommendations for future research are proposed:

1. Perform longitudinal and mixed-methods studies to measure the effectiveness of HIV education programmes already implemented in schools and communities in improving HIV knowledge and behaviours of former secondary school-going young women regarding HIV prevention.

2. Analyse the influence of sociocultural factors such as gender roles and expectations, cultural beliefs, communication within families, and HIV stigma on young women's access to HIV information and HIV prevention services to inform culturally appropriate HIV prevention interventions.

3. Explore the accessibility and youth-friendliness of HIV prevention and sexual and reproductive health services including the availability of services, confidentiality, operating hours and communication skills of healthcare providers to identify barriers to service utilisation.

4. Measure the effectiveness of peer education and youth leadership programmes in increasing HIV knowledge and HIV prevention behaviours, self-efficacy and community involvement amongst former secondary school-going young women.

5. Analyse the impact of socioeconomic factors such as poverty, unemployment, unstable housing and lack of education on HIV knowledge and HIV risk amongst former secondary school-going young women to inform multi-sectoral HIV prevention strategies.

6.6 Conclusion

This study was initiated to explore the critical factors contributing to the limited HIV knowledge amongst young women who have completed secondary education in the township communities of KZN. The persistently high infection rates within this demographic, despite the existence of various prevention programmes, highlight a pressing need for more effective information dissemination and comprehensive intervention strategies. This final chapter has synthesised the core findings of the research, presenting the key themes that emerged from the lived experiences of the

participants. Based on analysis of these data, the chapter has put forth a set of evidence-based recommendations designed to inform future strategies for HIV education and support for young women in similar contexts. By concluding with a discussion of the study's broader implications, its inherent limitations, and its distinct contributions to the fields of youth education, HIV prevention, and community health development, this research aims to provide a valuable foundation for future HIV prevention education in schools.

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ANNEXURE A: INVITATION LETTER

INVITATION LETTER FOR PARTICIPANTS

University of South Africa

College of Human Sciences

School of Social Sciences

Department of Sociology

Dears Sir/Madam

I am an MA (Social and Behaviour studies) student at the University of South Africa, presently engaged in a research study entitled exploring the reasons for the lack of knowledge on HIV to prevent infections amongst former secondary school going young women in township communities in KwaZulu-Natal under the supervision of Mr HJL Roets of the Department of Sociology.

The objective of this study is to explore the reasons why there is a lack of knowledge on HIV to prevent the spread of HIV amongst former secondary school going young women in township communities in KZN and to gain insight and understanding on their challenges on HIV prevention.

To complete this study, I need to conduct interviews of approximately 30 to 45 minutes' in duration, which will be audio-taped for verification of findings by an independent qualitative research expert.

In this study I undertake to safeguard your anonymity by omitting the use of names and places. Confidentiality will be assured by the erasure of taped material on completion of transcriptions of these tapes. The transcribed material will only be shared by myself and an independent expert in qualitative research. You are giving

your informed consent to these proceedings and reserve the right to cancel it at any stage of the proceedings. It is understood that you are under no obligation to participate in this study.

The benefit of participating in this study is that you will have the opportunity to express your knowledge on HIV as well as to come up with solutions and strategies as to how to assist in the reduction of future transmissions, how the future generation can be taught as well as to teach people of different cultures to be open minded when it comes to HIV and AIDS discussions with their loved ones. To also encourage parents to be able to teach their children without any fear or stigma being involved.

A summary of the research findings will be made available to you on request. Should you wish to contact the researcher, please do so at the following address:

Nondumiso Dlamini : Researcher

Email address : 57115354@mylife.unisa.ac.za

Contact number : 079 715 4569

Or

HJL Roets : Supervisor – MA (SBSHIV)

Email address : roetshjl@unisa.ac.za.

Contact number : 012 429 6975

Thank you.

…… ……..

SIGNATURE (PARTICIPANTS) DATE

N Dlamini

RESEARCHER – BA Hons (Psych)

HJL Roets

SUPERVISOR – MA (SBSHIV)

ANNEXURE B: CONSENT LETTER

CONSENT TO PARTICIPATE IN THIS STUDY

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

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

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

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of face-to-face interviews and focus group session interviews.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname THANDO MTHEMBU (please print)

Participant Signature ..... Date 20/06/2024

Researcher's Name & Surname NONDUMISO DLAMINI (please print)

Researcher's signature ..... Date 20 JUNE 2024

ANNEXURE C: PERMISSION LETTER

PERMISSION LETTER

The researcher will ask permission to conduct the study on the young women of the community at the community leader (Gatekeeper) of which will be present at the time when the study is being conducted.

Exploring the reasons for the lack of knowledge on HIV to prevent infections amongst former secondary school going young women in township communities in KwaZulu-Natal.

Contact person's name :

Contact person's telephone number :

Contact person's email address :

Dear Sir/Madam

I, Nondumiso Dlamini am doing research with Mr Leon Roets, a lecturer in the Department of Sociology towards a MA Degree in Social and Behaviour Studies (HIV/AIDS) at the University of South Africa.

We are inviting you to participate in a study entitled "Exploring the reasons for the lack of knowledge on HIV to prevent infections amongst former secondary school going young women in township communities in KwaZulu-Natal".

The aim of the study is to explore the importance of knowledge on HIV to prevent infections amongst young women of which are the most vulnerable population group to HIV infections as well as to assist them not only through the school system but also through and by parental involvement in order to enhance their knowledge on HIV also through the implementation of other effective strategies.

You have been selected to participate in this study because the study would like to hear your views as young women on HIV and HIV prevention and how young women are most affected by it. The study also seeks to find solutions as to how HIV knowledge can be implemented and enforced in the school's curriculum, how parental involvement and discussions can assist in the reduction of the virus as well as how developing new strategies and techniques of conveying HIV knowledge and prevention can assist in decreasing HIV infections/transmissions amongst young women.

The study will entail in-depth face to face and focus group interview sessions where open ended questions will be asked followed by probing questions to allow the participant to not feel limited, restricted and/or threatened when answering questions.

The benefits of this study is that the participants will have the opportunity to express their knowledge on HIV as well as come up with strategies to assist in the reduction of transmissions. These strategies will be beneficial for the next generation of young women as they will be more knowledgeable about the virus and how to prevent or protect themselves from contracting it. Older adults from different cultural backgrounds who are also not knowledgeable of and about HIV will also gain knowledge about the virus and be exposed to such discussions with their loved ones.

Potential risks would be that because the study is very sensitive and HIV is a sensitive issue; participants might be hesitant and also feel the need to withdraw from participating.

Feedback procedure

A summary of the research findings will be made available to you on request. Should you wish to contact the researcher, please do so at the following address:

Nondumiso Dlamini : Researcher

Email address : 57115354@mylife.unisa.ac.za

Contact number : 079 715 4569

Or

HJL Roets : Supervisor – MA (SBSHIV)

Email address : roetshjl@unisa.ac.za.

Contact number : 012 429 6975

Yours sincerely

N DLAMINI

NONDUMISO DLAMINI

BA HONS.

ANNEXURE D: INTERVIEW GUIDE FOR FACE-TO FACE INTERVIEWS

Part 1

1. What causes the lack of knowledge on HIV?
2. How can the lack of knowledge of HIV be overcome?
3. How does insufficient knowledge act as a barrier to HIV education?
4. What challenges do young women face when receiving and/or gaining HIV knowledge and knowledge on HIV prevention?
5. What are the different types of HIV and AIDS education interventions?
6. How can the different types of HIV education interventions be provided to young women in secondary school level?
7. How can the different types of education interventions enhance HIV prevention amongst young women
8. Does culture play a significant a role on the impact of HIV knowledge?

❖ **Questions followed by a few probing questions**

- *How do you think we can improve knowledge and awareness, are there any programmes or strategies you think could be effective?*
- *How does this barrier of insufficient knowledge impact ones behaviour, attitudes and choices?*
- *What form of delivery of HIV education do you think would be effective?*
- *Do you think culture impacts or limits the amount of HIV education that should be provided to school?*
- *Could the challenges faced by young women when receiving or gaining HIV knowledge be related to social, cultural or economic factors?*

Part 2

1. What do you think could be the contributing factors to the lack of knowledge on HIV?

2. What do you think can be done to overcome the lack of knowledge on HIV?
3. Would you agree that insufficient knowledge act as a barrier to HIV education?
4. What are some of the challenges that young women face when receiving or gaining knowledge on HIV and HIV prevention?
5. What do you think could be the different types of HIV intervention strategies?
6. How do you think the different types of HIV education interventions can be provided to young women in secondary school level?
7. Do you think that the different types of education interventions to enhance HIV prevention amongst young women will be effective? And how?
8. Do you agree or disagree that culture does play a significant role on the impact of HIV knowledge?

❖ **Questions followed by a few probing questions.**

- *Would you agree or disagree that education, stigma and lack of accessibility to resources could contribute to the lack of HIV knowledge?*
- *What approaches could be used to better assist within schools and in communities?*
- *Which methods would be most suitable for this age group to receive HIV education in? (in traditional classroom settings or in digital platforms)*
- *Because of its impact and influence, do you think cultural norms either assist in promoting awareness or hinder HIV awareness, how?*

ANNEXURE E: UNISA ETHICAL CLEARANCE

UNISA university of south africa

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

02 October 2023

NHREC Registration # :
Rec-240816-052
CREC Reference # :
57115354_CREC_CHS_2023

Dear Ms Nondumiso Dlamini

Decision:
Ethics Approval from 02 October 2023 to 02 October 2024

Researcher(s): Name: Ms. N. Dlamini
Contact details: 57115354@mylife.unisa.ac.za
Supervisor(s): Name: Mr. H. J. L. Roets
Contact details: Roetshjl@unisa.ac.za

Title: Exploring the reasons for the lack of knowledge on HIV to prevent HIV infections among former secondary school going young women in a township community, KwaZulu-Natal

Degree Purpose: Masters

Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is granted for one year.

The ***high-risk application*** *was reviewed by* College of Human Sciences Research Ethics Committee, in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.

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