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Narrating student life in a time of risk

Abstract

Students speaking to students reveal how they perceive and experience risk — and specifically, risk associated with HIV — during their years attending a small university in the Eastern Cape Province of South Africa. Data were collected in twenty focus group discussions that spanned two years and two cycles of an action research project designed to infuse HIV/AIDS-content/issues into a closely supervised third-year Sociology research methodology course. The project was undertaken in response to a call by HEAIDS (Higher Education HIV/AIDS Programme, funded by the EU) for universities to address HIV/AIDS in curricula. The intention is to prepare young graduates to respond meaningfully to HIV and AIDS when they enter the world of work in a country with alarmingly high levels of HIV prevalence and incidence.

Insights from theorists Ulrich Beck (1992) and Mary Douglas (1986) on the cultural dynamics of modernity were used as lenses to view the narratives of students in relation to three key HIV risk factors: alcohol consumption, multiple and concurrent sexual partnerships, and condom use. Gender, which emerged as a cross-cutting issue, was also explored. The rich qualitative data were brought into a dialogue with selected statistics from the HEAIDS 2010 sero-prevalence survey conducted in 21 higher education institutions in the country.

Data show that risk perception and risk behaviour are formulated at individual, social network, and societal/structural levels — as well as at the interface between these. Understandably there was variation in how individual students perceive, experience and negotiate risk, but overall, participating students assessed risk in terms of its immediate importance or threat to them, prioritising the now and choosing not to think about the

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future. Social bonding, including peer pressure, exerts considerable influence on the ways in which students construct and re-construct their perceptions of risk, and HIV/AIDS. From a structural perspective the smallness of the university and the town lulls students into trusting easily and believing that greater visibility leads to greater safety. Sex is “no big deal” and casual sexual relationships are accepted by many as the norm. Although students report high condom use in casual sexual encounters, which mitigates risk, condom use drops sharply in the context of alcohol consumption — and the often excessive consumption — which is “the order of the day”.

Overall, patterns in risk perception and behaviour suggest that many student participants feel justified — by virtue of being students and free at last to explore and experience the edges of their adult life — to push the boundaries of risk.

Keywords

HIV risk; University students; Sexuality; Alcohol; Multiple concurrent partnerships; Condom use; Gender; Eastern Cape Province of South Africa.

Modern society is often regarded as one which organizes itself in response to risk, which pervades myriad aspects of everyday life. HIV/AIDS is one of the primary risks faced by people in South Africa. The country has one of the highest HIV/AIDS prevalence² rates in the world, with 5.2 million adults and children estimated to be living with HIV in 2008, representing 10.6 percent of the total population (Shisana *et al.* 2010). Since 2007 South Africa has seen a decrease in HIV prevalence among young people (Shisana *et al.* *ibidem*). This is reflected in a recent survey of 21 higher educational institutions in the country, which found a mean prevalence of 3.4 percent among students (HEAIDS 2010). Among university students in the Eastern Cape Province, however, the prevalence rate was 6.4 percent — the highest in the tertiary education sector (HEAIDS *ibidem*). Although this is considerably lower than the national average, higher education in South Africa, and more specifically in the Eastern Cape, has no reason to be complacent — a 6.4 percent prevalence rate is still very elevated, particularly when taken together with the fact that South Africa currently has the highest rate of incidence (*new infections*³) in Eastern and Southern Africa (UNAIDS 2010).

This article attempts to widen our understanding of how a group of students at Rhodes University in the Eastern Cape experience, and importantly negotiate, risk in the context of their potentially high exposure to HIV. Data were collected over a two-year period (2008 – 2009) by means of twenty focus group discussions among students at this university. The research comprised two cycles of an action-research pilot project that infused HIV/AIDS-content/issues into a research methodology course in the Department of Sociology.

Conceptualizing Risk Society

Risk is intrinsic to everyday life. The ways in which people understand risk are “inevitably developed via membership of cultures and subcultures as well as through

² ‘Prevalence’ refers to the number of people in a population who are HIV-positive.

³ ‘Incidence’ refers to the number of *new* infections in a population.

personal experience” (Tulloch and Lupton 2003: 1). Because of their pioneering works in the field of risk theory Ulrich Beck (1992) and Mary Douglas (1986) are seen as authorities in the field. They offer quite different accounts of the cultural dynamics of modernity. Even though both claim that our beliefs are shaped by social contexts and cultural processes, Beck and Douglas differ with regards to how they assess the ‘reality’ of conflicting interpretations of the risks we face (Wilkinson 2001: 5).

Beck (1992b) claims that our modern situation is novel: the result of our ‘hazardous’ technological-scientific advancement. He claims that it is impossible to insure ourselves against “the high-consequence risks which are imposed upon our lives as the side-effects of industrial societies’ pact with progress” (as summarised by Wilkinson 2001: 3). Thus, the ‘risk society’ was borne under the counter-force of hazard and the threat of self-annihilation (Beck 1992b: 3). Late modernity, according to Beck (1992a), has meant the weakening of tradition and the surge of individualisation. This means that individuals are ‘forced’ to invent new certainties so as to make their way through life without the guidance of the norms and expectations of tradition (Tulloch and Lupton 2003: 4). This is often referred to as ‘reflexive modernisation’, a situation in which individuals are left to construct their own identities in the absence of long-established communal identities (Jones and Raisborough 2007: 4). Jones and Raisborough (2007: 5) criticise Beck, claiming that he concentrates too much on the macro or structural level risks. They state: “The degree of agency, choice and resistance that individuals have in the face of normalising discourses is contingent on socio-cultural context” (Jones and Raisborough 2007: 16), and so we need to take into account the multiple aspects of reality within which each individual lives.

Douglas (1986), on the other hand, claims that what we conceive as the ‘reality’ of risk “is determined by our prior commitments towards different types of social solidarity” (Wilkinson 2001: 1). In other words, Douglas believes that what individuals define as ‘risk’ is shared within cultures or communities. In this way she advances a structural-functionalist interpretation of risk perception. She emphasises that risk judgements are shaped by “shared understandings and anxieties about phenomena” (Tulloch and Lupton 2003: 7). In an effort to protect themselves, groups gather “a common set of aims and objectives” (Wilkinson 2001: 4), and they perceive ‘others’ as the cause of the threat, projecting the blame outwards. Such collective representations of risk, claims Douglas, perform an important function in the maintenance of social solidarity (Douglas 1990: 4). There are clearly differences between Beck and Douglas in as far as the way in which modern society operates. Wilkinson (2001: 15) refers to a third way of describing how risk impacts on people’s lives by stating that there are contrasting and sometimes also contradictory ways in which people may “construct and experience their knowledge of the future as one which imposes different types of hazardous uncertainty upon their lives”. Wilkinson therefore cautions against the attempt to restrict the meaning of risk to one particular form of social construction (2001).

In his paper titled ‘Risk theory in epidemic times’ Tim Rhodes (1997) contributes to the debate by distinguishing between two specific theories regarding risk behaviour, *viz.* ‘situated rationality’ and ‘social action theory’. The former tends to be limited to individual rationality and choice, which “[fails] to capture the distribution and influence of *power* in negotiated actions and the *habituated* nature of risk behaviour” (Rhodes 1997: 208). ‘Social action theory’, in contrast, considers how risk is socially organised with the aim being “to understand the interplay of social factors which give rise to individuals’ situated risk perceptions and actions” (Rhodes *ibidem*). Rhodes (1997) thus outlines the two main explanatory paradigms – the ‘individual’ and the

'social'. Where the 'individual' paradigm views risk as the outcome of individual choice and action, the 'social' paradigm views risk as the outcome of the interaction between numerous individual and social actions (Rhodes 1997: 210). Rhodes also claims that historically the theorising of HIV and AIDS has been epidemiological⁴, favouring a one-dimensional, as opposed to an holistic approach – which is unsatisfactory. Noting that the spread of HIV is not random but is linked to and follows the many different paths of human interaction and behaviour, Rhodes (1997: 209) proposes that if social scientists hope to formulate a comprehensive theory of risk behaviour they need to combine 'individual' and 'social' theories, as a divide between these only serves to hinder a proper understanding of the way in which the interplay between individuals and society produce risk behaviour (Rhodes 1997: 211).

People who perceive habituated risk behaviours as carrying less risk than benefit, "particularly if harm is yet to occur" (Rhodes 1997: 220), assess risk in terms of immediate importance and immediate threat. Helene Joffe (1999: 1-2) adds that people often externalise threats so as to attain a sense of invulnerability to risk. So when initially faced by risk, people tend to shift the blame for and vulnerability to risk by responding: 'not me', 'not my group', 'others are at fault' (Joffe *ibidem*). She claims that in the context of HIV, fear of infection intensifies people's need to distinguish between 'us' and 'them' (Joffe 1999: 23). In this regard people tend to be "unrealistically optimistic in relation to their own susceptibility to dangers" (Joffe *ibidem*: 7). This is the theory of 'optimistic bias' in which "people evaluate their own risk in comparison to how much at risk they imagine others to be" (Joffe *ibidem*). The personal shock evoked by mass risks — such as HIV/AIDS — "sends people along a defensive pathway of representation" (Joffe *ibidem*), protecting them from unwelcome emotion. Joffe (1999: 10) also claims that when people encounter new risks, they draw on ideas that originate within 'their' group to understand and explain them — emphasising the role of group affinity in shaping ideas. In short, processes that lie beyond the individual help to forge how she/he responds to risks (Joffe 1999: 8). Peer pressure and the social construction of sexuality and sexual norms via narratives, experiences and beliefs generated in social groups may well predispose young people to poor sexual health (MacPhail and Campbell 2001: 1615).

HIV/AIDS in Higher Education Institutions in South Africa

HIV/AIDS is one of the greatest risks that South Africans, and in the context of this paper, university students face. This section summarises HIV statistics specific to the higher education sector, forming a backdrop to discussing how students perceive and experience HIV-risk. Statistics from the national HEAIDS (2010) report are used because reports for individual institutions — including Rhodes University at this stage — remain private. The sampling methods used for the HEAIDS sero-prevalence study yielded results generalisable to the sector nationally, but it must be noted that considerable variation was found between universities and between provinces.

As mentioned earlier, the mean HIV prevalence among students was 3.4 percent. Echoing a long-standing trend in prevalence among all South Africans — and statistically significant — in the higher education sector females (with

⁴ Epidemiology – in relation to HIV – is the study of how a virus behaves in a population. Primary tools of epidemiology are statistical measures and modelled projections.

a prevalence of 4.7 percent) were more than three times as likely to be HIV-positive as were males (at 1.5 percent).

Prevalence was lowest in the 18-19 age group (0.7 percent), rose in the 20-25 age group (2.3 percent), and was highest among those over 25 years (8.3 percent). So a high risk of becoming infected with HIV exists for younger students who have unprotected sex with older students. This trend is clearly seen in the populations with generalised epidemics⁵, where HIV jumps *down* the age ladder from older to younger cohorts.

In terms of the number of sexual partners, echoing national trends, more male students reported having had sexual partners (19%) in the month prior to the survey, compared to female students (6%). Concurrency, as discussed later, is a potent factor in HIV transmission, but this potency is deflected in the context of condom use. Although the majority of students who had sex in the past year (60 percent) reported using condoms at last sex, there were indications of high levels of binge drinking – a context that is not conducive to consistent, correct use of condoms.

Overall knowledge of HIV was high, but students lacked deeper understandings of how HIV could be prevented, for instance through the use of PEP (post-exposure prophylactic) – a course of antiretroviral treatment administered after rape, violent crime, accident and so forth. This is ominous given that only 61 percent of students reported feeling safe from physical harm in their institutions, and only 38% agreed that female students were safe from sexual harassment at their institutions.

Although the numbers differ, overall patterns of infection in the higher education sector are consistent with what has been reported in national sero-prevalence, behaviour and communication surveys (HEAIDS 2101).

Factors Related to Sexual Risk Behaviour and HIV Infection

There are several factors that impact on HIV prevalence and incidence. This article focuses on three key themes in the data: alcohol consumption; multiple and concurrent partnerships (MCPs), and condom use. Gendered power relations, which emerged as a cross-cutting issue, are also discussed.

Alcohol consumption

Rhodes University has a reputation of being a 'drinking university'. Young and De Klerk (2007: 1-2) explore this in their report on alcohol consumption at Rhodes University. Because of the small size of the University social networks are strong, and because a large portion of students relish the social aspects of their university experience, many get roped into the drinking culture. This can happen irrespective of student's prior attitudes and beliefs concerning the excessive alcohol consumption which is encouraged, and largely normalised, within many of the student social networks. Young and De Klerk (2007: 6) report that only 11% of respondents indicated that they do not drink at all, with the remainder drinking at least occasionally, and many drinking excessively. Many students reported drinking patterns that were either hazardous, harmful or alcohol dependent (Young and De

⁵ Generalised epidemics are where HIV has spread into all demographic groups in a population and HIV is primarily transmitted through heterosexual sex. Concentrated epidemics, on the other hand are where HIV is primarily found in sub-sectors of the population such as men who have sex with men, intravenous drug users, and sex workers.

Klerk 2007: 7) — as many as 18.4% drank at levels harmful to their health, with an estimated half of this proportion potentially being alcohol dependent.

Because of the role of alcohol consumption in university culture it is important to examine its influence on sexual behaviour. Pithey and Morojele (2002: 2) point out that “alcohol use and HIV-related sexual risk behaviours are growing problems that affect most sectors of the community in South Africa”. There is a high level of acceptance of heavy drinking, and it is a popular pastime for many South Africans, with the easy availability of alcohol in South Africa encouraging its use (Pithey and Morojele *ibidem*: 8). Adolescents and youth are particularly affected by heavy drinking and HIV-related sexual risk behaviour, with women being the most affected group (*ibidem*: 2). Higher rates of drinking were found in urban areas, with white males (71%) and females (51%) topping the list (Pithey and Morojele *ibidem*: 9). Parties, clubs and shebeens were named as the most popular venues for alcohol consumption.

A study by Fischer *et al.* on adolescent risk behaviour (based on a population from Cape Town schools) indicated a significant relationship between binge drinking and sexual intercourse (Pithey and Morojele *ibidem*: 25). Simpson’s 1996 study on predominantly white Rhodes University students likewise showed significant associations between alcohol use, number of sexual partners and knowledge of HIV transmission (Pithey and Morojele *ibidem*: 25-26). A World Health Organization (2005: 8) report confirmed that there was low condom use among those under the influence of alcohol and apparently, being under the influence of alcohol is often culturally accepted as an excuse for irresponsible behaviour, including risky sex (WHO *ibidem*: 46). It is known that sexual risk behaviour accounts for much of the HIV transmission in South Africa, “and alcohol has been shown to increase such behaviour” (WHO *ibidem*: vii). The WHO report (*ibidem*) also states that the coexistence of these two behaviours (sexual risk behaviour and alcohol consumption) has the potential to increase harms associated with each of these separately. Alcohol use and sexual behaviour actively support one another “with alcohol use and beliefs acting as both precursors and outcomes of sexual behaviour” (WHO *ibidem*: 46).

Multiple and concurrent partnerships (MCP)

Multiple and concurrent partnerships are sexual relationships that overlap in time: either where two or more partnerships continue over the same time period, or where one partnership begins before the other terminates (CADRE 2007: 5; UNAIDS 2009: 2). Multiple concurrent partnerships occur where there are long-term/steady sexual partners, short or long-term ‘side’ partners, casual sex encounters, or all three (*ibidem*). Concurrency has been dubbed the ‘superhighway’ of HIV transmission and is particularly dangerous in a context of low consistent and correct condom use (CADRE 2010).

MCPs substantially increase the risk of HIV transmission, because they create a sexual network where “a new infection has the potential to move rapidly between people as a product of high viral load in the early phase of infection, where transmission is up to ten times more likely to occur than during the latent phase of HIV infection” (HSRC 2009: 41). HIV spreads faster through the population (a) because of the increased likelihood of transmission per sex act in this early stage of infection (called acute infection) when newly infected people have no way of knowing that they are carrying the virus, and (b) because the higher number of sexual

partners creates repeated short time frames for potential onward transmission (CADRE 2010; UNAIDS 2009: 2).

Concurrent sexual partners are common among young South Africans aged 20-30 (CADRE 2007). In their report, CADRE (*ibidem*: 42) noted that many South Africans did not have a strong sense that having many partners or that having concurrent partners is a major risk factor for HIV transmission. While people have a high level of awareness of HIV and its negative impacts, there is not much consideration given to HIV prevention in sexual relationships, particularly in longer-term relationships, and where trust is given early on in new relationships (CADRE *ibidem*: 45). There is also the notion of having a 'main' partner based on 'love and caring' and 'other' partners, distinguished by 'opportunistic sex' and sometimes by economic benefit. "If a 'main' partner was unable to meet one's economic needs, this justified getting those needs met by others" (CADRE *ibidem*: 42). This duality between 'main' and 'other' partners is widely regarded as acceptable.

The HSRC report (2009: 41-43) notes that in 2008 five times more males (30.8%) reported having had more than one sexual partner in the past twelve months, as opposed to their female counterparts (6.0%). In the higher education sector men also reported having more sexual partners in the month before the study (19%) than did women (6%) (HEAIDS 2010). Gendered power relations and notions of masculinity are two important factors underlying this trend.

Nationally, there was an overall increase in multiple sexual partners between 2002 and 2008 (from 5.5% to 10.6%) – clearly there is a need for more preventative education in this regard. Epidemiological modelling based on evidence from other parts of Africa demonstrates how even a small reduction in MCPs at the individual level would significantly slow the spread of HIV at the population level (UNAIDS 2009: 1). Furthermore, according to UNAIDS (*ibidem*: 3), we need reduction strategies that are both locally driven and locally relevant whilst being national in reach, large-scale and also rapidly scaled up — the time for debate, vacillation and pilot projects is over. MCP reduction has to become the overarching focus and priority of education, communication and implementation, and it needs to be supported by condom programming (CADRE 2007: 7; CADRE 2010; UNAIDS 2009: 4). Furthermore, such initiatives should include messages "to address behavioural formation among the young, behaviour change among those with formed behaviours [that are high-risk] and behavioural maintenance [of risk-averse practices] among all groups. [Initiatives must also link] messages about MCP to messages about the interface between alcohol, MCP, casual sex, and unsafe sex" (CADRE 2007: 7).

In order to achieve any sort of positive behaviour change, we need to understand what motivates people to engage in MCP. According to Soul City (UNAIDS 2009: 5), and CADRE (2010) contextual drivers of MCP include: low appreciation of risk; sexual dissatisfaction in relationships; lack of communication between partners — exacerbated by taboos that restrict partners from talking about sex; the influence of culture and social norms; the desire for money and new consumer values that coincide with rapid urbanisation; harmful use of alcohol; peer and family pressure; and resilient stereotypical beliefs about male domination and the inability of men to control sexual desire. Regarding more positive influences — it seems that the choices people must make in order to reduce the risks of HIV infection are not "strongly supported by peers or broader social norms" (CADRE 2007: 6). Given the role that MCPs play in the rapid spread of HIV it is imperative to tackle issues at several levels — individual, social network, community and societal/structural (CADRE 2010).

Condom programming

Consistent and correct condom use remains a critical element of HIV prevention and treatment (HSRC 2009: 44; UNAIDS 2004: 1). Research on heterosexual sero-discordant relationships (where one partner is infected with HIV and the other is not) clearly show that correct and consistent condom use significantly reduces the risk of HIV transmission. Avert (2009) notes that the 256 million male condoms distributed in 2007 by the South African government, is down from the 376 million distributed in the previous year. Notwithstanding reported shortages in condom supply, both the HSRC (2009: 45) and Avert (2009) report that there has been a significant increase in the number of people using condoms between 2002 and 2008: “For adults 15+ years, the overall proportion of people who reported using condoms at last sex more than doubled from 27.3% in 2002 to 62.4% in 2008” (HSRC 2009: 45). Furthermore, it is younger people who show the highest rates of condom use “which bodes well for the future of prevention” (Avert 2009). High condom use is also reported by South African university students (HEAIDS 2010) – particularly in the context of casual sex – which confirms that communication, education and other interventions have had a positive impact on this aspect of behavioural formation.

It has long been the lament of HIV/AIDS practitioners, researchers, governments, NGOs, funders — in short just about everybody from international to local levels — that knowledge about the risks of HIV does not necessarily translate into good prevention practices. As MacPhail and Campbell (2001: 1617) point out, “knowledge of sexual health risks is not necessarily a good predictor of condom use.” They propose that six factors reduce or hinder condom use: lack of perceived risk (by externalising the threat); peer norms (felt most strongly among the male population); condom availability (more problematic for females than males); adult attitudes to condoms and sex (adults don’t condone the use of condoms by young people — they insist on abstinence instead); gendered power relations (high levels of coercion and violence as well as financial dependency constrain females from refusing sex or negotiating safer sex); and, the economic context of adolescent sexuality (the ‘commercialisation’ of youth sex through, for instance, transactional relationships; the fact that for some, condoms are a luxury) (ibidem).

Gender issues

Stirling (*et al.* 2008: 1) proclaim that the AIDS epidemic in South Africa is sustained by “the relentless cycle of vulnerability affecting girls and young women”. Almost two-thirds of all HIV-positive young people in the world live in sub-Saharan Africa, and around 75% of all infections among the 15-24 year age group are among young women (Stirling *et al.* 2008: 2). Between 2005-2007 prevalence rates in the 15-24 age group in South Africa show that young males had a prevalence rate of 4% whereas young women had a prevalence of 17% (Stirling *et al.* ibidem). Echoing this trend, prevalence among female South African university students was found to be 4.7 percent — three times higher than males, at 1.5 percent (HEAIDS, 2010).

Andersson and Cockcroft (2008: 11) note how there are indications of higher HIV risk taking among people who have a history of gender-based violence and higher rates of violence are seen among those who are already HIV positive. It is often difficult to tell which comes first, but evidence favours gender-based violence “as a potentially actionable cause – direct or indirect – of HIV infection” (Andersson

and Cockcroft *ibidem*). This is particularly worrying in a South African higher education context where only 38% of students perceived female students being safe from sexual harassment at their institutions (HEAIDS 2010).

Methodological Notes

The data collected for this article are based in qualitative social research where understanding the life worlds of participants and the way in which they interpret their everyday experiences are central foci. In reaching towards an understanding of participants' life worlds we attempt to unveil some of the meanings and motives that underlie their behaviour. Qualitative/interpretive research approaches challenge the researcher in that they yield fluid and multiple perspectives of the world. This is because people actively construct, co-construct and reconstruct their own social reality — even during data collection processes. According to Coetzee and Rau (2009: 2), “people are endowed with consciousness and they see, interpret, experience and act in the world in terms of a vast range of subjectively and intersubjectively constituted meanings”, and thus there is no single objective truth. Social and individual reality contains elements of beliefs and convictions that often escape observation by either senses or mind. A hermeneutic challenge is that perceptions of risk and reported behaviours are constantly being redefined, creating challenges for the collection of data.

This research set out to *understand* how a group of university students experience risk in their everyday lives. A total number of 20 focus groups were conducted with Rhodes University students over a period of 2 years (10 focus groups were held in 2008 and a further 10 groups in 2009).⁶ Groups discussed the perceptions and subsequent behaviours of students with regards to life in a time of risk, with particular emphasis on their awareness of the risk of contracting or transmitting HIV.

Special attention was given to alcohol use/abuse; gendered power relations; economic constraints; peer pressure and cultural norms. How do students perceive their vulnerability to the disease? How do cultural norms and peer pressure affect their behaviour, regardless of their knowledge of the disease? Does succumbing to a ‘culture of drinking’ affect their susceptibility to the danger of becoming infected?

All focus group discussions were digitally recorded. Recordings were then transcribed and checked. Data collection, processing and analysis were guided by close supervision, including students' application of ethical processes and protocols.

Data Analysis and Discussion

General risk perceptions

Everyday behaviours are often perceived to carry more benefit than risk, “especially if harm is yet to occur” (Rhodes 1997: 220). This appears to be the case for student participants, who tend to assess risk in terms of immediate importance or threat, prioritising the ‘now’ and choosing not to think about the ‘future’. Students

⁶ A list of focus groups appears at the very end of this article. In the Data Analysis and Discussion section quotes are attributed to a specific focus group (FG). FG20, for instance, refers to focus group 20 conducted in May 2009.

don't want to have to think about things such as risks: "You want to live your life ... you don't want to have to be responsible" (FG6). "Because I'm having a good time I reckon it's worth it" (FG19). If a threat such as HIV has never been experienced personally (i.e. if one has never known anyone personally infected), students tend not to think about the possibility that they could be at risk. With as many as one in six South African students (18%) personally knowing someone who is HIV-positive (HEAIDS 2010) one would expect high risk aversion, but from what students say, they only perceive themselves to be at as much risk as those with whom they associate on an *everyday* basis. So when friends take risks, these behaviours become 'normalised', the threat of HIV becomes externalised and a sense of invulnerability prevails. As Joffe (1999: 7) notes, 'othering' — distinguishing between 'us' and 'them' — creates an unrealistic optimism in relation to their own susceptibility to HIV. As one participant stated: "It's got a lot to do with that 'It won't happen to me' mindset. It'll be like, 'I know all this stuff', but in the back of their mind they're saying: 'It's not going to happen to me, so why should I actually care?'" (FG5).

While student participants acknowledge that there is more than ample knowledge available on the topic of HIV/AIDS, some admit that they choose to ignore available information because they decide that it is not relevant to them or to their social group. Furthermore, some claim to be 'sick and tired' of hearing the same messages over and over again, so they 'switch off' when the issue is raised. From what they say it seems that many white, middle class students perceive HIV to be a disease of poor, uneducated black people. Some black students also share this view. 'Clean', educated people (such as themselves, they argue) are not at risk when it comes to contracting HIV. A participant in one of the groups claimed: "People see [HIV] as a dirty disease ... it's what poor people get; it's not like someone from a middle class background can possibly get HIV" (FG15).

Furthermore, Rhodes University students feel safe in the 'bubble' of Grahamstown: "It's a small town and, you know, you don't expect HIV to hit you" (FG11). As another participant put it: "We believe that nothing can touch us and that nothing happens outside of our little bubble, and we go about our everyday lives without taking into cognisance what we do and the repercussions of our actions" (FG14). The general idea is that ignorance is bliss, and there are risks some are prepared to take: "It's like the benefit almost outweighs the risk" (FG19). Because HIV threatens and happens to 'other' people, students appear willing to "laugh it off". Furthermore, because they do not want the risk to exist, or to accept it as real, they have a tendency to "wish it away" (FG16). All these factors combine to desensitise students to risk: "We are almost becoming used to it ... we are becoming so apathetic" (FG2). Apathy extends to a refusal to think about HIV risk, and the less students think, the less real it becomes to them.

Their new found freedom on arriving at university is another factor influencing how Rhodes student participants experience risk. Away from their family and parental control, students can explore and experience much more than was previously possible. Many students hold the view that they are only students for a short time in their lives and that they should enjoy every moment, be adventurous and do things they normally would not do: "I've never done this before and it's my chance to do it now ... while I'm here I just want to play" (FG15). The vulnerability of newcomers to university is confirmed in findings of the HEAIDS study, which reports that during first year "students lack the experience to make good, risk-aware decisions, especially regarding sexual liaisons and alcohol" (2010: xv). Making friends in this new environment can be difficult and some students do admit to falling prey to peer pressure in an attempt to fit in: "I think that given enough pressure we all give in to

risky situations” (FG15). The new environment often results in their foundations being shaken. As one participant articulates it: “Their securities are nowhere, so they’ll look at what the majority’s doing and be like, ‘Okay, where can I fit in?’” (FG13).

A structural factor in risk-taking behaviour that participants mention is that “Grahamstown is a small city and it gets boring, so you do things you don’t normally do” (FG15). For a lack of excitement, students actively seek risky activities. Pushing the boundaries is considered fun, as “half of the thrill is because you know that you are taking risks” (FG16). “Taking risks is an adrenaline rush” according to a male student (FG7). And because of perceptions that Grahamstown offers a safer environment than other bigger cities, student participants tended to feel that their ‘risky’ activities are not really as bad one would think. Rhodes and Grahamstown have an “environment of being laid back and being very casual” (FG1) and thus “students do tend to be a little more casual and a little more trusting” (FG1).

As Tulloch and Lupton (2003: 1) claim, the ways in which people understand risk are “inevitably developed via membership of cultures and subcultures as well as through personal experience”. This appears to be very much the case with Rhodes University students, who negotiate risk within the subculture of student life, and who claim to be unaffected by the reality of risks they face because they have no real personal experience of such risks and so, feel detached from them. Most participants point out that despite peer pressure and a need to conform to cultural and sub-cultural norms at the university, an individual chooses how to behave and “you need to take responsibility for yourself and your own actions” (FG1). The dilemma of behaviour change communication is aptly illustrated by one participant who points out that “actually taking action is the most difficult part of it all; awareness is very different from action” (FG2). This collaborates with Douglas’s (1992) notion that risk judgements are shaped through shared understandings of what constitutes risk – students know better, but they act in the moment and their decisions are shaped by what their peer group and social environment consider as ‘normal’ behaviour. By inventing new certainties students — particularly new students — negotiate their way in an unfamiliar and uncertain environment.

Alcohol consumption

Rhodes University is considered to have a strong ‘drinking culture’ among its students. Drinking is seldom strongly condemned, but rather, it is normalised and often encouraged amongst peers. Because the University is small, with strong social networks there is a high degree of trust that students are safe among ‘their own’. Drinking is also considered to be a vital part of one’s university experience, with alcohol being consumed for recreation, socialising, ‘de-stressing’ and celebrating.

It is well known that drinking lowers inhibitions, and some student participants say it increases their sex drive. So alcohol consumption and risky sexual behaviour are clearly linked in this context. Some participants even claim that they “won’t go out sober because they won’t be able to score” (FG9). Participants say that in itself sex is not that risky, but with drinking and lowered inhibitions they don’t think about the consequences of unprotected casual sex: “Like, if I’m pissed, I’m in the mood for fun, whatever – I don’t think about risks” (FG19). Participants mention alcohol giving “liquid courage” (FG3) — the ability to be more outgoing and talk to anyone. “Drinking does change you in a way that you do things that you would not normally do” (FG20). “Some guys even claim that when they go out with their mates they take bets as to who will find a partner first, and not using a condom is an occasion to cheer” (FG 10).

Many students don't feel pressurised into drinking – they want to drink: “Well, for me, when I came to Rhodes, my home is very strict, so I said: ‘I’m going to do all these things I’m not allowed to’. No one forced me to do it. It’s what I decided” (FG3). Others felt that they had succumbed to peer pressure: “I was trying to find friends; most people were doing things that I would not normally do ... the drinking culture, going out ... so I felt pressure to do it also” (FG3). There generally appears to be more pressure on male students than on female students. As one participant said of his male friends: “Everyone is around you, egging you on” (FG10). Participants also claim that it is difficult to exercise personal discipline when you are surrounded by people who are constantly going out and drinking: “You may as well get hammered” (FG9).

Proponents of the argument that drinking is not *that* excessive say that the main reason why drinking appears to be the ‘order of the day’ is because the students are in a much closer proximity to each other and the drinking is more noticeable. Adding to the notion of structure as constructing social realities, another says: “I think it’s also because of the location — it probably gives us a better opportunity to do what we do” (FG10). Because of the small scale of the town, everything is closer and more accessible, so it is easy to go out drinking and return to campus or other residences. As discussed earlier in **General risk perceptions**, the downside of being a small town is that there is not much alternative evening entertainment, and for some students drinking solves the problem: “It’s much more interesting being drunk ... We don’t have anything better to do” (FG19).

Students admit that they are more susceptible to many different varieties of risk when drunk (risks such as muggings, rapes or raping, car accidents, and getting into fights). One participant said: “I reckon as soon as alcohol comes into the equation you become a larger target for crime in general” (FG11). But alcohol makes the risk easier to accept. As a participant stated: “With alcohol, there is that belief that risk is worth it” (FG20).

Multiple and concurrent partnerships

Participants note that because Grahamstown is such a small environment, it is easier to go home with a random person: “There is so much more that you feel that you can do here and that you wouldn’t do back home — people are much more liberated at Rhodes” (FG5). There appears to be more trust because of the smaller environment and tight social networks. Students often perceive each other as known to everybody else and therefore think that casual partners would not try anything ‘dodgy’ because one of their friends (or, one of their friends’ friends) will know and tell (FG 15). This can lead to a false sense of security. Also, because of the tight social networks, students believe that if this person was ‘dirty’ (i.e. had HIV/AIDS or a sexually transmitted infection, or some other problem), then they would have heard about it (FG 5). The fact that they have not heard of a problem leads them to believe that the person is ‘clean’. Furthermore, they think that because they are at university and are educated they are not at high risk of contracting a sexually transmitted infection, particularly HIV. They also choose less risky looking people: if someone looks ‘clean’ and healthy then he or she must be fine. “I only sleep with clean people, so I am clean” (FG5), said one participant.

There is also the notion that boredom creates the need to “hook up” with different people: “You go find yourself a score” (FG6). As one participant stated: “It’s a sport almost to see how many people you can hook up with before you graduate”

(FG15). There appears to be more peer pressure among male students to have many casual partners, or one night stands: “Say I saw a lot of my friends getting together with people. Yes, there would be a tendency for me to up my game so to speak, probably just because you want to be one of the boys, that kind of thing” (FG5). Students see random sex as a kind of game; as something that is “a socially influenced thing ... like if your friends are hooking up and having naps [spending time in one another’s residence rooms] it’s more likely that you will be encouraged to do the same thing” (FG5). This appears to be an acceptable, normalised activity and thus perceived as not particularly risky. The idea of celibacy is laughed at and referred to as “rubbish” (FG17).

Because students perceive other students to have an acceptance of drinking and randomly hooking up with people whilst drunk, it gradually becomes acceptable behaviour. As one participant said: “I think that in the society that we live in its okay to have multiple sexual partners. It’s okay to drink and behave in an uncontrolled and debaucherous manner” (FG16). Students condone casual sex and as long as they stick to ‘clean’ people like themselves, do not feel that they are placing themselves in any real risk of HIV. “I don’t think they are thinking about the whole AIDS thing and what could happen ... it happens to everyone else” (FG7). It is also acknowledged, however, that the small environment at Rhodes University escalates risk of contracting HIV or an STI, because “everyone is doing someone... you could end up sleeping with the same person your friend is sleeping with” (FG5) and someone along the line could be HIV-positive.

Sex is seen as a casual thing, “like a trend on campus” (FG6), and many students talk of “friends with benefits” — where friends sleep together, but there is no real relationship involved. Also, because of the higher female to male ratio at Rhodes, it is acceptable for males to have more than one sexual partner (a view held by the female participants too). As a female student commented: “When you’re at varsity, and you’ve got a boyfriend ... chances are you’re sharing him” (FG19). Knowing one’s partner’s HIV status is not common, placing people at even more risk of contracting HIV. Many students reported feeling uncomfortable or embarrassed to ask their partner to get tested with them, because it is seen as breaking the trust believed to exist in a relationship (FG 16).

The HEAIDS (2000) survey also found that university students are accepting of casual sexual partnerships, but it is not as accepting of multiple concurrent partnerships. Overall there were few Rhodes University students who expressed awareness of the risks involved in having multiple and concurrent partnerships. As noted earlier, at the national level students know the basic facts about HIV/AIDS but lack more nuanced understandings (HEAIDS 2010). Part of the reason is that in higher education institutions, and more generally in South Africa’s response to the epidemic, the detrimental influence of high viral load during acute infection has not been anywhere near as well conveyed as, for instance, condom use. Clearly, MCP is a prevention issue that requires more aggressive interventions at programmatic and communication levels (CADRE 2010).

Condom use

Student participants view condoms primarily as a contraceptive barrier, and secondarily as a way of preventing sexually transmitted infections (STIs). Falling pregnant is sometimes seen as being more of a risk and embarrassment than is the danger of contracting HIV, so preventing pregnancy becomes the higher priority: “All

these serious problems kind of fade away in your mind and the priorities become intimacy and pregnancy — you worry about those things simply because the person you are having sex with does not fit your perception of someone who has STIs or HIV/AIDS” (FG6). “Pregnancy”, in the words of one female participant, “is visible; it’s something that everyone can see and judge. Whereas HIV is up to you to tell” (FG5). And it would be up to the HIV-positive person to tell too, given confidentiality issues. Another factor inhibiting condom use is that if a female is on the pill, *this* will help with preventing unwanted pregnancies.

There is the perception that condoms are not necessary for sex with ‘clean’ and healthy looking people. They are also not necessary with regular partners or in longer-term relationships. As one participant put it: “Trust comes in and the condom just goes out the window” (FG19). If both partners know their HIV status and know that they’re HIV negative, then there is no reason to bother using condoms: they feel safe, they trust, and forgo prevention. In the context of a generalised epidemic, this is dangerous thinking. More heartening is that the HEAIDS (2010) study found a trend among students to use condoms during casual sex, which is likely one of the reasons why prevalence in this population is lower than the national average. As one participant commented: “If you’re having a one-night stand then you definitely must [use a condom] because you don’t have the right yet to not use one” (FG7). Older students are seen to prefer first year students because they’re ‘clean’: “They haven’t been exposed to the environment that we have been exposed to” (FG5). This raises the issue of young students who are not au fait with negotiating risk — and condom use — falling prey to older, more experienced, students. Space constraints preclude this article from exploring age-disparate sex, but it should be noted that this has become a priority area for HIV prevention interventions (CADRE 2010).

Unprotected sex is commonly spoken of by student participants as being more enjoyable. Speaking for many, one said: “I prefer the feeling of flesh” (FG6). Students also seem to think it embarrassing to ask a stranger to use a condom, and it is said that many males will coerce partners into not using one. Not wanting to “ruin the moment”, and that using condoms was “too much of a mission” (especially when drunk) were named as factors contributing to the non-use of condoms. There is often peer pressure among males to not use condoms. One participant went as far as to say: “I think it’s only pressure that influences people to have unprotected sex” (FG15). This relates to a statement from a different group where males in residences were said to “cheer you on for not using a condom” (FG4). As MacPhail and Campbell (2001: 1615) note, the social construction of sexuality might predispose young people to poor sexual health.

Students acknowledge that there are condoms freely available on campus and they appear to be aware of the location of condom dispensers. But they claim that these are located in arbitrary locations that are too public and that they would rather go without condoms than to be seen taking them. This may seem strange in a context where sex is seen as a casual thing but can have to do with the fact that many students do not think that the free government condoms are safe, or sexy, and prefer using brand names (such as Durex). Female students appear to be the most influential in this regard, as illustrated by one participant who says that “if a guy I am about to have sex with whipped out a government condom then I would rather refuse sex” (FG 7). It is seen as acceptable for males to carry condoms, but females believe that there is a stigma attached to them carrying condoms. They fear being labelled a “slut”, “loose”, “promiscuous”, and not trustworthy or “clean”. This brings us to a cross-cutting issue: gender.

Gender issues

Inequitable gender norms have long been acknowledged as one of the drivers of HIV infection. Participants in this research named culture as being one of the culprits of gender inequities. As one participant said: “That is how I was raised — men have always been viewed as more superior to women” (FG2). Some male participants believed that they have the right to demand sex, even though many of them do not act in this way. And several participants claim that this is “a socialised thing” and that men are “wired differently” to women (FG2). As one participant puts it, “...you can’t exactly blame the man – its society at large” (FG11). Regarding blame, many male participants believe that it is up to female students to be more responsible, and not go out and get drunk — getting drunk increases the risk that they will be taken advantage of or raped. “Women need to face that in reality, they can’t go out and get vrot [rotten] drunk and expect nothing to happen to them” (FG11), claims one male participant. This is perceived to be a “tragic fact of life” (FG11) which women need to accept, rather than expecting men to change their attitudes or reflecting why men can do so with impunity.

A few female participants noted how many women just sit back and accept this ‘fact’, rather than actively trying to fight back. South Africa was spoken of as being a patriarchal society, making it difficult for women to stand up for themselves and demand that their health and safety needs be met. Women have little chance of demanding that men wear condoms, and at Rhodes University it appears that many a female student is prepared to place herself at risk rather than disappoint her man: “Women just don’t want to empower themselves by using femidoms ... if a man says ‘No condom’, they just go with it because they are so eager to please” (FG15). As discussed earlier, some females fail to carry condoms fearing stigmatisation and rejection. Some even mentioned fear of violence if they bring up the issue. These factors are particularly pertinent to the finding that only 38% of university students nationally perceived female students as being safe from sexual harassment at their institutions (HEAIDS 2010).

Male students admit to making sex a game, taking bets on who will bring home a girl. And some are not averse to coercing a girl to get what they want, especially since they believe that their sexual desires are natural and need to be met. As one says: “It’s about making your stand [as] the alpha male” (FG6). Happily there are many male and female students who do not condone, and who are not shaped by, negative gender stereotyping.

Conclusion

The research aimed to broaden understandings of how Rhodes University students perceive their susceptibility to risks, particularly risks associated with HIV, and how they behave in relation to such risks. Some participants — both male and female — were non-drinkers, did not support negative gender stereotyping, did not engage in sexual intercourse of any kind, and were very aware of the consequences of promiscuous behaviour and unsafe sexual practices. On the other hand, the notion that ‘you’re only young once’ and that high risk behaviour is part of student life and culture came up often in the discussions. Many student participants, despite being well aware that they were placing themselves at risk, were clearly prepared to ignore the dangers and indulge in heavy drinking and high-risk sex.

Data show that risk perception and risk behaviour are formulated at the individual, social network, and societal/structural levels. Rhodes students appear to negotiate risk perceptions and susceptibility within their broader social environment: they only feel as much at risk as they believe their peers to be. Since students believe that they are relatively safe within the 'bubble' they call Grahamstown, they do not perceive the risk of acquiring HIV to be that severe, or particularly real.

Rhodes University does much to publicise and help students understand the risks involved in behaviours such as substance use and sex that puts them at high risk of HIV. Some students claim to be tired of hearing the same stories over and over again. Some even go as far as saying that the more the University attempts to change their behaviour, the more they attempt to actively seek out what is regarded as risky. It appears that risk is appealing and the feeling of getting away with something outweighs the danger of potentially negative consequences. As one participant put it: "The juice is worth the squeeze" (FG 20).

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Key to Focus Group Discussions (Exact dates given, where known).

FG1 – Focus group discussion on the Risk of Crime and Violence # 1, 12 May 2008

FG2 – Focus group discussion on the Risk of Crime and Violence # 2, April/May 2008

FG3 – Focus group discussion on Emotional Risk, April/May 2008

FG4 – Focus group discussion on Financial and Environmental Risk, 22 April 2008

FG5 – Focus group discussion on Health Risk # 1, 21 April 2008

FG6 – Focus group discussion on Health Risk # 2, April/May 2008

FG7 – Focus group discussion on Health Risk # 3, April/May 2008

FG8 – Focus group discussion on the Risk of Racism and Xenophobia, April/May 2008

FG9 – Focus group discussion on the Risk of Substance Abuse # 1, April/May 2008

FG10 – Focus group discussion on the Risk of Substance Abuse # 2, April/May 2008

FG11 – Focus group discussion on the Risk of Crime and Violence A, May 2009

FG12 – Focus group discussion on the Risk of Crime and Violence B, May 2009

FG13 – Focus group discussion on Emotional Risk, 5 May 2009

FG14 – Focus group discussion on Financial and Environmental Risk, May 2009

FG15 – Focus group discussion on Health Risk A, 6 May 2009

FG16 – Focus group discussion on Health Risk B, May 2009

FG17 – Focus group discussion on the Risk of Racism and Xenophobia A, May 2009

FG18 – Focus group discussion on the Risk of Racism and Xenophobia B, May 2009

FG19 – Focus group discussion on the Risk of Substance Abuse A, 18 May 2009

FG20 – Focus group discussion on the Risk of Substance Abuse B, May 2009

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