A Sociological Analysis of the Sex Education of Young Adult White Womxn and their Understandings and Practices of 'Safe Sex'

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ABSTRACT

This research sets out to examine the experiences and perspectives of young adult white womxn regarding their respective sex education. This is in terms of how sex education may shape and influence sexual practices. The relevance of exploring the sex education of this group is to gain an understanding of how constructions of sex education may facilitate the negotiation of sexual practices, particularly as these practices relate to the negotiation of 'safe sex'. This involves an exploration of definitions of 'safe sex' as well as an examination of the various sources of sex education. This research argues that sex education has been socially constructed within a 'heterosexual matrix' where both gender identities and sexuality are constructed in heterosexual terms in accordance with compulsory heterosexuality. Furthermore, that sex education as well as understandings and practices of 'safe sex' intersect with other social categories such as race, gender and sexuality. Much of the sex-related research conducted in South Africa focuses on people of colour, as a result very little is known about the sexual behaviours and practices of the white demographic. This research accounts for the absence of analysis of sexual practices and behaviour among white people by examining the sex education and sexual practices of young adult white womxn between the ages of 19 and 24. The research observed key sources of sex education which included parents, schools, religious institutions and the internet. Findings indicate that the sex education of participants reflected ideals of heteronormativity and misogyny which were found to directly influence their understandings and practices of both sex and 'safe sex'. Furthermore, that the sex education participants received has ultimately failed to promote 'safe' sexual practices.

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AO	Abstinence Only
CAPS	Curriculum and Assessment Policy Statements
CSE	Comprehensive Sexuality Education
DBE	Department of Basic Education
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
HSRC	Human Science Research Council
IPV	Intimate Partner Violence
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Questioning or Queer, Intersex, Asexual, +Myriad of other identities[1]
LO	Life Orientation
OBE	Outcomes-Based Education
STD	Sexually Transmitted Disease – the term has been updated to STI – when the term is used by participants, they are referring to STI
STI	Sexually Transmitted Infection
VAW	Violence Against Womxn

[1] University of Illinois Springfield, (2019). LGBTQIA+ Terminology. https://www.uis.edu/gendersexualitystudentservices/about/lgbtqaterminology/

CHAPTER 1: INTRODUCTION

1.1 Introduction

Sexuality can be seen as a set of boundaries demarcating sexual practices, identities, orientations and desires (Nagel, 2003: 46). Virtually all aspects of sexuality are both informally and formally scrutinized and regulated (Ibid., 46). Sexual socialisation refers to the process through which beliefs, attitudes and expectations about sexuality and sexual relationships are conveyed to individuals by multiple socialising agents such as parents, the media and broader social processes such as family relations and religion (Ballard & Morris, 1998, cited in Day, 2010: 3; Shtarkshall, Santelli & Hirsch, 2007: 116; Spanier, 1977: 87-89). The process of sexual socialisation is a long-term one beginning for each individual from birth, taking place implicitly as well as formally (Fox, 1980: 22). Formal sexual education is sex education taught in formal institutions such as religious, school and tertiary institutions. In South Africa, sex education is a compulsory part of the school curriculum, and over the past two decades sex education has mainly been taught in the context of HIV/AIDS (DoE, 2012d; Francis, 2010: 314; Francis & DePalma, 2014: 83). In this study I use the term *sex education* to include formal sexual education and sexual socialisation more generally.

The concept of 'safe sex' is socially constructed and socially contested (Bourne & Robinson, 2009: 284). Definitions of 'safe sex' have been offered by many, and 'correct' meanings have long been proposed usually by those from medical backgrounds (Bourne & Robinson, 2009: 284). Definitions usually follow the same principle: the separation of bodies and the establishment of fluid exchange barriers, specifically condoms (Ibid., 284). A biomedical definition of 'safe sex' may be accurate and healthy but may not form part of common concerns in everyday life (Bourne & Robson, 2009: 285). Another aspect of 'safe sex' involves the definitions individuals hold about sex. This is a concern particularly for the validity of self-reported sexual behaviour. Respondents of a study may respond to research questions based on different opinions about what behaviours constitute sex (Randall & Byers, 2003: 87). A gap in many studies pertaining to sex is that they do not require participants to define sex, which causes challenges when attempting to study other terms related to sexual behaviour (Ibid., 87). This research aims to address this gap within existing research by having research participants define the concept of 'sex' as a preface to discussions of 'safe sex'.

The theoretical framework of this research is informed by social constructionism, where knowledge is viewed as constructed as opposed to created and society is viewed as existing

both as a subjective and an objective reality (Andrews, 2012: 39). This research drew on Butler (1988: 519) who argues that gender is an identity constituted in time and is an identity enacted by a 'stylized repetition of acts'. Furthermore, Butler (2004: 52) argues that a crucial aspect of gender in a heterosexist society is heterosexuality, and thus gender norms also act as a regulatory means for the production and maintenance of hegemonic heterosexuality. In conjunction with social constructionism this research worked within an intersectional framework where categories such as gender and sexuality were taken into consideration with regards to how this influenced participants sex education, their understandings and practices of sex and 'safe sex'.

Within South Africa among the academic discourse regarding the issues of 'safe sex', there exists an absence of recognition of white people as being subject to the impact of sexually risky behaviour. Furthermore, because the white demographic group has often been excluded from research regarding 'safe sex', little is known about their sexual behaviours and practices. This research attempts to add to the sociological knowledge surrounding sex by focusing on young adult white womxn in a South African context. I chose to explore those more privileged in South African society and investigate the level and nature of their sex education as well as their current understandings and practices of 'safe sex'. This kind of research is important within the context of South Africa, firstly, because of South Africa's HIV/AIDS epidemic (Cooper, Mantell, Moodley & Mall, 2015; Fassin & Schneider, 2003: 495; Tillotson & Maharaj, 2001: 83-85). Within the South African context HIV/AIDS has been constructed as an illness predominantly affecting poor, black communities (Brown, BeLue & Airhihenbuwa, 2010: 444), and it could be argued that this has significantly impacted on the exclusion of the white demographic in sex-related research in South Africa. Secondly, because South Africa has one of the highest rates of violence against womxn (VAW) in the world (Kalichman *et al*, 2007: 20; Peacock *et al*, 2006: 73).

1.2 Goals of the Research

The primary objective of this research is to investigate the level and nature of young adult white womxn's sex education and how it links to their sexual practices. The research also aims to explore to what extent sex education has sufficiently prepared participants to negotiate sex as well as 'safe sex'.

1.2.1 Sub-Objectives

a) To investigate the sex education participants received including the sources they received this education from.

b) To investigate participants definition of ‘sex’ to ascertain the level that they engage in sexually risky behaviours.

c) To explore participants understandings of ‘safe sex’ which include understandings beyond a biomedical model.

CHAPTER 2: SEX, GENDER AND SEXUALITY

2.1 Introduction

This chapter will examine and discuss the theoretical framework of the study and comprises a number of sections. It will begin with a discussion of social constructionism which will lead to a brief discussion of social constructionism and gender. The section that follows will critically discuss the sociology of sexualities and the influence of queer theory on the field where it will be argued that queer theory pushes sociology to be more critical of social categories such as sex, gender and sexuality and to be mindful of the relationship between the three. These concepts are central to this study because they are interlinked and bound with the sexual socialisation of individuals which significantly influences individuals' sexual practices as well as their understandings of sex. A prominent influence on queer theory is Judith Butler's theory of the performativity of gender which will be examined. Butler extensively refers to the 'heterosexual matrix', showing that heteronormativity is a critical organizing principle of society, this is key to this study and thus there will be a section in which this concept is reviewed. Given that there are other factors such as ethnicity and sexuality that make up individuals' identities, a section of this chapter will include a discussion of the concept intersectionality. I will argue that intersectionality is integral in ensuring a comprehensive understanding of social phenomenon and thus justify its use in this particular study. Finally, before concluding I will make a case for why I will be using both queer theory and intersectionality.

2.2 Social Constructionism

Social constructionists view knowledge as constructed. Society is viewed as existing both as a subjective and an objective reality. Meaning is shared, constituting a taken-for-granted reality (Andrews, 2012: 39). Social constructionism takes a critical stance towards taken-for-granted knowledge and maintains that we should question our assumptions about how the world appears to be (Burr, 1995: 2). Knowledge is maintained by social processes and constructions of the world which support some patterns of social action and exclude others (Burr, 1995: 3-4). Furthermore, the ways in which we commonly understand the world including the categories and concepts we use are historically and culturally specific, meaning that they are historically and culturally relative (Burr, 1995: 3). Social constructionism has a strong focus on interaction, social practices and processes and thus according to this perspective, knowledge

is not individual but rather is shared by people. These social processes are inextricably intertwined with the social structure (Burr, 1995: 6). A key critique of social constructionism is that the framework is built upon the foundation that there is an absence of truth, which seems to deny that there is any material base to our lives and factors that have a significant effect on our lives (such as the economy, living conditions and health) are all effects of language (Burr, 1995: 59). I will argue that this is not necessarily the case with social constructionism and that within this framework it is possible to acknowledge both the socially constructed as well as the material.

Deconstructivist social constructionism leans towards a more critical realist analysis meaning that under this analysis there is a structural reality to the world. Often this lends itself to a strong focus on power relations because power relations underlie the ways in which we understand and talk about our social reality (Burr, 2003: 100). Queer theory could be categorised as deconstructivist social constructionism since its key tenet is the deconstruction of the social categories of sex, gender and sexuality. Furthermore, central to this perspective are power relations. Adding to this, the main purpose of the analytical tool that I will be using, namely intersectionality, is to analysis power relations and thus crucial to an intersectional analysis is our structural reality. I think however, fundamental to any strong research is the recognition of the material as well as the discursive – in other words recognising both agency and social constraints or structures. As noted by Burkitt (1999 as cited in Burr 2003: 101), material and social conditions place limitations on the constructions that can be built and therefore, discourse alone cannot construct the world signifying that 'reality' is a continuously evolving sphere that is both discursively and practically constructed by people. Although reality exists outside of discourse, I think it is important to note that reality does not determine knowledge in the same way that knowledge does not determine reality. Reality provides important constraints on the ways in which we can 'construct' our world. Knowledge is the result of people trying to mould and control the real world they live in and to a degree knowledge allows people to manipulate and predict reality (Burr, 1995: 60). In this view then knowledge cannot exclusively be the effect of thought, ideas and imagination, it must also be a function of what is real (Burr 1995: 60).

Burr (1995: 64), uses Gergen's principle of 'warranting voice' to demonstrate that people are users and manipulators of discourse and are not purely a product of them. This concept is helpful in understanding the relationship between agency, discourse and materiality which shows the possibility of personal agency and choice. In other words, individuals are not merely

passive recipients of discourse or social structures completely determined by them. With this said, Burr (1995: 63), appropriately notes that not everyone has equal access to all discourse and factors such as age, gender, sexuality, ethnicity, class and nation impose further restrictions on the kind of person individuals can be. This point links in well with the concept of intersectionality. Looking at the relationship between discourse and the materiality as well as individual agency highlights the 'performative' aspects of language – language is used to do things and ultimately to bring about effects in the world (Burr, 1995: 63).

2.2.1 Social Constructionism and Gender

According to social constructionists there are many processes that constitute the social construction of gender. Gender is a social institution, it is pervasive, and a central way people everywhere organize their lives. The process of gendering as well as its outcome are authenticated by law, religion, science and society's whole set of values (Lorber, 1994: 113). A constructivist approach to sexuality emphasizes how sexual identities, desires and practices are 'constituted through a complex and unstable fusion of biology, anatomy, intellect and discourses' (Cornwall, Correa & Jolly, 2008: 23). Feminist social constructionists have consistently acknowledged that the content and meaning of gender roles and gendered bodies vary across space and time (Nagel, 2003: 51). Bodies and 'sex' simultaneously produce and are reproduced by social meanings (Butler, 1988, 2004). Butler (1988: 519) argues that gender is an identity constituted in time and is an identity enacted by a 'stylized repetition of acts'. Butler (2004: 52) argues that gender norms are 'reproduced', enforced and presented by bodily practices. A crucial aspect of gender in a heterosexist society is heterosexuality, and thus gender norms also act as a regulatory means for the production and maintenance of hegemonic heterosexuality (Butler, 2004: 55). The body is an instrument of performance and a site of performativity, meaning that gender and sexuality are both performed and performative – conscious and unconscious, intended and unintended, explicit and implicit (Nagel, 2003: 53). These issues will be discussed further in the sections that follow.

2.3 Queer Theory and Sociology

Early sociology of sexualities was normally found within the subfield of 'deviance' but with the sexual liberation movements of the 1970s and 1980s the sociology of sexualities became more interested in sexuality as a basis of community and political life and moved out of the field of 'deviance' (Gamson & Moon, 2004: 47; Stein & Plummer, 1994: 178). A significant

influence of this shift of focus was queer theory, which was particularly evident from the 1990s onwards with its emergence making its mark on academic studies of sexualities (Gamson & Moon, 2004: 48). Queer theory is grounded in poststructuralism and maintains that sexual and other identities are 'arbitrary, unstable and exclusionary', in those 'knowledges and social practices that organize society as a whole by sexualizing' (Siedman, 1996: 11-13 as cited in Gamson and Moon, 2004: 48). Sociologists have consistently considered sex, gender and sexuality as separate variables with discrete attributes which are defined in binary terms. Bodies are either male or female, our gender presentation, behaviour and social roles are either masculine or feminine and finally our sexuality are either heterosexual or homosexual (Valocchi, 2005: 752). Queer theory deconstructs or 'denaturalizes' (Butler, 2004: 42) these very categories. As a result, it has revitalised the study of sexuality by encouraging academics to think of social categories more critically and be more aware that such categories may obscure the very subjects they are intended to name (Green, 2007: 30). Queer theory has managed to close the gap between the ideological constructs of these three concepts and actual lived experiences (Valocchi, 2005: 753). Previously sex was understood to be ascribed by biology (anatomy, hormones and physiology) whereas gender was said to be the cultural inscription of sex (socially created through physiological, cultural and social means) (West & Zimmerman, 1987: 125). Queer theory however, has a different way of understanding sex, gender and sexuality, viewing them as closely related and interlinked (Butler, 1990, 1993, 2004) and engages with sex, gender and sexuality within a discursive understanding of power, where sexual and gender identities are shaped from the designated systems of the dominant sexual and gender taxonomies (Valocchi, 2005: 751). As a result, these taxonomies police identity and social life in general (Ibid., 751).

2.4 Judith Butler on the Performativity of Gender

A key contributor to queer theory is Judith Butler's theory of the performativity of gender. For Butler (2010: 147), gender is performatively established and this calls into question the very idea that there is even such a thing as a 'stable gender' established and completed before the very expressions and activities that we understand as gendered expressions and activities. The performative theory of gender turns on its head the presumption that gender is a fundamental nature of reality that predates its expression (Butler: 2010: 147). Butler (1990: 10), argues that gender is more than just the cultural inscription of meaning on a pregiven sex, it is also the cultural instrument by which 'natural sex' is produced and constituted as prior to culture. In

other words, gender is the very instrument used to put across that 'sex' is just a fact about individuals, an apolitical neutral ground on which culture acts (Butler, 1990: 11). By arguing that there is no sex that is not already gendered, Butler has collapsed the sex/gender distinction (Salih, 2006: 55). However, I think it is important to note that they are not the same thing, but they are closely related. Butler (1990), has managed to show that sex and gender are interlinked, they cannot be understood separately from the social processes and practices that give meaning to these two categories. Saying that gender is performative is saying that it is a type of portrayal, gender is not just something one is rather it is something one does, a sequence of acts that consolidate one's 'gender', it is a verb instead of a noun, a 'doing' instead of a 'being' (Butler, 1990: 33; Salih, 2006: 55). The performativity of gender theory highlights firstly, that gender is not just any kind of process, it is a specific type of process a set of repeated acts within a highly inflexible and prescriptive frame (Butler, 1990; Salih, 2006: 56). Secondly, that there is no gender identity behind the expressions of gender, that identity is performatively constituted by the very expressions that are said to be its results (Butler, 1990: 25; Salih, 2006: 56). Ultimately Butler (2009: 1), is arguing that the 'appearance' of gender is often taken as a mark of its internal or organic truth when in reality gender is driven by obligatory norms to be one gender or the other (ordinarily within a strictly binary frame i.e. male or female – masculine or feminine). Therefore, the reproduction of gender is always a negotiation with power but the reproduction of these norms are always at risk of being undone or redone in new and unexpected ways which allows for the possibility of the reconstitution of gendered reality along new pathways (Butler, 2009: 1). Bodies are not passively scripted with cultural codes, but neither do embodied selves exist prior to the cultural instruments that fundamentally give bodies meaning (Butler, 1988: 52). This point highlights that individuals have the agency to act outside of what they have been told is 'true' albeit within the context of social constraints.

How does the category of 'sex' fit into the relationship between the materiality of the body and the performativity of gender? First and foremost, the matter of sexual difference is raised as an issue of material differences, the difference may be signified by for example, external genitalia. It is important to note however, that according to Butler (1993), the category of 'sex' is from the start normative, it is a 'regulatory ideal' (Butler, 1993). 'Sex' is an ideal construct that is forcibly materialized through time. The problem is that bodies over time never fully comply with the norms by which their materialization is forced because 'sex' is never complete as it changes over time. Markers of sex category depend heavily on cultural circumstances that vary across time, place and social group (Warton, 2005: 21). Furthermore, the fact that there are

individuals who are not born with regular primary sexual characteristics is evidence that the category of sex is an ideal especially considering that intersexed individuals have existed throughout time (Butler, 2004: 53). Even those who supposedly fit neatly into each category do not full comply with their sex category. Annandale & Clark (1996: 27-28), note that there is no absolute distinction between the sexes, only differences on a continuum whose centres are less heavily populated than its peripheral margins. Physicians have to mark sex at birth and use surgical or hormonal interventions to maintain that binary gender is absolute and thus biology is distorted by socio-legal classifications where gender differences are socially created with the suppression of similarities and the exaggeration of differences resulting in the oversimplification of sex and ultimately gender (Annandale & Clark, 1996: 28).

The process of sex assignment highlights Butler's (1990), point, that 'sex' is culturally constructed and that 'sex' itself is a gendered category. One's biological sex is understood in terms of the binary between male and female, and it is through that binary framework that individuals are labelled as either male or female. It is from this label that gender is enforced. 'Sex' therefore, can be understood as the categorization of individuals as either male or female based on socially agreed upon biological characteristics. The category of male or female then enforces a particular gender on an individual. The construct of 'gender' then leads to certain cultural inscriptions for that individual, where there are different rules for those that are labelled according to the sex category 'male' or 'female' which facilitates the assignment of values, judgments and beliefs on how men and womxn should behave. In other words, a sex category becomes a gender status through naming, dress and other gender markers (Lorber, 1994: 112). Gender thus can be understood as a representation that an (already) sexually differentiated body assumes, but even this representation only exists in relation to another opposing representation (Butler, 1990: 13).

2.5 The 'Heterosexual Matrix': Sexuality

Butler (1988: 524), argues that a way in which the system of compulsory heterosexuality, the 'heterosexualisation of desire' (Butler, 1990: 23), is reproduced and legitimated is through the creation of bodies into distinct sexes with 'natural' appearances and 'natural' heterosexual inclinations. The result is the claim, according to compulsory heterosexuality, that 'sex' is 'a cause' of sexual experience, behaviour and desire (Butler, 1990: 31). The institution of a mandatory and naturalized heterosexuality stipulates and organizes gender as a binary relation where masculine is differentiated from feminine and this differentiation is achieved through

the practices of heterosexual desire (Butler, 1990: 30). This shows that gender identity and sexuality are both constructed in heterosexual terms within a 'heterosexual matrix'. Queer theory has separated sexuality from gender, so that to have a gender does not mean that an individual engages in sexual practice in a specific way or that to engage in a given sexual practice does not mean that an individual is a given gender (Butler, 2004: 54). Related to this, queer theory has also argued that gender is not reducible to hierarchical heterosexuality (Butler, 2004: 54).

Sex, gender and sexuality are important because they are central to understanding the ways in which sexual practices, identities and desires are everywhere rooted within non-sexual social relations (Jackson, 2006: 107). Sexuality is not only ordered by gender but by other social identities and relations and therefore, sexuality is not reducible to gender (Jackson, 2006: 107). Sociologists have tended to examine homosexual identities and communities in self-contradictory ways that overlook the social construction of heterosexuality. Queer theory on the other hand, examines the relations between homosexuality and heterosexuality. In doing so, queer theory has the ability to provide important insights that can inform a sociological approach to sexuality that emphasizes the reproductive character of all sexual identities (Namaste, 1994: 220). Queer theorists have noted that heterosexuality is more than a form of sexual expression, it is a significant site where sex, gender and sexuality intersect but more than that it reveals the interconnections between the sexual and non-sexual aspects of life (Jackson, 2006: 107). Heterosexuality is a gendered relationship that orders both sexual life and domestic and extra-domestic divisions of labour and resources (Jackson, 2006: 107). Heterosexuality excludes, marginalizes and prohibits other sexualities to legitimize itself (Butler, 1990: 98), however it is crucial to note that within this perspective heterosexuality is not understood purely in terms of heterosexual sexuality. Heterosexuality is understood as heteronormativity where heteronormativity defines not only a normal sexual practice but also a normal way of life (Jackson, 2006: 107). Heteronormativity is a central organising principle of society where instutionalized heterosexuality is linked to the gender division of labour and patriarchal relations of production (Ingraham, 1994: 204). With this said, Donaldson (2015: 132) notes that 'heteronormativity' also refers to the way in which gender ideologies are constructed to position heterosexuality as 'natural' while sexualities that fall outside of heterosexuality are rendered 'other' and thus abnormal. Furthermore, the implication of heteronormativity is that all 'other' identities are measured against heteronormative standards

with those who do not conform deemed abnormal or amoral and sometimes in need of correction (Donaldson, 2015: 132).

2.6 Intersectionality

As has been pointed out by many academic scholars, the traditional feminist concept of patriarchy (i.e. gender inequality) has constructed a homogenizing concept of gender oppression that simplifies and depicts a shared experience of patriarchy for all womxn (Carbado, Crenshaw, May & Tomlinson, 2013: 303; Lugones, 2016: 18; Nash, 2008: 2,). Furthermore, using a standardized category of 'womxn' renders womxn ahistorically to a status of gender identity, without acknowledging other factors which have determined their identity such as class, race and sexuality (Aguinaga, Lang, Mokrani & Santillana, 2013: 47). In the late 1980s 'intersectionality' was introduced as an interrogative term to focus on the contentious dynamics of differences and the solidarities of sameness in the context of antidiscrimination and social movements politics (Cho, Crenshaw & McCall, 2013: 787). The notion of intersectionality – rooted in Black feminism and critical race theory – is a method, an analytical tool, that can be used to engage in 'issues, social identities, power dynamics, legal and political systems and discursive structures in societies' (Carbado *et al*, 2013: 304). The term was first introduced by Kimberlé Crenshaw in 1989 in an essay that addressed the marginalization of Black womxn within antidiscrimination law and feminist and antiracist theory and politics (Carbado *et al*, 2013: 303; Crenshaw, 1989). Crenshaw (1989: 140), uses examples of race discrimination cases and gender discrimination cases to illustrate that dominant conceptions of oppression along a single categorial axis result in the elimination of Black womxn in the formulation, identification and restitution of race and gender discrimination (Walby, Armstrong & Strid, 2012: 226). The consequence of this is that in terms of race discrimination, it tends to be examined in terms of sex or class privileged Black individuals (Black men). At the same time the focus of gender discrimination has largely been on race and class privileged womxn (white middle-class womxn) (Carbin & Edenheim, 2013: 3).

Crenshaw (1989; 1991: 1241) has pointed out that although racism and sexism intersect in the lives of real people they rarely do in feminist and antiracist discourses. Traditional feminism has taken a one-dimensional experience of white cisgender heterosexual womxn (white womxn themselves do not share one experience of oppression and under this understanding local context is also ignored) and normalised it as the experience of all womxn. By doing this,

traditional feminism has ignored key aspects of the experience of womxn who do not fit into the above category and has erased the nature of the oppression experienced by these womxn, making traditional feminism exclusive and simplistic. Furthermore, traditional feminism has not sought to investigate the ways in which white womxn are oppressive to other groups of people and womxn as well as the ways in which they hold certain privileges that other groups of womxn do not. This hegemonic view of gender oppression has led to a one-dimensional analysis of gender oppression that has taken the most privileged group of womxn as the norm. Single-axis thinking undermines disciplinary knowledge production, legal thinking and social justice which further limits the understanding of our social environments and feminist thinking (Cho *et al*, 2013: 787).

Intersectionality has exposed the intersection of race and gender and in doing so, has exposed intragroup differences (Nash, 2008: 2). The result has been the destabilization of the race and gender binary. Intersectionality is a useful analytical tool that is capable of capturing and theorizing the simultaneity of race and gender as social processes. Intersectionality is not limited to only analysing the above two axes of power because the examination of the dynamics of difference and sameness amongst groups of people has allowed for the consideration of other axes of power such as sexuality, class and nationality (Cho *et al*, 2013: 787; Nash, 2008: 2; Walby *et al*, 2012: 224-225). Intersectionality shows that axes of power are closely interlinked and interconnected, and they need to be studied in relation to each other, viewing them as a 'matrix of domination' (Collins, 1990 cited in Choo & Feree, 2010: 129; Purkayastha, 2012: 55; Walby *et al*, 2012: 224-225; Winkler & Degele, 2011: 53). The key contribution of intersectionality as an analytical tool is its ability to show the multidimensionality of individuals' lived experiences (Nash, 2008: 2). Because of this, intersectionality is able to adequately capture intragroup differences based on a number of axes of power resulting in a much more comprehensive explanation of social phenomenon. Lykkes (2011, as cited in Cho *et al*, 2013: 788), notes that intersectionality is a nodal point as opposed to a closed system, it is a gathering place for open-ended investigations of the overlapping and conflicting dynamics of race, gender, class, sexuality, nation and other inequalities.

2.6.1 Intersectionality and this Study

This study focuses exclusively on young adult white womxn and some may argue that this is not intersectional because the study does not give a voice to marginalized womxn. Cho *et al*, (2013: 798) have termed this kind of critique as the 'what about white men question' arguing

that any study can use an intersectional lens to acknowledge and analyse intragroup differences and similarities because intersectionality is an engagement with power (Ibid., 798). In this study I have specifically chosen to exclusively focus on white womxn for two reasons. The first being that as will be shown in later chapters there is limited sex-related research on white womxn, and whites in general, in South Africa. As a result, very little is known about the white demographic's sexual behaviours and practices. However due to time and space constraints I have limited the study to white womxn. Secondly, as noted by Choo & Feree (2010: 133), including difference often replaces an inherent norm of whiteness which and often includes 'nonnormative' groups in a comparative analysis that replicates the idea that the dominant group is the standard. Considering the position that I hold as a white womxn, I did not want to include womxn of colour in this study because this study would then create a dichotomy between black and white which could potentially reproduce hegemonic discourses of femininity that are very much based on whiteness as the norm. Adding to this intersectionality also calls for a more critical analysis of the cases defined as 'normative', which is another justification for why I have chosen to use this particular analytical lens for my study.

2.7 Queer Theory and Intersectionality

Queer insights such as Butler's are useful in rethinking sex, gender and sexuality because they have tasked sociologists to refocus their analytical lenses, paying closer attention to the production of sexual identities and acknowledge the pervasive effect of heteronormativity as a critical organizing principle throughout the social order (Gamson & Moon, 2004:48). It is for this reason that this study's main theoretical framework is taken from queer insights such as Butler, in conjunction with the sociology of sexualities. Butler (1990: 6) recognises that gender intersects with racial, class, ethnic, sexual and regional modalities of discursively constituted identities and therefore it is impossible to separate out gender from the political and cultural intersections in which it is produced and maintained. In fact, queer theory has long recognised the need for a consideration of multiple points of oppression to the study of social phenomenon. Queer theory's key contribution to intersectionality is that it has brought a focus to sexuality as a category of intersection. With this said, Cohen (1997: 438 as cited in Gamson & Moon, 2004: 52) notes that queer theory has often reinforced dichotomies between heterosexuality and everything 'queer' while at the same time ignoring differences of race class and gender. Furthermore, the problem with many sociologists of sexuality has been that while they have adequately attended to the intersections of sexuality and gender, they have tended to treat race

and class as secondary variables and thus have not contributed to their general understandings of sexuality (Gamson & Moon, 2004: 52). This is why it is important to use intersectionality as an analytical tool so that other variables of oppression can be taken into serious consideration and thus a stronger analysis can be brought forward in understanding sex, gender and sexuality.

2.8 Conclusion

The chapter began with an outline of social constructionism which argues that knowledge is constructed. I argued that within this framework it is possible to recognise both the material and the discursive – agency as well as social constraints. In this chapter it was also shown that queer theory denaturalises the categories of sex, gender and sexuality and challenges sociology to think more critically of these categories. Butler's theory of performativity has been very insightful because, accordingly, gender is more than just the cultural inscription of meaning on a pregiven sex, it is the very instrument used to construct 'natural sex' as prior to culture. Furthermore, by saying that gender is performatively established, Butler is saying that gender is not something that one is but rather is something that one does. It is a sequence of acts that consolidates one's 'gender'. Linked to this is what Butler refers to as the 'heterosexual matrix' where heteronormativity constructs heterosexuality as 'natural'. As demonstrated in this chapter, intersectionality is able to capture the multidimensionality of individuals' lived experiences by highlighting intragroup differences along a number of axes of power such as ethnicity, class and nation. The key purpose of this research is to investigate the ways in which gender and sexuality are performatively established amongst participants and that is why queer theory has been used. As has been mentioned, important to individuals' identities are other factors such as race, class and nation and the use of intersectionality as an analytical tool is to bridge that gap.

CHAPTER 3: SEXUALITY IN SOUTH AFRICA

3.1 Introduction

The previous chapter outlined the theoretical framework of this study and this chapter will provide the context within which this study fits. This chapter will highlight that there has been limited sex-related research on whites in general in South Africa. As a result, very little is known about the white demographic's sex-related behaviour, which is where this research fits in. Throughout this paper I will argue that focusing on this demographic is important for two main reasons: the HIV epidemic in South Africa as well as the extremely high rates of gender-based violence in South Africa. The chapter is divided into a number of sections; the chapter will begin with a discussion of sexuality in South Africa in particular during apartheid. The section that follows will discuss gender and the rampant gender-based violence that exists in contemporary South Africa which will lead to a discussion of the HIV/AIDS epidemic in South Africa. The chapter will conclude with a discussion of thirty-six sex-related studies I reviewed that have been conducted in South Africa.

3.2 Race, Gender and Sexuality: Key Sites of Control

To understand the current context in South Africa with regards to gender relations, I need to briefly discuss how colonialism has shaped much of the current ways in which sex and gender have been constructed. Sexualities were highly controlled in the making and development of white identities and society and in South Africa the state created and harnessed a particular idea of sexual morality to the construction of 'whiteness' (Ratele, 2009: 169). Sex in the colonies both divided as well as united people, laws were passed to keep white settlers separated from black colonial subjects. Because intimacy disintegrated the racial hierarchy and sealed the social space that colonial laws tried to produce and maintain, these laws were strictest on relationships of intimacy (Bhana, Morrell, Hearn & Moletsane, 2007: 132). A significant fear was miscegenation, from the Latin miscere (to mix) and genus (race) (Sussman, 2019). 'Racial contamination' was a key concern, in 1917 the Prime minister Jan Smuts stated that there must be 'no intermixture of blood between two colours' and in 1927 J.B. Herzog's government passed the Immorality Act which banned sexual contact or relations across racial groups (Reynolds, 2006: 76).

In 1950 the apartheid government passed the Immorality Amendment Act which can be viewed as the reinforcement of the meaning of South African whiteness which came to mean that it was morally, sexually and racially distinct from other groups (Ratele, 2009: 170). The apartheid government, an authoritarian and a government which claimed to be driven by Christian principles, historically reinforced ideologies of patriarchy which in turn extensively dictated the parameters of sexual relations. These principles of Christian fundamentalism resulted in sexually restrictive legislative policy, and the Immorality Amendment Act also served as an important tool in regulating sexual relations between unmarried people. For example, there were laws that prohibited adultery including the earlier Immorality Act where 'illicit carnal intercourse' was forbidden which was defined as 'carnal intercourse other than between husband and wife' (Ratele, 2009: 169). With this said, more important to the government was the prohibition of sexual relations between 'whites' and 'non-whites' (Ratele, 2009: 170). The Act was intimately linked with the process of racial classification (Ibid., 2009: 170), which highlights the intersection between race and sexuality and how both of these were key sites of control for the apartheid state. The Act played a significant role in reinforcing 'whiteness' where white was understood to be not only racially but also morally and sexually distinct and superior to other racial groups (Ratele, 2009: 170). Furthermore, the laws did not bear the same consequences for all people even amongst whites because apartheid was a patriarchal system, according to which white womxn were viewed as bringing more shame than white men if they engaged in sexual or intimate relations with those from other racial groups (Ratele, 2009: 172). Linked to this, this legislation created and reproduced a hyper-masculine white male identity and a soft, subordinate white femininity (Ibid., 172). It is important to note however, that white womxn still held structural white privilege as a result of apartheid and were not necessarily innocent bystanders (Holland-Muter, 1995: 56). White womxn themselves still did and had the ability to subordinate and oppress other people (in particular people of colour) as a result of their structural position (Ibid., 57). The above discussion illustrates the ways in which gender and race intersect, white men were placed and treated as superior to all, even white womxn, while at the same time white womxn held racial structural power over other racial groups. This highlights the hierarchy enforced by the apartheid government where white men were put on a pedestal and held the highest position in the hierarchy and white womxn were relatively far up the hierarchy even with the oppression they faced as womxn. This again shows the intersection of race, gender and sexuality which indicates further that sexuality and gender too were very much important sites of control for the racist, patriarchal and nationalist government.

The apartheid state subjected sex and sexuality to heavy censorship and repressive policing (Posel, 2005: 128). There were massive regulations and prohibitions to control the practice of sex as well as its public representations. For example, legislation forbade any media from displaying explicit depictions of sex or 'sex talk' and pornography was prohibited (Ibid., 128). The apartheid regime was also inherently heterosexist, the system prescribed particular forms of sexuality and not only criminalised sex between people of different skin colour but also criminalised sex between those of the same sex (Epstein & Morrell, 2012: 473). This all has impacted the ways in which sexual identities are currently constructed and performed. I say performed as well because as noted previously, gender is performative, it is not a mere fact about individuals, it is consistently produced and reproduced, both conscious and unconscious.

3.3 The Gender War in South Africa

South Africa has one of the highest rates of sexual violence in the world, and South Africa's high rates of sexual violence against children and womxn coupled with the failure of the criminal justice system and health systems to respond to the crises indicates that there is an unacknowledged 'gender war', a 'state of emergency' (Peacock *et al*, 2006: 73). Due to racial inequalities that have continued in South Africa after the end of Apartheid, there are major inequalities between different groups of womxn in particular between black and white womxn. Before discussing the gender war, I think it is important to first define Gender Based Violence (GBV) to allow for a better understanding of the situation in South Africa. GBV is defined as violence directed against an individual or group on the grounds of their gender (Stats SA, 2017; EIGE, 2019). The majority of victims of GBV are womxn and girls and most GBV inflicted on womxn and girls are carried out by men (EIGE, 2019; Safer Spaces, 2019). This reflects that there are a disproportionate number of particular crimes inflicted against womxn and girls. It is because of this that in many instances when there is a discussion of GBV the term is used interchangeably with the term violence against womxn (VAW). Safer Spaces (2019), notes that most acts of interpersonal GBV are committed by men against womxn and that the men perpetrating violence are commonly known by the womxn. Violence against individuals who form part of the LGBTQIA+ community can also be categorised as GBV as often times they have violence inflicted on them for not conforming to assigned gender roles. There are many manifestations of GBV which include sexual harassment, stalking, intimate partner violence (IPV), domestic violence, sexual violence and rape (Berkowitz, 2004: 2; Britton, 2006: 149;

Safer Spaces, 2019). Population-based surveys in South Africa show that the most common form of VAW is IPV (Safer Spaces, 2019). IPV includes physical, sexual and emotional abuse and controlling behaviour by a current or former intimate partner or spouse which occurs in heterosexual relationships and same-sex relationships. The second most common form of VAW is sexual violence which refers to 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality by using coercion, by any person regardless of their relationship to the victim, in any setting including but not limited to home and work' (Safer Spaces, 2019). Rape is an act of sexual violence but rape itself is defined as 'all forms of sexual penetration without consent irrespective of gender' (Safer Spaces, 2019).

Morrell (2003: 46) argues that South Africa is an extremely violent country, and this is largely as a result of the gender relations that emerged under colonialism and apartheid which found expression in violent forms of masculinity. The manifestation of societal power relations namely, gender inequality is VAW (Crooks, Goodall, Hughes, Jaffe & Baker, 2007: 219) and it has been shown that South Africa has the highest per capita rate of reported rape in the world (Peacock *et al*, 2006: 73). Stats SA (2017: 6), reported that violent crimes against womxn increased dramatically between 2015/16 and 2016/17. Over 39 000 cases of rape were reported to the police between April 2016 and March 2017 however it is believed that cases of rape are grossly under-reported (Amnesty International, 2019). Accurate statistics of GBV are difficult to obtain, one of the key reasons being that most incidents are not reported.

Kaufman (2001: 10) notes that children are socialised into expectations of behaviour by broader society at a young age and gender expectations of boys tend to emphasize control through aggression. Consequently, when it comes to conflict and violence the ability to dominate becomes a display of 'manhood' (Kaufman, 2001: 10). Flood (2011: 359) argues that constructions of masculinity play a significant role in shaping VAW at multiple levels: individual, family and relationships, community and society as a whole. The author illustrates that studies have found that men's adherence to patriarchal, sexist and sexually hostile attitudes are an important indicator for perpetrating VAW. Male dominance is also a key predictor where male economic and decision-making dominance in the family is one of the strongest predictors of high levels of VAW (Flood, 2011: 359). Another factor shaping VAW is gender attitudes. Kalichman *et al*, (2007:25) found that men with a history of perpetrating sexual assault were significantly more likely to endorse hostile attitudes towards womxn and beliefs that VAW can

be justified. According to Wood, Lamber & Jewkes (2007: 278), public health research indicates that the most widespread forms of sexual coercion and violence experienced by womxn occur within their sexual partnerships. For example, Abrahams, Jewkes, Hoffman & Laubscher (2004: 335) conducted a study in Cape Town and found that sexual violence in intimate relationships was a common occurrence amongst the group of men in their study. It is important to note that white men were included in the study. They found that predictors of men perpetrating sexual violence were associated with the use of violence and to solve problems in other settings, having more than one current partner, alcohol abuse and verbally abusing a partner. Conflict was associated as a predictor however only two types of conflicts were predictors - conflict over sexual refusal and conflict when men perceived their authority to be undermined (Abrahams *et al*, 2004: 335). They concluded that conflict associated with predictors stemmed from ideas of male entitlement and authority and these results support the argument put forward by Flood (2011). In another study it was found that young womxn who had their first sexual experience at an early age were more likely compared to other womxn to report that their first partner had physically forced them into non-consensual sex (Pettifor, O'Brien, MacPhail, Miller & Rees, 2009: 87). Furthermore, that young womxn were more likely than young men to report that their first partner had physically forced them to have sex (Ibid., 87). The authors noted that their finding was consistent with results of studies conducted in other African countries and that the number of womxn who reported non-consensual sex were consistent with life-time prevalence of non-consensual sex in other South African studies (Pettifor *et al*, 2009: 87). An issue that was mentioned previously is that the number of reported sexual assaults may not be accurate, as mentioned by Pettifor *et al*, (2009: 87), due to the sensitive nature of sexual assault, the true prevalence of non-consensual sex is most likely higher than reported by participants.

A crucial point is made by Peacock *et al*, (2006: 78) that to challenge men's VAW in South Africa requires a shift in representations of men's violence. These representations need to go beyond standard racist stereotypes of VAW. Generally, the stories of domestic and sexual violence that gain the most media coverage are stories of black men's violence. Furthermore, there is very little media coverage or academic analysis of white men's violence (Ibid., 78). This implies then that white men raping is perceived as far less of a problem A key method to challenge these racist representations is to acknowledge VAW within white communities (Peacock *et al*, 2006: 78). The dominant discourse surrounding rape as has been highlighted above further highlights the importance of adopting an intersectional lens because GBV is a

problem faced by all communities within South Africa. Framing GBV through racist depictions implies that GBV for the most part is a problem for certain communities which ultimately implies that rape is predominantly perpetrated by certain men.

3.4 HIV/AIDS and Gender

Human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) pose a serious threat to the development of a country. HIV/AIDS lead to serious psychological, social, economic and educational problems for individuals (Hartell, 2005: 171). South Africa has the largest HIV epidemic in the world with 14% of the population being HIV positive which is approximately 7.9 million people (HSRC, 2012: xxix). Gender inequality and vulnerability to HIV/AIDS are inextricably linked, and VAW plays a significant role in the transmission of HIV/AIDS and those who are more at risk. Therefore, ending violence against womxn is crucial to the controlling of the epidemic (Bhana & Pillay, 2011: 67; Kalichman *et al*, 2007: 20; Kaufman, Schefer, Crawford, Simbayi & Kalichman, 2008: 434; Mantell, Needham, Smit, Hoffman, Cebekhulu, Adams-Skinner, Exner, Mabude, Beksinska, Stein, & Milford,2009: 142; Peacock & Levack, 2004: 174; Tallis, 2000: 58; Wood *et al*, 2007: 227).

There are many factors that contribute towards the link between gender inequalities and HIV/AIDS infection. One such link is highlighted in the findings of a study conducted in Cape Town among 309 men, where negative attitudes towards womxn were positively associated with a high level of HIV risk behaviour (Kaufman *et al*, 2008: 439). Another study found that men with a history of sexual assault reported significantly higher HIV risk sexual practices than men who had not been sexually assaultive (Kalichman *et al*, 2007:24). Furthermore, that men who had sexually assaulted a womxn were much more likely to have had multiple sex partners without consistently using condoms (Ibid., 24). Because gender inequalities affect individuals' vulnerability to HIV/AIDS they are the main problem impeding HIV/AIDS prevention. HIV/AIDS prevention programmes however tend to overlook gender (Tallis, 2000: 58). It is critical to change practices that disempower womxn, part of this is by not only focusing on womxn with regards to HIV/AIDS prevention because the burden of HIV/AIDS is placed on womxn which often fuels the perception that womxn are to blame (Tallis, 2000: 65). HIV prevalence is particularly high for young womxn between the ages of 15 and 24 (Bhana & Pillay, 2011: 67). The fifth wave of the South African National Prevalence, Incidence, Behaviour and Communication survey conducted by the Human Science Research Council

(HSRC, 2017), found that HIV prevalence among womxn between the ages of 15 and 24 was more than double that of men within the same age group. The percentages were 10.9% and 4.8% respectively (HSRC, 2017: 53). HIV prevalence among 20 to 24-year olds was more than three times higher among womxn (15.6%) than men (4.8%) (Ibid., 53).

3.5 HIV/AIDS and Race

The social construction of HIV/AIDS has had a large impact in the way in which the pandemic is viewed and who is perceived to be at risk (Brown *et al*, 2010: 442). The social construction of the epidemic has had a significant consequence on interventions (Brown *et al*, 2010:442), but more importantly it has informed much of the research on HIV/AIDS. This is evident in the abundance of literature that focuses solely on those that are perceived to be at-risk groups such as black and coloured South Africans. It is important to highlight the way in which the crisis has been socially constructed, as this has a significant impact on people's perceptions surrounding HIV/AIDS including HIV risk as well as their behaviour. According to Fassin & Schneider (2003:496), the first appearance of HIV/AIDS in South Africa was immediately interpreted in racist terms. Some white leaders evoked a supposed African 'promiscuity' and publicly declared the danger that infected black people posed to the nation (Fassin & Schneider, 2003: 496). Furthermore, in 1992 a white public leader who was a member of parliament publicly rejoiced over the possible elimination of black people by HIV/AIDS (Ibid., 496). Brown *et al*, (2010: 444) argue that this is indicative of social construction by stating that at the beginning of the pandemic, HIV/AIDS was constructed as an 'African disease', which is characteristic of how it is presently constructed - as an illness of poor, black communities. The sweeping representations of Africans as a diseased population and overtly sexualised bodies has further led to such perceptions (Hodes, 2007:158). In their study, Connelly & Macleod (2003) explored the discourse of war against HIV/AIDS that was evident in the *Daily Dispatch* (a South African daily newspaper), from 1985 to 2000. They found that the diseased body was positioned as the 'other', as a dangerous force and this took on racialised overtones. For example, in the 2000 articles that were analysed no direct references were made about HIV/AIDS affecting particular race groups. Nevertheless, the diseased body became the poor body, with the accompanying association with 'Black' people (Connelly & Macleod, 2003: 68).

Hodes' (2007) study of HIV/AIDS in South African documentary films of 1990 to 2000 highlighted that racism and homophobia were predominantly evident in the documentaries under review. The prejudicial and stigmatizing images present in many of these documentaries resonated with the reactions of the apartheid state in the beginning years of the pandemic. A large proportion of these documentaries involved elements of bias, relied on stigmatising stereotypes and perpetuated misrepresentations. The films implicated perceived risk groups rather than risk behaviours in the spread of the pandemic which has had a significant impact on the way that the pandemic is viewed (Hodes, 2007:171). This has further perpetrated the misconception that HIV/AIDS is an illness of poor black communities and fuels the interpretation of HIV/AIDS in racial terms.

In 2017 7.9 million people in South Africa were living with HIV which is approximately 14% of the population. The numbers are higher than the previous surveys: 10.6% in 2008 and 12.6% in 2012 and the results from the 2017 survey indicate that there is a consistent trend of HIV prevalence increasing over time (HSRC, 2017: 47). This trend is also true for race except among Indian/Asians. Amongst whites, HIV prevalence more than tripled since 2012 where HIV prevalence was 0.3% and 1.1% in 2017 (Ibid., xxxi). The HSRC (2017: 43) notes that because only 42.3% of white participants agreed to HIV testing the prevalence estimates are not completely accurate and as a result the estimates for the white population need to be interpreted with caution due to the relatively small sample size. The low participation rates for this group were observed in the previous four HIV surveys and participation among whites remained an issue in the 2017 HIV survey. As a result, the current data from the HIV testing part of the survey could not be interpreted with confidence (HSRC, 2017: 150-151). The HSRC linked their refusal to participate in the HIV survey to the perception that HIV is not a problem in their particular communities as an influence on their decision, and further, that their lack of participation may increase the perception that whites are rarely affected by HIV/AIDS and therefore, do not need targeted interventions which creates a false sense of security (Ibid., 151). As noted by the HSRC (2017: 151), this may be realistic at the present, however could become dangerous in the near future as new communities find themselves bearing a heavy burden of HIV/AIDS. Although the results from both the 2012 and 2017 HIV surveys with regards to HIV prevalence estimates for the white group cannot be interpreted with confidence it is still significant that since 2012 their HIV prevalence estimates more than tripled and points to the need for more research into this demographic as very little in known about this population group.

3.6 Sex-Related Research in South Africa

To support my argument that there is very little sex-related research on the white demographic in South Africa, I reviewed demographic variables (in particular ethnicity) of participants of sex-related studies that have been conducted in South Africa. Because much of the sex-related research in South Africa has been conducted in informal settlements it is important to first briefly describe and discuss informal settlements. The Department of Human Settlements defines an informal settlement based on five characteristics; illegality and informality, inappropriate locations, restricted public and private sector investment, poverty and vulnerability, and social stress (SERI, 2018). Apartheid-era forced evictions and race-based town planning resulted in South Africans of colour to live in informal settlements on the outskirts of the cities (SERI, 2018: 14). The fact is that the post-apartheid state has failed to address the legacy of apartheid spatial planning as well as the fact that poverty is still split amongst racial lines, the majority of those living in informal settlements continue to be people of colour: black, coloured and Indian/Asian people. Epstein & Morrell, 2012: 472; SERI, 2018: 15). The relevance of this discussion is that it is fair to assume that participants recruited from informal settlements are most likely people of colour which further supports my claim that there is very little sex-related research on the white demographic in South Africa.

In total I reviewed thirty-six studies (1997-2019)[2] and discovered a pattern. Firstly, nineteen (52.8%) studies were focused on HIV/AIDS. This is not surprising due to South Africa having the largest HIV epidemic in the world. Secondly, seventeen (47.2%) of these took place either in informal settlements or participants were recruited from informal settlements. Approximately twelve (33.3%) did not explicitly state the racial makeup of the study and thus I needed to deduce and make certain assumptions based on a number of factors including: language data was collected in, areas that the study took place (many took place or recruited from informal settlements) including the racial makeup of these areas in general, pseudonyms that were used (one study used only Black African names for participants and recruited participants from informal settlements). Of these based on the above factors and other information given the majority of participants of eight (66.7%) studies were Black African, in two (16.7%) studies there was a mix (not including whites), one (8.3%) study had only Black African participants and there was one (8.3%) study that I could not deduce the racial makeup of the sample. Thus, when looking at all the studies together, ten (27.8%) studies comprised

[2] See appendix 1 for a list of all the studies reviewed

only Black African participants, ten (27.8%) studies consisted of a majority of Black African participants, five (13.9%), studies comprised of a mix (these did not include white participants), ten (27.8%) studies consisted of a mix which included white participants, and one (2.8%) study it was not possible to deduce the racial composition of the sample. The total where there was a large majority of Black African participants (adding the totals of Black African only and majority Black African), was twenty studies (55.6%). None of the studies focused on the white demographic alone and those that did include white participants, had a very small sample of white participants. This further supports my claim that very little is known about the white demographic in South Africa in terms of sexual behaviours and practices. This trend is of course understandable given that white South Africans only makeup 8% of the population (Stats SA, 2017). With this said, as I have mentioned previously there has been a racial construction of HIV/AIDS and studies that focus on 'poor' black communities play into racist ideologies that purport HIV/AIDS as an issue of poor 'black' communities. The table below provides a visual representation of the way the studies have been broken down.

N=36	**HIV/AIDS**	**Informal settlements**	**Majority Black African and Black African only**	**Black African only**	**Majority Black African**	**Mix**	**Mix that included Whites**	**Unknown**
Total	19	17	20	10	10	5	10	1
Percentage	47.2%	52.8%	55.6%	27.8%	27.8%	13.9%	27.8%	2.8%

The review is not exhaustive, however it is still a comprehensive review of all the sex-related studies conducted in South Africa that I could find over the last eight months. My review of sex-related research in South Africa suggests that there is very little research on the white demographic in South Africa and that there is no research that solely focuses on the white demographic, as a result very little is known about the white demographic with regards to HIV prevalence rates, sexual behaviours and practices and highlights the need for sex-related research on the white population. The review exhibits a gap in sex-related research in South Africa which justifies the current study and why more research like this is important.

3.7 Conclusion

This chapter attempted to provide the context within which this study fits in. Colonialism as well as apartheid shaped much of South Africa's race and gender relations and laws were put in place to keep individuals in their 'raced' and 'gendered' place. Laws were also put in place to prohibit sexual or intimate relationships across racial lines and to prohibit relations between people of the same sex. It was highlighted that sexualities were controlled in the creation and development of South African whiteness, where this came to be constructed as morally, sexually and racially distinct. Furthermore, that the project of whiteness privileged white males over all other sex-race groups. White womxn held structural racial power while at the same time experienced gender oppression as they were viewed as inferior to their male counterparts. South Africa continues to be a patriarchal society and little progress has been made in addressing gender inequality. GBV is rampant in South Africa which has the highest per capita of reported rape in the world. GBV is intimately linked to another epidemic facing South Africa; namely HIV/AIDS because GBV places womxn at a higher risk of HIV infection. Both GBV and HIV/AIDS have been socially constructed in racist terms which perpetuates the misconception that these are problems that only affecting certain communities mostly poor Black communities. The last section of the chapter reviewed thirty-six sex-related studies conducted in South Africa and highlighted that there is very little research on the white demographic and thus very little is known about the sexual behaviours of white people in South Africa. This further justifies the current study and its importance. Focusing on the white demographic is important for two main reasons: the HIV epidemic in South Africa as well as the extremely high rates of gender-based violence in South Africa. Furthermore, HIV/AIDS, although often constructed as a problem only affecting 'poor Black communities', is an issue that affects all communities which is especially true for people between the ages of 15 and 24 years (noted as the age groups with the highest rates of HIV incidence and prevalence).

CHAPTER 4: SEX EDUCATION

4.1 Introduction

The previous chapter set up the context within which this study takes place. As stated previously in this study, the term *sex education* refers to both sexual education and sexual socialisation more generally. Therefore, it is important to define and discuss sexual socialisation and sexual education so as to clarify what this study means when using the term *sex education*. This will be the starting point of the chapter. In South Africa HIV/AIDS and sexuality are key content learning areas in Life Orientation (LO) and are part of formal sex education. The sections that follow will examine formal sex education in South Africa and the challenges and barriers surrounding it. Because informal sex education also plays a significant role in the sex education of individuals, the final section will discuss the sources of informal sex education which include parents, peers and the media.

4.2 Sexual Socialisation, Sexual Education and Sex Education

Sexuality is an essential part of human life and sexual health is intimately linked to physical and mental health (Shtarkshall *et al*, 2007: 116). Through the process of socialisation an individual acquires an understanding of ideas, beliefs and values, shared cultural symbols, meanings and codes of conduct (Shtarkshally *et al*, 2007: 116). Sexual socialisation refers to the process through which beliefs, attitudes and expectations about sexuality and sexual relationships are conveyed to individuals by multiple socializing agents such as parents, the media and broader social processes such as family relations and religion (Ballard & Morris, 1998, cited in Day, 2010: 3; Shtarkshall *et al*, 2007: 116; Spanier, 1977: 87-89). The process of sexual socialisation is a long-term one beginning for each individual from birth and is a process that continues for individuals throughout their lives (Fox, 1980: 22). Physical differences between males and females as well as parents' responses to the ways in which children use sexual language help shape children's awareness of sexuality (Shtarkshally *et al*, 2007: 116). Sexual socialisation also takes place outside of the home as children and adolescents observe community norms, consume mass media and participate in cultural and religious activities (Shtarkshally *et al*, 2007: 116). Schools play a significant role in sex education, as noted by Epstein & Morrell (2012: 474), they are a place where femininities and masculinities are constructed, enacted, reproduced and contested. As shown by Bhana & Pillay's (2011) study of girls in a single-sex school, there is a social complexity in the

construction of alternate forms of femininity that go beyond passive femininity. Alternate forms of femininity are based on both physical and verbal contestation and are linked to sexuality, race and ethnicity. This study highlights the intersection of other categories to the formation and reproduction of an individual's form of femininity. Furthermore, it highlights that although there may be certain social constructions of 'what it is to be a 'womxn' or 'girl', individuals themselves are still able to contest such notions and perform their gender in a variety of ways. In this study the term *sex education* refers to both sexual socialisation and sexual education within formal institutions such as school.

4.3 Formal Sex Education in South Africa

Formal sex education is the foundation on which most HIV and AIDS prevention programmes lie, and with the high rates of HIV/AIDS prevalence and incidence amongst 14 - 24-year olds the urgent need of sex education in South Africa has been reinforced (Francis, 2010: 314). Thus, with regards to policy, HIV/AIDS and sexuality are a significant content area in Life Orientation (LO) a programme introduced as a learning area in South African schools post-1994 with the transition of the education policy to Outcomes-Based Education (OBE) (Francis, 2010: 314; Helleve, Flisher, Onya, Mukoma & Klepp, 2009: 191). Life Orientation (LO), is defined as the 'study of the self in relation to others and to society'. According to the Curriculum and Assessment Policy Statements (CAPS) for LO (DoE, 2012c: 9; DoE, 2012d: 9), the subject focuses on knowledge and emphasises the importance of the application of skills and values in real-life situations, participation in physical activities, community organisations and initiatives. LO is one of the four fundamental subjects required for the National Senior Certificate which means it is compulsory for all students (in both public and private schools) from Grades 7 to 12 (DoE, 2012c: 9; DoE, 2012d: 9). A specific aim of LO stated in the CAPS document is to, 'guide learners to make informed and responsible decisions about their own health and well-being and the health and well-being of others' (DoE, 2012c: 10; DoE, 2012d: 10). Subject areas identified by the Department of Basic Education (2012d) in its CAPS document for Grades 10 to 12 include power relations, gender inequality, gender roles, relationships, differences between men and womxn in terms of reproduction, sexual abuse, teenage pregnancy, violence, STIs (including HIV/AIDS), physical, emotional and social changes, values and skills pertaining to decision-making regarding sexuality (where abstinence is explicitly stated) and behaviours that have the potential to lead to sexual intercourse. In the more primary years of school Life Skills is a subject that addresses these issues, however the

aim of this subject is for children to gain knowledge of their personal health and safety (DoE, 2012a: 8). Issues that need to be addressed for grades R to 6 include HIV/AIDS, safety and violence and abuse (DoE, 2012a; DoE, 2012b).[3]

There are two prominent positions in sex-education, abstinence-only (AO) education and comprehensive sexuality education (CSE). AO prescribes abstinence from sex and is based on the presumption that young people are not sexually active or will not become sexually active until marriage and thus teaches abstinence from all sexual activity as the only appropriate option (Francis & DePalma, 2014: 81). AO programmes restrict students' access to information on sexuality and contraception, rarely includes basic information on sexual health relating to puberty and reproduction and covers limited information about pregnancy and STI prevention (Ibid., 81). CSE on the other hand, acknowledges that young people are or will become sexually active and thus emphasizes the need to teach about STIs as well as STI prevention which includes condom and contraceptive use (Francis & DePalma, 2014: 81). CSE prides itself on including scientifically accurate and current information as well as the freedom to talk about and act out sexuality (Ibid., 82). The two positions are viewed as opposing each other, however Lesko (2010 as cited in Francis & DePalma, 2014: 82) has reframed this and argues that the two positions are not necessarily in opposition. Firstly, they are both based upon the power of correct knowledge that is rationally implemented to result in desired outcomes. Secondly, they both imply a knowing that is stable, unchanging and without context, history or politics. Thirdly, they require teachers to create an emotional climate that is safe and predictable and encourage confidence in their ability to regulate young people's sexuality and to determine their sexual options. Fourthly, teachers adopting either one or the other approach do not really want young people to have sex (Francis & DePalma, 2014: 82). Therefore, I would argue that the primary purpose of both of these approaches is the prevention of young people engaging in sex, where a top-down approach to knowledge dissemination is the cornerstone. The purpose then is not to recognise adolescents as actual sexual beings, but to stop adolescents from becoming sexual beings.

4.3.1 Barriers to Formal Sex Education in South Africa

A concern for teachers teaching sexuality education is that simply having the 'sex talk', can be difficult because merely engaging students in a discussion about sex can be misinterpreted as

[3] See appendix 2 for a summary of the Life Skills and LO sexuality education curriculum.

promoting sexual activity (Hamill & Chepko, 2005: 160). In terms of South African schools, schools and teachers are given a large amount of responsibility and autonomy with regards to the implementation of the LO sex education programme (Francis, 2011: 319). As a result, teachers teaching sex education often lack training, the skills and the knowledge to teach sexuality to adolescents (Francis, 2010: 318; Francis, 2011: 321). Another consequence is that there is a lack of uniformity in the teaching of the LO sex education curriculum and the effectiveness of sex education in schools is largely based on the overall comfort and confidence of the teacher around the issues and topics to be covered (Francis, 2010: 318; Francis, 2011: 321). Lastly, teachers are caught between contradictory values that are not easy to reconcile: national policy and curriculum, the school, their own personal beliefs and social and cultural pressures (Francis, 2011: 321; Glover & Macleod, 2016: 5). For example, parental objections to content that may be seen as encouraging sexual activity forms a large barrier to that content being taught (Francis, 2010: 317). Helleve *et al*, (2009: 202) found that teachers in their study preferred to avoid challenging existing norms and values and indirectly stated that they did not think that teaching sexuality should conflict with local norms and values. In a study conducted among LO teachers it was found that teachers were supportive of teaching sexuality and HIV/AIDS as a part of LO and saw sex education as necessary because in their view some students were already sexually active (Helleve *et al*, 2009: 194). Most teachers understood the purpose of teaching sex education as essentially preventing young people's engagement in sexual behaviour in general and some viewed the purpose and necessity of teaching sex education was to restore moral values. They also expressed less concern about the prevention of HIV (Helleve *et al*, 2009: 200). Helleve *et al*, (2009: 201) argue that the link between sexuality and morality can be explained in various ways. One such way is the fact that the LO curriculum includes topics that cover religions and morality. Religions to a large extent have explicit rules on sexuality such as forbidding pre-marital sex as well as explicit gender norms which often have an important influence on the ways in which sex education is taught (Ibid., 201). Francis & DePalma (2014: 85) found that all teachers in their study advocated abstinence and most teachers despite the reality of high levels of sexual activity in their school privileged AO. The overemphasis of an AO curriculum was due to their inaccurate understanding that sex and HIV education lead to increased sexual behaviour (Francis & DePalma, 2014 86). A significant theme that emerged from both studies was that an official adult construction of knowledge dominated sexuality education as opposed to reflecting actual young people's own sexual experiences (Francis & DePalma, 2014; Helleve *et al*, 2009).

A study conducted among young people from the Eastern Cape found that participants deployed a 'discourse of disconnect' (Jearey-Graham & Macleod, 2015: 18). Sex education was viewed as being delivered in inadequate and non-relational styles of communication and this sex education was largely irrelevant to participants' lives. All participants indicated that they wished for more in-depth discussions about sexuality and that they mostly only received 'scare' messages with warnings about STIs, pregnancy and ultimately to not engage in sexual activity but to rather abstain from sex all together (Jearey-Graham & Macleod, 2015: 18). This speaks to a theme that has been dominant in sex education within South African schools which Glover & Macleod (2016: 2) refer to as the messages of 'danger, disease and damage' where sex education mainly focuses on the negative consequences of young people engaging in sex. Glover & Macleod (2016: 2) also argue that this theme dominates both AO and CSE pointing to the need of an approach outside of these two camps that gives accurate unbiased information that speaks to the reality and needs of adolescents' sexual lives. Another important theme that emerged from sex education within South African schools was that of heteronormativity and homophobia where the topic of homosexuality is hardly covered in schools and LO programmes maintain heteronormative conceptions of gender which assists in fostering a culture of heterosexuality (Glover & Macleod, 2016: 4). This further side-lines those who do not identify as heterosexual in the schooling system (Ibid., 4), and this speaks to Butler's (1990) notion of the 'heterosexual matrix' and how this has been incorporated at every level including schools. Finally, researchers have found that LO sex education reinforces a fixed gendered order with prescribed roles that young womxn and men should embody (Glover & Macleod, 2016: 3). This impacts and reinforces gender inequality which is intimately linked to sexual violence. As shown in a study conducted by Bhana (2012: 356) there is a persistence of sexual violence in the experience of young girls both inside and outside of the South African school and that the school curriculum can be an important vehicle for advancing gender equality. Furthermore, that teachers are central to enabling gender friendly environments particularly within schools (Glover & Macleod, 2016: 3). Formal sex education in South Africa needs a radical transformation where teachers are properly trained, the curriculum made uniform and where accurate unbiased information that speaks to the needs of adolescents take the centre.

4.4 Informal Sex Education: Parents, Peers and The Media

Shtarkshall *et al*, (2007: 117) note that both parents and educators have significant roles in strengthening sexual literacy and sexual health. Furthermore, that accurate parental input can

complement children's school-based sex education. Jearey-Graham & Macleod (2015: 12) support this and claim that parents are a primary adult source of information and values about sexuality, through both explicit and implicit communications. Fox (1980: 21) argues that the mother-daughter relationship can be viewed in terms of a sexual socialisation structure. This is because mothers frequently serve as the initial source of sex role learning for daughters. Furthermore, mothers and daughters are linked through their common female sexuality (Fox, 1990: 21). In terms of this relationship, Fox (1980: 22) found that much communication about sex and sexuality was unspoken, indirect and non-verbal. Research in South Africa and sub-Saharan Africa has found that much parental communication about sex is authoritarian and one-sided and consists of vague warnings about the dangers of sex and the need to avoid sex (Jearey-Graham & Macleod, 2015: 14). In their study, Jearey-Graham & Macleod (2015: 21) found that participants constructed their parents as reacting poorly to their sexuality by offering inadequate or moralistic information as well as not accepting them as sexually active people. Interestingly participants largely spoke about their mothers as inadequate (Ibid., 21). Parental communication is key to youth practicing safer sex. For example, a study conducted by LaSala (2007: 52) found that over half of the participants reported that their relationships with their parents influenced their decisions to engage in safer sex. In another study, it was found that some participants indicated how inadequate parental communication about sex let to 'sexual mistakes' (Jearey-Graham & Macleod, 2015: 24). Interestingly, James, Reddy, Taylor & Jinabhai (2004: 266) found that among their participants family was reported as the least accessed source of information with regards to STIs and HIV/AIDS. This indicates that parents and their communication around sex and sexuality play a significant role in individuals' sex education and subsequently could have a key influence on their decisions regarding the practice of safer sex.

It seems that peers also have a significant impact on individuals' sex education. Brook, Morojele, Zhang & Brook (2006: 270) found that adolescents' peer group involvement was the most direct predictor of their risky sexual behaviour which was especially true for boys. For boys associating with deviant peers (peers who are involved in various problem behaviours including drug and alcohol consumption), it was more likely that they would engage in risky sexual behaviours (Ibid., 269). Furthermore, James *et al*, (2004: 266) found that both young men and womxn who participated in their study communicated largely with their friends about sensitive issues. This highlights the importance of peers as a source of sex education as well as being a key influence in how individuals may engage in sexual activity.

The media has also become an increasingly important source of sex education. In a study conducted by James *et al*, (2004: 266), it was found among their adolescent participants that the most common reported source of information with regards to STIs and HIV/AIDS was the media and included newspapers, magazines and television. The mass media which includes television, music, magazines, movies and the internet (including social media) are important sex educators. Youth today can see and hear sexual talk and portrayals in every form of media making media a key source of sexual information and education (Brown & Keller, 2000: 255). The media can be useful because as found in a study, students enjoyed the sex education information as well as media's appeal to them as knowledgeable and mature compared to the more patronising approach perceived as coming from parents and school (Bragg, 2006: 329). According to Smith, Gertz, Alvarez & Lurie (2000: 690), the internet has changed the way in which society receives information and young adults – especially those hesitant to discuss sensitive or private topics with parents or teachers – may make use of the internet as a source to access sex education information. In their review of USA adolescents' use of the internet as a sex education source Simon & Daneback (2013) found that adolescents did use the internet for sex education. Furthermore, they found that adolescents were interested in various topics including STIs and pregnancy (Ibid., 315). They argue that their review of the literature suggests that adolescents want sex education to go beyond sexual health and want to learn about sexual experiences too and therefore, the internet could better serve adolescents sex education interests (Simon & Daneback, 2013: 315). Daneback, Monsson, Ross & Markham (2012: 583) found that more than half of their participants used the internet for sexual issues and their results suggested that the need for sex education persists through individual's adult years. The internet has been able to deliver sex education in new and exciting ways and the above findings suggest that sex education is not limited to a specific time in an individual's life but is a life-long process and the internet could serve as a source of sex education that is easily accessible for individuals at different stages in their lives. All the above-mentioned sources of informal sex education play a key role in the sex education of individuals which may have important consequences for how they conduct themselves in their sexual lives which includes the ways they may or may not practice safer sex.

4.5 Conclusion

The chapter outlined what this study means by the term sex education. Sex education in this study refers to both sexual socialisation as well as sexual education that occurs within formal

institutions such as schools. The chapter distinguished between formal and informal sources of sex education. Formal sex education in South Africa takes place in the LO curriculum where topics such as sexuality and HIV/AIDS are covered. There are many barriers to formal sex education within South African schools which include a lack of training for LO teachers, lack of strict guidelines in terms of the curriculum, a discourse of disconnect and sex education that does not position students as sexual beings and thus a sex education that does not speak to the reality of adolescents' lives. There are many sources of informal sex education including parents, peers and the media. All of these sources also play a significant role in the sex education of individuals and subsequently the ways in which individuals conduct themselves in their sexual lives.

CHAPTER 5: 'SEX' AND 'SAFE SEX'

5.1 Introduction

The previous chapter looked at sex education as well as the demographic make-up of sex-related research conducted in South Africa. This chapter will discuss the literature surrounding the terms 'sex' and 'safe sex'. Before discussing 'safe sex', it is imperative to critically look at the definition(s) of 'sex' to gain an understanding of what constitutes 'sex' which is then linked to the ways that 'safe sex' is practiced and promoted to be practiced. It will be shown that with both terms there is a social construction of these terms and that dominant discourses often do not encapsulate the concerns and practices of everyday life. As will be illustrated in the discussion of 'safe sex', the biomedical definition (dominant definition) of 'safe sex', does not take into account the concerns of individuals and ignores the situational features of a sexual encounter. With regards to individuals subscribing to the dominant definition it is very dependent on a number of factors which include drug or alcohol consumption, the type of sexual relationship (intimate, long-term, casual, regular) and the assumptions brought by individuals to a sexual encounter.

5.2 What is 'Sex' Anyway?

The term sex is often used however there is a lack of clarity about its definition. The lack of clarity of the definition of sex adds to the concern about the validity of self-reported sexual behaviour (Randall & Byers, 2003: 87). Respondents may use their own individualistic definitions of sex and thus respond to research questions based on different opinions about what behaviours constitute sex (Randall & Byers, 2003: 87). This leads to further challenges when attempts are made to define, and study other terms related to sexual behaviour. Asking participants to define what sexual behaviours constitute 'real' sex will allow for a better analysis of the extent participants engage in sexually risky behaviour. There are many factors that may influence individuals' definitions of sex and as a result sex researcher cannot assume that participants subscribe to a specific definition of having sex. For example, students with a broader range of sexual experiences may subscribe to a broader definition of sex that encompasses all of the sexual behaviours they have engaged in (Ibid., 89).

Gavey (2005: 124) argues that the coital imperative is the most powerful of all contemporary norms of heterosexual sex. It refers to the notion that the defining feature of (hetero)sex is

penetration of vagina by penis and usually with male ejaculation inside the vagina. This kind of sex is the defining feature of (hetero)sex and sex in this sense is intercourse. Sexual acts outside of this are often viewed as 'foreplay', the build up to the main event – intercourse (Gavey, 2005: 124). The coital imperative is not the same thing as coitus, the coital imperative is the cultural framework in which coitus takes place that makes it a defining feature of sex. Within this dominant construct, the coital imperative is viewed as the most natural sex act formulated for human reproduction (Ibid., 124). Lastly, under this construction intercourse is a designated feature of mature sex highlighting that this main event is the transition from inexperienced to experienced (Ibid., 124). Previous studies have supported the above argument, finding that penile-vaginal penetration is a key feature of respondents' definitions of sex (McPhillips, Braun & Gavey, 2001: 238-239; Peterson & Muehlenhard, 2007: 259). Randall & Byers (2003: 91) found that approximately 95.8% of participants defined penile-vaginal intercourse as having sex and 81.15% defined penile-anal intercourse as having sex. It was only 21.4% of participants who included oral sex (both receiving and performing oral) as part of their definition of having sex (Randall & Byers, 2003: 91). It is important to note however, that this study was done only on those who identified as heterosexual which has important consequences for how individuals would define sex. Sexuality is an important factor in individuals' understandings or definitions of sex. McPhillips *et al*, (2001: 238), whose study specifically focused on heterosexual sex, support the above findings. They found that both men and womxn in their study directly and indirectly confirmed a coital imperative. Furthermore, that penile-vaginal intercourse with male ejaculation was often taken for granted as an inherent element of (hetero)sex and ultimately a defining feature of it (McPhillips *et al*, 2001: 238). Holland, Ramazanoglu, Scott, Sharpe & Thomson (1990: 340) substantiate these claims as they also found that the predominant definition of heterosexual sex accepted by the majority of the young womxn they interviewed was penetration of the vagina by the penis. Additionally, that 'sex' was usually taken to mean vaginal intercourse with male orgasm (Holland *et al*, 1990: 340). Peterson & Muehlenhard (2007: 259) also found that for the majority of their participants if there had been penile-vaginal penetration the act would be regarded as sex. Importantly, the majority of those who participated in this study identified as heterosexual. Their findings were interesting because they found that participants did not have clear and consistent definitions of 'sex' where the decision about labelling an experience as sex was influenced by the consequences of applying that label (Ibid., 256). One motive for participants not labelling an experience as 'sex' even when the experience corresponded with their definition of 'sex' was them not wanting to behave in ways that were inconsistent with their religious belief (Ibid.,

2007: 266). Another motive was not wanting to challenge their heterosexual self-construction. Peterson & Muehlenhard (2007: 266) argue that the motivation to define 'sex' narrowly could be motivated by abstinence-only sexuality education and conservative religious ideologies. The consequence of this is that if individuals are not having 'sex' according to their rigid definitions they may deem it unnecessary to use condoms which in the end could place these individuals at a greater risk of STIs (Ibid., 266).

The dominant discourse surrounding the term 'sex' points to Butler's (1988, 1990) notion of the 'heterosexual matrix'. This dominant discourse constructs sex as heterosexual sex and there is a reproductive element to this kind of sex, which is the principal reason for sex. The problem with this rigid definition of sex is that it only encompasses heterosexual sex making it seem like the most 'natural' way of having sex and relegates any other form of sex or sexuality invisible. Furthermore, because other sexual behaviours outside of sexual intercourse may not be viewed as sex, there may be implications for the ways that individuals then practice safer sex such as condom use. Defining sex in this way raises some very crucial questions such as, what about individuals who fall outside of heterosexuality, are the sexual acts they are engaging in not counted as sex? Do sexual behaviours outside of the coital imperative mean there is no risk of STI infection? What about individuals who engage in sexual behaviours outside of sexual intercourse? As noted by Peterson & Muehlenhard (2007: 256) understanding how individuals define 'sex' has critical scientific and health-related consequences. Due to the significance of how individuals define 'sex', a key question in all interviews conducted for the study was how participants would define 'sex' as well as what sexual behaviours according to them did not constitute 'real' sex. How an individual defines sex has important consequences for 'safe sex' practices and ultimately their risk of STIs.

5.3 Defining 'Safe Sex'

It has been noted that the concept of 'safe sex' is socially constructed and socially contested (Bourne & Robinson, 2009: 284). Definitions of 'safe sex' have been offered by many, and 'correct' meanings have long been proposed usually by those from medical backgrounds (Ibid., 284). AVERT (2007), a leading HIV charity, defines 'safe sex' as 'any activity through which you are at no risk of becoming infected with HIV or a sexually transmitted infection… it is sex that doesn't allow any infected bodily fluid to enter your body' (Bourne & Robson, 2009: 284). Definitions or descriptions of heterosexual safe sex follow the same principle: the separation

of bodies and the establishment of fluid exchange barriers, in particular condoms (Ibid., 284). One of the most common components of HIV/AIDS prevention programmes is the promotion of condom use (Eggers, Aarø, Bos, Matthews & de Vries 2014: 135). A biomedical definition of 'safe sex' may be accurate and healthy but may not form part of common concerns in everyday life (Bourne & Robson, 2009: 285).

In terms of 'safe sex' practices in real life (i.e. condom use), it has been found by previous studies that the situational features of a sexual encounter as well as the assumptions brought to the encounter by individuals were crucial in making a decision about 'safe sex' and carrying it through (Moore & Rosenthal, 1992: 416). Various studies have also shown that knowledge about HIV/AIDS and safe sex practices do not predict condom use among adolescents (Moore & Rosenthal, 1992: 416). The notion of intersectionality is also underpinned by Warwick, Aggleton & Homan's, (1988:215) argument wherein they emphasise that demographic variables such as age, ethnicity, gender, and social class are frequently linked to the ways in which understandings of health and illness are constructed. Therefore, these demographic variables need to be considered when analysing participants responses. Another important point which needs to be made leading into the next section is that the biomedical definition of 'safe sex' only takes into account heterosexual sex (the coital imperative) and thus makes other forms of sex invisible as well as the individuals who do not identify as heterosexual. This is important because the way an individual defines and understands not only 'safe sex' but 'sex' itself will largely be impacted by their sexuality. Furthermore, those who identify as heterosexual may themselves not engage in sexual intercourse but engage in other kinds of sexual behaviours which still puts them at risk of STIs.

5.3.1 Gender and 'Safe Sex'

With the existing backdrop of the devastating effects of gender-based violence in South Africa as well as the subsequent effects on the experience of schooling for South African girls, single-sex schools have been promoted as a strategy to protect girls from violence (Bhana & Pillay, 2011: 65). The logic that single-sex schooling and its assumed association with non-violence, are based upon notions of passive femininity that ignores the cultural variants of femininities (Ibid., 65). Conventional femininity which is based upon notions of passive femininity has been found to be an unsafe sexual identity. Reddy & Dunne (2007: 160) found that the dynamics within heterosexual relationships were usually guided by the preferences of the male partner.

Furthermore, that there were clear different sexual standards for males and females regarding sexual practices. Subsequently these differences encouraged high-risk sexual behaviour. Females had to 'risk it', by either insisting on condom use and risk rejection or to remain silent and risk STIs or unwanted pregnancy (Reddy & Dunne, 2007: 167). They found that disempowerment is integral to the performance of heterosexual femininity, females who conformed to traditional femininities were implicated in their own disempowerment, and in risking their own sexual safety (Reddy & Dunne, 2007: 167). In another study it was found that over half of the womxn participants reported having refused sexual advances from their most recent partner. Of these, 71% admitted that their attempts were not successful, and refusal almost always resulted in physical coercion, abuse or partners' threats of rejection. As a result, many womxn chose not to refuse sex, to prevent physical abuse and ensure the stability of the relationship (Varga, 1997: 56). Linked to this was womxn participants' responses regarding condom use. Over half of these participants avoided discussions or requests of condoms, and the themes that were reflected in responses were: fear of physical abuse, rejection, a lack of intimacy in the relationship and their fidelity questioned (Varga, 1997: 57).

As stated earlier, the situational features of a sexual encounter play an important role in an individual's decision to practice 'safe sex'. One important feature that impacts individuals' 'safe sex' decision-making is the kind of sexual relationship an individual is engaging in. In their study, Rosenthal, Gifford & Moore (1998: 45) found that if an individual perceived sex in terms of being 'in love' then that individual might not act upon the message of 'safe sex'. Willan, Ntini, Gibbs & Jewkes (2019: 6) found that womxn's views about love significantly influenced their willingness to tolerate violence in their love-relationships and 'minor incidents' which included being shouted at, being slapped or being locked up were understood as a sign of love. Violence and love were often intertwined for participants and they viewed tolerating violence as an inevitable part of a love-relationship (Ibid., 8).

The discourse of war on HIV/AIDS mentioned earlier that was analysed by Connelly & Macleod (2003: 71), reproduced traditional gendered practices within the fight against HIV/AIDS where womxn were constructed as both primary care-givers and responsible for the prevention of the virus in the home whereas men for the most part were absolved from these duties. This speaks to a broader issue with regards to STIs, sex and 'safe sex' where the responsibility of 'safe sex', be it in terms of contraception or in terms of STI prevention is largely placed on womxn. Mantell *et al,* (2009: 150) conducted a study among Indian and

African South African womxn and found that participants highlighted that womxn were more responsible for condom use than men and that there was an expectation that womxn be responsible for decisions around contraceptive use.

5.3.2 Substance Abuse and 'Safe Sex'

As noted by Simbayi, Chauveau & Shisana (2004 as cited in Brook *et al*, 2006: 259), risky sexual behaviours such as inconsistent condom use and sexual intercourse with multiple partners is common among adolescents and youth in South Africa. Risky sexual behaviours lead to an increased risk of unwanted pregnancies and transmission of STIs which is particularly true of HIV which is a major concern in South Africa (Brook *et al*, 2006: 269). Because alcohol and drug use alter an individual's judgement and removes their inhibitions it often results in high risk sexual behaviours (Adefuye, Abiona, Balogun & Lukabo-Durrell, 2009: 8). Morojele, Kachieng'a, Mokoko, Nkoko, Parry, Nkowane, Moshia & Saxena (2006: 218) conducted a study looking at the relationship between alcohol consumption and sexual risk behaviour. The authors found that a significant effect of alcohol consumption on sexual encounters was that it often resulted in a reduction in condom use. The long-term or negative effects of sexually risky behaviour was less likely to be considered where the satisfaction of a sexual urge became more important (Ibid., 224). They also found gender differences amongst their participants. They found that amongst their male participants heavy drinking was encouraged and condoned by peers and heavy drinking came to symbolize masculinity. The same was true for having sex with multiple partners and was an important part of their masculine identities (Morojele *et al*, 2006: 224). Although most of the participants feared contracting HIV and tried to practice safer sex, most men with multiple sexual partners failed to use condoms with their regular partners (Ibid., 224). Other studies have also supported these findings, Brittain, Myer, Phillips, Cluver, Zar, Stein & Hoare (2019: 136), observed a link between the male gender and behavioural health risks which includes risky sexual behaviour and substance abuse. Brook *et al*, (2006: 269) found that adolescent boys involved in risky sexual behaviours were associated with deviant peers where drug and alcohol consumption was common. Interestingly, a study conducted in the US found that amongst womxn marijuana and alcohol consumption was associated with low condom use. Morojele *et al*, (2006: 224) found that womxn meanwhile, were less often involved in casual sexual relationships. They also reported a dislike for sex when they had been drinking because it often led to unwanted sexual acts (Ibid., 224).

5.3.3 STI Knowledge, Perceived STI Risk and 'Safe Sex'

As has been shown in many studies and with the discussion above, there seems to be a gap between knowledge of STIs and behaviour. James *et al*, (2004: 264) found that there was a discrepancy between awareness behaviour. While participants were aware of how STIs were transmitted and accepted condoms as a means of protection against STIs, they had an unrealistic perception of their own risk of contracting an STI despite engaging in sexually risky behaviour. They also viewed themselves as being at less risk than their peers (Ibid., 268). This is supported by Hartell (2005: 177) who states that adolescents display a high level of awareness about HIV/AIDS, but this knowledge has not resulted in significant behavioural change. Although most adolescents acknowledge the gravity of HIV/AIDS few see it as a personal threat or perceiving themselves at risk despite engaging in risky sexual behaviour (Ibid., 2005: 177). Tillotson & Maharaj (2001: 92) found that almost all participants in their study stated that their condom use was not consistent. One reason participants chose to not use condoms was their belief in their ability to distinguish which girls were infected with HIV and which were not, there was a consensus amongst participants that an individual can ascertain which girls could be 'trusted' and which could not. Importantly, 94% of the participants knew that HIV was transmitted through sexual intercourse (Ibid., 87), which highlights again a gap between knowledge and behaviour. These findings are consistent with findings of studies conducted outside of South Africa. In a study conducted in the US Adefuye *et al*, (2009: 1) found that students in their study sample perceived themselves at low or no risk of HIV infection despite having engaged in various HIV risk behaviours. This suggests that there is a disconnect between knowledge and behaviour and that factual knowledge about STIs is not a predictor of condom-use or safer sex practices. This highlights the need for sex education to be delivered more effectively and in a way that goes beyond technical information about STIs. Furthermore, the findings discussed in this chapter point to gaps between the biomedical definition and the situational features of the sexual encounters of individuals and that there are factors that need to be considered with regards to individuals practicing safer sex. These include but are not limited to substance abuse, the type of sexual relationship, and individuals' priorities or considerations at the time of a sexual encounter. This illustrates the conflict between the biomedical definition of 'safe sex' and the reality of individuals' sexual lives and lives more generally.

5.4 Conclusion

This chapter attempted to critically discuss the definitions of ‘sex’ and ‘safe sex’. The term ‘sex’ is often used however there is a lack of clarity regarding its definition. The dominant construct of heterosexual sex is the coital imperative where a defining feature of sex is the penetration of the vagina by a penis, usually ending with male ejaculation inside the vagina. This dominant construction ignores all other forms of sex and has important implications for the ways in which ‘safe sex’ is defined. The term ‘safe sex’ has become synonymous with condom use however this does not take into account individuals’ own definitions or perceptions of ‘safe sex’ which are often based on the situational features of a sexual encounter which also includes the assumptions brought by all those involved in a sexual encounter. Therefore, a biomedical definition fails to encapsulate the common concerns of everyday life. Finally, as illustrated in the last section of the chapter, the literature suggests that there is a gap between individuals’ awareness or knowledge about STIs and their behaviour. Furthermore, the literature suggests that individuals lack an appreciation of their risk of STIs despite engaging in sexually risky behaviour. This speaks to the failure of sex education and the need for a more effective way of delivering, communicating and discussing sexuality.

CHAPTER 6: RESEARCH METHODOLOGY

6.1 Introduction

The previous chapters provided the theoretical underpinnings of the study as well as a review on the literature surrounding the topic. This chapter outlines the research methods used during the research process to attain the study's objectives. Since this research sought to obtain an in-depth understanding of participants' sex education as well as their current understandings and practices of 'safe sex', a qualitative research design was most appropriate to achieve the study's objectives. The chapter begins with a discussion of qualitative research, what it involves and how it connects with the theoretical framework, namely; social constructionism. The section that follows will discuss the research methods that were used in this study. There are a number of sub-sections within this section including in-depth and semi-structured interviews, research participants and gaining access and ethical considerations. The chapter will conclude with a discussion of the limitations of this study.

6.2 Qualitative Research, Social Constructionism and Intersectionality

As the research aimed to gain an in-depth understanding of the level and nature of participants' sexual education, as well as their current understandings and practices of 'safe sex', a qualitative research design was most appropriate. Qualitative research refers to the meanings, concepts, definitions, characteristics, metaphors, symbols and descriptions of things (Lune & Berg, 2017: 12). It involves studying the meanings of people's lives and seeks to gain a deeper understanding of social realities (Flick, von Kardorff & Steinke, 2004: 3; Yin, 2010: 9). A qualitative research design attempts to describe, interpret and explain social reality through the medium of language (Beuving & de Vries, 2015: 19). It effectively looks for answers by studying multiple social settings and the groups or individuals who exist in these settings (Lune & Berg, 2017: 15). A key concern then for qualitative research is firstly, how humans establish themselves and their settings and secondly, how those who exist in these settings make sense of their surroundings through things such as social structures, symbols and social roles (Lune & Berg, 2017: 15). This kind of research design is useful for the investigation of phenomena and experiences from the perspectives of the individuals experiencing them (Kalof, Dan & Dietz, 2008: 80), as it examines how people learn about and make sense of the themselves, others and their social reality (Lune & Berg, 2017: 16).

Social constructionism takes a critical stance towards taken-for-granted knowledge and maintains that we should question our assumptions about how the world appears to be (Burr, 1995: 2). Importantly, a noteworthy feature of qualitative research is its ontological position which can be described as constructionist. Under this paradigm social property is seen as the result of social interactions and not as the result of phenomena just 'out there' and separate from those involved in its construction (Bryman, 2012: 380). As noted by Kalof *et al*, (2008 80) social constructionism has been particularly significant in the formation of qualitative inquiry. This significant feature of qualitative research highlights the way in which social constructionism and qualitative research are connected and well-suited to each other. Because they speak to each other, it further justifies the use of a qualitative research design to achieve this study's objectives. Intersectionality is an analytical tool (Carbado *et al*, 2013: 303), and the research also worked within an intersectional framework acknowledging race and recognising that the experiences of white womxn are different to those of womxn of colour, especially within the context of South Africa. Furthermore, that each participant's experience was influenced by the intersection of other categories such as sexuality.

In using social constructionism and intersectionality as a guide, the primary objective of this research was to investigate the level and nature of participants' sex education, and how their sex education links to their sexual practices. A key subsequent focus of the research was to understand participants' current understandings and practices of 'safe sex' and how participants carried out these practices and why. The kinds of schools that participants attended including categories such as public or private school, co-ed or single-sex school, boarding or day school, faith-based or secular school and whether participants were boarders or not were obtained to understand if the kind of schools participants attended (in particular if the school was faith-based or secular), influenced the formal sex education they received. Furthermore, the intersection of sexuality was also examined to analyse how this category intersected with their sex education and their practices and understandings of 'safe sex'.

6.3 Research Methods

6.3.1 Semi-structured Interviews

In qualitative research, the researcher aims to understand people's lives as they are lived, and interviews produce deeply contextual accounts of participants' experiences and their interpretation of them (Doody & Noonan, 2013:2). Interviews are useful to researchers because

participants are perceived as ‘talking’ which is natural, and as a result are responding in their own words (Ibid., 1-2). Qualitative interviews are useful because they have a more informal, conversational character. This allows for more flexibility in each interview because the interview is shaped by the interviewer’s pre-existing interview guide as well as by concerns that emerge in the interview (Bloor & Wood, 2006: 104). Interviews can be done in several ways - this research utilized face to face, semi-structured interviews to gather data. As I sought to gain an in-depth look into each participant’s sexual education, their current understandings of ‘safe sex’ as well as their practices of ‘safe sex’, semi-structured interviews were the most appropriate method. Face to face interviews offered me the opportunity to create a good interview atmosphere. An interview guide was used in all interviews, however the ordering and the questions asked were guided by the interview itself. The use of open-ended questions allowed participants to elaborate and clarify their thoughts. With this said, there were key questions and topics that were covered in all interviews.

The use of semi-structured interviews allowed me to adjust questions as needed, for example, after the first interview I found that I needed to add questions with regards to participants ‘safe sex’ practices so that I could analyse to the extent that participants engaged in sexually risky behaviours. I added questions like ‘what sexual behaviours do you feel ‘safe sex’ is not needed for?’ I found that I needed to be more specific. I also needed to change the wording of some of my questions so that they were more easily understood. After the first interview, I needed to change my question ‘what do you think about one-night stands in relation to gender-based violence’, as this question was not understood, and Genevieve found it extremely difficult to answer. I changed the question to ‘how safe do you feel with one-night stands?’ After the first three interviews I added questions surrounding STI testing and HIV testing so that I was able to ascertain to what extent participants engaged in sexually risky behaviour. I was able to go back and ask two out of the three interviewees the additional questions. As a result, the STI testing history of one participant is unknown which impacted the results of that section of the analysis. With this said, I was still able to ascertain the extent to which they engage in sexually risky behaviour based off of their ‘safe sex’ practices. Semi-structured interviews were the primary research technique used to gather data.

6.3.2 Research Participants and Gaining Access

Purposive sampling is a technique in which the units of analysis are selected in terms of criteria that allow the research questions to be answered. Thus, the researcher selects a sample with

their research goals in mind (Bryman, 2012: 418). Because the aims of this study were to ascertain, examine and analyse young adult white womxn's sexual education and current understandings and practices of 'safe sex', a purposive sampling method was most suitable. To achieve the research objectives, I required participants to be between the ages of 18 and 24, white womxn and sexually active and thus purposive sampling was required. All participants were white womxn, between the ages of 19 and 24, sexually active and Rhodes University students. In conjunction with purposive sampling I employed a snowball sampling technique. In a snowball sampling approach, the researcher initially samples a small group of people relevant to the research questions and these sampled participants then propose other participants who have characteristics relevant to the research (Bryman, 2012: 424).

To gain access to participants I asked white womxn Rhodes University students who were close to me to participate in the study. In turn they helped me to recruit their friends or peers. In recruiting their friends or peers it was made clear that participants would need to speak about their own sexual lives. This was done to minimise risk of embarrassment to participants. It was only once an individual indicated to their friend that they were interested in participating in the study that I contacted them and set up an interview. This method was used as it was a way of securing participants safely through their friends. Social distance was ensured as it was emphasised that this was not a casual conversation on sex, but an academic study exploring the impact of sex education on participants' 'safe sex' practices and understandings.

Semi-structured in-depth interviews were used to collect data. Interviews were between forty-five minutes to an hour and a half in length. I did follow-up interviews with Genevieve and Charlie Witton to clarify some points that were made. These follow-up interviews were approximately ten to eighteen minutes long. The interviews took place where participants felt most comfortable which included, on Rhodes University campus, at their respective digs or at my digs. In many cases, rapport was established before the interview due to my having a relationship with them. I was able to create a comfortable interview atmosphere with participants that I did not have a relationship with by discussing the topic before the interview and ensuring that they understood the objective of my study by answering any questions they had prior to the interview. Because sex education occurs over the course of an individual's life, I asked participants to speak about their sex education from the very beginning (as far back as they could remember), all the way to that very present moment in their lives. The process of sex education is a long-term process beginning with the earliest days of an individual's life and therefore, if I were to ask about participants' sexual education at a single point in time in their

lives, I would miss the richness of the sex education process that stretches throughout an individual's life (Fox, 1980: 22).

6.3.3 Ethical Considerations

Research ethics are the guidelines for good professional practice, which function to inform and guide researchers as they conduct their work (Bloor & Wood, 2006: 64). Before conducting the research, the proposed study was approved by the Higher Degrees Committee of Rhodes University and the Sociology Department's Ethics Committee. Thereafter, the study adhered to all guidelines set by both Committees. Once the proposed study had gained ethical clearance it became necessary to find relevant research participants, following the ethical guideline of 'voluntary participation'. Voluntary participation means that no one was forced physically or psychologically to participate (Babbie, 2011: 67). To achieve this, I asked those closest to me if they would like to participate in my research, and if they were interested, they indicated that. Furthermore, I only contacted other participants once they had indicated to their friend that they were interested in participating. Thus, all research participants voluntarily participated in the study.

A crucial ethical consideration in any study is that no harm is brought to the participants as a result of participating in the research. It is important as a researcher to never cause harm to the people being studied. Linked to this is obtaining informed consent from participants which is premised on respondents basing their voluntary participation in research projects on a full understanding of the risks involved (Babbie, 2011: 68). Due to the sensitive nature of my study I ensured that all participants received a full explanation on what my study was about, making it clear that participants would have to discuss their own sex lives in detail. All participants were given the opportunity to ask any questions to clarify anything before the interview was conducted. I received informed consent from all participants, in which they were required to sign a consent form.

Linked to not causing harm to participants is the ethical concern of confidentiality. Confidentiality is guaranteed when the researcher can identify a given participant's responses but promises not to do so publicly (Babbie, 2011, 2018). I have done so through the use of pseudonyms, ensuring that participants' real names and the schools they attended are not listed on any report or presentation as well as not stating the age of each participant. Furthermore, I have described each participant in a way that participants' identities cannot be deduced. Most participants chose their own pseudonyms. Some included a first name and surname; others only

chose first names. I also sent all participants their transcripts, which gave them the opportunity to clarify, explain or add anything they felt they needed to. I felt it was important to do this due to the very personal and sensitive nature of the study. As a result, I was able to gain the trust of my participants which led to the very rich research data they provided as well as ensuring that the data was reliable because participants felt they could be honest. All participants will receive a copy of the final thesis. All interviews were recorded, later transcribed and subsequently deleted.

6.4 Limitations of the Study

As noted by Bryman (2012: 418), purposive sampling is non-probability sampling and as a result it does not allow for the generalization to a population. There are a number of limitations of this study. First and foremost, this study consisted of a very small sample and studied only seven white sexually active womxn between the ages of 19 and 24. All participants were university students and the majority of the participants mostly engaged in heterosexual sex. Furthermore, as white men were excluded from this study no comparisons could be made between white men and white womxn therefore, gender differences based on the research topic could not be shown. Secondly, all participants were not living with their parents and so I assume that they have had much more sexual freedom than individuals who still reside with parents or guardians. Thirdly, most participants were twenty-three years of age and this study did not comprise any first-year students and so this study only pertains to older respondents. Lastly, because I have rapport with many of the participants, I would argue that this was beneficial to my research because participants were more open and honest with me. It could, however, also be argued that because I have a personal relationship with four of the participants, they may have cared more about what I thought of them and so may not have always been completely honest in their responses. Future research should include a larger sample size that is more diverse within this demographic including educational level, gender, age and sexuality. With this said, the study does add value in that it gives valuable insights into how sex education influences individuals understandings and practices of ‘safe sex’.

6.5 Conclusion

In conclusion, this chapter aimed to illustrate why a qualitative research design was most suited in the achievement of the study’s objectives. In doing so, the chapter has highlighted the ways in which qualitative research and the theoretical approach of the study are connected. I then

discussed the research methods employed, how I gained access to participants, who made up the study and the ethical considerations of conducting such a study. Finally, I concluded this chapter with an overview of some of the limitations of the study.

CHAPTER 7: DATA ANALYSIS

7.1 Introduction

The previous chapters reviewed the literature on this topic and outlined the theoretical framework as well as the research methods. This chapter will analyse the data collected. This research has examined seven white womxn's perceptions regarding 'safe sex'. The purpose of this analysis is to investigate the level and nature of young adult white womxn's sex education and how it links to their sexual practices. A number of themes emerged from the interviews including sex education, sources of sex education, the messages received from sex, definitions of sex and 'safe sex', perceived STI risk and the policing of bodies. Participant names will be replaced with pseudonyms of their own choice and will be illustrated by the use of an asterisk upon the first use of the pseudonym. In the interest of consistency, I will be using the gender-neutral pronoun 'they'/ 'them'/ 'their'[4] when referring to participants.

7.2 Brief Description of Participants

In the interest of confidentiality only a brief description of participants will be provided. All participants were white womxn who were studying at Rhodes University at the time that the study took place and were between 19 and 24 years of age. The tables below provide information with regards to the kinds of schools participants attended which includes information such as public school or private school, single sex or co-ed and secular or faith-based. The tables also include information about whether participants stayed on campus residence during their studies. All participants resided in residence for at least their first year of studies with some staying in residence beyond their first year. After staying in residence all participants moved into their own dwelling, and for most participants they lived in their own digs at the time of the interview.

Daniela				
Schools	**Public/Private**	**Single Sex/Co-ed**	**Secular/Faith-based**	**Day/Boarding**
A (Zim)	Private	Single-sex	Anglican	Boarding
B (Zim)	Public	Single-sex	Anglican	Boarding
C (SA)	Private	Co-ed	Methodist	Boarding and Boarder
University	**Residence**			
RU	2 years			

[4] https://www.mypronouns.org/they-them

Jessica Rabbit				
Schools	**Public/Private**	**Single Sex/Co-ed**	**Secular/Faith-based**	**Day/Boarding**
A (Gr0-7)	Private	Co-ed	Christian	Day
B (Gr8-12)	Public	Co-ed	Secular	Day
University	**Residence**			
RU	1 year			

Frances Brooks				
Schools	**Public/Private**	**Single Sex/Co-ed**	**Secular/Faith-based**	**Day/Boarding**
A (Primary)	Private	Co-ed	Secular	Day
B (Primary)	Private	Co-ed	Catholic	Day
C (Primary)	Public	Co-ed	Secular	Day
D (Gr8 - 12)	Public	Single-sex	Secular	Boarding and Boarder
University	**Residence**			
RU	2 years			

Robyn				
Schools	**Public/Private**	**Single Sex/Co-ed**	**Secular/Faith-based**	**Day/Boarding**
A (Gr0 - 4)	Public	Co-ed	Secular	Day
B (Gr5 - 7)	Private	Co-ed	Catholic	Day
C (Gr8 - 12)	Private	Single-sex	Methodist	Boarding and Boarder
University	**Residence**			
RU	2 years			

Genevieve				
Schools	**Public/Private**	**Single Sex/Co-ed**	**Secular/Faith-based**	**Day/Boarding**
A (Gr0-7)	Private	Co-ed	Secular	Day
B (Gr8-12)	Private	Co-ed	Secular	Day
University	**Residence**			
RU	3 years			

Charlie Witton				
Schools	**Public/Private**	**Single Sex/Co-ed**	**Secular/Faith-based**	**Day/Boarding**
A (Gr0-2)	Public	Co-ed	Secular	Day
B (Gr3-12)	Private	Co-ed	Christian	Day
University	**Residence**			
RU	2 years			

Jade				
Schools	**Public/Private**	**Single Sex/Co-ed**	**Secular/Faith-based**	**Day/Boarding**
A (Gr0-2)	Public	Co-ed	Christian	Day
B (Gr3-12)	Private	Co-ed	Christian	Day
University	**Residence**			
RU	1 year and 1 term			

The sections that follow will analyse the data. As will be shown, the kinds of school(s) participants attended as well as their place of residence had an impact on participants' sex education. Furthermore, participants' place of residence had a significant impact on their sexual practices or the freedom to engage in sexual activity.

7.3 Sex Education

When analysing participants' responses with regards to the sex education they received, it became evident that there were three distinct periods and a common theme emerged from these three periods. These periods were a) early and primary school years, b) high school years and c) university years. The paragraphs that follow will elaborate on each period.

7.3.1 Early and Primary School Years: The Silence around Sex

What became evident in a number of interviews was a re-emerging theme of silence around sex talk, particularly for participants in their earlier years. The level of silence surrounding sex varied amongst participants. Drawing on deconstructivist social constructionism, power relations have a strong bearing on how the world is constructed (Burr, 2003: 100). In this period in participants' lives the authority figures (particularly within institutions such as school) used silence as a way to avoid discussing sex. The implication of this silence is that for many participants knowledge surrounding sex and sexuality was not made accessible, and as a result it was made clear that 'sex talk' was not appropriate for them at this stage in their lives. For most, there was a silence in formal sex education but for some their families openly discussed sex. This was particularly true for Daniela*, Jade* and Robyn* where much of their initial sex education (in terms of actually talking about sex itself) was received from their parents or in Robyn's case their mother and aunt. However, Frances Brooks*, Jessica Rabbit* and Charlie Witton* experienced a silence around sex especially at home. As stated by Charlie Witton:

> "I grew up in a very, very religious household, very Christian household so sex was… I mean firstly, ironically enough actually as much as I know a lot about that it was wrong no one ever spoke about it at all. It was like it's so wrong that you don't even speak about anything sexual or promiscuous or anything like that."

Frances Brooks had a similar response and when asked what they remember being told about sex in their early years they responded:

> "I remember it being something that is bad."

For both Charlie Witton and Frances Brooks 'sex' was immediately remembered at that time as something negative however there were not many discussions surrounding 'sex' and knowledge about sex beyond it being constructed as 'bad' or 'wrong' was almost non-existent. This silence around sex extended beyond the home as pointed out by Jessica Rabbit:

> “Primary school was weird because I think like it [sex] was quite taboo in my primary school, like a lot of us were like weirdly obsessed with it. So, like I remember being like in grade one and people would always like joke or talk about sex, but like obviously none of us had done it or knew what it was. So, some girls would be like, "oh sixteen candles on the birthday cake", and that was like weird like slang for sex, but that was kind of it.”

Adding to this, with regards to formal sex education, sex itself generally seemed to only be discussed more in-depth in high school. For most participants the formal sex education they received in primary school spoke more about puberty and for some sex was touched on briefly. There was one exception; Genevieve* where from about grades five to seven their formal sex education did talk about sex as well as safe sex practices such as condom-use. Drawing on the Life Skills curriculum for grades R to 6 key topics that need to be covered are only in relation to the body (DoE, 2012a; DoE, 2012b). This could explain why sex or sexuality was not discussed in the earlier years of participants’ formal sex education. The implication of this is that sex as a topic was not viewed as something that was appropriate to discuss with participants when they were young children, indicating that sexual knowledge is something that must be handed down to individuals when adults feel that is appropriate.

7.3.2 High School Years: Sex is Constructed as Dangerous

An emergent theme among participant responses was that during their high school years sex was explicitly constructed as inherently dangerous, that engaging in sex led to negative consequences: either pregnancy or STIs. After analysing both the Life Skills and LO CAPS documents, sexuality and sexual behaviours are only discussed from approximately grade 7 (DoE, 2012a; DoE, 2012b; DoE, 2012c; DoE, 2012d). Sexuality and sexual behaviours generally were topics covered in LO which is a compulsory school subject from grades 7 to 12. Participants’ responses indicate that it was from approximately the beginning of high school that topics surrounding sexuality and sexual behaviours were discussed, more explicitly in formal sex education. As indicated by Robyn:

> “See all the stuff like STDs, HIV, pregnancy, all of that I only learnt in high school. I had no idea about you know the intricacies and nuances of sex when I was in like primary school.”

According to CAPS, LO, is defined as the 'study of the self in relation to others and to society' (DoE, 2012d: 9). When looking through the CAPS documents for the senior phase (grades 7 to 9) and FET (grades 10 to 12), it became evident that engagement in sexual behaviour of any kind was categorised as a factor that impacts negatively on individual healthy and balanced lifestyle choices. Furthermore, that the purpose of sex education was to prevent adolescents from engaging in any kind of sexual behaviour. It becomes clear that at an institutional level sex has been socially constructed as inherently dangerous, something that can only lead to negative consequences. This was evident because within the documents the risks of engaging in sex were emphasised heavily and there were no topics throughout any document that spoke to any positive aspects of sex. Sex in the documents were framed as risky, dangerous and something that adolescents should not be engaging in. Adding to this, abstinence was mentioned as a strategy to deal with unsafe sexual behaviours and to prevent adolescent engagement in sexual intercourse. Linking this to participants' responses it becomes clear that this was emphasised in their formal sex education in particular in their high school years. Daniela explained that in grade 11 their grade had a 'sex talk' at school:

> "They had a nurse come in and show us all the STDs that we could get and that was basically it. No mechanics about how sex works or how to go about it safely beyond, use a diaphragm, use a condom, this is what birth control is, but it was mostly centred around STDs and those like horrific pictures. It was very graphic, I think they were going for that shock factor, to almost scare us not to have sex but I think it was a bit late in grade eleven […] most people by that stage had already had sex."

As pointed out by Daniela, at this stage adolescents are often already engaging in sex or sexual behaviours which was the case with many participants. It became clear that participants were not acknowledged as sexual beings but rather attempts were made to prevent them from becoming such or to deny that they were. As a result, the curriculum did not speak to the reality of participants' lives but rather sex education reflected an official conservative adult construction of sex. This has been found in two other studies conducted among South African teachers where an official adult construction of knowledge dominated sexuality education as opposed to reflecting actual young people's own sexual experiences (Francis & DePalma, 2014; Helleve *et al*, 2009).

7.3.3 University Years: The Process of Unlearning

A common theme for all participants was what Jessica Rabbit termed as a 'process of unlearning'. For many participants University was a place where participants could explore their sexuality fully, learn more about sex and unlearn harmful or inaccurate information they were told about sex during their younger years. As stated by Jessica Rabbit:

> "So, like that's when I did like most of my like unlearning, I like to say. […] and that was when I was like this is such bullshit that I was made to feel like this, and everything. But that was me finding out on my own."

Some participants learned completely new things. For example, Daniela learnt that:

> "It's something I actually only found out about at university that you can actually get diseases from oral sex with womxn."

The findings here indicate that sex education failed participants in a number of ways and in ways that were dangerous to their health and safety. Drawing on Butler's (1990), 'heterosexual matrix', gender identity and sexuality are both constructed in heterosexual terms which has had a negative and dangerous impact for participants such as Daniela. Religion seemed to play an important part in participants' sex education even for those that did not come from religious households. For those that did come from religious households, religion played an even more significant role in their sex education. For some, the value placed on virginity for example had a significant impact on how participants navigated their sex lives. Charlie Witton and Jessica Rabbit experienced guilt and shame when they first began to engage in sex or sexual behaviour. It was only once at university that they began a process of unlearning to move past this with Charlie Witton noting that was still something they are working on.

When asked how their living situation has impacted their sex life, Jade responded:

> "Huge, huge and I think like again I touched on it as well, there's an independence that kinda comes with it. And my living situation now, living on my own I think there's even more independence."

Jade pointed out that not only living away from home but living in their own digs allowed them to have sexual independence. This trend was notable for all participants at this stage of their lives where because they weren't living at home with their parents, they had much more freedom to explore their sexuality. This likely played a significant role in participants' unlearning some of the harmful messages they were told. Further, for some such as Jade living

in their own digs enabled participants to explore their sexuality and engage in sexual behaviours even more. This illustrates the constructed nature of sex and that sex education is an ongoing process of socialisation that continues for individuals throughout their lives. This section has also highlighted that the living situations participants found themselves in impacted the ways in which they could explore their sexuality and was an influence in their sex education.

7.4 Sources of Sex Education

Key sources of sex education for all participants included school, religion, peers, parents and media. For Jade, Jessica Rabbit, Daniela, Robyn and Genevieve books about sex and puberty were either given or made accessible to them by their parents. Books were used as a tool by parents to pass on information with regards to sex and puberty. Most of the books mentioned were aimed at children, were often in comic form and covered puberty and touched on sex. Daniela was given a Kama Sutra by their mother which they read and Robyn was given access to a Kama Sutra by their aunt which they chose not to read. Jessica Rabbit and Genevieve did not tell anyone that they had read the books that were made accessible to them by their fathers. This indicates that books were an important sex education transmitter. It also suggests that there seemed to be a delegation of sex education to other sources so parents could avoid having the 'sex talk', be it through the use of books or relegating it to a task for schools to carry out. Another important source of sex education was the family in particular for those who had open households, mothers seemed to be the key contributor to sex education. This points to Fox's (1990: 21) argument that the mother-daughter relationship can be viewed in terms of a sexual socialisation structure. This structure was very important to some participants as a source of sex education. However, for some, the source was exclusively their fathers because their mothers were no longer present for various reasons.

One of the most significant sources was peers and close friends. All participants mentioned peers as a very important source. It was through peers that participants could have frank discussions about sex and could share their experiences. They were able to learn from the experiences of others who were in a similar age group and thus conversations that were not adult constructed could be had freely. Furthermore, most participants stated that close friends would be a place they would go to for sexual help if they needed, which indicates that this source continues to be an important source of sex education continuing into adulthood.

Frances Brooks acknowledged that particularly at the time of the interview they learnt a lot from their friends with regards to 'safe sex':

> "I think like this year for the first time I had like friends who I've like spoken about safe sex with quite a lot, and that's been really, like a good, I don't know like I feel like I've learnt a lot from my friends this year in terms of that. Or just having friends who also think that, that's important, if that makes sense? Uhm because I've never, before now, I haven't had friends who like sort of like speak about safe sex in that way."

Their statement highlights the importance of peers with regards to sex education as well as the kinds of peers one is surrounded by. Because their friends thought that 'safe sex' was important, discussions were had surrounding that topic and it was through these discussions that Frances Brooks learnt more about 'safe sex' and what that meant especially in terms of health. As a result, their views and practices around 'safe sex' have changed as they have learnt more which has included them going for a full STI test as well as the Human Papillomavirus (HPV) vaccine to further protect themselves from STIs and their sexual and reproductive health.

7.4.1 The importance of the internet as a source of sex education

Simon & Daneback (2013: 306), note that the internet has allowed for a unique delivery of sex education in the digital age. The data from my study demonstrated that the internet was an especially important tool or source for sex education. A recurring theme for all participants with the exception of Daniela was the importance of the internet in their sex education. This has been especially true over the past few years up to the present. This may be because the internet is quick, easily accessible and participants are able to look up all sorts of information that they may be otherwise too embarrassed to discuss or ask others about. The internet gives participants access to pornography, information with regards to STIs, medical advice, blogs that address the topic of sex, and generally any information with regards to sex that participants wanted access to. In terms of the present, all with the exception of Daniela stated that one of the first places they would go for any sexual help or education was the internet. The internet has many positive attributes however there are some negative qualities too. Participants noted this was especially true with regards to seeking medical advice online, especially in terms of STIs. For example, Charlie Witton stated:

> "Like I get a rash and I'm like, "what STD has this rash?" And obviously it tells you that you've got like the most intense disease because it's google, which is a bit of a mess."

Charlie's statement indicates an internalisation of the stigmatisation of STIs and exhibits the fear they had of contracting an STI. This was also evident in Jessica Rabbit's statement:

> "The most common thing that I would definitely have looked up was like symptoms of STIs [...] So, definitely the most common search would be like symptoms, and then you'd read like syphilis doesn't have to have symptoms in the first stage [and you think], that's it, I'm gonna get stage four syphilis and die."

These findings contradict the findings in Jones & Biddlecom's (2011: 119) study in which they found that a number of the adolescents in their study did not frequently use the internet to find educational information about sexual health. With this said, there are important differences between my study and theirs. First, the participants in their study were all adolescents, the participants in my study are all young adults and so sexual health may be more important to my participants because they are older and more sexually experienced. Secondly, their study specifically looked at adolescents looking for information with regards to contraception and abstinence whereas I looked at any information looked up with regards to any aspect of sexual health and sex more generally. The findings in my study are in line with the findings of Batchelor, Kitzinger & Burtney (2004: 674), who found that more than half of their participants used the internet to pursue information about sexual issues. They argue that this indicates that the need for sex education persists through individuals' adult years. This was evident in the participants' responses from my study, there never has been an end point for their sex education which implies that sex education is a continuous life-long process with the process continuing into and through adulthood.

These findings indicate that participants felt more comfortable going to the internet for information than professionals or institutions regardless of the fact that the information may not necessarily be consistently reliable, especially with regards to seeking out information about STIs. Almost all participants exhibited an internalisation of the stigma associated with STIs and indicated that they feared contracting any kind of STI. This could explain why participants would rather seek potentially unreliable or overexaggerated information from the internet to maintain their anonymity than seek information from professionals and be a part of

a stigmatised group. This will be expanded on later in the section that discusses participants' perceived risk of STIs.

7.5 Messages Received from Sex Education: 'Sex is Between a Man and a Womxn'

What became apparent when analysing the data was that sex was always constructed as heteronormative in the sex education that participants received. Heteronormativity and homophobia have been noted as an emerging theme from sex education within South African schools where the topic of homosexuality is barely covered in schools (Glover & Macleod, 2016: 4). Participant responses confirmed this notion and noted that sex was only ever taught as heterosexual sex, something that occurs between a man and a womxn. As noted by Jessica Rabbit:

> "No and like it also wasn't framed like, so, you know like oral sex is still sex? It was never spoken about like that. Well, it wasn't even really like that was spoken about, like you didn't know. But sex was heterosexual penetrative sex."

It is important to note that the notion of sex as heterosexual was not limited to formal sex education but permeated all forms of sex education. Robyn mentioned that they had a very open home and from a young age they were taught what heterosexual sex was by their mother. Jade for example stated that media, specifically entertainment media, is where they received much of their sex education and mentioned that with regards to how sex was portrayed there was always a recurring theme:

> "Literally the one I think that probably hit me the most was just well sex is between a man and a womxn, that's what I saw, and also, sex is a penis and a vagina."

Drawing on the concept of the 'heterosexual matrix' both gender identity and sexuality are constructed in heterosexual terms (Butler, 2004: 54). The above indicates that participants received a sex education that was heteronormative where normal or 'natural' sexual practices were defined as heterosexual. Interestingly, they received a heteronormative sex education from many sources including parents, school and the media. As Jade mentioned, the heteronormative 'talk' or portrayal of sex was not limited to the sex education given by school or parents but was also reflected in the media, including entertainment media. This highlights the pervasiveness of heteronormativity in almost all sources of sex education. In terms of formal sex education, the responses from participants reflect the institutionalisation of heterosexuality.

Religion further played a key role in how sex was constructed, and this is evident in the point that Charlie Witton makes. They noted that not only was sex only ever taught or spoken about in terms of heterosexual sex, but sex was also only spoken about within a certain context:

> "I mean it wasn't even spoken about between a man and a womxn except if they loved each other very much and that's how babies were made (laughs). But never ever in terms of homosexual relationships ever [...] Heterosexual sex with love in bold. Always with love [...] It's not just physical, it's not just fun, it's to make babies or build a connection with your soul mate. That's pretty much the crux of it [...] Once you're married not even engaged."

The idea that sex is reserved for those that are 'in love' and/or married was a common message relayed to participants. It was especially common for participants who went to Christian schools or grew up in religious households. The above depicts how religion intersects with sex education. The link between sexuality and morality could be partially explained by the fact that the LO curriculum includes topics that cover religions and morality (Helleve *et al*, 2009: 201). Religions tend to have explicit rules on sexuality such as the prohibition of premarital sex (Ibid., 201). Importantly, for the participants from this study, the link between sexuality and morality was evident in many sources of sex education beyond formal sex education. For example, Genevieve explained:

> "I remember one of the most prominent things that kept me from having sex was that if you do, you're a slut, and that in having sex it like degrades you as a womxn."

Genevieve noted that this construction was a recurring message surrounding sex and was even evident in movies that they watched. Their statement points to the intersection of gender and sex education where there are explicit gender norms with regards to what is appropriate and what is not. This theme of a womxn's worth being linked to sex was evident in most participants' responses especially those that went to a Christian school or who grew up in religious homes. When spoken about within a religious context, the above was linked to the notion that premarital sex was 'wrong' or 'sinful'. In both cases however more emphasis was placed on a womxn's worth than a man's. Drawing on social constructionism it is evident from participant responses that the process of gendering individuals, its outcomes and the establishment of sexual identities, desires and practices are reinforced by religion as well as society's whole set of values (Lorber, 1994: 113). Radical feminism argues that society is constructed in terms of a hetero-reality, where there is a belief that a womxn's purpose is to be

‘for men’ and therefore, identifies single womxn as promiscuous (Rowland & Klein, 1996: 16). Womxn who are promiscuous are then viewed in a negative way as being available to any man (Ibid., 16). Furthermore, the institution of marriage often serves the sexual desires of men, not womxn (Shulman, 1980: 598). It could therefore be argued that by constructing sex as only appropriate within a heterosexual marriage or relationship, sex education is used as a support and justification for a patriarchal structure that seeks to hold womxn as the property of men. Drawing on Butler’s (1990: 95), theory it has been made clear in this section how sex was constructed in terms of something occurring between a man and a womxn and as something only appropriate within a certain context, is that both sexuality and gender identity have been constructed in heterosexual terms.

7.6 What do you mean when you say, “I had sex”?

A key theme emergent amongst participant responses was the inability to provide concise definitions of the term ‘sex’. Almost all participants initially struggled to define the term ‘sex’. I had to ask all participants what they meant when they said, *“I had sex”.* It was only when I related the question to themselves that they were able to define what ‘real sex’ was in relation to themselves. The majority of participants initially had a very broad definition of sex. Frances Brooks initially defined ‘sex’ as:

> “All sex is real sex.”

When I posed the question differently and asked what they mean when they say, *“I had sex*”, Frances Brooks responded:

> “Oooh, then I’d definitely mean penetrative sex.”

Five of the participants defined ‘sex’ as penetrative, two of which explicitly stated penile and vaginal intercourse. Furthermore, Robyn and Genevieve stated that foreplay was everything that occurred before sex (i.e. penetrative sex). Daniela and Jade on the other hand had much broader definitions of sex. Daniela noted that identifying as bisexual influences the way in which they understood sex and defined sex as:

> “I've had either intercourse with an individual or we've had oral sex those would probably be if I were to say the parameters.”

Jade also pointed out that identifying as pansexual influenced how they defined sex, stating that the genetalia of at least one partner had to be involved for an act to be considered sex.

Sexual behaviours that did not count as 'real' sex for those who identified as heterosexual were all acts outside of penetration which included petting, oral sex, anal sex, and foreplay. Sexual behaviours that did not count as 'real' sex for Daniela included dry humping and petting and for Jade any act that did not involve the genetalia of at least one partner. Jade viewed sex to be on a continuum and noted that they experienced a duality in their understanding of and experiences of sex:

> "I think when it comes to people that identify as male, I think we've kind of been shown and I've kind of been very much exposed to this idea that sex should look like this, which is very much I think penetrative and kind of like heterosexual. But then there's this kind of like duality in when I'm with partners that kind of don't identify as male or just don't have a penis. It's a lot more I think fluid in a weird way. I think because it's not the norm it has to be fluid."

Jade's statement emphasises the importance of not viewing sex in strictly binary terms based on their practices of sex. This links to queer theory in that sex, gender and sexuality cannot purely be understood in binary terms (Butler, 2004: 53). They are all much more fluid and Jade and their experiences demonstrate the fluidity of these categories. Drawing on intersectionality, single-axis thinking limits the ways in which social phenomenon can be understood or explained (Cho *et al*, 2013: 787), and thus it is important to note that the way in which participants defined sex illustrates the significance of sexuality on participants' definitions of sex especially with regards to themselves. All participants who defined sex as penetrative identified as heterosexual whilst those who held much broader definitions of sex identified as bisexual and pansexual respectively. What has been made clear by participants' responses is that the category of sexuality directly influenced the ways in which sex was understood, exposing intragroup differences and similarities amongst participants.

Importantly for Genevieve for an act to be considered sex, it had to be consensual. When asked what acts did not count as 'real' sex, they responded:

> "Uhm, rape, firstly. So, consent to me is very important to the definition of sex, 'cause it's two people, so, there has to be permission with both sides."

This highlights the intersection of gender and sexuality because GBV is something that largely affects womxn (Safer Spaces, 2019), which could explain the fact that consent was key to Genevieve's definition. This question was a difficult one for participants to answer because for some it was the first time they had consciously thought about it. For example, Daniela stated:

> "It's actually quite hard to think about I've never like put it in boxes, I guess."

The way in which sex was taught could partially explain why most participants defined sex in such narrow terms especially for those who identified as heterosexual. With this said, all participants who identified as heterosexual noted that sex did not necessarily mean penetration when they spoke about sex in relation to others. They recognised that sex and how individuals defined or practiced sex was very personal but in terms of their understanding of engaging in sex for themselves they understood it as penetrative sex. Jessica Rabbit pointed out this contradiction:

> "So, this is weird because when I say I've had sex I mean penetrative sex. But when I talk about it or think about it like in the conversation now, I say oral sex is sex as well, you know like [not that I have anal sex] but that would be sex as well."

The findings from this study support the findings from other studies, in particular for those participants that identified as heterosexual. Other studies have found that penile-vaginal intercourse was a key feature of respondents' definitions of sex. (Holland *et al*, 1990: 340; McPhillips *et al*, 2001: 238-239; Peterson & Muehlenhard, 2007: 259; Randall & Byers, 2003: 91). Furthermore, as was the case with Robyn and Genevieve, sexual acts outside of intercourse are often viewed as 'foreplay', as the build up to the main event - sexual intercourse thus making penetration the defining feature of hetero(sex). Importantly all these studies were conducted on those who identified as heterosexual which would explain the differences found in this study. As stated earlier, those who did not identify as heterosexual held much broader definitions of sex. Randell & Byers (2003: 89) note that students with a broader range of sexual experiences may subscribe to a broader definition of sex that includes all the sexual behaviours they have engaged in. This was not found in this study but rather those who identified as bisexual or pansexual subscribed to a broader definition of sex suggesting that sexuality rather than sexual experience plays a more significant role in the ways that participants defined sex.

7.7 'Safe sex': Beyond a Biomedical Understanding

For all participants 'safe sex' was important, however most held multiple definitions of 'safe sex', which were influenced by the context and situational features of a sexual encounter. What may be considered safe in one sexual encounter may not always be considered safe in another. With this said, one participant only held a biomedical definition of 'safe sex' regardless of the context of the sexual encounter. Jade understood 'safe sex' as both condom-use and

contraceptive use but importantly for them condom-use was something that needed to occur with any sexual encounter to be considered safe. They did note however:

> "I think for me in this part of my life now it very much is important always. Maybe that will change when my kind of social surroundings change and maybe I have like a partner or something like that and my idea surrounding safe sex will change. But now it's very much in how I'm kind of practicing my sexuality, now it is a criteria for safe sex."

This suggests that the definition of 'safe sex' for individuals is not fixed, it is flexible and continuously changing. Although the biomedical definition forms a large part of Jade's understanding of 'safe sex', they recognise that, that may change in the future. This idea that the definition of 'safe sex' evolves, and changes for individuals was a common theme among all participants. For example, for Frances Brooks past experiences impacted the way they understood 'safe sex' presently and when asked when they felt that condom-use was most important, they stated:

> "I think now, post being in that relationship I think it's important all the time. Uhm, and I think that if I were to go into another relationship, we'd get tested before we started having unsafe sex."

For Frances, condom-use was always important even if one was in a committed relationship. They further pointed out that contraception coupled with condom-use made sex even safer as there would be a double layer of protection against pregnancy. Importantly, they were the only participant that defined sex without a condom within a committed relationship as unsafe. This suggests that condom-use has become fundamental to their current understanding of 'safe sex' and that their past experience played a significant role in this understanding. Health played a crucial role in participants understanding of 'safe sex'. For all participants STI prevention as well as the prevention of pregnancy were very important. Almost all participants held this dual understanding of 'safe sex' in terms of their health. It was especially noted that preventing pregnancy at this stage in their lives was a major concern. Robyn for example stated:

> "If I had to fall pregnant, I would get an abortion, one hundred percent. One of my best friends got one, so I know who to go to, who to ask, what to expect because I was with her in the room when it happened. So, I'm not even ashamed to say that I will get one because I'm not ready."

For participants who used the term ‘unprotected sex’ they meant engaging in sex without using a condom, but this was not understood as unsafe sex. Furthermore, they often viewed sex as still protected if one was on contraception because preventing pregnancy at this stage in their lives was viewed as crucial. This is most probably because all participants were students, many still financially dependent and thus it was not the ‘right’ time for children while for others they simply did not want children at any stage. Linking this to intersectionality it becomes clear that participants’ gender intersects with how they understand ‘safe sex’ in terms of their health because if they were to fall pregnant they would probably be left with the bulk of the responsibility both in terms of child rearing and in terms of actually carrying the child to term physically. The findings in this section indicates that health plays a key role in participants’ understanding of ‘safe sex’. The section that follows will discuss that although health plays a key role it is not the only way ‘safe sex’ is defined for participants.

7.7.1 The Significance of Situational Features of Sexual Encounters

Although health played an important role in their understanding of ‘safe sex’, there were many dimensions to participants’ understanding of ‘safe sex’, many of which went beyond health. This study sought to look at ‘safe sex’ beyond the scope of health and in doing so, many other issues came to light. The dimensions include; health, personal/psychological well-being, personal safety, type of relationship and what conditions are needed outside of condom-use and or contraceptives for a sexual encounter to be considered safe. The next section will discuss how participants understood ‘safe sex’ beyond their health.

A very important aspect of how ‘safe sex’ was understood was very much dependent on the kind of sexual relationship or situation in which participants were engaging. This was also found in other studies, where the situational features of a sexual encounter played a significant role in participants’ decision to carry out ‘safe sex’ with regards to condom-use (Moore & Rosenthal, 1992: 416; Rosenthal *et al*, 1998: 45). Previous studies have found that the situational features of a sexual encounter as well as the assumptions brought to the encounter by individuals were crucial in making a decision about ‘safe sex’ and carrying it through (Moore & Rosenthal, 1992: 416). For example, Robyn agreed that ‘safe sex’ involved condom-use but noted that ‘safe sex’ was something specific to an individual’s sexual relationship. During the time of the interview Robyn was in a committed relationship so for them at that point in time ‘safe sex’ was understood as:

> "My boyfriend and I now we both got tested and we both clean, and I do trust him that he won't cheat on me and visa-versa. So, we have sex without a condom and I'm currently on the pill as well. So, for me it's safe sex."

Jessica Rabbit held a similar view when talking about their 'safe sex' practices:

> "The first time I had unprotected sex was only with my third sexual partner and only once we'd both been tested, and we were like in a committed like monogamous relationship right. and so, it was like fine, that's us having unprotected sex and by that, I mean condoms, like I was still on birth control. [...] But like I didn't think I was having unsafe sex with my ex."

Key to many participants understanding of 'safe sex' in particular within this context which has been illustrated in the previous statements is the element of trust. As noted by Charlie Witton's current understanding of 'safe sex":

> "But for me just at moment it's just more like having a contraceptive and trusting your partner."

This highlights the importance of context, and that individuals' understandings and subsequently their practices of 'safe sex' may change according to the sexual encounters' individuals find themselves in. All participants held multiple understandings of 'safe sex' which was very much influenced by a number of factors, specifically the situational features of a sexual encounter as well as the assumptions brought to the encounter by the individuals involved. Robyn highlights this very well:

> "The first time I had sex I wore a condom. So, the first boyfriend I ever had who I had sex with we always wore condoms because I was hella (sic) scared about getting pregnant. And then my second boyfriend who I had dated for a while like one and a half, two years. We started off with condoms and then obviously I went on the pill and we were super in love, so we didn't wear condoms. And then I came to university and I thought I could just not wear condoms and I was like ok wait, fuck this needs to hold, slow down and then I did. So, I've kind of gone here and there depending on my situation you know."

Almost all participants shared these sentiments and had decided how they would practice 'safe sex' based on the situation they found themselves in. The implication is that a biomedical definition of 'safe sex' does not reflect the common concerns of individuals' lives.

Furthermore, the findings also suggest that the meaning of 'safe sex' is a flexible practice for participants. In the section that follows one-night stands will be discussed which will again emphasise the importance of the situational features of a sexual encounter on participants' definitions of 'safe sex'.

7.7.2 How safe are one-night stands?

Five participants expressed that they were not comfortable with one-night stands in general, for some it was specifically with someone they did not know. For Jade it was purely because they simply did not feel comfortable engaging in sex with someone they did not know. For the other four participants it was a case of 'stranger danger', where they felt that engaging in sex with someone, they had just met increased the chances of sexual violence occurring. They felt that it was more likely that a stranger would be sexually violent towards them than somebody they knew. Genevieve's view of this issue was based on their own past experiences as well as the fact that South Africa has extremely high rates of VAW:

> "I don't think it's safe, especially in terms of what happens to womxn in the current political climate. Like weekly you hear about some womxn who's been burnt and thrown in a field. I think going home with someone let's say who you have never seen or met before in your life and who your friends don't know, puts you in a potentially very high-risk situation. That's what I've been in."

South Africa has very high rates of GBV, Stats SA (2017: 6), reported that violent crimes against womxn increased dramatically between 2015/16 and 2016/17. Over 39 000 cases of rape were reported to the police between April 2016 and March 2017, however it is believed that cases of rape are grossly under-reported (Amnesty International, 2019). This could explain why sexual violence was a particular concern for many participants in this study. Robyn also spoke about the situation in South Africa for womxn but also noted that since first and second year they have learnt more sexual violence:

> "So, right now if I had to be in a one-night stand I wouldn't feel safe because of the social and political climate at the moment, everywhere in South Africa. [...] Fear for my own safety and also just because people are scaly at Rhodes and throughout the other universities. [...] Men are trash, but specifically for me, like a heterosexual womxn. You just can't trust people [...] But now that I know there's things such as rape

> and sexual harassment and you know the nuances and the complexities of rape, I'd rather just protect myself. I'd rather just avoid being in that situation."

Charlie Witton also viewed a one-night stand with a stranger as more dangerous:

> "But hooking up once with a stranger feels a bit more dangerous to me than anything else. Because you don't know anything about them, they could lie to you very easily and things could go wrong more easily than if you did know them. And they have no responsibility or accountability either, 'cause they can just disappear and you'll never see them."

For Frances Brooks they felt that somebody they knew was more likely to check in which was key for them to feel safe:

> "I try to only get into situations like that with people who I know. Like who I've chatted to quite a lot or whatever, and then I don't feel unsafe 'cause I know them [...] Generally if you know somebody then they're like, they're quite like, "are you sure this is what you wanna do?", you know? And that's nice. That like makes me feel safe."

Frances Brooks, Charlie Witton, Genevieve and Robyn all exhibit an internalisation of 'stranger danger'; where they viewed strangers as more dangerous and more likely to commit acts of sexual violence towards them than somebody that they knew. Ironically, an individual is more likely to experience GBV by somebody that they know. Population-based surveys in South Africa show that the most common form of VAW is IPV (Safer Spaces, 2019). IPV includes sexual and emotional abuse by a current or former intimate partner or spouse (Ibid., 2019). The concerns of these participants also highlight the intersection of gender in their oppression because as a result of their gender they are much more likely to experience GBV and thus this formed a crucial consideration when they engaged in sexual activity. What became clear was that there was a lack of talk around GBV in all participants' sex education (particularly in the early years, primary school years and high school years) which could partially explain these findings. Robyn and Genevieve stated that it was only when they came to University that topics such as sexual violence were discussed. The implication of these findings is that gender has a significant influence on what is considered 'safe sex', these understandings go beyond a biomedical definition and that 'safe' for many participants also meant personal and physical safety.

The above sections on ‘safe sex’ in this chapter indicate that the situational features of a sexual encounter were closely linked to participants’ definitions of ‘safe sex’, suggesting that how ‘safe sex’ is understood is not one-dimensional and is instead relatively flexible. Individuals’ definition of ‘safe sex’ and the potential flexibility of this definition needs to be seriously considered when developing interventions. If we do not consider this, interventions promoting ‘safe sex’ may be ineffective as they are in conflict with the actual reality of individuals sexual lives. It is worth emphasizing that ‘safe sex’ was understood not only in terms of what participants did but also in terms of who they were doing it with, what situations they would allow themselves to be found in and what situations participants found themselves in. Therefore, the definition of ‘safe sex’ varied considerably among participants and participants themselves held various understandings of ‘safe sex’, depending on the situational features of the sexual encounters they found themselves in.

7.8 Experience leads to knowledge: You need to have sex to learn about sex

The most important source of sex education for all participants was actually engaging in sexual activities. It was through their experiences of having sex that participants felt they learnt the most about sex and the reality of having sex. Each participant felt they learnt various things from having sex. Frances Brooks observed that:

> “The thing is like when you have sex then it’s like very natural and easy and fine, but like before, like you even know what it’s like you like, it’s very weird.”

Because most participants felt that the sex education they received did not include the nuances of sex and the actual experience of having sex (how it works), participants felt that the most significant and important way they learnt all of that was through actually having sex. This highlights that the technical information participants received lacked the personal dimension. Many felt that the information they received was not the information they wanted; sex education, especially formal sex education, did not answer the questions participants wanted the answers to. This may be due to the very impersonal manner with which formal sex education was delivered. Formal sex education was largely delivered in a very technical manner, covering limited topics such as pregnancy, STIs, contraception, condoms and abstinence. Daniela learned a number of things including from their perspective that ‘safe sex’ was impractical especially when they were with partners who were womxn:

> "That using protection is not practical, the first time I had sex with a womxn I thought oh if I were to use protection what would it be and I didn't even know, I couldn't even think of a way to do it."

Importantly, they only learned that STIs could be transmitted through oral sex when they came to university, which points to two things. First, by talking about sex only in terms of heterosexual sex (sexual intercourse) and ultimately constructing sex within what Butler (1990) calls the 'heterosexual matrix', key sexual behaviours outside of this such as oral sex are left out of the discussion. Second, that this has important consequences for how 'safe sex' is taught and ultimately how it is understood. As has been stated previously, this has important consequences on how individuals practice 'safe sex' and with which sexual behaviours they believe condom-use is necessary. Drawing on intersectionality, it is clear that for Daniela their gender as well as their sexuality intersect with how they understand and practice sex and 'safe sex'. Jearey-Graham & Macleod (2015: 18) found that among their participants sex education was viewed as being delivered in inadequate and non-relational styles of communication and that sex education was largely irrelevant to participants lives. This section indicates that the participants from my study held a similar view and that it was only through the engagement in sexual activity that the true nature of sex as well as 'safe sex' for each participant was learned.

7.9. Perceived risk of STIs

All but two participants had little appreciation of the risk that they were at for STIs. Jade and Frances Brooks perceived themselves to be at risk of STIs, Robyn and Genevieve perceived themselves to be at no risk of STIs and Daniela, Charlie Witton and Jessica perceived themselves at low risk of STIs. The overwhelming majority of participants perceived themselves to be at low or no risk of STIs. The table below illustrates participants' perceived risk, STI testing history and an explanation of their engagement in risky sexual behaviours. I was unable to get the STI testing history of Jade.

Name	Perceived Risk	STI Testing History	Sexually Risky Behaviour (condom-use)	Level of Sexually Risky Behaviour
Robyn	No risk	HIV testing annually, never done a full STI screening Aware of HIV status	Currently in a long-term relationship and does not use condoms. Aware of partner's HIV status	Medium
Jade	At risk	Unknown	Uses condoms with every sexual encounter	Low
Charlie Witton	Low to no risk	Never done an HIV test or a full STI screening	Engages in sexually risky behaviour: Hardly uses condoms. Currently with a long-term partner, does not use condoms and does not know partner's or their own STI or HIV status.	High
Jessica Rabbit	Low risk	HIV testing annually Full STI screening done once in 2018 Aware of HIV status Has had the HPV vaccine	Engages in sexually risky behaviour: Oral sex with a casual partner does not use condoms, has also recently engaged in casual sex with more than one casual partner without using condoms and without knowing their status.	High
Genevieve	No risk	One full STI screening	In a long-term relationship and currently does not use condoms with their partner Is not aware of partner's STI status or HIV status. Has assumed partner is STI free, because they were a 'virgin' before engaging in sex with Genevieve.	Medium
Daniela	Low risk	Regular testing: Donates blood every two months (is contacted if something comes up). HIV testing done twice a year if they have not donated blood that year. Done a couple of full STI screenings in particular during a year they felt they were 'promiscuous' Is particularly aware of HIV status as it affects their immigration status.	In a long-term relationship. When a partner becomes regular requires them to go for an HIV test especially men. Engages in risky sexual behaviour with womxn as only uses condoms with men.	Medium
Frances Brooks	At risk	Two full STI screenings, done in 2016 and 2018. Has had the HPV vaccine	Uses condoms for every sexual encounter and has stated that in future, they will do STI testing regularly with every new partner. Prior to this was in a long-term relationship and did not use condoms nor was aware of their partner's STI or HIV status. Their partner was not faithful.	Low

Those that viewed themselves at low or no risk of STIs, nevertheless engaged in sexually risky behaviours. I have classed participants as low, medium or high to indicate the level at which they engaged in sexually risky behaviour. Interestingly, those who perceived themselves to be at risk of STIs engaged in a relatively low level of risky sexual behaviours whereas those who perceived themselves at low or no risk of STIs engaged in medium to high levels of risky sexual behaviours. The table above illustrates participants' perceived risk, STI testing history and an explanation of their engagement in risky sexual behaviours. In the categorisation of participants' levels of their engagement in risky behaviours, their STI testing history was also taken into consideration. For example, Charlie Witton perceived themselves at low to no risk of STIs yet had no STI testing history, had previously and was currently not using condoms when engaging in sex and did not know their partner's status. Therefore, Charlie was engaging in risky sexual behaviour placing them at a higher risk of STIs. This is compared to Robyn who tested regularly for HIV and thus already knew their HIV status when the interview was conducted. Robyn's perception of their risk was based on their HIV status, their partner's HIV status and the kind of relationship they were involved in at the time of the interview. I placed them at medium risk because of the fact that they did not know their own or their partner's status with regards to other STIs and their partner could be unfaithful and as a result could put them at risk of STIs.

All participants seemed fairly knowledgeable about STIs, in particular how they could be transmitted. However, this knowledge did not translate to safer sex practices, in particular condom-use. This finding is consistent with findings in other studies. Other studies have shown that individuals are aware of how STIs are transmitted yet engage in sexually risky behaviour and have an unrealistic perception of their own risk of contracting an STI despite this (Adefuye *et al*, 2009: 1; James *et al*, 2004: 264; Tillotson & Maharaj, 2001: 92). The participants' responses from this study indicate that STI knowledge is not a predictor of consistent condom-use and even though STIs were heavily emphasised in participants' sex education, it has not translated to safer sex practices in participants lives. Hartell (2005: 177) found that adolescents recognised the severity of HIV/AIDS however few viewed it as a personal threat even though they engaged in risky sexual behaviour. This was true for Jessica Rabbit who stated that they thought that most people were relatively safe in terms of HIV and felt that it was not in their reality. As the table indicates, Jessica Rabbit engaged in a high level of risky sexual behaviours yet did not view HIV as a personal threat. With this said, they did note that their view may be

influenced by the stigma attached to HIV/AIDS as well as the fact that they did not personally know anyone who was HIV positive.

A possible explanation for participants' perception of their risk of STIs could be an internalisation of the stigmatisation of STIs. As observed by Jessica Rabbit:

> "I've just been so socialised to believe that like it's the end of the world. Like even if you have like chlamydia and it's like cured, it's like ah you still had an STI."

Anderson, Beutel & Maughan-Brown (2007: 99) state that recognizing one's own risk of contracting HIV acknowledges the chance of being part of a stigmatized group. The same could be said about STIs more generally. As noted by Farrell (2002: 143), although HIV-related stigma is still common throughout Africa, stigma is also attached to STIs. As has been found by Anderson *et al*, (2007: 99), youth may avoid being a part of a stigmatized group by downplaying their personal risk due to HIV and AIDS being highly stigmatized in South Africa. What became evident in my study is that participants downplayed their risk (with the exception of Jade and Frances Brooks), of contracting STIs which could be as a result of the fact that STIs are highly stigmatised. Linking this then to participants' sex education, the stigmatisation may be as a result of sex being constructed as inherently dangerous during their high school years. All participants stated that 'scare tactics' were used to discourage sexual activity and as a result the fear of contracting an STI was instilled in them as a key part of their sex education. The implication of this is that sex education has clearly failed participants and has not resulted in behaviours that reduce the risk of STIs. As has been shown previously, the low appreciation of their risks are in line with findings of other studies conducted amongst South African youth. Ultimately this has important consequences not only for the transmission of STIs but in particular HIV, which is especially worrying in a country with the largest HIV epidemic in the world (HSRC, 2017: 46). The findings from my study highlights the importance of researching the white demographic in South Africa as well as the fact that this research is warranted. Although most participants are engaging in sexually risky behaviours, few perceive themselves to be at risk of STIs which contributes to the high rates of STIs amongst those aged 15 to 24. Furthermore, this finding indicates that the way sex education is delivered is not resulting in sustained behaviour change which points to the failure of it.

7.10 The Policing of Bodies and Sexuality: Beyond Passive Femininity

A key site of control and policing was sexuality not only in terms of when sex was appropriate but also in terms of whom it was appropriate to have sex with. Heteronormativity was used to police the sexuality of in particular two participants; Robyn and Daniela. Perhaps the most extreme case was Daniela's:

> "My parents were very open and my family although they are Catholic are very open. I knew that being gay was illegal in Zimbabwe, so it was very much I knew exactly what was going on and I understood my sexuality, but I hid it in Zim because I knew the repercussions of that."

The implication of heteronormativity is that all 'other' identities are measured against heteronormative standards with those who do not conform deemed abnormal or amoral and sometimes in need of correction (Donaldson, 2015: 132). Daniela's case is the most impactful and overt example of institutionalised gender oppression, and points to the extent of the institutional control over Daniela's sexuality where their identity had to be hidden for their own safety. By making homosexuality illegal, the state has rendered anything outside of heterosexuality punishable. Daniela's experiences highlight how their gender and sexuality intersects with their oppression. In Robyn's case their school seemed to fear that the girls would become homosexual and thus there were strict rules of conduct:

> "So, we weren't allowed to bath together. We weren't allowed openly speaking about like periods and ya. I know my group of friends would all sit in each other's rooms and talked about sex and if we got caught, (gasps) we would get in so much trouble, we would honestly get in so much trouble. [...] we weren't allowed to be too touchy feely with each other."

In Robyn's case not only was gender heavily policed but so was sexuality. It is important to note that Robyn's school at this stage was a Catholic all-girls boarding school, which could explain why there was a strong emphasis on policing their sexualities and to ensure that the students did not behave in any way that was perceived as homosexual. There were clear standards at this school where homosexuality was punished in some way or another. For example, Robyn mentioned that a student at their school was expelled for identifying as lesbian. In terms of Catholicism, homosexuality is viewed as a sin which could explain why this was a key site of control for the school. Both Daniela's and Robyn's cases point to the

institutionalisation of heteronormativity and could further be linked to the ways in which sex education was taught in heterosexual terms.

A recurring theme amongst the majority of participants was the policing of their bodies and one manifestation of this was how they dressed. The policing of their bodies was evident in the school rules around school uniform or civvies as well as through parents' rules or ideas of how they should dress outside of school. Importantly, what came up amongst these participants was the resistance to the norms and values placed on their bodies. All participants resisted and pushed back in their own ways which speaks to social constructionism: individuals are not determined by social structures, they have their own agency and are not merely passive recipients of discourse or social structures (Burr, 1995: 64). With this said, participants were constrained in certain ways: in the ways in which they could or understood how they could resist. This is illustrated in Charlie Witton's statement:

> "I always compensate, like if I wear a crop top, I wear jeans basically. Or if I wear shorts then I'll wear something that covers my stomach. Like I never show too much because in the back of my head I have this you look like a slut voice from my mom."

They went on to say:

> "Like I'm about a certain thing and I'm gonna be confident in my dress choices and this is who I am, you can't tell me to change, versus like making people really uncomfortable. Like I'm trying to find a balance."

Charlie felt that they needed to compromise in some way or another. Robyn instead, resisted their school's issue with their hair and made no compromises:

> "I got in huge shit for having short hair, I'd like to just say. I'd always get in trouble for having my hair too short. [...] They just said that you can't have it that short and my mom fought for me as well she was like, "why? Why can't she have short hair?" And they never actually gave a reason, they just kind of tuned me all the time. Eventually they dropped it because I was like, "it's literally my hair guys"."

Importantly in Robyn's situation they had their mother's support which may have allowed them more room to push back. Drawing on Butler's (1988: 52) theory of the performativity of gender, what is evident in participants' responses is that the reproduction of gender is always a negotiation with power, however the reproduction of these norms is always at risk of being redone in new and unexpected ways. This allows for the reconstruction of gendered reality

along new lines (Butler, 1988: 52). Importantly, as has been illustrated in participants' responses, individuals have the agency to reconstruct/negotiate their gendered reality, however this negotiation always occurs within a certain social reality which places certain social constraints on how this negotiation can take place. This point is evident in Charlie's above statement, there is a constant negotiation with how they would like to dress and with how they feel they will be perceived. For Charlie there needs to be a compromise, where it takes place slowly and with a dialogue with people around them because they still do not want to make people around themselves 'uncomfortable'. They still resist the policing of their body, however they do this within the context of certain social constraints. A potential explanation for why Charlie compromises more than Robyn is that Charlie often had to negotiate with their own family in particular their mother who policed their dress heavily growing up. This points to intersectionality where religion and gender intersect for Charlie which places further social constraints on the ways in which they are able to negotiate their gendered reality. As is evident by the examples given the extent to which an individual will negotiate varies from each individual which was evident among participant responses. All participants negotiated their gendered reality albeit in their own ways further emphasising that participants are not passive however all participants had to negotiate this within certain social constraints which were further influenced by factors such as religion and sexuality.

7.11 Conclusion

The analysis has highlighted that participants received sex education from various sources and although formal sex education was a significant source other important sources included family, friends or peers and the internet. The internet was a very important source because it was easily accessible and maintained anonymity. The internet gave participants the ability to have access to any information with regards to sex or sexual health that they wanted to which minimised their risk of embarrassment when finding the information they wanted. Sex education did have a link to participants who identified as heterosexual's definitions of 'sex'. As noted, all participants received a largely heteronormative sex education. This speaks to the notion of the 'heterosexual matrix'. As a result, Jade and Daniela's experiences were marginalised, silenced and ignored. Religion also played a key role in the sex education of participants, even for those who did not come from religious households. This was due to the fact that at an institutional level religion was incorporated into their formal schooling and thus religious messages filtered through into their formal sex education. The effect of religion on

participants' sex education, their sexual lives and navigating sex varied. For some, the values placed on virginity for example had a significant impact on how participants navigated their sex lives. Charlie Witton and Jessica Rabbit experienced guilt and shame when they first began to engage in sex or sexual behaviours, and it has taken them a process of unlearning to move past this. Participants' definitions of 'safe sex' indicated that there was a link between the situational features of a sexual encounter and participants decisions to practice 'safe sex'. The implication of these findings is that a biomedical definition of 'safe sex' does not reflect the common concerns of individuals lives. Furthermore, the findings also suggest that the meaning of 'safe sex' is a flexible practice for participants. Lastly, sex education has clearly not resulted in 'safer sex' practices because most participants perceived themselves at low risk of STIs despite engaging in sexually risky behaviour.

CHAPTER 8: CONCLUSION

8.1 Conclusion

The primary aim of this study was to document, explore and analyse young adult white womxn's sex education and their understandings and practices of 'safe sex'. Sexuality is a significant part of human life and sexual health is intimately linked to physical and mental health. This research was contextualised within the theoretical framework of social constructionism in particular Butler's theory of the performativity of gender, where gender is understood as being performatively established, it is not an internal truth but rather a sequence of acts that consolidates one's 'gender'. In a heteronormative society, gender norms then act as a regulatory means for the production and maintenance of hegemonic heterosexuality and as a result both gender identity and sexuality are constructed within a 'heterosexual matrix'. In conjunction with this an intersectional lens was employed in the study where social categories such as race, gender and sexuality are examined and considered in how they intersect in the lives of individuals exposing intragroup similarities and differences. The research was conducted through a qualitative approach, utilizing semi-structured in-depth interviews of seven sexually active white womxn between the ages of 19 and 24.

Sexual socialisation is a long-term process beginning at birth and continuing throughout an individual's life. It is the process through which beliefs, attitudes and expectations about sexuality and sexual relationships are transmitted to individuals by various socialising agents such as parents, the media and religion. Formal sexual education is sex education taught within formal institutions such as school and tertiary institutions. In South Africa HIV/AIDS and sexuality are key content learning areas in LO and constitutes formal sexual education. In this study I used the term *sex education* to include both sexual socialisation and formal sexual education.

The term 'safe sex' has become synonymous with condom-use and this dominant definition of 'safe sex' is a biomedical definition. Under this definition 'safe sex' occurs with the separation of bodies and the establishment of fluid exchange barriers specifically condoms. The problem with the dominant definition is that firstly, it refers to heterosexual 'safe sex' which ignores any sexual behaviours outside of that. Secondly, the biomedical definition does not reflect common concerns in everyday life and thus, is often in conflict with individuals' reality and their experiences. Factors that have been found to influence individuals' decisions to practice 'safe sex' (in particular condom-use) include the situational features of a sexual encounter, the

assumptions brought to a sexual encounter by all those involved and the type of sexual relationship (casual or regular). Linked to this is a lack of clarity surrounding the definition of sex, and many sex-related studies do not require respondents to define sex, which causes challenges when attempting to study other terms related to sexual behaviour. Studies have found that penile-vaginal penetration constitutes a key part of respondents' definition of 'sex' and 'foreplay' is often viewed as the build up to the main event: sexual intercourse. The dominant definition of both 'safe sex' and sex have both been constructed within a 'heterosexual matrix' and ignores the intersection of other social categories such as sexuality in individuals' understandings of both terms.

HIV/AIDS in South Africa has been socially constructed as a problem predominantly affecting 'poor' Black communities which is also reflected in the abundance of literature focused on those perceived to be 'at-risk' groups such as Black or Coloured South Africans. As shown in my review of thirty-six sex related studies conducted in South Africa most studies had a sample that comprised of majority Black African participants largely recruited from informal settlements. None primarily focused on the white demographic and those that did include white participants had a very small sample. As a result, very little is known about the sexual behaviours and practices of the white demographic. Furthermore, the HSRC estimated that HIV prevalence amongst the white population was 1.1% in 2017 and 0.3% in 2012 which indicates that prevalence rates have increased for this population group. With this said, it was noted that these estimates cannot be interpreted with confidence because over half of the white participants refused to participate in the HIV testing component of the study suggesting that these results may not be an accurate reflection of true prevalence rates amongst the white demographic. Although the estimates need to be interpreted with caution the results are still significant and points to more research needed on the white population. This is where this research fits in and focusing on white womxn amongst the identified age group is important for two reasons. The first being that South Africa has the largest HIV epidemic in the world and the second being, that South Africa has one of the highest rates of GBV in the world. HIV/AIDS vulnerability and GBV are intimately linked further justifying the focus of this study. HIV prevalence amongst womxn between the ages of 20-24 in 2017 was more than triple that of men in the same age group, the estimates from the HSRC are 15.6% and 4.8% respectively.

The findings from this study indicate that participants largely experienced a sex education that portrayed sex as inherently dangerous with a strong focus on the negative consequences of sex

which included pregnancy and STIs. As a result, participants were not given an accurate or comprehensive understanding of what sex and 'safe sex' entails. Notably, in particular during their school years GBV, sexual violence or rape were topics that were rarely covered. Participants received sex education from various sources which included parents, school, religious institutions and the internet. Each source played differing roles throughout differing stages in participants lives with parents forming the first stage, religious institutions and schools forming the second stage and the internet forming the latter. Significantly the findings indicate that sex education as a process has not ended but rather remains an ongoing process. As has been found in previous studies, the findings from this study indicated that understandings of 'safe sex' went beyond a biomedical definition and participants held multiple understandings of 'safe sex' where participants' decision to practice 'safe sex' depended on many factors including the situational features of a sexual encounter, the assumptions brought to the encounter and their relationship to their sexual partner(s). Importantly, their gender intersected in their understanding of 'safe sex' where sexual violence was held as a key consideration when engaging in sexual activities for most participants. Finally, most participants perceived themselves to be at low or no risk of STIs despite engaging in sexually risky behaviours. As has been illustrated in the findings of this study participants' sex education was inextricably shaped by the 'heterosexual matrix' which reflected ideals of heteronormativity and misogyny which directly influenced participants understandings and practices of sex and subsequently 'safe sex'. Social categories such as gender and sexuality were significant influences on how participants navigated themselves in their sexual lives. More research on the sexual practices and behaviours of white people in South Africa is needed and future research should include a larger sample size that is more diverse within this demographic including educational level, gender, age and sexuality.

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Appendix 1: Demographic Breakdown of Studies Reviewed

BA: Black African **C**: Coloured I/**A**: Indian/Asian **W**: White **O**: Other

STUDY	DESCRIPTION	DATA	BA	C	I/A	W	O
1. Campbell, C. & MacPhail, C. (2002). Peer education, gender and the development of critical consciousness: Participatory HIV prevention by South African youth. *Social Science and Medicine*, Vol. 55, pp.331-345.	Critical case study of a school-based peer education programme in a SA township school.	Summertown township-population at the time 150 000 Black Africans. Men and womxn ages 13-25. Longitudinal case study of programme, interviews and focus groups of young people in the township.	x				
2. Bhana, D. (2012). "Girls are not free" - In and out of the South African school. *International Journal of Educational Development*, Vol. 32, pp.352-358.	Interviews conducted with township girls in South Africa show enduring experiences of sexual violence both in and out of school.	Paper draws from a larger interview-based project. Paper's focus is only on Inanda High an all-African township school. Grade 11 learners (generally between 16 & 17 years old) Total of 12 participants, 6 men and 6 womxn.	x				
3. James, S., Reddy, S.P., Taylor, M. & Jinabhai, C.C. (2004). Young people, HIV/AIDS/STIs and sexuality in South Africa: The gap between awareness and behaviour. *Acta Paediatr*, Vol. 93, pp.264-269.	Data to provide details of students' knowledge of STIs, perceptions of their vulnerability and their sexual practices. Results show that knowledge levels are high however significant deviation in reported behaviours.	Cross-sectional study carried out among 1113 grade 11 students in 19 randomly allocated schools in the midlands district of KwaZulu Natal. Data collected through structured questionnaires. Men and womxn, between the ages of 15 and 21, that were urban and rural dwellers. Racial composition: unknown but majority of the participants home language was Zulu and only 26% indicated that English was their home language. Therefore, I assumed that there was a mix.					x
4. Mantell, J.E., Needham, S.L., Smit, J.A., Hoffman, S., Cebekhulu, Q., Adams-Skinner, J., Exner, T.M., Mabude, Z., Beksinska, M., Stein, Z.A. & Milford, C. (2009). Gender norms in South Africa: Implications for HIV and pregnancy prevention among African and Indian women students at a South African institution. *Culture, Health and Sexuality*, Vol. 11 (2), pp.139-157.	Focus group discussions to understand how gender norms might be used to buttress HIV and pregnancy prevention. Gender norms regarding womxn's and men's roles, condom and contraceptive use, sexual communication and sexual pleasure.	10 semi-structured focus groups. 67 womxn students. At a tertiary institution campus. Indian and Black African.	x		x		
5. Bhana, D. & Pillay, N. (2011). Beyond passivity: Constructions of femininities in a single-sex South African school. *Educational Review*, Vol. 63 (1), pp.65-78.	The experiences of a selected group of girls in a single-sex Durban school are illustrated to provide a counter argument to the logic upon which single-sex schooling in the country rests.	Interviews conducted with 14 girls aged 15 - 17 years in Grade 10 at Thekweni High School. Racial composition at the school: 90. 4% Black, 2% White, 3%					x

	Illustrates the social complexity in the constructions of alternate forms of femininity (beyond passivity). These forms closely tied to sexuality, race and ethnicity.	Indian and 4.25% Coloured. Chief means focus groups. Racial composition not specified but assume that there was a mix.					
6. Francis, D.A. & DePalma, R. (2014). Teacher perspectives on abstinence and safe sex education in South Africa. *Sex Education*, Vol. 14 (1), pp.81-94.	AO and CSE: LO teachers try to reconcile the two by promoting abstinence as the only appropriate choice for young people while recognising the value of some of the broader issues of CSE for example relationships and safe sex.	In-depth interviews with 25 LO teachers across Free State Province. Among participants there was an average of 15.6 years of teaching experience and 7.04 years of teaching LO. All teachers were Christian. 16 womxn and 9 men. English was the second language to Afrikaans or Sesotho. White: 11, Black African: 11 and Coloured: 3. Range of school contexts: urban township, urban-suburban, small town, rural state and rural farm schools.	**x**	**x**		**x**	
7. Jearey-Graham, N. & Macleod, C. (2015). A discourse of disconnect: Young people from the Eastern Cape talk about the failure of adult communications to provide habitable sexual subject positions. *Perspectives in Education*, Vol. 33 (2), pp.11-25.	Report on a study conducted with FET students in EC and highlight participants common deployment of a 'discourse of disconnect'.	Focus- groups with same-sex and mixed groups. 38 participants: 24 womxn and 14 men Participants recruited from a FET college in the Eastern Cape. Participants were between the ages of 19 and 25 years with the average being 21 years. Young, black, isiXhosa individuals.	**x**				
8. Helleve, A., Flisher, A.J., Onya, H., Mukoma, M. & Klepp, K. (2009). South African teachers' reflections on the impact of culture on their teaching of sexuality and HIV/AIDS. *Culture, Health and Sexuality*, Vol. 11 (2), pp.189-204.	Aims to explore South African LO teachers' perceptions and practice of teaching HIV/AIDS and sexuality in a cultural perspective. Many viewed teaching these topics as a response to declining moral standards, others suggested that they were teaching issues that parents failed to address.	28 LO teachers in schools participating in the South African and Tanzanian (SATZ) programme in Cape Town and Mankweng (Polokwane). Semi-structured interviews. 13 womxn and 7 men Racial composition not specified.					**x**
9. Reddy, S. & Dunne, M. (2007). Risking it: Young heterosexual femininities in South African context of HIV/AIDS. *Sexualities*, Vol. 10 (2), pp.159-172.	The paper focuses on young womxn's accounts of the feminine identities. The dominant discourses of femininity through which these young womxn made sense of their sexual selves, stood in direct contradiction to their sexual safety.	Male and female learners in a selected co-ed state school in KwaZulu Natal. Participants were between 15 and 19 years. Black African and Indian.	**x**		**x**		
10. Kaufman, M.R., Schefer, T., Crawford, M., Simbayi, L.C. & Kalichman, S.C. (2008). Gender	The Gender Attitudes-Power-Risk (GAPR) model of HIV risk behaviour was tested using survey data collected	309 men that completed a survey that was administered in Xhosa,	**x**	**x**		**x**	**x**

attitudes, sexual power, HIV risk: A model for understanding HIV risk behaviour of South African men. *AIDS Care*, Vol. 20 (4), pp.434-441.	from men who were attending STI services in a primary health care clinic in Cape Town. Results show that negative attitudes towards womxn was positively associated with a high level of HIV risk behaviour.	English and Afrikaans. Racial composition of participants: Black African: 302 White: 1 Coloured: 3 Other: 2					
11. Kalichman, S.C., Simbayi, L.C., Cain, D., Cherry, C., Henda, N. & Cloete, A. (2007). Sexual assault, sexual risks and gender attitudes in a community sample of South African men. *AIDS Care*, Vol. 19 (1), pp.20-27.	The study examined hostile attitudes towards womxn, acceptance of violence against womxn and masculine ideological beliefs in relation to sexual assault history among men in a Cape Town township.	435 men residing in a township and its surrounding informal settlements in Cape Town. Survey administered in English, Xhosa and Afrikaans. Participants identified themselves as: 35% Coloured 57% Black African 8% White or Indian	**x**	**x**	**x**	**x**	
12. Varga, C.A. (1997). Sexual decision-making and negotiation in the midst of AIDS: youth in KwaZulu Natal, South Africa. *Health Transition Review*, Vol. 7 (3), pp.45-67.	Addresses issues surrounding sexual negotiation and decision-making SA youth in the face of AIDS. Choices made and extent it is influenced by HIV/AIDS. Communication between partners poor, young womxn appeared powerless to enforce their preferences in sexual situations and AIDS was not a significant factor in sexual-decision-making.	Interviews conducted in Zulu (structured and open-ended questions). 39 Womxn: Primigravida adolescents (15-19 years). 24 Men: involved in sexual relationships that landed up in pregnancy and subsequent parenthood in the last three years (18-26 years). Participants recruited from Durban, northwest township and three other neighbourhoods of the city.	**x**				
13. Tillotson, J. & Maharaj, P. (2001). Barriers to HIV/AIDS protective behaviour among African adolescent males in township secondary schools in Durban, South Africa. *Society in Transition*, Vol. 32 (1), pp.83-97.	Explores possible barriers to HIV preventative behaviour amongst Zulu-speaking adolescent males in Durban.	56 black Zulu-speaking adolescent males between the ages of 15-23 in township secondary schools in Durban. Semi-structured focus groups and mixed open-ended and closed-ended questionnaires.	**x**				
14. Kaufman, C.E. & Stavrou, S.E. (2010). 'Bus fare please': The economics of sex and gifts among young people in urban South Africa. *Culture, Health & Sexuality*, Vol. 6 (5), pp.377-391.	Paper examines the economic context of gift-giving or receiving among like-age adolescents and its relationship to risky sexual behaviour. Findings: common and important in shaping sexual relationships.	Focus group discussions collected in the Durban metropolitan area among young people aged 14-22. Cross-racial approach. Black African: 42 Indian: 11 White: 11	**x**		**x**	**x**	
15. Pettifor, A., et al. (2009). Early coital debut and associated HIV risk	Explores early coital debut and associated HIV risk factors among	A household survey with	**x**	**x**	**x**	**x**	

factors among young women and men in South Africa. *International Perspectives on Sexual and Reproductive Health*, Vol. 35 (2), pp.82-90.	young SA men and womxn.	structured interviews. 51% of participants were womxn and, 49% were men. The mean age of participants was 19.1 years with participants being between the ages of 15 and 24. Racial composition of participants: Black African: 82% Coloured: 8% White: 7% Indian: 2%					
16. Morrell, R (2003). Silence, Sexuality and HIV/AIDS in South African Schools. *The Australian Educational Researcher*, Vol. 30 (1), pp.41-59.	Focused on problems which township teenagers routinely encounter and explored understandings of risk, violence, friendship and intimate relationships. Researcher interested to see how interviewees spoke about AIDS given the stigma surrounding it.	Interviews and class discussions. Participants were between the ages of 15 and 20 from two Durban secondary schools over two years. Participants were all Black African form working-class backgrounds.	**x**				
17. Wood, K., Lambert, H. & Jewkes, R. (2007). "Showing roughness in a beautiful way": Talk about love, coercion and rape in South African youth sexual culture. *Medical Anthropology Quarterly*, Vol. 21 (3), pp.277-300.	Ethnographic study of the spectrum of practices relating to sexual coercion and rape among young people in a township in the former Transkei. Racist depictions/ framing rape as a problem of certain communities.	I assumed that there were no white participants as this study took place in an urban township in the Transkei region of Eastern Cape which is mainly Xhosa speaking. Furthermore, the researcher stated that the community was astonished to see a young white womxn living amongst them, and thus the community it is fair to assume that the community was not a white community. I assumed that participants were Black African. Data comprised of participant observation and in-depth semi-structured interviews with 76 young people aged 14 to 25. 46 womxn and 30 men.	**x**				
18. Anderson, K.G., Beutel, A.M. & Maughan-Brown, B. (2007). HIV risk perceptions and first sexual intercourse among youth in Cape Town. *International Family Planning Perspectives*, Vol. 33 (3), pp.99-103.	Examines whether there is a reciprocal relationship between sexual experience and perceived HIV risk.	Longitudinal data collected in 2002 and 2005 from 3017 youth in Cape Town. Participants were between the ages of 14 and 22 years. Racial composition: Black: 28.2% Coloured: 51.9% White: 19.9%	**x**	**x**		**x**	
19. Mall, S., Middlekoop, K., Mark, D., Wood, R. & Bekker, L. (2013). Changing patterns in HIV/AIDS stigma and uptake of voluntary counselling and	Study explores the changes in stigma and VCT access in a peri-urban township in the Western Cape with high HIV prevalence following	Two cross-sectional community surveys assessing HIV knowledge, attitudes and uptake of VCT services. They were					**x**

testing services: The results of two consecutive community surveys conducted in the Western Cape, South Africa. *AIDS Care*, Vol. 25 (2), pp.194-201.	education and research interventions and the introduction of a wide-scale ART programme.	conducted 4 years apart in a peri-urban township in 2004 and 2008. Predominantly low socio-economic status. Racial composition not specified but assume no white participants as the study took place within the community of a township.					
20. Peltzer, K., Nzewi, E. & Mohan, K. (2004). Attitudes towards HIV-antibody testing and people living with AIDS among university students in India, South Africa and United States. *Indian Journal of Medical Sciences*, Vol. 58 (3), pp.95-108.	Aim to examine the attitudes toward HIV testing and determinants of attitudes towards PLWA.	South Africans: 200 students from Limpopo province. 100 men and 100 womxn between the ages of 17 and 34 years. Black students only.	**x**				
21. Brown, D.C., BeLue, R. & Airhihenbuwa, C.O. (2010). HIV and AIDS-related stigma in the context of family support and race in South Africa. *Ethnicity & Health*, Vol. 15 (5), pp.441-458.	Purpose of research to develop an intervention that could be implemented in Black and Coloured communities in Cape Town. Within the context of the family race, cultural values and religious values all contribute to HIV stigma in SA and therefore interventions should address the role of stigma within families in order to promote better HIV prevention, treatment and care.	Participants were recruited from two communities in Cape Town: Gugulethu and Mitchell's Plain. Black and Coloured township. 16 item multi-part interview questionnaire. Examined the racial and cultural similarities and differences between Black and Coloured communities in Cape Town.	**x**	**x**			
22. Clark, J. (2006). The role of language and gender in the naming and framing of HIV/AIDS in the South African context. *Southern African Linguistics and Applied Language Studies*, Vol. 24 (4), pp.461-471.	HIV/AIDS cannot be separated from the ways in which we think, talk and act on it. Article attempts to provide a contextualised interrogation of the meanings that have been made of HIV/AIDS. Analyses general everyday talk and participant's narrative accounts within the research context.	Life-narratives of black womxn from rural settings in KZN. Individual interviews and focus group discussions	**x**				
23. Maughan-Brown, B. & Nyblade, L. (2014). Different dimensions of HIV-related stigma may have opposite effects on HIV testing: Evidence among young men and women in South Africa. *AIDS & Behaviour*, Vol. 18 (5), pp.958-965.	Used data on young black men and womxn from the 2009 Cape Area Panel Study (CAPS) to examine the independent effect of stigmatising attitudes, perceived stigma and observed-enacted stigma on HIV-testing.	Used data from the 2009 wave of CAPS. Restricted data to black respondents due to far higher HIV rates among this population group.	**x**				
24. Petros, G., et al. (2006). HIV/AIDS and 'othering' in South Africa: The blame goes on. *Culture, Health & Sexuality*, Vol. 8 (1), pp.67-77.	To explore the relevance of social concepts such as stigma and denial to the transmission of HIV, this study sought to examine cultural and racial contexts of behaviour relevant to the risk of HIV infection among South Africans.	39 focus group discussions and 28 key informant interviews. Two categories: 18-24 years and 25-49 years. Racial composition not specified but it was a mix including white individuals.	**x**	**x**	**x**	**x**	**x**
25. van Dyk, A.C. & van Dyk, P.J. (2003). "What is the point of knowing?": Psychosocial barriers to voluntary HIV counselling and testing	Presents a study of attitudes towards VCT in South Africa, attempts to ascertain the reasons for people's continued resistance to VCT	Semi-structured questionnaire with 1422 participants.	**x**	**x**	**x**	**x**	**x**

programmes in South Africa. *South African Journal of Psychology*, Vol. 33 (2), pp.118-124.	programmes.	37.8% men and 67.2% womxn. Racial composition: 57.2% Black 27.4% White 8.6% Coloured 6.5% Asian 0.3% Other					
26. Morojele, N.K., Kachieng'a, M.A., Mokoko, E., Nkoko, M.A., Parry, C.D.H., Nkowane, A.M., Moshia, K.M. & Saxena, S. (2006). Alcohol use and sexual behaviour among risky drinkers and bar and shebeen patrons in Gauteng province, South Africa. *Social Science & Medicine*, Vol. 62, pp.217-227.	Paper describes South African component of the WHO multisite rapid assessment and response project seeking to develop a methodology for studying factors associated with alcohol use-related sexual risk behaviour in diverse cultural settings.	Participants were adults between the ages of 25 and 44 who were recruited from a township and suburb site in Gauteng. Data comprised of 18 key informant interviews, observation in 7 drinking venues, 6 focus groups and 16 in-depth interviews with risk drinkers and their partners. Participants predominantly black, could not gain access to two venues in the city with mainly white patrons (owners did not give consent).	**x**				
27. Brittain, K., Myer, L., Phillips, N., Cluver, L.D., Zar, H.J., Stein, D.J. & Hoare, J. (2019). Behavioural health risks during early adolescence among perinatally HIV-infected South African adolescents and same-age, HIV-uninfected peers. *AIDS Care*, Vol. 31 (1), pp.131-140.	Compared behavioural health risks (any self-report of substance use, sexual activity, bullying others or suicidality, or a positive urine toxicology screen) among perinatally-infected adolescents ages 9–14 years to that of an HIV-uninfected comparator group; and explored the effect of behavioural health risks on adolescent and caregiver report of adolescent suboptimal adherence and elevated HIV viral load.	Cape Town Adolescent Antiretroviral Cohort (CTAAC): CTAAC study, perinatally-infected adolescents were recruited from seven routine ART services across Cape Town and were eligible to participate if they were aged 9–14 years, had been on ART for >6 months. Adolescents in the HIV-uninfected comparator group were recruited from a youth centre in Masiphumelele, a low socioeconomic township in Cape Town. 506 perinatally HIV-infected and 110 HIV-uninfected adolescents.	**x**				
28. Eggers, S.M., Aarø, L.E., Bos, A.E.R., Matthews, C. & de Vries, H. (2014). Predicting condom use in South Africa: A test of two integrative models. *AIDS Behaviour*, Vol. 18, pp.135-145.	This study tested two integrative socio-cognitive models to assess their hypothesized motivational pathways for the prediction of condom use during last sexual intercourse.	Students (N = 1066) from Cape Town, South Africa, filled out questionnaires at three different time points. Only sexually active students. Mean age: 14.31 Participants were a mix	**x**	**x**	**x**	**x**	**x**
29. Willan, S., Ntini, N., Gibbs, A. & Jewkes, R. (2019). Exploring young women's constructions of love and strategies to navigate violent relationships in South African informal settlements. *Culture, Health &*	This paper explores young womxn's experiences and constructions of love-relationships and intimate partner violence in South Africa, and the role of agency in womxn's decisions to remain in or leave violent love-	Data was collected from 15 young womxn from two urban informal settlements in eThekwini Municipality between the ages of 18 and 30. Data comprised of semi-	**x**				

Sexuality, pp.1-15.	relationships.	structured in-depth interviews and all data was collected in Zulu I assume there were no white participants and that the majority were Black African as the pseudonyms used were Black African names such as Noluvuyo, Zoleka, Langa, Sthelo, Ntombi, Enhle, Ndoni, Sebenzile, Thembeka, Olwethu.					
30. Fearon, E., Wiggins, R.D., Pettifor, A.E., MacPhail, C., Kahn, K., Selin, A., Gómez-Olivé, F.X. & Hargreaves, J.R. (2019). Friendships among young South African women, sexual behaviours and connections to sexual partners. *AIDS & Behaviour*, pp.1-13.	Friends could be influential on young womxn's sexual health via influences on sexual behaviours and as connections to sexual partners but are understudied in sub-Saharan Africa. We cross-sectionally surveyed 2326 13–20-year-old young womxn eligible for grades 8–11 in rural South Africa about their sexual behaviour and up to three sexual partners. Participants each described five specific but unidentified friends and the relationships between them in an 'egocentric' network analysis design.	The study was set in the Agincourt Health and Socio-Demographic Surveillance System (HDSS) in rural Mpumalanga, northeast South Africa. The site, a former Apartheid 'homeland', is densely populated but rural and has high levels of poverty and unemployment. Agincourt district: Agincourt or Matsavana is a town in Bushbuckridge Local Municipality in the Mpumalanga province of South Africa. A survey was conducted in either English or Shangaan. The racial composition was not specified however according to the Stats SA 2011 census the population of the area is as follows: Black: 97.38% Coloured: 0.17% Asian: 0.04% Other: 0.10% (White are not even listed).	**x**				
31. Louw, J.S., Peltzer, K. & Ramlagan, S. (2018). Self-esteem, sexual-risk behaviour and lovelife exposure among South African young women. *Journal of Psychology*, Vol. 9 (1-2), pp.9-17.	Various risk behaviours have been identified to explain the increased risk of HIV infection among young womxn including factors such as poverty, gender-based violence as well as low levels of self-esteem. This study investigated young womxn's self-esteem, sexual-risk behaviour and exposure to LoveLife, a youth HIV prevention programme.	A population-based household survey of youth aged between 18-24 years in four South African provinces was conducted, using multi-stage stratified cluster sampling. The sample included 1417 womxn in Gauteng, Eastern Cape, KZN & Mpumalanga. Data comprised of a self-reported questionnaire. The majority of participants were Black African womxn.	**x**				
32. Brook, D.W., Morojele, N.K., Zhang, C. & Brook, J.S. (2006). South African adolescents: Pathways to risky sexual behavior. *AIDS Education & Prevention*, Vol. 18 (3), pp.259-272.	This study tested a developmental model of pathways to risky sexual behaviour among South African adolescents. Topics included adolescents' sexual behaviours, household poverty levels, vulnerable personality and behavioural attributes, parent–child relations, and	633 South African adolescents in Durban were interviewed in 2001-2002. 368 (58%) were girls and 265 (42%) were boys between the ages of 12 and 17. Racial composition: Black (N=340), Coloured (N = 26),	**x**	**x**	**x**	**x**	

	deviant peers.	White (N = 64), and Indian (N = 203). Of all the provinces, KwaZulu–Natal has the highest rate of HIV infection of 36.5%					
33. Galappaththi-Arachchige, H.N., Zulu, S.G., Kleppa, E., Lillebo, K., Qvigstad, E., Ndlhovu, P., Vennervald, B.J., Gunderson, S.G., Kjetland, E.F. & Taylor, M. (2018).Reproductive health problems in rural South African young women: Risk behaviour and risk factor. *Reproductive Health*, Vol. 15. (138), pp.1-10.	South African young womxn continue to be vulnerable, with high prevalence of teenage pregnancy, HIV, sexually transmitted infections (STIs) and female genital schistosomiasis (FGS). This study seeks to examine the underlying factors that may be associated with these four adverse reproductive health outcomes. South African young womxn continue to be vulnerable, with high prevalence of teenage pregnancy, HIV, sexually transmitted infections (STIs) and female genital schistosomiasis (FGS). This study seeks to examine the underlying factors that may be associated with these four adverse reproductive health outcomes.	A cross-sectional study of high school students in KwaZulu Natal. Targeted high schools with more than 300 pupils, situated in rural areas in Ilembe, uThungulu and Ugu districts. Data consisted of interviews that were conducted in the local language Zulu and clinical examination and laboratory analyses. In total, 1413 sexually active young womxn of median 18 years (range 16–20) were included in the study					**x**
34. Price, J., Pettifor, A., Selin, A., Wagner, RG., MacPhail C., Agyei Y., Gomez-Olive, F.X. & Kahn, K. (2019).The association between perceived household educational support and HIV risk in young women in a rural South African community (HPTN 068): A cross sectional study.*PLoS ONE*, Vol. 14 (1), pp.1-14.	To characterise perceived household support for female education and the associations between educational support and HIV prevalence, HSV-2 prevalence and sexual risk behaviours.	2533 young rural Black womxn aged 13–20 years old and in grades 8–11 at enrolment. The study was nested in the Agincourt Health and Socio-Demographic Surveillance System (HDSS) site in the area, which provided a sampling framework for the trial - study was located in Agincourt, Bushbuckridge–a rural area in Mpumalanga, South Africa. This cross-sectional study involved analysis of baseline data collected as part of theSwa KotekaCash Transfer Trial.	**x**				
35. Scorgie, F., Stadler, J., Baron, D., Ju, S., Ikaneng, T., Mabude, Z., Makgopa, S., Malefo, M.A., Manenzhe, K.N., Mazibuko, T., Ntjana, H., Nkala, B., Palanee-Phillips, T., Gray, G., Rees, H. & Delany-Moretlwe, S. (2018). "It was not my aim to sleep there": The impact of timing and location of sex on adherence to coitally-dependent HIV pre-exposure prophylaxis. *AIDS & Behaviour*, Vol. 22, pp.3692-3704.	The FACTS 001 trial found that vaginal pre- and post-coital application of 1% tenofovir gel did not prevent HIV-1 infection amongst young South African womxn. The trial included a multi-faceted approach to adherence support and collected objective and self-reported adherence measures. Using qualitative data collected from a random sub-set of FACTS 001 participants (135 in-depth interviews at product discontinuation and 13 focus group discussions at dissemination of trial results), we explore the importance of 'place' and 'timing' in shaping acts of sexual intimacy and product adherence. Demographically, this qualitative sub-sample is similar to the trial cohort of predominantly young, unemployed womxn living with parents or other family members. Sexual intimacy was largely unpredictable and happened across multiple locations in which womxn had limited privacy, autonomy, or control	Study conducted in a number of sites; Gauteng (5 sites); North-West Province (1 site); KwaZulu-Natal (2 sites); and Western Cape (1 site) between October 2011 and August 2014. Sites were: Masiphumelele, Soweto, Soshanguve, Tembisa, Rustenburg, Yeoville, Garankuwa, Ladysmith and Edendale. Racial composition not specified.					**x**

	over the timing of sex. This made adherence to the dosing strategy challenging. Findings may inform the development of future event-driven pre-exposure prophylaxis regimens or products.						
36. Closson, K., Hatcher, A., Sikweyiya, Y., Washington, L., Mkhwanazi, S., Jewkes, R., Dunkle K. & Gibbs, A. (2019). Gender role conflict and sexual health and relationship practices amongst young men living in urban informal settlements in South Africa. *Culture, Health & Sexuality,* pp.1-17.	Qualitative research suggests that men's inability to achieve dominant forms of masculinity may be related to HIV-risk behaviours and intimate partner violence (IPV) perpetration. Using clustered cross-sectional data, we assessed how young men's gender role conflict was associated with HIV-risk behaviours in urban informal settlements in KwaZulu-Natal, South Africa.	Data was drawn from the Stepping Stones and Creating Futures trial and conducted in eThekwini municipality. Participants were 449 men, between the ages of 18 and 30 and recruited from urban informal settlements Racial composition not specified.					**x**

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Appendix 2: A Summary of the Sexuality Education Curriculum for Life Skills and Life Orientation

1. Life Skills

1.1. Foundation Phase: Grades R – 3[5]

1.1.1. Grade R

My body (DoE, 2012a: 9)

- Identify and name body parts
- Functions of different body parts
- Who may or may not touch my body
- What the body needs to keep healthy

1.1.2. Grade 1

Keeping my body safe (DoE, 2012a: 31)

- Safe and unsafe situations and places
- 'Yes' and 'no' feelings
- Practicing saying 'no'

1.1.3. Grade 3

Keeping my body safe (DoE, 2012a: 54)

- We are not safe with everyone
- Rules to keep my body safe
- Trusting 'Yes'/'no' feelings
- How to say 'no' to any form of abuse
- How to report abuse
- 'This section should focus on the prevention of physical and sexual abuse' (DoE, 2012a: 54).

[5] Department of Basic Education: Republic of South Africa. (2012a). *Curriculum and Assessment Policy Statement (CAPS):* Life Skills, Foundation Phase, Grades R-3.

1.2. Intermediate Phase: Grades 4 - 6[6]

1.2.1. Grade 4

a) Development of the Self (DoE, 2012b: 15)

- Respect for own and others' bodies

b) Health and Environment Responsibility (DoE, 2012b: 18)

- HIV/AIDS education: basic facts including blood management:
    - Basic explanation of HIV/AIDS
    - Transmission of HIV through blood
    - How HIV is not transmitted
    - How to protect oneself against infection through blood

1.2.2. Grade 5

a) Development of the Self (DoE, 2012b: 19)

- Relationships with peers, older people and strangers:
    - Safe and unsafe relationships
    - Bad and good relationships

b) Social Responsibility (DoE, 2012b: 20)

- Child abuse: where to get help and report abuse
- Age and gender in different cultural contexts in South Africa:
    - Responsibilities of boys and girls in different cultural contexts
    - Contributions of womxn and men in different cultural contexts

c) Health and Environmental Responsibility (DoE, 2012b: 22)

- HIV/AIDS stigma:
    - Dealing with stigma
    - How to change attitudes towards people living with HIV/AIDS

[6] Department of Basic Education: Republic of South Africa. (2012b). *Curriculum and Assessment Policy Statement (CAPS):* Life Skills, Intermediate Phase, Grades 4-6.

1.2.3. Grade 6

a) Development of the Self (DoE, 2012b: 23)

- Body image:
    - Understanding and respecting body changes
    - Other influences on body image: media and society
    - Acceptance of self

b) Social Responsibility (DoE, 2012b: 25)

- Gender stereotyping, sexism and abuse:
    - Effects of gender stereotyping and sexism on personal and social relationships
    - Effects of gender-based abuse on personal and social relationships
    - Dealing with gender stereotyping, sexism and abuse

c) Health and Environmental Responsibility (DoE, 2012b: 26)

- HIV/AIDS education:
    - Myths and realities about HIV and AIDS including risks and perceptions about HIV/AIDS and caring for people with AIDS

2. Life Orientation

2.1. Senior Phase: Grades 7 - 9[7]

2.1.1. Grade 7

a) Development of the Self in Society (DoE, 2012c: 12)

- Changes in boys and girls: puberty and gender constructs:
    - Physical and emotional changes
    - Understanding changes and how it impacts relationships
    - Respect for own and others' body changes and emotions
- Peer pressure:

[7] Department of Basic Education: Republic of South Africa. (2012c). *Curriculum and Assessment Policy Statement (CAPS):* Life Orientation, Senior Phase, Grades 7-9.

- How peer pressure may influence unhealthy sexual behaviours

b) Constitutional Rights and Responsibilities (DoE, 2012c: 13)

- Dealing with abuse in different contexts: between children and adults and between peers

c) Health, Social and Environmental Responsibility (DoE, 2012c: 15)

- Common diseases including HIV/AIDS:
    - Causes
    - Treatment
    - Resources on health information and services
    - Strategies for living with HIV/AIDS

2.1.2. Grade 8

a) Development of the Self in Society (DoE, 2012c: 16)

- Sexuality:
    - Understanding one's sexuality
    - Influence of friends and peers on sexuality
    - Family and community norms on sexuality
    - Cultural values that impact sexuality
    - Social pressures including media on sexuality
    - Problem solving skills: identity formation and development

b) Constitutional Rights and Responsibilities (DoE, 2012c: 19)

- Gender equity:
    - Defining gender-based violence
    - Emotional, health and social impact of rape and gender-based violence
    - Prevention of violence against womxn: law on sexual offences
    - Sources for help for victims: safety for girls and womxn

c) Health, Social and Environmental Responsibility (DoE, 2012c: 18)

- Informed, responsible decision-making about health and safety: HIV/AIDS:
    - Management with medication, diet, healthy living and a positive attitude

- Prevention and safety issues
- Caring for people living with HIV/AIDS

2.1.3. Grade 9

a) Development of the Self in Society (DoE, 2012c: 20)

- Sexual behaviour and sexual health:
    - Risk factors leading to unhealthy sexual behaviour
    - Unwanted results of unhealthy sexual behaviour: teenage pregnancy, STIs, HIV/AIDS, low self-image and emotional scars
    - Factors that influence personal behaviour including family, friends, peers and community
    - Strategies to deal with unhealthy sexual behaviours: abstinence and behaviour change
    - Protective factors, where to find help and support
    - Adverse consequences of teenage pregnancy for teenage parent(s) and the children born to teenagers.

b) Health, Social and Environmental Responsibility (DoE, 2012c: 22)

- Health and safety issues related to violence:
    - Common acts of violence
    - Reasons violence occurs
    - Impact of violence
    - Alternatives to violence
    - Prevention: where to find help – national health and safety promotion programmes

2.2. Further Training and Education (FET): Grades 10 – 12[8]

2.2.1. Grade 10

a) Development of the Self in Society (DoE, 2012d: 11-18)

- Definitions of concepts: power, power relations, masculinity, femininity and gender:
    - Differences between a man and a womxn (reproduction and roles in the community, stereotypical views of gender roles and responsibilities and gender differences in participation in physical activities)
    - Influence of gender inequality on relationships and general well-being (sexual abuse, teenage pregnancy, violence and STIs including HIV/AIDS)
- Changes associated with development towards adulthood: adolescence to adulthood:
    - Physical changes (hormonal, secondary sex/gender characteristics and primary changes in the body: menstruation, ovulation and seed formation)
    - Emotional changes (maturing personality and changing needs, interests, feelings, beliefs, values and sexual interest)
    - Social changes (relationship with family and interaction with social groups)
- Values and strategies to make responsible decisions regarding sexuality and lifestyle choices to optimise personal potential:
    - Behaviour that could lead to sexual intercourse and teenage pregnancy, sexual abuse and rape
    - Values (respect for self and others, abstinence, right to privacy, right to protect oneself, right to say 'no' and self-control)
    - Skills relating to sexuality and lifestyle choices including critical thinking, assertiveness, negotiations, communication, refusal and information gathering
    - Where to find help regarding sexuality and lifestyle choices

b) Social and Environmental Responsibility (DoE, 2012d: 11-18)

- Contemporary social issues that impact negatively on local and global communities:

[8] Department of Basic Education: Republic of South Africa. (2012d). *Curriculum and Assessment Policy Statement (CAPS):* Life Orientation, Further Education Training, Grades 10-12.

- Social issues: violence and HIV/AIDS
- Harmful effects on personal and community health

c) Democracy and Human Rights (DoE, 2012d: 11-18)

- Human rights and violations:
  - Concepts: diversity, discrimination and violation of human rights
  - Contexts (race, religion, culture, language, gender, age, rural/urban, xenophobia, human trafficking and HIV/AIDS status)
  - Living in a multi-religious society

2.2.2. Grade 11

a) Development of the Self in Society (DoE, 2012d: 22-28)

- Healthy and balanced lifestyle choices:
  - Factors that impact negatively on lifestyle choices
  - Risky behaviours and situations (sexual behaviour, STI's including HIV/AIDS and risk of pregnancy)
- Gender roles and their effects on health and well-being:
  - Unequal power relations (power inequality, power balance and power struggle between genders, physical abuse, incest, domestic violence, sexual violence/rape and sexual harassment)
  - Negative effects of unequal power relations on health and well-being
  - Addressing unequal power relations and power inequality between genders

2.2.3. Grade 12

a) Development of the Self in Society (DoE, 2012d: 28)

- Human factors that cause ill-health, crises and disasters:
  - Lifestyle disease as a result of poverty and gender imbalances: STIs including HIV/AIDS
  - Contributing factors: substance abuse and unsafe sexual behaviours