

**PATTERNS OF EARLY ADOLESCENT SEX AND IMPLICATIONS FOR
HIV/AIDS RISK PREVENTION:**

A contextual study in the Amatole Basin, Eastern Cape.

PUMLA L. NTLABATI

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Abstract

This study involves an analysis of accounts of first and subsequent early sexual experiences in a deep rural area of the Eastern Cape in South Africa over the last forty years. Through interviews and focus group discussions, the enculturation of youth into sexual activity in the community of interest is explored. The study looks into sexual experiences from childhood, through early adolescence to adults of up to sixty-five years old, allowing an analysis of the changing forms of sexual experimentation and sexual debut in this context. Contextual factors mediating these changes are explored, with special emphasis on the changing regulatory practices around early sexual experiences and the effect thereof on behaviors connected to HIV infection risk.

Practices that were previously important mediators of sexual behavior were: anxiety about the social consequences of pregnancy, which was previously a significant disincentive to sexual intercourse; men's previous acceptance of the need to practice non-penetrative forms of sex and girls postponing sexual debut for as long as possible. All these were culturally endorsed, but are now noted to have changed due to changes in the regulatory practices surrounding youth sexuality. The context of early sexual experiences and the surrounding cultural practices have also changed significantly, and this needs to be taken into account in understanding receptivity to condom use messages. Implications for HIV/AIDS prevention are discussed.

Among other interventions, the study describes a participatory, community-based, multi-sectoral approach that takes social conditions into account as a way of empowering the community to strengthen its response to the pandemic. This incorporates different sectors of the community, including youth, parents, religious and traditional leaders, and various other structures, services and institutions that make up the community.

Note on terms used:

- *Culture*: Complex set of norms held by varying racial, ethnic, social class, and religious groups which differ with environmental contexts and may vary through differing points in time.
- *Gender*: the socially defined roles and responsibilities of men and women, boys and girls.
- *Gender equality*: equal treatment of men and women in laws, social practices and policies, and in access to resources and services within families, communities and society at large.
- *Intlawulo (Damage fee/ damage payment)*: refers to the fine a man who has sexual intercourse or impregnates an unmarried woman has to pay to the elders of the woman's family.
- *Maternal health/ women's rights*: an issue not only of women's health, but also of their rights; to do with a woman's rights and sexuality, including HIV/AIDS, sex education, contraceptives, pregnancy and abortion; the rights to make decisions and choices about a wide set of day-to-day issues (e.g. relationships, sexual orientation, marriage, childbearing etc.) free of coercion and violence.
- *Mediator*: an agent influencing or effecting a transition between one stage and another.
- *Phenomenological*: pertaining to describing and analysing phenomena subjectively, as they are directly experienced.
- *Regulatory*: pertaining to or involving regulation of.
- *Sexual rights*: the rights of people to decide freely and responsibly on all aspects of their sexuality, be free of discrimination, coercion or violence in their sexual lives and in all sexual decisions, and expect/demand equality, full consent, mutual respect and shared responsibility in sexual relationships.
- *Sexuality*: socially learned pathway that is part of one's personal identity; covers a range of aspects including how one feels

about/perceives oneself as a sexual being to actual sexual experience and sexual interaction with others.

- *Ukuradisa*: older girls initiating younger boys.
- *Ukusoma (Thigh sex/Intracrural sex)*: a form of non-penetrative sex where the man is only allowed to 'play' on the woman's thighs.

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CHAPTER 1. INTRODUCTION

1.1 Background to the Research

1.1.1 Orientation

This study is an exploration of factors mediating very early sexual debut in a deep rural area of South Africa. A survey (Kelly, 2000) identified a particular rural community as having very high levels of early adolescent sexual activity and a qualitative study was initiated to better understand this phenomenon. The research program as a whole represents part of an ongoing attempt to re-conceptualize high HIV risk adolescent sexuality as an environmental, social and cultural problem rather than specifically as a problem located within the individual, with an interest in developing more effective and sustainable approaches to risk prevention.

It is important to understand patterns of early sexual activity in trying to understand HIV prevalence trends. Factors leading to high levels of sexual activity amongst early adolescents need to be addressed in crafting responses to the HIV/AIDS epidemic. There has been a general lack of recognition in South Africa of high levels of early adolescent sexual activity. Intervention strategies for youth have largely aimed at promoting condom use and there has been a marked lack of intervention at the level of delaying sexual onset (Attawell, 1998).

As Parker in Gillies (1996) comment, sex research has always been a low priority in the social sciences, but the HIV/AIDS pandemic has raised the need for better understanding of sexual behavior. He goes on to point out that, "As the epidemic has continued to expand, dissatisfaction with current sexual behavior research has increased." (p. 137). Kelly and Kalichman (1995) point out that "insufficient attention has been paid to the many psychological, relationship, cultural, affective-arousal, and situational influences that surround and form the context for human sexual behavior" (p.907). The result has been that HIV/AIDS prevention efforts have undoubtedly underestimated the difficulty people have in following risk-reduction recommendations, for instance, that they refrain from sex except in a monogamous relationship, and use a condom under other circumstances.

HIV/AIDS research has been dominated by descriptive public health and epidemiological approaches (Parker, 1995). Research conducted in this fashion has tended simply to reduce sexuality to 'quantifiable' behavior, such as the percentage of people who have engaged in a

particular type of risky behavior or who used a condom the last time they had sexual intercourse. Indicators used for monitoring and evaluation have typically not looked at the background factors, which might mediate sexual behavior, and there has been little accrual of understanding of these. Rather, the focus has been on measurable descriptive indicators, which are designed to understand the impact of programmes, without necessarily understanding why such outcomes might have been attained. Knowledge, attitude, beliefs and practices (KABP) studies, are for the most part of this type (Parker, 1995).

The study of sexual activity through epidemiological research has largely been divorced from its socio-cultural context (Tan, 1995). In addition, the focus has been on documenting behavioral frequencies within a relatively limited range of population groups (especially in perceived 'high risk' populations such as gay men or female prostitutes). Admittedly, there is an increasing tendency to conduct behavioral surveillance in general population groups as well (Parker, 1995). However, for obvious reasons, research conducted in this way has an impoverished view of what sex is (Bolton, 1995). The hope seems to have been that theoretical insights would emerge from such descriptive data (Parker, 1995), but there remains a paucity of theory both about human sexuality and risk management activity.

"More than ten years into a rapidly expanding epidemic transmitted above all else through sexual contact, we have still failed to develop the theoretical tools that might offer a fuller understanding of sexuality in relation to AIDS as well as other aspects of health" (Parker, 1995, p.266). According to Parker (1995), this problem stems from the naturalist perspective of sexuality that has dominated AIDS research. In terms of this approach, "sexual desire has been treated, in many ways, as a kind of given, and the social and cultural factors shaping sexual experience in different settings have largely been ignored, even when lip service has been paid to their potential importance" (Parker, 1995, p.260). Emphasis, instead, has been placed "largely on individual determinants of sexual behavior and behavior change, and the diverse, cultural, economic, and political factors potentially influencing or even shaping sexual experience have more often than not been ignored" (Parker, 1995, p.261).

The study of sexual biographies might reveal a large range of reasons for people wanting to have sex, apart from wanting to feel sexually relieved. Sex can be connected with power, with affectional needs, with transpersonal communication, with needs for affirmation, and much

else besides. This poses a challenge, for if sexual activity is not a unitary phenomenon it is hard to imagine how we might develop models for behavior change in the sexual domain. We cannot analyze the reasons for not using condoms by a simple account based on the presence or absence of knowledge, attitudes and beliefs, perception of vulnerability or any other rationalistic explanation. These aspects represent only the tip of the iceberg of sexuality.

The research addresses the following questions:

- What is the progression of sexuality in this community from middle childhood (8-9 years) to late adolescence (17-23 years)?
- Are there different patterns for boys and girls?
- Have these patterns/practices changed over time, and if so, how?
- What factors appear to be mediating such changes?
- What are the implications for the promotion of HIV risk prevention behaviour?

The primary orientation in this research on contextual determinants of early adolescent sexual activity is to understand how it is regulated, in other words how society responds to it and structures the sexual experiences of subjects. If we can understand how sexuality is regulated in given contexts we will be better positioned to understand how to promote sexual risk aversion.

To understand the sexual regulatory forces of a context we might begin by asking people about how their sexuality emerged in the context of subjective, interpersonal, familial, cultural, societal and material influences. But when we take a community or place as the focus of research we are interested in interpreting the influences which are common to people, which exist in the context, so to speak, before any particular individual becomes the subject of attention; that is, the characteristics of place which define the framework and governing processes for the emergence of sexuality in that place. We do this more comprehensively when we try to understand how phenomena within a society are changing across time; that is, historically. The historical trajectory which shows in changing forms of regulation of a particular phenomenon over time tells us about forces at play within the context which might not otherwise be perceived. These need to be taken into account in understanding the

phenomenon, and especially in attempts to regulate the phenomenon, in this case in trying to promote more risk averse forms of sexuality.

Of immediate concern is sexual debut, or first sexual experience, and a cultural-historical approach is adopted to understand the changing regulatory context and the implications of this for HIV prevention efforts.

1.1.2 Context of the study

The study was conceived as part of a larger qualitative study examining contextual factors mediating youth response to HIV/AIDS (Kelly, 2000). The broad objective of the larger study was to understand the contextual determinants of behavior and behavior change amongst youth and how these impact on HIV/AIDS prevention. The present study is aimed to go beyond this and to provide further insight into findings of the previous study, by providing further insight into sexual behaviours and practices across the age range.

In the quantitative study (Kelly, 2000), the average age of first sexual intercourse for males in the site which is the focus of this study was 14.8 years and for females 15.9 years. In respect of age of sexual debut this site stood out from five other sites across the country, as having significantly lower age of sexual experimentation and intercourse debut. It also stood out as the site with the highest 'yes' response to 'Sex was not discussed with my parents'. For this reason it was decided to investigate further what factors are at play in shaping early sexual experiences in this context.

As this study is about personal and societal vulnerability to HIV/AIDS, it represents an attempt to discover what forces shape the response to the epidemic and how these have operated over time, and hopefully to offer new ways of responding to the multiple challenges this epidemic poses for South African society as this country has become the site of one of the fastest growing HIV epidemics in the world (UNAIDS, 2001). This study is then aimed at uncovering some of the perhaps overlooked facets that complicate an effective response.

An understanding of the spread of the disease as a social phenomenon is desirable, while a coherent understanding of many of the social dynamics that help the disease's spread is essential. There is a need to go beyond describing our society, and to provide analytic categories to facilitate understanding, to gain an authentic sense of who we are engaging with,

and thus to know how people culturally and socially process a phenomenon as complex as HIV/AIDS.

Understanding should be lodged in behavioural patterns and value systems people are actively involved in, to provide conceptual tools for effective behavioural and attitudinal changes. This necessitates comprehensive understanding of social, cultural and ideological terrains on which strategies have to be implemented, thereby conveying the need for change in a way that will be meaningful to people's lives and realities.

1.1.3 Objectives of the study

The following objectives were identified for the study:

- ❑ To study enculturation of youth into sexual activity in the community of interest over the last 40 years.
- ❑ To investigate changing patterns of early sexual experiences in this community.
- ❑ To look at community regulatory practices, peer and gender relations with a view to understanding early sexuality.
- ❑ To understand what HIV/AIDS has meant in the context of the evolving culture of youth sexuality.
- ❑ To appreciate the impact of the background cultural-historical context for HIV prevention.

CHAPTER 2. LITERATURE REVIEW

Attempts to reconceptualize adolescent sexuality as a social and cultural problem rather than an individual problem promise to lead to a more holistic approach to prevention of adolescent pregnancy and sexually transmitted diseases. New interventions must take into account the devastating effects of poverty, the influence of significant others and the cultural meaning of sexual relationships, pregnancy, childbearing, contraceptive use and gender roles in the target population. This study represents an attempt at such an approach.

Adolescent sexuality research in developing countries

According to McPhail (1998), social research has been concentrated in knowledge, attitudes, practices and behaviour (KAPB) surveys:

While these types of surveys provide some valuable information, they are usually operationalized as narrow quantifiable variables, with little attention to the societal, normative or cultural contexts within which phenomena such as knowledge, attitudes and behaviour are negotiated or constructed (p.96).

The call would therefore be not so much to reinvent the wheel, but to open up avenues of further exploration as "the response of South African social theorists has been timid" (McPhail, p.98), to say the least.

2.1 Limitations of adolescent sexuality research in developing countries

MacPhail (1998) provides an interesting overview of trends in research on the topic of HIV/AIDS and sexuality. She is of the view that there has been much focus on HIV knowledge levels and reported sexual behaviour rather than on the influence that complex social negotiations of sex may have on HIV transmission. More attention needs to be paid to social dimensions of sexuality so that interventions can address societal sexual perspectives, moving away from the assumption that safe sex behaviour can simply be learnt and implemented, as this ignores complex social interactions and norms influencing sexuality.

MacPhail maintains that there has been continued emphasis on describing factors such as age at sexual initiation, number of partners, usual methods of contraception, teenage pregnancy, amongst other issues, possibly to the detriment of the development of an informative body of work concerning sexuality. This means very little exploration has been conducted of the

socially influenced constructs of adolescent sexuality and the impact this has on adolescent risk of HIV infection and health behaviour. Studies that consider variables like age of sexual debut, levels of condom use, awareness of condoms and knowledge of AIDS need to look at the norms of adolescent sexuality in those particular societies and delve into health behaviour change which requires changing normative beliefs. Tentative attempts have been made to understand issues of adolescent sexuality, but there is still room for developing understanding of the normative social influences, which shape adolescent experiences of sex.

Historical perspective on sexuality

Aries (1960) traces the shift in attitudes to childhood and childhood sexuality in Europe from about 300 years ago to the present in relation to the changing demands of society. He looks at the transient and shifting way in which 'childhood' has been viewed and sees it more as a construct that is created by society, than some kind of universal category that is outside of history and culture. The question as to when sexuality is deemed appropriate is therefore moot, and is contingent on history and culture rather than universal ideals.

Sexual socialization: related studies

A recent study (Kelly, 2000) shows that the onset of sexual experimentation leading to sexual intercourse appears to follow different courses in the six communities in South Africa that were studied. One of these communities, a group of deep rural villages in the Eastern Cape, showed a unique pattern of consistent increment in the incidence of sexual debut from middle childhood (8 to 9 years) through to the regular practice of sexual intercourse in the middle to late teens. In other sites there was a relatively low childhood prevalence of sexual experience and a sudden jump after the onset of adolescence. Evidence is also presented in this study to suggest that experimentation with sexuality in late childhood is not a new phenomenon, although there has been a significant drop in the age of commencement of the process in the last fifteen years.

It seems from the preliminary data collected in the Kelly (2000) study, that many other practices, which historically accompanied early experimentation, and served to acculturate youth into sexuality in a regulated way, have not survived. It is not surprising, given early experimentation and lack of regulated cultural input in this area, that all indicators of adolescent sexuality in this site are considerably higher than they are in most other sites, with

the exception of a site in rural KwaZulu Natal where a similar cultural-historical picture is evident. Furthermore, these sites are remarkably lower on indications of HIV prevention behavior than is the case in other sites.

The present study aims to assist in the search for solutions based on context -specific understanding and is directed towards issues of adolescent sexuality that need further exploration, i.e. the impact of norms, values and entrenched social belief systems that might provide some answers for the limited success of existing HIV interventions. Aggleton, Davies and Hart (1990) feel that success is rooted in the recognition that HIV/AIDS is a community issue, requiring a community-based response.

Implications for HIV/AIDS

In order to understand the history of the epidemic, to design interventions to manage it, and to evaluate the impact of interventions that are implemented, it is essential to gather information on the patterns of sexual activity as these impact on the rate of infection (Attawell, 1998). It is particularly important to know how these patterns vary with factors like gender, age and migrancy status. Sexual networking and sexual practices are important in determining the rate of spread of any sexually transmitted disease (STD), including HIV (Varga & Makubalo, 1996). For example, a high rate of partner change and other sexual practices that increase the risk of transmission such as not using condoms, 'dry sex'¹(Kun, 1998) and other risky practices all serve to increase the number of people who become infected.

2.2 Gender issues

Gender imbalances become explicit when condom use is advocated. Adler in Rivers & Aggleton (1999) estimates that 60-80 % of African women have had only one partner, but became infected because they are in a weak position to negotiate safe sex or prevent their partners from having additional sexual contacts. Cultural considerations and implicit, skewed power relations have implications for empowerment of women to act as catalysts in behaviour change. There are complex ways in which women engage in transactions of submission in order to achieve comparative equilibrium and security. For example, having to weigh condom

¹ The use of herbs and other substances to dry and tighten the vagina for sexual intercourse is known as "dry sex."

use against sanctions that might incur, such as loss of social, financial or psychological security (Varga & Makubalo, 1996).

These gender imbalances are pervasively entrenched and become part of childhood socialisation processes. Given this, behaviour change cannot be achieved without a concerted effort to change both men's and women's attitudes about gender roles as they relate to sexuality and risk of HIV infection. Gender socialisation cannot be overemphasized as it has far reaching implications for the spread of HIV. For instance, in a culture where women are socialised to defer to male authority, particularly in sexual interaction, they may engage in high risk sexual behaviour if they believe it is expected of them by their male counterparts, or even from the simple belief that it will please the man (Wood & Jewkes, 1997).

2.3 Migrancy

The spread of disease in societies is shaped, at least in part, by the political, social and economic environment in which people live (De Beer, 1984 in Lurie, 2000). The link between migrancy and HIV/AIDS has to be given special note as it often means sexual involvement with other/multiple partners when away from the primary relationships. This might mean exposure to sex with casual partners or commercial sex workers. A study of the link between migration and HIV (Lurie, 2000) showed higher rates of HIV infection among migrants and their partners compared to non-migrants and their partners. The findings of the study also highlight the fallacy of assuming that transmission is from the migrant men to their spouses at home, which was not the case in 40% of the participants of the study.

In a study conducted in a mining community in Carletonville (Williams et al, 2000), 79% of the mineworkers had a wife or a girlfriend living elsewhere. There were reports of a high prevalence of casual sexual relationships and very low condom use with spouses. Interviews with the mineworkers highlighted three themes relevant to the transmission and prevention of HIV within these mining communities (Campbell & Gillies, 2001):

- That HIV prevention messages transmitted in HIV-awareness campaigns are mediated through pre-existing beliefs that mineworkers may have about health and sexuality – and that these competing beliefs are unlikely to be changed by simply providing miners with factual information in non-participatory interventions. An example is the belief

that abstinence is abnormal, unhealthy and leads to illness (Nielsen in Williams et al, 2000).

- Attention needs to be paid to norms of masculinity that encourage men to engage in high-risk sex. Such norms serve as key obstacles to behavior change, and are unlikely to be altered through factual biomedically oriented information about sexual health risks.
- Aspects of migrant workers' social and occupational life also need to be regarded as important factors placing them at risk of STIs.

Generally, interventions would need to incorporate cultural explanations and people's perceptions of illness, disease and well-being, as well as knowledge of biomedical facts. As the reasoning discussed above (see pre-existing beliefs) is mostly applied to male sexuality (Cassimjee, 1998 in Williams et al, 2000) cultural considerations may be part of the problem of young people failing to postpone sexual encounters when condoms are not available (Disler, 1990) and for men to have other partners when away from their spouses.

CHAPTER 3: METHODOLOGY

3.1 Research questions

The research questions addressed by the enquiry were expected to shed light on the norms and values that influence adolescent sexuality and to move understanding of sexual decision-making away from cognitive models of behaviour change to understanding the social context, which determines behaviour. The choice of a qualitative approach was made as this facilitates a richer, more detailed account of the information that is gathered.

The study aims to study enculturation of youth into sexual activity over the last forty years in the community of interest, by studying the childhood and early adolescent sexual experiences of individuals ranging from contemporary youth to adults of up to sixty-five years old. In this process data collected by the researcher relates not only to traditional community and familial cultural practices, peer and gender relations, but also the role of the media, religious and educational institutions, health workers and others in shaping the culture of sexuality.

It is hoped that by describing contemporary sexual practices and trends, this study will go some way towards understanding this community's sexual practices and influences around them and would thus help provide pathways for action towards combating the progress of the AIDS epidemic.

3.2 The Research Context

Field research for the study was undertaken in June/July 2000. The site is Amatole Basin in the Eastern Cape, a cluster of villages in a remote rural area, between Alice and Hogsback in the former Ciskei area. The area, at the time of the research, had no electricity, limited piped water, subsistence type agricultural activities, and housing in permanent brick and wattle and daub structures, with multi-generational 'households' grouped together in clusters.

3.3 Sources of data

Two sources of data were used. In the first instance a survey and focus group were used to evaluate youth responses to HIV/AIDS. This fieldwork was conducted as part of a six-sentinel site survey conducted in communities across South Africa (Kelly, 2000). This was followed by a qualitative evaluation of contextual mediators of youth response (the present study) where specific issues from the first stage of the study were identified for particular attention. In the

case of Amatole Basin, the very early age of sexual debut was identified as an area for investigation, because of its HIV risk potential. A methodology was designed for understanding the practices and communication contexts surrounding this through cross-generational interviews.

3.4 The Team

Research for this study was conducted by a team of two researchers. The team was assisted by an independent researcher who had been involved with the first phase of the research project and previous participatory research in the community. This was important for the research since she knew the community well and it made it easier to make contact with the community, which might otherwise have been a daunting feat since the place is an isolated deep rural area. Having someone to act as a bridge to the community was invaluable in that not only could the researchers link up with potential respondents easily, but also a sense of trust had been pre-established. This was felt to be significant especially in view of the sensitive nature of the issues to be discussed. Another advantage was immediate access to and support from key people in the community (e.g. the village chief and parents).

Use was also made of an assistant researcher who was familiar with the community from previous research forays in the area.

3.5 Methodological Orientation

The goal of this study is to arrive at a deeper understanding of the factors that mediate sexual negotiation by giving primacy to the lived world or lived experience of the participants (Rhodes, 1995). A phenomenological multiple case study approach (Edwards, 1997) was adopted. This approach is described as "the commitment to understanding human phenomena in context, as they are lived, using context-derived terms and categories" (Terre Blanche and Kelly, 1999, p67).

The study looks at accounts of the first and subsequent sexual encounters of participants ranging in age from adolescence to 60 years. In each case the researchers examined the context of adolescent sexuality and the ways in which sex is negotiated within the confines of community (societal) norms and expectations. To this extent the research moves beyond investigating isolated, decontextualized issues such as 'how often' or 'with whom' people have

sex, and moves towards seeing sex as a complex social activity which... "occurs within a social context replete with assumptions, values, ideas, attitudes and beliefs, and that the knowledge of this context is important in understanding sexual behaviour and the mechanisms of behaviour change." (Moore and Rosenthal in McPhail, 1998)

3.6 Procedures

Selection of participants

The participants were chosen on a basis of suitability and availability in collaboration with research assistants and other key people in the community. Openness to discussing the issues in question and willingness to share insight into their attitudes, motivations and experiences was an important criterion in choosing participants to be interviewed.

Inclusion criteria also included participants having been raised in the area and having their own sexual enculturation take place in this setting. Twelve interview respondents were selected: two males and two females aged 55-65 years old; two males and two females aged 35-45 years old; two males and two females aged 18- 24 years old.

As the nature of the study and requirements for participation were explained, some of the volunteers who did not meet the criteria withdrew, but provided names of others who did meet the criteria. Participants were provided with a thorough explanation of the purpose of the research, and could then decide if they wanted to participate. Those who wished to participate then had to sign a consent form, with parents/guardians signing on behalf of those under the age of 16.

Data Collection

All proceedings were conducted in Xhosa and were audio-recorded. Once selection of the participants had been done, data was collected by means of interviews. The interviews were of a semi-structured nature in that guiding questions had been prepared beforehand to facilitate, to give direction to and standardise the interview process, though the researcher often followed the lead of the respondents.

Initially what was aimed at with each participant was an understanding of their biography of initiation into sexual experience. Social circumstances surrounding the emergence of each individual's sexuality were explored, and the stages through which each individual went in

becoming aware of, understanding and coming to terms with both sexual knowledge and practice were also looked at.

There was then a progression from this initial knowledge and practice into patterns the individual had settled into, until the present. Issues such as fidelity and monogamy, the depth of relationships, whether they had concurrent or serial monogamous relationships, and whether there was any kind of stability in these patterns, were also discussed. Respondents' expectations of, and shortcomings (of self and other) perceived in relationships were also discussed. Beliefs and norms informing conduct in relationships also formed part of the discussions. Further, the discussions were contextualized in the sense that parental, as well as peer influences were probed in detail.

The respondents were allowed to give their own subjective description of their experiences and thereby enabled the researcher to understand their individual meaning and reality. Allowing individual categories of meaning to come through is deemed to be essential in exploring a subject as intimate as sexuality. Detailed information was obtained from interviewees to gain understanding of sexual behaviour and factors influencing risk-taking behaviour.

Amongst other issues, the interviews covered the following:

Mediators of awareness; communication contexts and content; sexual debut issues; sexual negotiation and gender relations; courtship and sexual practices; community regulatory practices and risk prevention factors including contraceptive and condom use.

The following areas were focused on:

- Early sexual communication.
- Sexual experimentation and what forms it took.
- Sexual debut –including age of first sexual experience ; whether this was the same or different for boys and girls; how the context has changed across generations.
- How relationships were conducted across the generations.
- Patterns or trends in relationships (e.g. issues of fidelity; concurrent or serial monogamy).
- Sexual negotiation in relationships.

- Subjective accounts of first sexual experience and factors like negotiation vs coercion.
- Perception of risk (pregnancy, STDs).

Questions prepared to guide/facilitate the interview process covered the following issues:

- *Information dissemination regarding HIV/AIDS:* How do people get AIDS? How do people know about AIDS? Are people informed and warned about AIDS so that they can protect themselves? How are they informed?
- *Communication and first knowledge about issues of sexuality:* How did you come about knowledge about sex and sexuality issues? Did boys and girls come about this knowledge in the same way? When and how did sexual experimentation happen? How old were you when this started?
- *Relationship issues:* When did you move from experimentation to the next step (a relationship)? What determines this move? How does one go into a relationship? What happens when you are in a relationship, what is expected of you? What determines how long a relationship lasts? What community regulations were/are in place regarding conduct within a relationship? What were you told/warned about regarding being in a relationship? Who spoke to you about these matters?
- *Issues around sex and risk protection:* How did you learn about sex? When did you first have sex? Sexual practices within relationships. Subjective experience of sex. Sexual negotiation issues. Knowledge of, negotiation and use of condoms and contraceptives. How did you know about condoms and contraceptives?
- *Discussion around sexual issues:* Are matters of a sexual nature (including contraceptives) discussed with children, or in the case of youth, with parents. Reasons for not communicating about sexual matters, if applicable. Whether they think matters of a sexual nature should be discussed with children and what exactly should such discussions be about.

On average, the interviews lasted for 60 minutes.

Interpretive process

The interviews were conducted in Xhosa, translated to English and then the data was transcribed.

A basic open coding method (Glaser & Strauss, 1967) was used to analyze the data, employing Atlas.ti computer software as a coding tool. The researchers were particularly interested in the situations which revealed the context of early sexual experiences and the communications and social practices surrounding these.

CHAPTER 4. PRESENTATION AND DISCUSSION OF FINDINGS

This chapter outlines the major findings of the research and covers the content and timing of early sexual communication; how youth in this community become aware of and experience sex; their first sexual experiences, sexual practices and the changing context thereof over time; how sex is negotiated, including gender roles; community regulatory practices and how these have changed over time; risk and fidelity issues; and the role of parents and the community in shaping sexual culture.

4.1 Early Sexual Communication

Learning about sex

Identified community-based sources of information for the study were parents, siblings, peers, health educators, teachers and the church. However, the latter three sources of information proved to contribute little to the sexual enculturation of youth in this site, through not being a source of meaning or influence to any significant degree.

Between parent and child

There is less intergenerational communication about sex in this site than in any of the other sites studied and it seems that educative cultural practices, for instance around the education of girls in 'the ways of women', have not survived culturally. In this context the patterns of sex communication between parents and children have not changed very much over the past forty years. There is little discussion of sexual matters in the home and cultural and community practices have for many years not included any significant form of sexual education including discussion about HIV/AIDS at home. There is and always has been little communication between either sons or daughters and their fathers. Mothers have tended to communicate with their daughters only about the risk of pregnancy, and this tends to have been limited to their involvement in sex education.

There is evidence that pressure is being brought to bear on the parent-child relationship to talk more openly about sex. Thus, "People nowadays are talking about sitting down with your children and talking about these things, but I haven't done it, because it was never done to me." (female aged 58). The following extract from an interview with a 22-year-old female respondent also pertains:

Interviewer: Is it (condoms and sex) something that would make you feel funny and uncomfortable?

Respondent: No, I would like her (mother) to talk to me about such issues. I really would because I was listening to the radio yesterday, a programme on the radio, it was a phone-in programme. It was about parents and children, communication between them, things like that. And I kept saying to my mother, 'Ma do you hear that, do you hear how other parents relate to their children?' I mean I am interested in her talking to me and I was trying to communicate that to her yesterday.

In this situation the child shows an interest in promoting more open communication, possibly reflecting that the mother usually puts up barriers in this relationship. But the following suggests that reluctance to talk about sexual issues does not only come from the mother's side

and children are also sometimes uncomfortable with open communication. Age might possibly be a factor for communication as the following excerpt from the same interview may illustrate:

Interviewer: Does your sister discuss things with your mother?

Respondent: Yes, she has no problem, she speaks about everything with my mother, but I'm not comfortable doing the same thing... She's older and she's more comfortable talking to my mother about these matters, I don't know why but I'm not... When she was my age she was not comfortable either.

There clearly has not ever been a tradition of parents and children discussing sexual health issues. However, there was previously a strongly endorsed system of expectation relating to sexual norms that whilst not spoken about was widely held in place by admonishment and threat around avoiding pregnancy and some advice around the same.

In the words of a 58-year-old female: "What I did with my granddaughter is to send her to the clinic for contraceptives because I want her to continue with her studies and not to be disrupted by pregnancy." The abiding concern here is with pregnancy. It seems that historically in this community, parents have become involved in regulating the sexual affairs of their children primarily to avoid pregnancy. The content of communication between parent and child throws further light on this.

Content of communication

A 55 year-old woman had this to say: "(My grandmother) told me that a man is not supposed to touch a girl's body and that it was the girl's duty not to allow the man to go anywhere near her." Previously boys and girls were instructed "not to play inside". Adolescent sexuality had to be regulated for prevention of pregnancy. Adolescents were instructed to avoid penetrative sex, and only to have "panty" or "thigh" sex (*ukusoma*).

Across all generations interviewed the content of communication was limited to instructions about avoidance of sexuality and ultimately pregnancy. There was very little information conveyed besides. What communication there is, and was, is directed at the behavioural outcome of not having penetrative sex, and avoiding pregnancy: "You were told that (if you touch a girl's private parts) you would have a disease, you would be abhorrent, detestable... You would develop acne and no one would like you. There was absolutely no chance to wash your hands to prevent the disease. You absolutely shouldn't touch her there" (from a 56-year-old man). Ignorance and fear seem to be predominant in parental communication in this frame

of reference. For example, a 55-year-old woman had this to say: “Our parents stressed how important these matters were and it was the fear that kept us in line.”

There seems to be some change amongst the younger generation in that mothers seem much involved with daughters in pregnancy prevention, and there is greater acceptance of sexual intercourse amongst even children in their mid teens, in which case mothers’ roles are to ensure the use of contraception. There is evidence of this trend in the following statement: “What I did is to send them to the clinic for contraceptives after noticing they have boyfriends” (female aged 58, Eastern Cape).

Flow of information

With the older generation (35 and above) communication around sexual issues seemed to be largely between partners, with the girl imparting to her partner what knowledge had been imparted to her by her mother/other caregiver. However, very little was actually communicated. One 56-year-old man says, “It was the girls who told us about these things. We got all the information from them.” With the 18 to 25 age group there also seems to be very little teaching from caregivers, and most of what was learned prior to sexual experience came from older siblings. For example, as one 19 year old put it: “... when I first heard of such things, it was mainly from my older sister. I would see her often leaving the house and going to meet her boyfriend and eventually I asked her what was happening and she told me, she was open about it... she didn’t keep it a secret from me.” From a 23-year-old man, “There was also my elder brother who told me a lot, ... it was from him that I heard about a lot of things to do with girls.”

Form of communication

Especially with the older generations, parental input was minimal, and is mostly in the form of warnings issued with no real understanding behind them. What communication there is, is therefore not knowledge-based, but seems to be around received cultural practices. Certain practices were perceived as taboo and have dire consequences. Ignorance and fear seem to have predominated in parental communication. For example, a 55-year-old woman had this to say: “Our parents stressed how important these matters were and it was the fear that kept us in line.”

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4.2 The changing context of sexual debut

Historical Perspective

Early experimentation with sex is not new in this village, although only latterly has such experimentation increasingly involved intercourse. Sexual socialization begins as early as eight years and early sexual experiences mostly take place in the context of the kind of games discussed above.

It is widely reported that now "They start having sex early, even before they reach teenagehood, at maybe 10" (female, age 42). The following excerpt from an interview explains:

Interviewer: How old were you when you played this game?

Respondent: We were about 12 or 13 and then when we were about 15 we stopped playing Undize and had real boyfriends.

Interviewer: You said you would sleep with them, can you explain this to me?

Respondent: OK, well we would go hide with the boys in the bushes and that's where we would start sleeping with them. We would take off our panties and they would take off their 'undies' as well and it's then that we started having intercourse, but it was nothing serious at that stage.

Interviewer: When you slept with them was there penetration, or were you just 'playing outside', but just taking off your panties?

Respondent: Yes there was penetration but as I said to you it was not really serious. There was penetration but there was no ejaculation. We were just doing it and we didn't even experience any form of pleasure, hence I say it was nothing serious.

An interview with a 38-year-old male illustrates further:

Interviewer: Can you tell me about your first sexual experience? How old were you, and where did it happen?

Respondent: I was 15 and this was nothing serious. We were just playing Undize.

Interviewer: Was it your girlfriend you slept with?

Respondent: No, it was just someone I happened to hide in the same spot with. There was nothing between us and maybe the next time we play Undize it would be with another girl.

Childhood sexual games have been played in this community since the 1950s at least, but previously it was played with “dresses on” and some older members of the community did not think of Undize as being associated with sex. However, some older members (55 years plus) do recall that Undize involved some sexual exploration, but not to the same degree. Amongst youth it was well known by all respondents that it often involves sexual experimentation.

It should be noted that previously in this community there was no strong taboo on sexual experimentation but there used to be a strong distinction between sexual experimentation and sexual intercourse. This distinction appears to have blurred so that sexual experimentation much more rapidly translates into intercourse, to the extent that Undize now involves sexual penetration, albeit somewhere between experimentation and fully-fledged intercourse (Kelly, 2000). This seems to have a lot to do with the fact that fear of pregnancy, which was the strongest deterrent, has been done away with by the introduction of contraceptives into this community (see below for further details).

4.3 Awareness and initiation

Three main avenues of awareness and initiation were identified across all age ranges, namely:

Games as a context for early sexual learning

In the words of a 57-year-old resident: “Sex starts with playing”. The games referred to may begin at about the age of seven years and are commonly played into the early teen years. These games have always been a context for boys and girls to pair off and there has seemingly always been a risqué element to such games, with accounts of removal of underwear and boys and girls being physically close to each other in their hiding places. However, these games have become a context for exposure to sexual intercourse in this community and they were not previously. In the words of a local primary school teacher:

There is a game that the younger children play. It is called *Undize*. It is like hide and seek. The children hide and one asks: ‘Should I come?’ Whilst they are hiding, if there happens to be a boy and a girl, then there is sex.

Another game is that of 'Mother, father and child' (*oomama notata*). The child is sent off to get wood, and part of the game is that (s) he gets chased by a giant and has to run away. When the giant chases her, the 'mother and father' have sex. This is played at 8-9 years of age. Clearly, we should not think of this in the same way as we would sexual intercourse, but as experimentation, which might later lead to sexual intercourse.

Observation and personal accounts of older siblings and peers

Another common way of learning about sex, at least since the 1950s, is observation of older siblings and personal accounts of older youth and peers. The most direct form of interpersonal learning is younger children observing older children and especially siblings who provide a theatre for observing emerging sexuality (for example, observing them sneak away to be with boyfriends or girlfriends). Also peers talk with each other on a boy-to-boy and girl-to-girl level about what about what they have seen or heard and they share their learning experiences. Older siblings are also quite often a source of information for the younger group. In the words of one young boy, "And you would hear from the older boys that the clothes have to be taken off. Then we would go back with this knowledge... and we would try and get the girls to take off their clothes. Then you would do what the older boys have shown you or have told you to do."

There is also a learning path that involves older girls initiating younger boys (*ukuradisa*), and young boys getting instructions from older boys. In explaining how young boys in his time came to know about sex, a 55-year old man said an older girl (especially when the man with whom she is involved is away at work) would pick a younger boy and ask him to be her child. She would then proceed to teach him about sex (thigh sex in this context). This would be in the form of instructing him on what to do, what not to, what is allowed and what is not.

You would learn from her before you met with someone your age. The older girls would be careful to choose boys who would not tell about these practices, thus they had to choose carefully. You would learn everything from her, including how to have sexual relations on the thighs. You had to disappear as soon as the boyfriend got back or you'd be beaten. You would do this until you were old enough to have your own girl then you would move on. Such a move was expected and was no big deal, you didn't even have to tell her you were moving on.

This practice generally involved boys from the age of 14 and would end at about the age of 20, when the boy felt old enough to go into a relationship and have a girl of his own. This practice

was apparently something the boys enjoyed as it signaled a transition from boyhood to manhood for those thus chosen.

But mostly children take the cue from their peers about when it is appropriate to begin with sexual experimentation. This usually begins with the observation of peers being involved in activities of a sexual nature, which in turn becomes normatively acceptable and decisions to become sexually involved will be mediated by this, even when there is no strong individual desire. Thus “the others are doing it, so I can too” is a powerful mediator.

Many of the accounts about sexuality are informed by peer experience of sexuality and it seems that very early sexual experimentation is driven by normativity rather than sexual desire per se.

The accounts of women in this context are particularly expressive of a “go along with it” attitude and most first early sexual experiences seem to be driven by male insistence and a desire to please the man on the part of the women. These trends are present from the 1950s to the present.

Learning by experience/ experimentation

What happens with boys, though, is quite different in that they are actively encouraged by both their peers and family members to use their adolescent years to experiment sexually. From a 23-year-old young man, “My elder brother would encourage us, and he kept asking me why I didn’t bring a girl over, so much so that in the end I realized that I had a chance of doing these things and it was expected of me...” Also of note is the fact that sex happens in the man’s space and never in the woman’s. It is almost unheard of for a woman to take a man home with her. It is almost always the man’s responsibility to organize a space for them to be together. This is usually an outside room in the man’s home, or in cases where this is not so the man can arrange a time with a friend when he can bring his partner over and they can be assured of privacy.

4.4 Sexual debut

In the 1950s it was considered rare to have had sexual intercourse before the age of 16 years. People in this age group report the average age of first intercourse as 20. The reason could be that it was unacceptable for a girl to get pregnant before the age of twenty, but after age

twenty, though this was still frowned upon, the rules were somewhat more relaxed. This is still the case today with mothers being concerned that their daughters at least finish school before they fall pregnant. According to one mother: "...if I catch them at it (relationship) then I feel that I have to tell them to go and protect themselves through family planning. What I don't want is for my daughter to get pregnant before time."

The actual age of sexual debut has gone down over the years. In summary, in the 1950s it was considered rare to have had sexual intercourse before the age of 16 years. That this has changed is illustrated by the fact that in 1999, 72% of youth who had had sexual intercourse before (92% of sample) had their first sexual intercourse experience at or below the age of 16 years. An astonishing 22% had their first sexual experience at or below the age of 11 years (Kelly, 2000).

4.5 Early sexual practices

With the 55+ age group, as with the other age groups, virginity did not seem to be the main issue of concern, and both early sexual practices and social regulatory practices (see below) seemed to be geared primarily towards prevention of pregnancy, with the practice of non-penetrative sex, and when older, other technical preventative measures taking its place.

Also, for this older age group (i.e. 55+) reaching puberty, getting a period and growing breasts seemed to signal readiness for entry into the world of sexual relationships. The respondents reported that this is when parents would step in with warnings about pregnancy. At this stage though it seemed widely known that protective measures would have to be taken to avoid pregnancy. Initial sexual contact with the opposite sex was mostly through thigh sex, with the girl's underwear on. As they grew older and became more aware, there was then graduation to the 'withdrawal' method, where the man withdraws to ensure he does not ejaculate inside the woman and thus impregnate her.

It was only much later that penetrative sex with ejaculation was practiced, when it was felt that the stigma of an early pregnancy had been bypassed. This resulted in reports of pregnancy when the respondents were around age 20, which was not really considered to be a problem, as one mother says, "She must be at least 20 before she can get pregnant."

This now seems to have changed in that the transition from other forms of sexual activity (namely petting, thigh sex and the withdrawal method) to penetrative sex seems to have diminished dramatically, along with the practices that held it in place.

4.6 Sexual negotiation and gender roles

Generally in all the age groups boys typically initiate sexual relationships, and exchange of gifts (sweets, handkerchiefs etc.) once played an important part in the early negotiation of the relationship.

It is the boys' role to persuade their partners to come into their 'den', with the mutual understanding being that saying 'yes' to the boy's proposal of love is assenting to sex. Thus it seems that though girls are often aware of being coerced, they seem to believe there is no choice on their part, that their role is to go along and to please their partner if they still want a relationship with them. They may even be 'tricked' into first encounters, (e.g. being lured into the boy's room under false auspices) but there seems to be no sense of outrage at this. The pain and disappointment often experienced do not seem to be deterrents, which ties in with a general sense of poor self-efficacy (Bandura, 1986) among the females of the community.

Young women seem to feel that sex is something that happens to them and not something that they could or should initiate themselves. Women's experiences of sexual initiation seem to reflect a kind of passive victimhood, with most women reporting being coerced into sexual activity by their partners before they are ready for this commitment, resulting in reports of no enjoyment of the act until much later on. It is thus apparent that in this complex rite of passage, female adolescents' notions of what to expect seem to be couched in ideal, romantic and unrealistic terms, and in some cases the reality seems to jolt them. As one 35 year old woman describes it,

... the first time was all very scary and... I found the whole thing painful, it was not a very good experience; even now I don't know how I got used to it." And another says about it, "When I woke up the following day I told myself I would not go back to his house again, it was such an ordeal.

Agents of change: factors affecting the nature of sexual practices

Generational differences can be seen in that though the primary cultural concern with pregnancy is still evident in younger generations, none of the practices inherent in this mindset (e.g. inspections) are seen in subsequent generations. With the older generations it was not

uncommon for virgin inspections to be held to ensure that community/cultural rules were adhered to. With younger respondents we start hearing reports of boys refusing to 'play on the thighs', and even the men themselves stating that "though we knew that we were not supposed to have real sex, we did anyway". It appears with the respondents aged 35 to 42 that rules were now starting to be relaxed, with girls loosening their hold on what is acceptable and what is not, as, according to one woman, "Then you were expected to take care of things, to ensure that you don't get pregnant, there were no contraceptives at the time."

Historically, there were numerous regulatory mechanisms that stood between sexual experimentation and full sexual intercourse. Fear of pregnancy has historically been the most significant incentive for delaying sexual intercourse. Concerns about pregnancy seemed to outweigh those about the retention of one's virginity though in the sense that some of the respondents would allow for penetrative sex without being overly concerned about being virgins on marriage. It was the thought of getting pregnant in the process that seemed to sustain their efforts to hold back. This is not to say that retaining virginity was considered unimportant. In the words of a 62-year-old male, a girl's virginity was considered to be "part of the family's property". He explains: "The knowledge that I got was that when you meet a girl you should not play inside, that is penetrate, because the mistake of playing inside is taking the girls family's wealth in the form of cattle. So I kept that knowledge and whenever I played with a girl it was on the thighs and that was okay as it was stressed to me that you should never ever play inside because your family might be fined cattle for that". A female of 58 reports: "Even if you did sleep with your boyfriend you would make sure that you don't take off your panties".

Practices seem to have been influenced by factors not considered to be specifically cultural, such as high levels of migrancy, changes in family structures and perhaps by changing patterns of gender dynamics in the broader society. These issues were also explored in interviews.

The most significant factor to take into account in understanding this change is the introduction of contraception into this community. A community clinic administers injectable contraceptives and mothers, to prevent pregnancy quite often take their daughters for "injection" at the first sign of becoming involved with boys and often at menarche. "Well I'm very sharp actually, I know exactly what my children are doing. With my child the minute she

went on her period I took her to the clinic for family planning and that helped in fact because she only got pregnant in her twenties”, said one mother. This is often done in the absence of the father who is typically a migrant laborer, and in the context of the mother having to bear the full responsibility of both care and discipline in the family.

The effect of this has been that young men no longer face the anxiety and consequent restraint that was historically associated with the possibility of sexual intercourse. The removal of this constraint (fear of pregnancy) appears to have led to much higher levels of sexual predation and sexual activity. It should also be said that the lack of need to take any precautions on the part of men has created a poor context for introduction of condoms, and condoms are a relatively new introduction into the community. It could be that in areas where birth control is less ‘taken care of’ there would be a greater interest in males using condoms for birth control.

With the advent of contraception, cultural regulation of adolescent sexuality seems to have diminished considerably and youth have become sexually active much earlier. They tend now to bypass the intermediate stage of sexual experimentation without intercourse. Within relationships the transition from the stage of “proposing love” to sexual intercourse has diminished dramatically, and there is also a much higher turnover of partners. This has been nothing short of a sexual revolution within this community, the cultural ramifications of which are significant.

Regulation of adolescent sexuality was historically achieved in a large range of ways including regulating the movements of young people and limiting their opportunities to have sex. Certain kinds of gatherings (*Umtshotsho*², *Umgidi*³) and especially those surrounding male initiation were considered to be ‘high risk’ events as children would have to stay over in other villages rather than walk back after dark and these gatherings involved free mixing of boys and girls. Another factor, which traditionally regulated sexual activity, was not allowing children to have their own outside rooms. Men traditionally have their own rooms after initiation and their levels of sexual involvement increase markedly after this. Having an outside room provides opportunities to entertain girlfriends and numerous stories are told of how young women are lured to boyfriends’ rooms for sex, and how sexually active girls conspire to sleep over at their

² *Umtshotsho* is a traditional dance ceremony held by boys just before they go for initiation.

³ *Umgidi* is a festive gathering held in honour of boys that are coming out of initiation.

boyfriends under cover of being involved in other activities. It has increasingly become acceptable for young girls to have their own outside rooms (in one case as young as 15 years), whereas being required to sleep in the house traditionally regulated them.

These changes at household level are consistent with many other changes, which involve a diminishing degree of regulation of adolescent sexuality. For instance there was a taboo on boys and girls talking freely in groups in public, unless they were acknowledged as having a relationship. In the words of a 22 year old: "In fact even now, as old as we are, when we see an older person approaching you can't just stand there with your boyfriend, you have to pretend to disperse until they pass, then you can resume your talk with your boyfriend". But there is evidence that there have been changes at this level and older people interviewed expressed a sense of indignation that young people have no shame about associating with each other in public.

Caution should be exercised in talking too generally about these issues. As with any community there are notable variations within the community. Family differences, for instance, are notable. Thus, "Oh, youth start (having sex) very early, as early as 12 years, more especially those whose parents are drinking". The absence of fathers in families also seems to have a marked effect and the image of the father was often used, and still is, to warn children against becoming sexually involved. There is a high level of father absenteeism and the community is very noticeably devoid of working age men, other than over holiday periods. This has meant a lack of direct involvement of fathers in their children's lives. The above family circumstances have no doubt had a marked impact on sexual culture in this community, and on the socialization of adolescents. However, this is not new and even in the early 1950s there were well-established migrancy patterns in this community.

The introduction of injectable contraceptives into the lives of adolescents in this community, often with little real discussion with the girls involved, has had a marked effect on the sexual culture of this community. On the surface it appears to be an appropriate approach in the context of the risk of unwanted pregnancy. In cultural and socio-economic terms this also seems a well-reasoned and practical solution. Yet it has borne unpredicted fruit. The point is that the introduction of this particular reproductive health technology has had important negative ramifications. It has led to the exploitation of young women who are subject to higher levels of

sexual predation because of the lack of risk of pregnancy. It has meant that men have little awareness of the need to take responsibility for reproductive health and has created a poor context for the adoption of condoms as both a form of contraception and as an STI prevention measure. It has also led to changes in cultural and familial regulatory practices, the motivation for which has become redundant with the risk of pregnancy removed.

Family planning practices and community sexual regulatory practices

Injectable contraceptive availability seems to have introduced a shift in the culture of sexual debut and has brought about broad changes in sexual practice in that without the previously perceived risk of pregnancy, young girls can now dabble with sex without restraint. This, however, may possibly carry the unfortunate risk of 'communicating' to the younger girls the message that sex is safe, without really preparing them for the dangers of disease. Young girls seem to enter the sexual arena on a cloud of ignorance, with no proper conception of the dangers that go with the sexual act. The following illustrates this fact, (female, 16): "I never thought that I could get pregnant; I didn't think that you could get pregnant when you are young" (see below for further discussion on this).

This was not the case with the older groups as according to a 55-year-old woman:

We used to start sharing experiences; as soon as we started having boyfriends we used to tell one another how to avoid being with a man. We all understood this and we used to talk about it. We all knew that the danger was in becoming pregnant so we were trying to avoid this at all costs from the onset.

One of the important effects the changes have had is that it allowed parents not only to acknowledge their daughters' involvement in sexual matters, but to involve themselves, even if at a very rudimentary level. This was previously regulated more at a community practice level. Parents now became the predominant source of advice to teenagers on visiting family planning clinics, with peers following closely, and, sexual partners being the least common source. The boys indicated that it is the responsibility of girls to seek "protection"; they also assumed that their partners were protected from conception. The fact that the males see contraception as their partner's responsibility indicates that an attitude of joint responsibility for contraceptive practice is not yet socially viable in this area. This lacked sense of involvement also extends to sexual health more generally.

First sexual experience and use of contraceptives

Only one of the teenagers said they had visited family planning clinics before initiating sexual activity. Most exhibit high-risk behaviour, only visiting family planning clinics after several sexual encounters. Inadequate information about service providers, fear of adult disapproval and vague concerns about the side effects of contraceptives caused these delays.

Reports of early childhood sexual encounters seem to indicate high levels of experimentation, but it would appear that most of these encounters are once off, especially with young girls who experience the encounters as unexpectedly traumatic. The discrepancy between expectations and personal reality often puts them off sexual activity until much later on. With the boys, however, there are reports of lots of sexual activity, sometimes without much apparent pleasure derived from them, i.e. to show manliness through sexual prowess.

4.7 Community regulatory practices

Regulation of youth behavior

In the 55+ age group there seemed to be definable rules and practices in place to regulate youth behavior generally, and specifically with regards to sexuality. These regulatory practices were both at societal and parental level and included regulation of issues like possible times and places for meeting, and contexts for contact between genders. For instance, contexts for being with partners were within certain cultural parameters, including certain times and activities (e.g. on Sunday afternoons or when going to the river to fetch water). These seem to have been swept aside and rendered obsolete in the face of the decrease in the risk for pregnancy brought about by advances in reproductive health practices.

Parental control

It was unheard of for a parent to allow daughters to sleep in outside rooms, or not to spend the night at home, but this seems to be the case now that parents know that the daughters are not in any danger of getting pregnant. As one parent says, "... we don't really mind that they are sleeping out as long as we know who the boy is, we allow it to happen."

Courtship practices

There was also a range of courtship practices and games in this community, some of which still persist, which serve to regulate one partner relationships, so that other women would know when someone is 'taken' and to keep a check on male infidelity.

'Decorating' your boyfriend and 'putting your mark on him' was popular, as it let everyone know that the boy was taken, as one 55 year old woman describes it, " ... we used to decorate our boys, we would decorate them with wool, we would make something out of wool and the girls would put a spoon and a whistle and a boy would wear this on Sundays when going out for walks. It was up to you to make your boyfriend look beautiful. ... even if you didn't see the boy, you'd hear the tinkle of the spoons and the whistles and you'd know the boy was taken."

Another example is a game called "*Nomengo*" where girls would form a circle and a boy's name would be called out. The boy's girlfriend would then have to go to the middle of the circle, and if two or more girls had the same boyfriend, then there would be a fight, with the 'main' girl starting the fight as this was seen to be her right as the 'injured' party. Any adversaries would be fought off and humiliated into dropping out of the relationship.

4.8 The changing nature of social regulatory practices: factors mediating change

Culture and the nature of relationships

Though some practices seem to be entrenched within the culture and are observed from one generation to the next, (e. g. the use of social gatherings for sex; agreeing to be in a relationship automatically means having sexual contact; no real waiting period between saying 'yes' and having sexual contact, etc.), some changes can be noted even from one generation to the next in that certain practices like 'no penetrative sex' and the practice of sleeping out in the veld were no longer in place. These were replaced by having real sex in rooms of their own.

Regulation of space

One difference that has come out strongly in both the 35 to 42 and the 18 to 25 age groups is the acquisition of rooms of their own, doing away with the practice of sleeping out in the veld. This was more common with boys at first, and it enabled them to sneak in partners overnight without the knowledge of the parents. It appears that this has now become acceptable to parents in that they no longer seem to object to sons bringing partners over and will turn a blind eye to this. This is particularly the case with boys after initiation, and one of the older men from the 55+ age group states that he only became interested in girls after he had been circumcised and had been given a room of his own, and this was because he felt that he was at

a stage at which he should get himself a woman, which had much to do with the fact that he now felt that he was a man.

Relaxation of gender regulations

Of more importance though is the fact that acceptance of sexual involvement on the part of parents seems to have extended to girls too in that there are reports of mothers not only sending their daughters to the clinic for contraceptives, but also of giving them outside rooms once they realize that they have commenced with sexual activity. According to a 37 year-old woman, it is acceptable that children sleep out “because there’s nothing one can do other than maybe give them their own room but then make sure that they take precautions.”

Context of sexual practices

In the 55+ age group there seemed to be no sex during the day, but they would see the girls to make arrangements to meet later in the evening. They would also take strolls on Sunday afternoons, designed to get to know one another better and to enrich the relationships.

Popular activities used as meeting places were concerts, weddings, and other traditional ceremonies, where they would then sneak off with their partners, and thus opportunities to be together were created.

The 35 to 42 age group did not practice thigh sex but was involved in penetrative sex, which mostly took place at night. It was easy if one had access to a room, but even if one didn’t, one could organize with a friend to have use of his room for a certain period, or could even arrange to use the room overnight and the friend would go and spend the night elsewhere. Social functions were often used to get together, and popular activities here were Imijikelo⁴ and Imitshotsho⁵. It was then easy to leave with your partner to spend a carefree night as parents had no problems letting their daughters go since these were acceptable community practices.

In the 18 to 25 age range there seems to be mostly no overnight sexual activity as these are young people who have often just been initiated into sexual activity. Those who can often have to wait for their parents to go to bed, slip out, and come back before dawn. Social gatherings are also used as a chance to have sexual encounters, but it is important to bring the girl back

⁴ Imijikelo -overnight church services

⁵ Imitshotsho -boys’ initiation ceremonies

before the activity is finished so that she can then go back with the others. Popular activities here are soccer matches, parties and discos, and the usual traditional village activities. Meeting when girls are sent to the shop is also an important part of the context in that it is here that they fix times for meeting later on.

With the older groups (55+), there are also accounts of sex in secluded spots in the bush,

Interviewer: You said you would sleep with them, can you explain this to me?

Respondent: OK, well we would go hide with the boys in the bushes and that's where we would start sleeping with them.

The following account also refers to these encounters in the veldt:

We would choose a spot out there in the veld or somewhere bushy, anywhere you regarded as private, we would never sleep with our boys indoors. The boy would bring blankets and you'd find a grassy spot to lie down.

Whenever the boy tried to get close to you, you'd move away and the boy would keep advancing. This would happen for a long time, and if you went back to the spot the following day you would find a trail on the ground (where you'd been trying to get away from him) as if bulls had been fighting.

4.9 Risk and fidelity issues

Contraceptives, condom use and the nature of relationships

In the older (55+) age group no form of protection was used as there was no perceived risk in the era of thigh sex, and no knowledge or awareness of technical forms of protection is reported. There also seems to be a high level of ignorance regarding real facts behind some of the activities labeled as taboo (e.g. not touching a girl's private parts), with a lot of the information used to deter from sex being based on myths.

Especially in the age group 35 to 42, though contraceptives were known, they were not used. These were some of the thoughts expressed by the women, "It never entered my mind to use them"; "No one I knew was using them". The result was often that soon after they started having penetrative sex, they would get pregnant. It is reported that STDs were not common at the time and parental input was largely about not having sex and avoiding pregnancy, as opposed to input around STDs.

The role of contraceptives has also had implications for sexuality in that a shift has been introduced, which not only affects sexual negotiation, but also has a hand in the change in

gender roles. When pregnancy was a concern, a lot seemed to rest on the girl in that men used to take their cue from the women, which is now no longer the case. A lot rested on fear of pregnancy for both parties and though virginity didn't seem the central issue, it was desirable. Even social regulatory practices seemed to centre around pregnancy, but with the advent of contraceptives, a shift in the sexual debut sphere was introduced and youngsters could now indulge without fear of immediate consequences.

The result has been that dialogue and negotiation have been done away with, resulting in early commencement of sexual experience without any real chance to develop an understanding of one's own development or one's sexuality. This does not only apply to boys, as one of the participants reported that "orgasm came as a shock", but also for girls, who report that they will comply for these reasons: "I don't want him to go to others" and "I do it only because he wants it". Their main reason seems to be more to do with a fear of losing the boy rather than desire to be sexually active.

This seems to have overturned the balance of the relationships in that the men now seem to have the upper hand and are in a position to manipulate the women, thus we see a change in the gender dynamics in the community. The shift seems to have resulted in a decline in responsibility, and has done away with the hierarchy of practices and framework to behavior since there are no immediate consequences for irresponsible sexual activity. Partner turnover has also been affected in that there is a rush into a sexual relationship with no time to really get to know one another. These relationships are quickly discarded and the next one is started as quickly.

This is perhaps the most significant change that has come about, as it has done away with the regulatory practices that were in place, resulting in a state of unregulated sexual activity, with nobody at the helm to ensure safety. As there had initially been a 'social contraceptive' in place, perhaps the solution lies in finding a preventive mechanism for HIV/AIDS at a social level, with some social practices erected to regulate safe sexual activity.

Fidelity

With the oldest group it was quite common for boys to have multiple partners, though mostly from neighboring villages. This was unacceptable to the women in the oldest age group, as some of the games (see Nomengo) were designed to sniff out adversaries, during which fights

would ensue. The result would be that other partners would be discouraged from the relationship.

As with the older group, multiple partners were common with the men in the 35-42 age group. Of note in this age group is the women's accepting attitude towards this practice, as they seem resigned to the fact that their partners are unfaithful. One even recalls being quite friendly with her boyfriend's other partners, and another states that, "I couldn't do anything. I used to see him with other girls by the river and I would just get the water and head home without saying a word to him." This signals a change in attitude from the previous aggressiveness and possessiveness indicated by the older age group, and is on par with the relaxation of attitudes and rules seen in this age group.

Infidelity is also common among boys in the 18-25 age group, but not with the girls. The girls seem content not knowing whether the partners are faithful or not and will choose to think or to trust that the partners are faithful. When they are faced with the fact of the partner's infidelity, they will often live with this fact for quite some time before giving up on the relationship if it looks like the partner doesn't let up even after several confrontations.

Though rarely, with girls it would sometimes happen that she get herself another partner when the boyfriend was away at work, though it was frowned on and was not really acceptable.

According to one woman:

What was common then was that the boys would leave to go and work in Johannesburg and it was up to you to wait for him to come back. Some of us girls couldn't wait and one would then have a boyfriend whilst your boyfriend is away, but this was not regarded positively. When the boyfriend got back the new guy would be dumped and the girl would get back together with her boyfriend. In some cases the girl would be too involved to stop the new relationship and the old boyfriend would have to give up on her.

Condom use

On the use of condoms, both males and females in the 35 to 42 age group report problems with partner attitudes towards the use of condoms. As a result of these reported attitudes condoms are rarely used though mostly they think that they would and should use condoms more frequently if only partners weren't against it.

In the age group 18 to 25, there seems to be a problem of boys not wanting to use condoms in spite of the girls' expressed desire to use them. The girls' non-challenging attitude towards this

is also striking, and indicates that they are too disempowered within their sexual relationships to enforce condom use, despite general awareness that they are protective and therefore desirable.

Multiple concerns about using condoms are mentioned, the most common of which is that boys want 'flesh-to-flesh' intercourse in order to be sexually satisfied, and to illustrate this they frequently use the analogy of the impossibility of eating sweets without removing the wrapper. Sexually Transmitted Infections (STIs) do not seem to be of concern to both the young women and their parents, illustrated by parents sending their daughters to the clinic for injectable contraceptives, but not for condoms to prevent disease.

The difficulties that people experience in negotiating condom use at the interpersonal level are made worse by personal factors, such as self-esteem and self-efficacy for condom use, and cultural taboos against frank sexual discussion between men and women (Eaton et al, 2002).

4.10 Shaping the traditional sexual culture: parental and community roles and attitudes.

Parental role

The father's role in this regard is negligible, with him often only present as a distant authority figure from whom things have to be kept. Thus the mother often has to take lead in overseeing the family. Attitudes towards the daughters' sexuality seem to express concern coupled with resignation to the fact.

The mother's role often covers the following:

- Setting rules, (e.g. times of coming home in the evening).
- Warning daughters against the dangers of having sex (concern here seems to be with pregnancy rather than with STIs).
- Advise daughters to go to the clinic (concern over having her studies disrupted). Whether this is a good place to start remains moot, as it might seem to imply that the girls are not capable of taking responsibility. According to one mother, "I thought it wise to take her to the clinic for family planning...because they can't be relied on to do the proper thing..."
- Seeing to it that daughters do things 'right' (e.g. coming home in time, being there in the morning after a night out).

On the whole, mothers do not seem to resist their daughters being sexually active and will turn a blind eye as long as they know who the boy is, and, as one mother puts it, “I never actually say you can go, but I just allow it to happen”.

Sex no longer seems an issue to parents now that pregnancy is no longer a problem. They might even allocate an outside room when they know that children are sexually involved, whereas being required to sleep in the house traditionally regulated them. Attitudes towards pregnancy seem to soften after age 20, with the parents becoming more accepting and no longer regarding this as shameful.

The seemingly contradictory practices in this society warrant special mention as there seems to be an important dynamic at play here, that is, the pretence on the parents’ part that they do not know what is going on ‘behind their backs’, and the similar demeanor of the daughters, who, while fully knowing that the parents know, will also play their part in this pretence. Daughters will be allowed to go to activities parents well know to be centers of sexual activities (see context of sexual practices), but the parents will not want to be seen to condone their offspring’s sexual involvement.

There seems to be a complex labyrinth of unspoken rules and games that are played out, all designed to absolve parents of active acknowledgement of what is known to be taking place. Perhaps this ties in with a lack of ability on the parents’ part to turn back the tide of the advances in sexual attitudes. At the same time it would seem that they are concerned about what their peers will think of them if they know what they allow to happen in their homes. This comes out quite forcefully in the statement of one mother who says, “You ... tell her that this is not the time to be coming back (from a night out) and that she should make sure that she’s not seen by people... it’s not that she shouldn’t go to her boyfriend, but it’s not proper for her to be seen by other people (woman, 55).”

The role of the community

The community also has a role to play in regulating sexual practices, as is evident in the accounts of the 55+ age group. They report that certain regulatory measures were in place to see to it that the young men and women behaved responsibly. For example, periodic inspections by elderly women were performed to see to it that the girls did not indulge in early sexual activity. There were also immediate negative consequences for those who broke the

rules, e.g. once a girl fell pregnant, her peers were all inspected and all the parents became extra vigilant towards their daughters' comings and goings. It was not only the particular girl who had to bear the shame, but also the boyfriend, in that elderly women would come together, sing and march to the responsible boy's home to demand a fine in the form of livestock from the boy's family, in a process called 'Isihewula'. All this was done with much fanfare and the boy's family not only had to pay immediately, but also had to live with the shame their son had brought upon them.

It was the community's responsibility also to see to it that 'proper values' are upheld through myths generated and little real information disseminated, keeping the youth in fear and ignorance, to ensure that they did not meddle in sexual matters and assume roles deemed beyond them by the community.

The result was a certain respect the youth had for members of the community, and they would do anything to uphold the family name and to keep themselves from shame and humiliation. According to one of the men (in the 55+ age group), "No young girls got pregnant in our time".

With the shift in the focus of community concerns around pregnancy, these practices have been done away with, and only the older group reports that they had been practised. This may then account for the permissive attitude the youth now have towards sex, which goes apparently unchallenged by the parents, as their concerns with pregnancy have also been alleviated.

CHAPTER 5. DISCUSSION AND CONCLUSIONS

A number of conclusions can be drawn from all the findings above, and the following synthesis serves as a framework for understanding. The results have described norms or 'rules' within the culture of the community of the present study that have served the purpose of providing limits or constraints to behavior and practices in the domain of adolescent sexuality.

Communities are in part defined by rules concerning the expression of sexuality as well as mechanisms for controlling sexual behavior (Fuglesang, 1997). In the absence of these rules sexual behavior's potential to lead to negative consequences was widely recognized within this community and these rules were thus upheld and safeguarded in multiple ways. It has been generally found that cohesive communities have codes of conduct relating to when, where and with whom sexual relationships might take place (Rivers and Aggleton, 1999). In this

particular context we have seen these slip away in the changing structure of rules around sexuality and communication and they don't seem to have been replaced by a widely endorsed set of alternatives or new sets of norms.

However, it cannot be argued that the influences that have been described (e.g. introduction of contraceptives and migrancy) have in and of themselves led to or caused the changing set of regulatory practices in this community (e.g. younger ages of sexual debut). There are many possible influences which might not have been described. For example, it may well be that contemporary media and particularly television content has been a factor. It might also be hypothesized in some contexts that availability of condoms has led to early experimentation in some contexts where otherwise youth would have been hesitant to engage in sex because of the risk of pregnancy. This hypothesis is quite widely supported by focus group respondents across the six sentinel sites covered by the qualitative arm of the original sentinel site study (Kelly & Parker, 2000b). But we cannot say that these or the observed influences described in the results section played a causal role on their own. Nonetheless, they played a mediatory role, meaning that they shaped developments and were an important influence especially in the eyes of the community. No claims are being made about specific causes of the reduction in age of sexual debut, and the issue at stake here is to look at how this change has been mediated and thus might be remediated at community level.

The changing context of sexuality and implications

Change in community practices has had negative implications for sexual health and other related factors, and behavior change for the better is desirable. The cultural history of the community could be used to inform such change although past patterns of social regulation are not necessarily adaptive or useful in the changed context. For example, there were rules in place that set parameters for practices of courtship and sexual activity, which bound this community to certain norms of behavior. These cannot simply be resuscitated as in the case of virginity testing, without violating contemporary sensitivities. However, such specific cases should not overrule the possibility of forms of socially endorsed normative practices being part of the solution, as an alternative to the more usual call for individual behavior change.

With this in mind, we could postulate that behavior change is not dependent on making a choice, but on precommitments (Elster, 2000) to certain practices. Precommitments are agreements by which parties bind themselves such that they have a mechanism by which they can persist with their intentions and plans for action. Precommitment has been discussed at some length by Jon Elster in his book *Ulysses and the Sirens*. As the classic example of the title suggests, Ulysses has himself bound to the mast of his ship as it approaches the sirens' shore. He recognizes his weakness of will; he does not trust his ability to resist temptation, and he knows that if he succumbs, the larger purpose of the voyage will be undermined. The ties that bind us to paths of action in a reflective way are in a sense the conventions, expectations, sanctions and endorsements of everyday culture. In the instance of young people in this community these were community and culturally based.

Within this community there has been loss of these precommitments in the sense that few processes are in place to regulate youth sexual behavior. For example, with the older generations in the community of interest, we have seen precommitments of avoiding pregnancy being effective to a very large extent, and perhaps a desirable solution for the present would be erecting in place new precommitments that would endorse desirable behavior. Developing cultural frameworks for bringing about socially desirable ends is a largely unexplored approach to HIV prevention.

The notion of precommitments may explain what is missing in the youngest age group's tendency towards risky behavior and lack of commitment to safe sexual practices. Perhaps it needs to be pointed out that at times the sexual act is an act of passion more than reason, in which case measures should be introduced to inject much needed reason into the situation. Cultural rules should be in place to reflect exactly this, with devices for precommitment being put into place in order for the sometimes 'irrational' and therefore unsafe sexual act to be turned into a rational and therefore safe act.

Changing patterns of sexuality have emerged from the study, to the extent that teenagers regard 'playing outside' or 'thigh sex' as 'kid stuff'. This represented the outer limits of permissible sexual expression in adolescence until perhaps the late 70's, which was acceptable to those involved and was a sexual learning experience, a way to discover one's sexuality. Of special note is the role played by the introduction of injectable contraception in taking away the sense

of 'responsible play' and eliminating the fear of pregnancy. There now seem to be no definite rules in place concerning issues like engaging in sexual intercourse and delaying sexual debut.

An important finding in the study is that these changes cannot always be viewed as the free choice of an individual and therefore cannot be divorced from other factors like, for example, the prevailing socio-economic milieu. The importance of the study being in the rural areas has vast cultural implications as migrancy is one of the factors affecting the spread of the epidemic (Shabangu in Marais, 2000). Migrant labour, for instance, deems that men live separately from their families for prolonged periods, often in single-sex hostels, and are therefore at increased risk when they take urban girlfriends. The social turmoil associated with forced resettlement and labour has disrupted traditional sexual practices and networks. The role of migrancy needs to be better understood as both rural and urban dynamics of this phenomenon need to be considered. Successful prevention efforts could do well to concentrate not only on the urban 'receiving' areas but on the rural 'sending' areas as well.

Thus rural to urban labour migration has had an impact on sexual culture. It has affected trends in courtship and other practices, and has therefore played a hand in transforming sexuality patterns in the rural areas. This of course has vast negative implications like the multiple partner relationships this encourages. Households in the community are also affected in that where both parents are away at work, or in cases where there is a single parent who has to go elsewhere to earn a living, this results in older children having to run the house and to look after their younger siblings. In such cases, there isn't much that stands between these children and their freedom to engage in unsupervised sexual activity, which of course has implications for sexual health.

Change in the regulatory environment

The introduction of injectable contraceptives into the lives of adolescents in this community, often with little real discussion with the girls involved, has had a marked effect on the sexual culture of this community, as the following points illustrate:

- It has served to do away with previously erected regulatory mechanisms.
- On the surface it appears to be an appropriate approach in the context of the risk of unwanted pregnancy.

- In cultural and socio-economic terms this also seems a well-reasoned and practical solution, yet it has born unpredicted fruit in that it has led to the exploitation of young women who are subject to high levels of sexual predation.
- It has meant that men have little awareness of the need to take responsibility for reproductive health.
- It has created a poor context for the adoption of condoms as an STI prevention measure.

This should lead to caution about the introduction of health technologies in place of developing embedded responses to the HIV/AIDS health crisis.

The potential for sexual behavior to change social relationships and responsibilities makes sexuality a domain of sociality which attracts particularly high levels of attention relating to codes of conduct about when, where and with whom sexual relationships might take place (Rivers and Aggleton, 1999). In the community in question we have seen evidence of rapid and dramatic change in the regulatory environment governing sexual practices amongst youth, and we have seen that the current regulatory environment has mediated a marked drop in the age of sexual intercourse. We have also seen that the changing nature of regulations around sexuality has largely left behind an earlier culture activated around forms of non-penetrative sex and the use of withdrawal as a contraceptive method. The advent of injectable contraception has made the primary motive supporting these cultural forms, namely the will to avoid unwanted pregnancy redundant.

With this a range of practices became somewhat redundant around how space is managed in the household, communication across generations, relations between the self-regulation of sexual urges, courtship practices and social meeting practices. These changes have coincided with family structures in disarray, as a consequence of men, and sometimes mothers, having to spend extended periods away from their families. In this context a previously regulated environment of youth sexuality has fallen apart. Young men freed of their anxieties about pregnancy and the punishment regimes attached to early pregnancy are not restrained in their sexual imperatives. This is not necessarily to suggest that male sexuality is by nature predatory, but this is certainly the case in this context. It's a male sexual world and women are

lured, tricked, manipulated into participating in it on male terms, with limited enjoyment or positive value attached, other than that it is necessary in order to keep a partner.

Parents and change

We have also seen a shift in parental attitudes from being agents of constraint to the other end of the spectrum, where they seem to be abetting unsafe practices by either failing to address them (for example, the question of condom use and STDs), or by being in complicity with youth by, for example, providing them with outside rooms and not cautioning them against the fatal dangers of unprotected sex. This behavior on the parents' part can perhaps be understood to be a result of an inability to deal with social change, as in, for example, the fact that contemporary culture fosters open communication and more permissive attitudes around sexuality. The parents then find themselves caught up in the change, with no models for how to deal with this, and on the other hand, the realization that openness and communication are desirable. Most parents in this community think it is right to speak to your children about sexual issues but of note is the fact that when asked if they had done this, none of them had.

One common belief is that young people are of their nature sexually promiscuous and that giving them information about sex will make them more sexually active (Friedman, 1993). Often parents and other family members will withhold information in the belief that they are protecting young people from what may lead to sexual experimentation. This runs contrary to evidence in Western industrialized societies which suggests that young people who openly communicate about sexual matters with their parents, especially mothers, are less likely to be sexually active or to become pregnant before marriage (Gupta, Weiss and Mane, 1996). But in the Amatole Basin context, and probably in many contexts across the world, parent-child relationships are not constructed in such a way as to allow open dialogue between parents and children. Parents, and especially mothers, as fathers are largely not present, have an abiding concern about pregnancy and see their primary responsibility in this domain as ensuring that daughters do not get pregnant. Injectable contraception is the primary vehicle for this and remains the dominant and failsafe method for dealing with the perceived need to educate children about sex. Unfortunately this has provided a poor context for dealing with the new context of HIV/AIDS.

Parents have received no sexuality education from their families of origin and are therefore struggling to find a balance between what is acceptable and what is not. The ensuing tension then results in the contradictory behavior they subsequently display. Perhaps it can be argued that they have no real chance at achieving a desirable balance unless the whole system of communication can be transformed and opened up within the home, without emphasis being put specifically on sexual communication as a vehicle for sexual behavior change, as it must be very difficult for them to start discussing a subject they have never heard discussed.

The prevention of problems to do with adolescent sexuality is a major challenge and perhaps other measures could be put into practice from alternative sources of information. An example would be the introduction of comprehensive AIDS programs in schools, and ensuring that resources are provided to sustain such programs. Parents would need to be involved in this venture, schools would have to give them workshops to ensure that they understand the nature of these programs and also to gain their support as this could never be effective if it gets no support once the child gets home.

Social Capital and health behavior

Social capital can be defined as resources embedded in a social structure, which are accessed or mobilized in purposive actions (Lin, 1998). Social capital is applied to those features of a community that promote cohesion and a sense of belonging and that enable its members to cooperate in ventures that are of benefit to the community. First, there is a need to separate out the individual from the population effects. It has long been known that at an individual level, networks, social participation, and supportive social relationships are good for a person's health. These ideas are sometimes extrapolated to whole populations, to propose the hypothesis that the level and quality of social ties or mutual cooperation in a society may help explain why some countries, or even populations, are healthier than others (Whitehead & Diderichsen, 2001). Simply put, social capital can be described as a process embracing clear but culturally nuanced mechanisms for enabling people and organizations to work together in trust for mutual social benefit (Cowley, 2002).

According to Whitehead & Diderichsen (2001), social capital is produced by features of societies and communities, which facilitate coordination, cooperation and reciprocity. It fosters social networks for communication, which are fundamental to partnership building. It is this

aspect that is hoped to lend itself to the promotion of preventive health-related activities in the community. This augurs well for community-based mobilization intervention programs involving acceptance of an ideology and a common value system for the Amatole community. The various sectors of this community, including traditional community leaders; parents; youth and community forums and institutions of relevance (e.g. schools, the clinic, community development forum) could pool resources and work out a community plan that would structure a multi-sectoral response to the survival and well being of the community. This would help address a diversity of issues including education and health, and would also be a basis for mediation of factors like poverty and issues like child headed households. This would then be the model for the promotion of social cohesion and health, and for the prevention of disease.

Gender issues

During adolescence (ages 10 to 19) women are exposed to a new set of health risks. Lack of knowledge about their bodies and limited access to appropriate health services put adolescent women at risk of early childbearing, unwanted pregnancy, and unsafe abortion as well as sexually transmitted infections, including HIV/AIDS.

In a study (Susser et al, 2000) conducted to explore awareness among women in Southern Africa of the HIV epidemic and of what they can do in heterosexual negotiations to protect themselves from infection, the authors found that the female condom and other woman-controlled methods are regarded as culturally appropriate among many men and women, and are crucial to the future of HIV/AIDS prevention. Political and economic concerns, combined with historically powerful patterns of gender discrimination and neglect of women's sexuality must be viewed as the main obstacles to the development and advocacy of methods women can control.

The broader social context including widespread poverty and unemployment is one of the major causes of the spread of HIV/AIDS, particularly among women. In the study mentioned above the women talked about lack of economic alternatives as cause for the commercialization of sex. Their feeling was that only the provision of work for women could alleviate economic needs and thus prevent HIV. Today, women's increased vulnerability to HIV is becoming better understood. Women's economic dependence on men makes them vulnerable, while social norms limit their access to information about sexual matters. At the

same time, greater social acceptance of high-risk male sexual behavior can expose both men and their partners to infection (Women's Health Weekly, 2000, p19). This clearly points to the need for programs involving 'Men as Partners' -e.g. 'Mobilizing young men to care' (Morrell, 2002)- to work with both men and women around issues of masculinity, femininity and gender.

Condom efficacy

A study carried out by the Centre for Population Studies (Maharaj, 2002) identified an emerging awareness of the need to encourage men to assume shared responsibility for family planning and reproductive health. "Several studies show that men often play an instrumental role in decision-making and it is therefore important to understand their role in preventing unwanted pregnancy and HIV/AIDS"(p1).

Protecting simultaneously against both unwanted pregnancy and sexually transmitted infections is referred to as "dual protection". The study found that knowledge of condoms as a method of dual protection against preventing pregnancy and HIV/AIDS is almost universal. Despite this, condoms are not a popular method of contraception. There is widespread resistance to male condoms among both men and women. Both men and women complain that condoms interrupt sexual activity, cause discomfort and ruin the excitement of flesh to flesh contact. "From the focus group discussion it was clear that most people would not use condoms at the same time as other methods of family planning. Most of the respondent stated that they would prefer to use one method, preferably a method that was controlled by women"(Maharaj, 2002, p1).

A major disadvantage of condoms is that they depend heavily on partner co-operation. Many of the male and female respondents reported negative attitudes on the part of their partners to the use of condoms. In many sexual encounters, men exert the dominant influence over the sexual decisions. Many women lack the power to assert their personal needs and convince their partner to use a condom (Maharaj, 2002).

A report by the USAID Inter-Agency Gender Working Group (2001) states that in spite of the potential for reducing both unwanted pregnancy and STIs, several factors lessen the acceptability and consistency of use of both male and female condoms. These include the need to use and to negotiate condom use with every act of sexual intercourse; the perception,

particularly on the part of many men, that the use of condoms will dramatically reduce sexual spontaneity and pleasure; and, the association of condoms with illicit sex. The stigmatization of condoms and the people who use them has arisen, in part, as a response to programs targeting condoms largely to sex workers and "at risk" populations. Promoting condoms for pregnancy prevention can help to reduce this stigmatization.

Contraceptives and condom use

Though prevention of unwanted adolescent pregnancy through effective contraceptive use is a national priority, it should also be said that the lack of need to take any precautions on the part of men has created a poor context for the introduction of condoms, whereas in sites where birth control was less 'taken care of' there has been a greater interest in males using condoms for birth control (Mfono, 1998). Thus the negative aspects of the injectable contraceptive need to be looked into.

Contraceptive services, even when they exist, often do not meet women's needs. A full range of modern methods, including emergency contraception, is often not available. Providers are often poorly trained and do not counsel women in the proper use of appropriate and available methods (Mfono, 1998).

HIV/AIDS makes dual protection a must. Condoms—the only contraceptive method that can protect against HIV as well as against pregnancy—are vital to controlling HIV/AIDS. This may seem obvious, but, in fact, condoms are not as frequently used as other means of family planning,

More people using family planning need to know about the added benefit of condoms — as an effective barrier against infection — in order to make an informed, free choice on their personal contraceptive method, say the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Population Fund (UNFPA). For those millions of women who already use effective family planning other than condoms, this may mean adding condom use to their chosen family planning method.

According to a study (Sangi-Haghpeykar & Pointdexter, 1997) on the use of condoms for protection against STDs among women using the injectable contraceptive, DMPA, which

stands for depot-medroxy-progesterone acetate, only 18% of the women in the study reported using condoms consistently while on DMPA.

Their data also reiterates that the majority of users of injectables are not protected from exposure to the human immunodeficiency virus and other STDs. Though it is a highly effective long-term contraceptive method and has expanded family planning alternatives for women, “DMPA does not provide protection from infection with the human immunodeficiency virus (HIV) or other sexually transmitted diseases (STDs). Therefore, women who use DMPA may be at risk of disease exposure if they do not also protect themselves with condoms, which provide effective prophylaxis against STD infection.”

According to these authors, studies examining the combined use of condoms with various other contraceptives have demonstrated that among women who use non-barrier methods (e.g., the pill, sterilization or hormonal implants), only a small percentage also use condoms consistently, or plan to use them.

Among the women who completed the baseline questionnaire (N=463), 32% reported having used condoms alone or in conjunction with other methods during the three months prior to receipt of their first DMPA injection (condom use in the three months prior to baseline was recorded as a dichotomous variable). About 50% of these women reported never or rarely using condoms while relying on DMPA. Thus, 18% of the women for whom follow-up data were available reported having discontinued condom use once they began using DMPA (about one-half of those who were using condoms prior to beginning injectable use). Although women who used condoms before receiving DMPA were more likely than nonusers to combine both methods, nearly half of former condom users (49.7%) abandoned the use of condoms once they started using DMPA.

The findings indicate that while women initiating DMPA enhance their protection against unintended pregnancy, they place themselves at risk of exposure to HIV and other STDs. Other significant findings of the study are that there is a higher probability of consistent condom use among DMPA users who have completed their childbearing than among women using the injectable to delay or postpone a birth. This may be an important factor to bear in mind since adolescents fall within the latter category, which therefore has implications for future interventions.

They also found that women who have more access to condoms and are frequently reminded about the importance of their use may be more inclined to use them in conjunction with their primary method of contraception, further emphasizing the potential influence of health care providers in contraceptive decision-making. A conclusion that can be drawn from this is that women requesting injectables, or any other form of contraceptive, should receive adequate counselling about the importance of using condoms, regardless of whether they have used them in the past.

Implications for HIV/AIDS

In the HIV/AIDS context the above study is indicative of a need for discretion in the introduction of health technologies in place of developing culturally supported responses to the health crisis. There is much more that could be said here, and certainly it raises questions about the ramifications of the widespread distribution of condoms through the society. Whilst this may indeed be a very viable solution in HIV prevention terms, as injectable contraception was to the problem of teenage pregnancy, it is an intervention which history may well show to have unexpected ramifications. These may of course prove to be of a positive nature, especially since condoms are a technology which (female condoms aside) is applied to the male anatomy, and which mostly alter the male experience of sexuality. Also needing to be taken into consideration is the fact that the unequal power relations between men and women, or boys and girls, render young women especially vulnerable to coerced or unwanted sex, and can therefore influence the capacity of young women to influence when, where and how sexual relations occur (Rivers and Aggleton, 1999).

Gender norms significantly affect risk and societal vulnerability to HIV/AIDS because they ascribe distinct productive and reproductive roles to women and men insofar as gender determines how and what men and women are expected to know about sexual matters, including behaviours, pregnancy and STIs. Societal constructions of ideal feminine attributes and roles typically emphasize sexual innocence and ignorance for girls as a sign of purity, hence the poor communication of sexual matters from one generation to the next. This, unfortunately, has led to men being expected to be more knowledgeable and experienced, and therefore to take the lead in sexual decision-making.

In rural communities, it might appear that though sexuality education for women is generally ignored, they often receive at least some information in the form of warnings against pregnancy and concerning the value of protecting their virtue and the family name. Girls may be persuaded by their boyfriends or even by girlfriends that the advantages of spontaneous unprotected sex outweigh the disadvantages. Without alternative adult supports or salient community norms, girls may be reluctant to lose a boyfriend by questioning their evaluation of unprotected sex (Eaton et al, 2002).

The above have various implications for HIV/AIDS prevention and education programs. In an article entitled 'Education for protection' in *Agenda*, 1995 (27) p 37-41, it is stated that attitudes towards sex and sexuality (e.g. men's use of sex and sexuality as a source of power over women, and women's acceptance of this) are seen to be the major cause of vulnerability to HIV/AIDS. Thus, what is indicated is safer sex education aiming to provide a level of general, collective cultural empowerment, encouraging individuals to identify one another's needs, and to regard one another as a community united in its response to the epidemic.

Aggleton et al (1997) advocate a move away from the 'look-after-yourself' model of health education as this is seen to reinforce the delusion that HIV is only a risk from extraordinary sources that are external to the lives of decent, ordinary folks.

Gender and Vulnerability

In many traditional African cultures, girls are taught to be submissive and subservient to men. These social and sexual inequalities promulgated during childhood and adolescence, deprive women of the right to refuse to have sex or negotiate safer sex, such as condom use. Violence against women is widely condoned and sexual coercion underlies many young women's sexual experiences.

Since men retain primary control over the use of condoms, women and adolescent girls are urgently in need of means of achieving dual protection. Because of existing gender disparities, men are more likely to decide on the timing and conditions of sex, and on the means of preventing infection, if any, and women often are unable to negotiate condom use with their partners.

The socialization of girls and women often curtails their autonomy and undermines their ability to negotiate with men. It limits their knowledge of sex and reproductive functioning, and it discourages them from challenging male partners on many issues including sexual relations. Women who take the initiative to have condoms on hand may risk appearing "too ready for sex."

In suggesting condom use when they suspect their partners of being unfaithful or even of being infected, women may risk physical abuse or accusations of infidelity. In this site some of the women state that even when they do not live with their spouses and suspect that there is no fidelity on the part of their men, they are unable to ask the men to use a condom because of the reasons stated above.

For some women (especially adolescents), a pregnancy prevention rationale is essential for encouraging their partners to use condoms. However, many women are unable to negotiate condom use on this basis because they are already using another method of contraception, such as sterilization, IUDs, oral contraceptives, implants or injectables. This is especially the case with the older women, and in cases where a male partner is aware of ongoing contraception or the woman is already pregnant, other strategies are needed to negotiate condom use.

Unwanted pregnancy and HIV/STIs pose a growing social and health burden that must be addressed. The integration of dual protection strategies into family planning programs is, therefore, increasingly urgent. To meet this challenge, programs must find creative ways to:

- Promote positive and equitable power relations between men and women, in part through efforts to increase couple communication and to challenge the prevailing norms and stereotypes that underlie risky behaviors;
- Educate males and females of all ages about healthy sexual behavior, reproductive functioning and health, the risks of unprotected sex and the means of pregnancy and HIV/STI prevention, including condom use and all forms of non-penetrative sex;
- Contribute to making physical and sexual coercion and gender-based violence unacceptable, and encourage men to question their own risk-taking behaviors in an effort to protect themselves, their partners and their families; and
- Make the importance of dual protection strategies known to health workers and reward them for encouraging such strategies among their clients (USAID, 2001).



For men, on the other hand, although there is almost total absence of reliable information (perhaps a warning against getting a girl pregnant), the elder generation seems to turn a blind eye to their sons' sexual proclivities. An attitude of bravado and denial of personal vulnerability to HIV can be seen as a personal risk factor. But research suggests that this response to HIV is much more common in young men than in women (McPhail & Campbell, 2000), perhaps because of social norms that encourage young men to show sexual bravado, defiance of risk, and high levels of sexual activity (Kelly & Parker, 2000).

Some communities continue to inculcate young men with notions of manhood that include encouraging them to view having multiple partners as natural and normal. At the same time they are told that it is their right, if not their duty to carry on the family name and the family line by having as many children as possible. In this era of HIV/AIDS, different priorities must be developed and different values exemplified by our young men. Multiple partners not only endanger the young men themselves and their partners, it also endangers the lives of any children they might have. Instead of carrying on the family name, they should understand that they are helping to destroy it.

The above is of significance for intervention programs to be drawn up for combating HIV/AIDS, and has specific implications for adolescent plans of action. The dialogical conditions of negotiation are too weighted in the interests of a male dominated sexual realm. Interestingly much of the communication literature is around the concept of choice, but it would seem that in this context at least, the lack of development of a culture of response to HIV/AIDS would need to be developed as a guiding and perhaps restraining 'culture' in addition to individual responses based on rational choice and response.

Patterns of sexual behaviour might well be the primary cause of the variable extent of the epidemic, other factors being perhaps of subsidiary importance. What is emerging is that HIV must be understood within the social, cultural and normative conditions that pertain in particular communities. Interventions should thus include the promotion of safer sexual practices, with social factors topping the list of considerations in strategising and developing a theoretical framework for promoting behaviour change.

But who safeguards a culture of youth sexuality is a point at issue, especially as within this community the guardians of sexual culture have withdrawn from office as the anxiety about

pregnancy has found a medico-cultural solution, which requires little input or involvement on the part of people. Perhaps in this instance at least women need to lead the way. Over the course of the last forty years women in the community of the study have stopped regulating their own sexual context. It would appear that, in the interest of survival they need again to do so. Perhaps, and this is controversial, it would help in bringing men back to sexual culture, if rural clinics promoted condoms as the contraceptive method of choice amongst youth.

Interventions and levels of social change

Though a laissez-faire approach seems to prevail on contraceptive use, social change has come to a point where the need for sexuality and reproductive education of adolescents can be denied only at great cost to them as the failure to help them deal with their sexuality may lead to a high incidence of STDs, HIV and AIDS.

Adolescence is commonly a time for experimentation and risk-taking, often with little regard for possible consequences. Peer influences on young people press them to adopt life styles and behaviors that identify them with their social network. Often young people tend not to perceive their own actions as affecting their health - they hold traditional beliefs of disease causation - or they discount the risk of becoming ill or dying in the future against the value of satisfying their immediate needs, including excitement. Adolescents themselves have yet to develop the responsibility and initiative to seek out the sources of information that will help them take advantage of the reproductive health services available to them (Mfono, 1998).

Interventions clearly need to be both at individual and at community level. An approach that could prove to have a crucial outcome could be the recognition that communities need to play a leading role in prevention and to empower themselves through social mobilization to combat the epidemic.

There is much complexity to sexual behaviour and a lot that is unknown to all about sexual practices and the various contexts within which they occur. It is obvious that steps need to be taken in order to set about change from risky sexual practices, and to set up mechanisms that will impact on infection coping practices within such contexts. Awareness programs need to intensify if results like the reduction of casual sex, increased condom use, later age for sexual debut, monogamous and faithful relationships, increased use of counselling and testing services and reduction in stigma, are to be achieved. Though not by a long shot the only indicators, any

achievement in these areas could surely be chalked as 'progress', as these could arguably fall within the 'success' end of the continuum if we were to use "success - failure" framing for development interventions. Programs to facilitate such change would very well chart the way to success in intervention against HIV/AIDS especially if interventions are contextualized and target individuals within a cultural and contextual realm.

Socio-cultural interventions

Communities have always had sets of rules for a range of activities including sexual activity. In this era of HIV/AIDS, change might need to be introduced in community structures, roles and practices, in family and traditional roles and even in the way services are run. Communities need to be engaged in setting up structures and processes and, ideally, to have a coordinated response to the epidemic. This translates into involvement of different sectors of the community, including youth, a sector that is traditionally often left out of community-level interventions and structures, which are deemed the arena of the adult population, especially in this community. Examples include having youth representatives in structures like church and clinic committees, and involving youth in community development forums. This could aid coordination efforts and would help bridge the gap between expectations and actual processes in the reality of this community.

Rationale for a culture-based approach

Culture is the basis and core of any economic and social transformation where sustainable development is concerned. It takes into consideration a community's traditional references and resources as key references in building a framework for actions (UNESCO/UNAIDS, 2000). A participatory, community-based approach has the advantage of letting the community deal with its own unique sexuality, sexual communication and general health issues, allowing it to work with other community health structures towards the common goal of promoting healthy attitudes and behaviors in dealing with the AIDS issue.

Mobilizing communities around issues of common concern stimulates them to play an active and meaningful role in local programs and would be useful for any AIDS prevention/care programs. This would be an effort that seeks to strengthen community competence for health through the sharing of information, engaging in reciprocal schemes and the sharing of efforts e.g., involvement of the community in school health projects. Hence health promotion becomes

a process of building alliances. Emphasis is on the sharing of information, resources, power, responsibility and authority for change.

This approach (Kelly et al, 2002) involves:

- Recognition that interventions at individual, family and community level need to be stimulated, strengthened and utilized for optimum effectiveness.
- Involving all sectors of the community and having them work together towards a common goal.
- Restructuring programs to guide the response to the epidemic and prioritizing these on the basis of local needs.
- Empowering communities for optimum involvement in the fight against AIDS by, for example, striving to lessen certain behaviors that put the community at risk while at the same time endorsing those that protect them from HIV infection.

Primary objectives of this approach would be:

- To improve the health status of adolescents through a range of strategies at the health service, community and school level.
- To influence behavior change within the context of the community's social environment.
- To facilitate better ways of handling gender and generational issues, and issues of sexuality.
- To equip parents as a group in dealing with parenting issues.
- To foster understanding through the negotiation of more open lines of communication, by bringing awareness of problems and issues other groups are faced with and have to deal with, to each sector of the community.
- To equip the community to deal with issues of sexuality in a better way both on a personal and societal level, which in turn will impact on all aspects to do with combating the HIV/AIDS epidemic.
- Raise awareness of available services and encourage use thereof.
- Facilitate a proactive process of prevention and care.

- Stimulate sustainable and ongoing community prevention activities through the existing local groups (e.g. youth-driven peer education instead of ‘outside’ interventions; localizing the issue through discussion instead of talking about it generally as a problem ‘out there’).
- Promote risk averse behavior.

Community capacity building strategies

This includes community mobilisation and sensitisation, with a focus on the development of community education and capacity building towards responding to the pandemic (UNAIDS, 2001). Prevention activities would also be part of this and would include HIV/AIDS/STD information dissemination, education and prevention programmes; lifeskills education; youth AIDS programmes; condom promotion and distribution; training of peer educators; improve present services (e.g. family planning and STI/HIV prevention services need to be better integrated; service providers and counsellors need to be trained about dual protection; use of adolescent friendly clinics and services, including improving access to VCT).

Gaps would need to be addressed in the transition if communities are to optimize their input. At community level, leadership would have to be tailored to suit the changing times. For instance, as custodians of community traditions, traditional leaders could develop and spread an understanding of the principles that lie behind traditions, so that those principles might be maintained, while unhelpful practices are eradicated. Traditional leaders are among the people that help develop values and they must be among the people that have to be educated to challenge and change those values when they undermine rather than strengthen our communities. They can use their influence to help build new visions of what tradition/culture is, though this is not usually the case as most traditional leaders tend to want to retain practices and values, in spite of harm they might be causing the community.

Working with parents and youth structures in the issue of covering special occasions (e.g. overnight traditional and religious ceremonies) could also prove invaluable as this is an area that is not covered in ensuring adolescent sexual health. This could lay a very firm foundation for the establishment of cultural precommitments towards the regulation of changes that facilitate identification and modification of cultural practices and behaviours that increase transmission of HIV.

Change is also envisaged at the level of the family, where input from parents around youth introduction to sexuality issues and education around sexual health is almost non-existent. What little input is forthcoming is around the issue of pregnancy prevention through access to injectable contraceptives. It needs to be recognized that this should not just be a sole activity in the context of an island of silence but requires discussion and education to ensure that correct choices are made. Also, input around HIV/AIDS and other STIs, which is vital, needs to be part of these discussions.

Community training programs could identify gaps in the needs of the particular community (e.g. the burden of the community in the case of parentless households, training of parents in the skills necessary to engage meaningfully with their children). Peer training programs could also be a useful vehicle for information dissemination as they could facilitate a two way dissemination process: they could be used in peer education programs that promote knowledge based awareness among peers, and could also be used as a pathway for sibling information sharing. The community that is the focus in this study has already shown a strong peer group culture, which could be stretched to include siblings educating, guiding and setting examples for one another.

Other community structures and institutions (including clinics, schools, traditional healers/educators) could also work in collaboration with community structures in providing services tailored to meet community needs.

Conclusions and recommendations

Empowering, strengthening and supporting culturally appropriate and gender-sensitive community-based initiatives in a sustainable and participatory way; fostering the support of the local, traditional and religious communities and institutions; developing information, education and communication approaches aimed at triggering behaviour change in the context of supportive cultural practices; developing programmes and activities in formal and non-formal education targeted at rural youth, making sure to include HIV/AIDS issues and concerns should augur well for rural communities. This should ensure an enabling environment for the development and consolidation of social capital and cohesion at the community level. This would in turn develop the efficacy of such communities in responding to the crisis of AIDS,

and in building an inherent resilience in the context of the enormous and varied challenges of HIV/AIDS.

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APPENDIX 1

CONSENT FORM (ENGLISH)



RHODES UNIVERSITY

Grahamstown • 6110 • South Africa

DEPARTMENT OF PSYCHOLOGY • Tel: (046) 603 8500 • Fax: (046) 622 4032

I/The parent of.....have been informed that the present study falls under the Department of Health. The purpose of this investigation is to develop an understanding of sexuality, sexual communication and early sexual patterns and the implications for HIV/AIDS. I have given consent to take part in this investigation, well aware of the fact that my/my child's name will not be used in the report and that everything that has been done will be kept confidential.

Signed by.....(in person/ the parent)

APPENDIX 2

ISIVUMELWANO (XHOSA)



RHODES UNIVERSITY

Grahamstown • Pietermaritzburg • South Africa

DEPARTMENT OF PSYCHOLOGY • Tel: (046) 603 8500 • Fax: (046) 622 4032

Mna / Umzali ka ndazisiwe ukuba olu luphando oluphantsi kweSebe leZempilo. Injongo yolu phando kukuqonda ngonxibelelwano nendlela abantu abaqhuba ngayo malunga nezesondo, ngokungqamene ne HIV/AIDS. Ndivumile ukuthatha inxaxheba kolu phando, ndisazi nokuba igama lam / lomntwana wam alukusetyenziswa kwingxelo ngolu phando, nokuba iinkcukacha ezivezwe apha ziyakuphathwa njengomcimbi ofihlakeleyo.

Isayinwe ngu (ubuqu / umzali)

