

A situation analysis of sex education and communication and the implications thereof for HIV/AIDS prevention work.

**Thesis submitted in partial fulfilment of the requirements for the degree
of Master of Arts in Clinical Psychology**

Rhodes University

January 2003

Author: **Andiswa Mankayi**

Supervisor: **Dr Kevin Kelly**

ACKNOWLEDGEMENTS

I would like to express my sincere thanks and appreciation to the following people for assisting me in completing this research project:

- First and foremost I would like to thank God for being my anchor throughout all the trying periods of my life without His help I would not have managed to complete this task.
- My supervisor, Dr Kevin Kelly, for his guidance, support and patience.
- All the participants, whose availability and contributions made this study possible.
- Sizakele, Thuliswa and Thandeka, for their emotional support, love and encouragement while working on this thesis.
- Nadine Demsey, for editing and proof reading my draft manuscripts.

Finally, I dedicate this thesis to the two most dearest people in my life:

- My late mother, Mandisa, for all the sacrifices she made to get me an education. Thank you so much Mamngwevu, may your soul rest in peace.
- My daughter, Siyamthanda, the light of my life.

ABSTRACT

This study explores the history of sex communication and education over a period of fifty years (1950 to the present), in a deep rural area of the Eastern Cape. It describes patterns of sex communication between peers, between siblings, between children and parents and between young people and other non-familial agencies within communities. Communication trends are traced from the period before contraception was introduced, through to the introduction of female birth control methods into the HIV/AIDS era where the focus has been on attempting to introduce condoms.

Twelve semi-structured interviews and two four-person focus groups were conducted to gather information on how the participants acquired information about sexuality and their responses to the same. The findings of the present study suggest that the widespread use of injectable contraceptives has had a marked effect on the sexual culture of the community under investigation. It has led to the collapse of the regulatory practices which were previously in place. This in turn has significantly affected the sexual communication and negotiation context. Furthermore, it has had a determining influence on male involvement in sexual reproductive health matters and has created a poor context for the adoption of condoms as a prophylactic.

There were no major changes in the sexual communication context within families and within communities in that education has always been limited to instructions to avoid pregnancy. Of note was a culture of collusion between adults and children surrounding sexuality, which absolved the parties involved in addressing sexuality. These factors are understood have mediated response to HIV/AIDS prevention efforts, and need to be taken into consideration in the development of sex communication and education programmes.

CONTENTS

	Page
CHAPTER ONE: INTRODUCTION	1
1.1 Formulating the research problem	1
1.2 Purpose of the study	4
1.3 Note on terms used	5
1.4 Structure of the thesis	6
CHAPTER TWO: LITERATURE REVIEW	7
2.1 Major trends in sexual communication and education	7
2.1.1 Parents	12
2.1.2 Peers	14
2.1.3 Siblings	15
2.1.4 Cultural influences	15
2.1.5 Media	16
2.1.6 School	16
2.1.7 Church	17
2.2 Mediating factors in sexual communication and education	20
2.2.1 Migrancy	20
2.2.2 Gender as a mediating factor	21
2.2.3 Poverty	26
2.3 Theories and models of health communication and their impact on behaviour change	27
2.3.1 Health Belief Model	28
2.3.2 Theory of reasoned action	28
2.3.3 Social learning or cognitive theory	29
2.3.4 Diffusion of innovations theory	30
2.3.5 Social marketing,	30

2.4	Community Mobilisation Framework	32
CHAPTER THREE: METHODOLOGY		35
3.1	Research question	35
3.2	Methodological orientation	35
3.3	The study site	36
3.4	Sampling and recruitment	37
3.5	Data collection	38
3.6	Data analysis and interpretation	40
CHAPTER FOUR: PRESENTATION OF RESULTS		41
4.1	Summary profile of participants	41
4.2	Analysis of results	44
4.2.1	Learning about sexuality (Trends in acquisition of sexual information)	44
4.2.2	Contents of sexual communication and education	55
4.2.3	Contextual mediators in sexual communication and education	60
CHAPTER FIVE: DISCUSSION OF RESULTS		65
5.1	Intergenerational modes of learning about sexuality	65
5.2	Mediating factors in sexual communication and education	69
5.2.1	Introduction of injectable contraceptives	69
5.2.2	Gender inequality	72
5.2.3	The challenge of parenting	74
5.2.4	Breakdown of family structure	77
5.2.5	Lack of developed structures and ongoing sexuality education efforts	78
5.2.6	Community mobilisation as a response to the HIV/AIDS pandemic	80
6. CONCLUSION		86
6.1	Overview	86
6.2	Recommendations for further research	88
6.3	Limitations of the present study	89

CHAPTER ONE

1. INTRODUCTION

1.1 Formulating the research problem

The present study is part of a larger research programme aimed at understanding contextual factors influencing youth responses to HIV/AIDS. This is a project of the Centre for AIDS Development, Research and Evaluation (CADRE), which is concerned with promoting, and supporting activities aimed at reducing the risk of HIV infection, through programme development oriented research. The specific focus of this study is the area of sexual and reproductive health (SRH), education and communication.

International as well as local studies have shown that open communication about sex and early sex education are key to successful HIV/AIDS prevention efforts. Open communication about sex has been identified as a key element in prevention and this has been empirically verified in those countries, which have been more effective in HIV/AIDS prevention; e.g. Uganda and Senegal (Lovelife, 2000; Diop, 2000).

It has been widely acknowledged that cultural factors are paramount in the planning of sex education programmes (Parker & Aggleton, 1998). The profile of sexual practice in any community is intertwined with the cultural life of the community. It is therefore important to have a baseline understanding of the culture of sexuality within any community, before appropriate approaches to sex education can be developed. Given this need, and following a study of youth response to HIV/AIDS in six communities across South Africa (Kelly, 2000; Kelly & Parker, 2001), this project concerns a particular community which these larger studies identified as having a youth community highly 'at risk'. This is due to the particularly low age of sexual debut and other indicators of risk in this community. Some of the indicators of risk are low levels of condom use, and high age differentials in early sexual relations relative to other sites. There are two further reasons for selecting this site. Firstly, within this site there has been a marked decrease in

the age of sexual debut over the last fifteen years. There is, therefore, a need to understand the factors that may be influencing this change. Secondly, in this site there are relatively lower levels of parent-child communication about sex and HIV/AIDS.

In recent years there seems to have been a shift in public perception of sex, perhaps largely due to higher levels of media portrayal of sex, particularly on television. This impression is based on subjective observation, as there appears to have been no research on this important topic in South Africa. There has also been a concerted campaign on the part of loveLife in South Africa to promote openness about sexuality. However, it seems that in spite of these influences, sex is still not an open topic for discussion in some sectors of our society even though it is no longer considered taboo.

It is often assumed that parents should be the primary sources of sexual information for their children. Ezeil (in Brown, 1981) stresses this point when he says parents cannot choose whether to give sex instruction, they can only choose whether to be helpful or neglectful in this matter. Parents are thus often seen as primary socialising agents in the area of sexual knowledge. This assumption is, however, questionable in that parents do not necessarily lead the way. Kelly (cited in Brown, 1981) cites two reasons why parents do not communicate with their children about sex: Firstly, many parents are hesitant to accept the sexual and sensual nature of their children. Secondly, dealing adequately with sex in the home demands an open admission that children have sexual feelings, needs and preferences. In addition to this Gordon (cited in Brown, 1981) identifies some of the anxieties parents tend to have about this, such as: fear of being seen to be encouraging or condoning sexual activity and worrying that they will make mistakes in conveying sexual information.

It is important to understand barriers to parent-child communication, as there is strong evidence to suggest that such education can make a marked difference to sexual health behaviour. There is evidence, from a number of studies, to suggest that adolescents who talk to their parents about sex are likely to initiate sexual intercourse later than their peers and are more likely to use condoms and contraception when they become sexually active

(DiIorio et al., 2000). They are thus at less risk of being exposed to HIV than their peers. DiIorio et al (2000), in attempting to understand why some mothers talk to their children about sex and others do not, examine the role of two social cognitive variables, 'self-efficacy' and 'outcome expectancies', in explaining sex communication. The results of the analysis reveal that mothers who express higher levels of self-efficacy and more favourable outcomes associated with talking to their children about sex are more likely to discuss the issue. It is important to understand that these findings are embedded in the cultural context of the nuclear family and a social vision of cultural education, which point to the parent-child relationship as the central axis of enculturation. As important as parent-child communication may be by virtue of dependence of young children on caregivers, in many cultures parents are not necessarily as central to the socialisation process as can be expected. In situations of migrancy, for instance, siblings and grand parents or other family members may have as significant a role to play. Also in a development context where parents are frequently less educated than their children and less exposed to high sex-content media, it would not seem to be of value to study psychological variables such as self efficacy or outcome expectancy in understanding parent-child communication. Ultimately, it is important when developing models of SRH promotion to consider models of sex communication that are not based on the parent-child interaction, but, which rather proceed from school influences, the mass media or social institutions such as churches and health services and through social networks.

In this era of HIV/AIDS, it is more crucial than ever for there to be access to accurate and relevant sex information for young people as they become sexually active, and for there to be opportunities for informed discussion about all aspects of human sexuality. The socio-cultural context is, however, critical to understanding how this can happen. Preston-Whyte and Zondi (1991) identified barriers to the adoption of safe sex behaviours in South Africa which are not found in international literature. They discovered that one of the greatest barriers to the use of condoms are: (i) the pervasive view that girls should prove their fertility before marriage (ii) condoms are perceived to be incompatible with male notions of masculinity and their use is therefore restricted to persons already infected with either HIV or a sexually transmitted disease (STD). In

addition to this Abdool Karim, Preston-Whyte and Sankar (1992), identified the contraceptive value of condoms as being sufficient reason for their non-use. These are some of the factors that need to be taken into consideration when designing prevention programmes, as reception of health education programmes rests on the degree to which what is taught may be assimilated. The information provided should be culturally appropriate, and should not be at odds with social norms within the community at which it is aimed (Piotrow, Kincaid, Rimon & Rinehart, 1997). It is, therefore, important to take stock of these factors. The present study focuses specifically on the communication context. Other socio-cultural factors including beliefs about the body, health and sexuality are dealt with by way of understanding SRH communication.

1.2 Purpose of the study

Given the need to develop sex education programmes and the current efforts underway to develop school curricula for this purpose, this study has been conceived as a study of one context into which such programmes may be inserted. This will provide a baseline for studying the reception of such programmes, but will also serve to draw attention to the need for contextual sensitivity in the implementation of such programmes. The setting is in a group of rural villages in the Amatole Basin, which is a deep rural part of the former Ciskei area of the Eastern Cape.

The study looks at the nature of sex communication amongst youth in this area. It adopts an historical, biographic perspective in attempting to understand how the sex communication context has changed over the last fifty years, from the era before mass media was introduced (cf. Rubinstein cited in Brown, 1981), through to the current period of mass media, compulsory school education and HIV/AIDS. It appears from the preliminary work done by Kelly (2000); Kelly and Parker (2001) and Ntlabati, Kelly and Mankayi (2001) that traditional ways of educating children about sex in this site have largely fallen by the wayside, but what they may have been replaced by, is not clear.

It is hoped that this study will be useful in showing how best sex education should be approached, and to answer such fundamental questions as ‘Where would it be best to place sex education activities in this community’ ‘Should schools, the family, the health services, youth groups or churches be responsible for said education?’, ‘Should this responsibility be shared and if so by which groups?’ and ‘How would it be best to equip young people with skills and opportunities for exploration and development of values, attitudes, feelings and emotional needs pertaining to sex?’ (cf. Vergnani & Palmer, 1998a; 1998b).

1.3 Note on terms used

At this point, the need for conducting the present study has been established and motivated. It is now important to describe the key terms used in order to shed light on their contextual meaning.

Roffman (in Bolton & Singer, 1992) points out that ‘sex’ in American culture generally refers to intercourse and that it almost always implies penile/vaginal penetration. However, in this study the term sex is used in more general terms to denote all aspects of sexuality. The issue of what sex means and the specific forms it takes are very much a part of what this study sets out to explore. It is particularly important to determine young people’s understandings of sex.

The definition that captures our use of the term ‘education’ is the one provided by the Oxford Dictionary, which defines education as an intellectual, moral, and social instruction to a pupil or child, especially as a formal or prolonged process. As such, it is contrasted with terms such as socialisation and enculturation while still recognising that education is part of socialisation and enculturation. For the purpose of this study the word education will be used to refer to explicit attempts at generating learning.

‘Communication’ on the other hand, refers to a process in which participants create and share information with one another in order to reach a mutual understanding (Piotrow et

al., 1997). Mutual understanding then builds the foundation for mutual agreement, which in turn makes collective action possible. All human interaction involves some type of encounter which involves an implicit framework of understanding, but communication as a term is used to refer specifically to intentional dialogical type processes.

1.4 Structure of the thesis

The thesis is composed of six chapters. The brief outline is as follows:

Chapter 1- Introduction. Here the purpose as well as a brief background to the study is provided.

Chapter 2- Review of literature. Here the literature and research already undertaken in this field of study are reviewed.

Chapter 3- Methodology section. This section addresses the methods and procedures adopted in the study, including data collection and analysis.

Chapter 4- Results section. This section looks at the findings of this study as well as prominent themes that emerged.

Chapter 5- Discussion of results and conclusion section. In this chapter the findings of the present study are discussed in relation to available literature and research in the field. It further summarises the study and makes recommendations. Finally it highlights the shortcomings of the present study and offers recommendations for future studies.

CHAPTER TWO

2. LITERATURE REVIEW

This chapter is devoted to reviewing the literature already available on sexual education and communication. Unfortunately there is little qualitative research that has been undertaken in this area in South Africa and as a result most of the information used is drawn from international studies. MacPhail (1998) confirms this view when she argues that work among adolescents in the developing world has concentrated on knowledge, attitudes, practices and behaviour (KAPB) surveys. She further states that while these surveys provide some valuable information, they are usually operationalised as narrow quantifiable variables, with little attention to the societal, normative or cultural contexts within which phenomena such as knowledge, attitudes, behaviour are negotiated and constructed. This study attempts to overcome this limitation.

This chapter starts by focusing on trends in sexual education and communication, by looking at various sources of information, their impact and relative significance and then moves on to address theories normally employed in health communication for HIV/AIDS.

2.1 Major trends in sexual communication and education

Within western culture, around the turn of the twentieth century information concerning sexuality came primarily from direct experience and only minimally from a young person's family (Penland in Moran & Corley, 1991). This could be attributed to what Calderone (cited in Cassell & Wilson, 1989) observed in these societies. He discovered that the myth had been maintained that children can only grow up innocent as long as they are ignorant about the facts of sex, reproduction, sexual pleasure and other such subjects considered dangerous, until such time that their parents have deemed them ready to marry. Sex education at the time was characterized by a mixture of facts, superstitions, and myths, circumscribed in each context by prevailing knowledge and cultural

understanding. The parents' responsibility in educating their children about sex was a simple one. At some point before the child was married, the parent of the same sex was to provide the "secret" information about how to perform sexual intercourse. It was the mother's responsibility to inform daughters that menarche signaled the onset of "womanhood", which was usually a vaguely defined term (Kirkendall & Kelly cited in Brown, 1981).

Only after the beginning of the 20th century did the movement to develop formal and effective sex education begin to emerge. The main impediment to this development was the fearful, repressive atmosphere, which typically surrounded any discussions of sexuality and even of the body itself. Almost any direct mention of sexual matters was regarded as obscene and or pornographic. The only acceptable use of sexuality was that of procreation purposes (Kirkendall cited in Brown, 1981).

This however, does not seem to have been the case within Black communities in Africa. Delius and Glaser (2001) raise an interesting point that contemporary research on sexuality suggests an awkward intergenerational silence on issues of sexuality to the extent that some people see the silence as a product of 'our culture'. But material on earlier African communities paints a very different picture (p. 2). Schapera (cited in Delius & Glaser, 2001) describes openness in discussing sexuality in the Kgatla society of Botswana in the 1930's. Schapera states that he was continually struck by the importance these people attached to sexual aspects of social life and their open views on these matters. They had very little prudery with regard to with sex. Certain standards of decency were observed in speech and dress code but sexual behaviour was not a topic that needed to be deliberately veiled. The physical relations between men and women were spoken about freely and with relatively little embarrassment even in mixed company, for sex was considered a normal aspect of human life. There was no attempt to keep it a sacred mystery where young people were concerned. The ignorance until recently held to be so desirable in European girls before marriage was never considered desirable in Kgatla girls. From an early age children were familiar with the nature of copulation and much of their play consisted of games with a sexual character (p.3). This

is also corroborated by Pitjie (cited in Delius & Glaser, 2001) who made similar observations when he undertook research on the Pedi tribe in the 1940's. He identified sexual play amongst children which parents largely ignored. A similar dynamic was noticed by Corry (cited in Allen, 2001) in a study he conducted which explored the sexual socialisation of the Sukuma people of northwest and west central Tanzania. In this community there were no formal puberty initiation ceremonies but informal education took place in the 'Maji' (dormitories where young people slept upon reaching puberty) (Corry cited in Allen, 2001). He states that the ideal behaviour for a girl while living in the 'maji' was to have a few lovers so as to gain sufficient experience to be a good wife and to marry at the age of about 18 to 20 years.

The introduction of Christianity in the early 30's and 40's is highlighted by Delius and Glaser (2001) as the cause of the breakdown in the traditional sexual socialization process, as well as the silence on sexual matters that became especially damaging as other forms of sexual education withered. Christianity introduced new and strict rules and undermined existing practices and described them as uncivilized. It contributed to the abandonment of techniques like limited intercourse, which had provided a controlled outlet for adolescent sexuality (Delius & Glaser, 2001).

This situation has improved over the years, with increasing recognition of the need for sexual and reproductive health communication (cf. Genne cited in Brown, 1981). But the cultural frameworks for this are no longer in place and it falls to the lot of health workers and educators to create new frameworks for the same. In fact, because of the AIDS pandemic there is arguably widespread cognisance of the importance of communicating about sex. Even churches, which for decades have been opposed to sex education on moral grounds, are becoming involved in sex education programmes (cf. Bolton & Singer, 1992; "MAMEPE", 2002)

Gebhard (1977) in America, conducted a study to see whether there are any intergenerational differences in how people acquire basic sex information. He compared his sample findings with those of the Kinsey sample unpublished data from 1938 to 1960

on the same topic. The measuring instrument employed in both studies was the same. There were three major findings of this study. Firstly, children and young people were learning the basic facts about sexuality at considerably younger ages than did their parents and grandparents. This change was attributed to three factors; namely, an increased maternal effort in imparting information, increase of sex education in schools, and a greater and more explicit exposure to sex by the media. Secondly, sources of early sex information had shifted in their relative importance. Although same sex peers remained the dominant educators, they were losing some of their importance to other sources especially mothers. The number of persons reporting not one major source, but two or more had increased and this probably reflects the greater availability of sexual information. The schools, while still inconsequential as sources of knowledge, were making laudable progress, particularly at the high school level. Mass media continued to be an important source, particularly for more technical knowledge such as knowledge about fertilization or for types of information avoided by schools and parents (e.g. homosexuality and prostitution). However, as a sole major source of sex information, mass media had diminished in relative importance. Thirdly, differences in male and female patterns of acquiring knowledge were not significant. It was found that both learn most of the facts of life at an early age. Whereas in the Kinsey sample males learned of nearly all the sexual items at earlier ages than did girls, this was no longer the case. The only topic in which males still led was knowledge about condoms.

Finally Gebhard (1977) speculates as to how these trends of early acquisition of sexual information would affect American society. He suspected that they would ultimately have a generation of prepubescents with a rather comprehensive knowledge of human sexuality including coital techniques and practices all of which were previously regarded as deviant or offensive. He further contends that this knowledge would be superficial and that there would be considerable confusion because children would be unable to discriminate between misinformation and fact. He finds that the more important problem and one less simple to resolve is the fact that these children, burdened with copious amounts of information of varying validity, may be unaware of the psychological and social aspects of sex, which determine the meaning of any sexual act.

It should be understood that this is an American study and that the dynamics that operate in South Africa are different from those in America. For example, sex education has been recently introduced to our curriculum following the new education system (i.e. Outcomes Based Education (OBE)). Furthermore research conducted in South Africa suggests that parents are still reluctant to discuss sexuality with their children (Webb, 1997; K; Delius & Glaser, 2001; Kelly & Parker, 2000, 2001). However the American study provides us with valuable insights into the trends in sexual communication, which suggest a move towards openness in discussing sexuality.

Studies conducted recently in South Africa to investigate sexuality among young people reveal a marked decrease in the age of sexual debut, which often occurs from as young as 12 years (Verganni & Frank, 1998; Buga et al., 1996; Kelly, 2000). A disturbing finding from the latter study is that most of the adolescents' partners in their first sexual encounters are much older than themselves. These adolescents are thus more vulnerable to being exposed to HIV as they may be unable to negotiate safe sex practices with their partners. There is evidence from a number of studies to suggest that adolescents who talk to their parents about sex are likely to initiate sexual intercourse later than their peers (Leland & Barth, 1993; DiIorio, Kelley, & Hockenberry-Eaton, 1999, cited in DiIorio et al., 2000), and are more likely to use condoms and contraception when they become sexually active (Holtzman & Rubinson, 1995; Kotva & Schneider, 1990; Miller, Levin, Whitaker, & Xu, 1998 cited in DiIorio et al., 2000).

Chilman (1990) describes the ideal of sexually healthy adolescents, based on esteem and respect for the self and other people of both sexes. It embraces the view that both male and females are essentially equal, though not necessarily the same. These adolescents take pleasure and pride in their own developing bodies. As they mature they have an increasing ability to communicate honestly and openly with persons of both sexes with whom they have a close relationship. They accept their own sexual desires as natural but to be acted upon with limited freedom and within the constraints of the reality of the situation, including their own values and goals and those of significant others. This

vision is similar to the vision of sexual health widely promoted by loveLife in South Africa. loveLife is a communication activity primarily aimed at 12 to 17 year olds which strives for the development of healthy lifestyles incorporating the reduction of the number of pregnancies and prevention of HIV/AIDS and other sexually transmitted infections (STIs) (Kelly et.al, 2001; loveLife, 2001b). However, both the vision and the means of attainment are subject to the constraints of existing societal patterns. Such a vision would certainly not be attainable in societies where gender equality is not socially endorsed. Also, in situations bereft of opportunity it would seem to be overly optimistic as a vision. It may also be a culturally specific vision, although the implicit values of communication and dialogue are generally recognised as universally desirable in South African society. The point is that wherever the society may be heading, we must begin by taking stock of where we stand with respect to child-parent communication, school based sexuality education, cultural forms of sexual education and so on.

Regarding information provision, Webb (1997) alerts us to the fact that, there is no set formula and that a variety of sources of information might provide the most appropriate set of messages. Let us now take time to look at the various sources of sexual information individually, focusing on trends, their impact, and patterns of communication.

2.1.1 Parents

The influence of parents on sex communication and education has been the most widely researched area. This may be because of the contention that parents should be the primary providers of this information. However, research on how children and youth in South Africa learn about sex reveals little evidence of communication between parents and children on sexual issues (Glaser & Delius, 2001; Kelly & Parker, 2000 & 2001; Webb, 1997). Parents find it very difficult to broach the issue of sex with their children who, as a result, have little option but seek to the information elsewhere and in most instances from peers. Hedgepeth and Helmich (1996) share valuable insights into the problems that often contribute to parent-teen lack of communication. These include poor communication in general, different values about sex and dating, and a desire to avoid conflict. Webb (1997) in a study related to HIV/AIDS, looks particularly at community perceptions of

the causes of teenage pregnancy. He discovered that the lack of parental care for the well being of the teenagers was a contributing factor. Parents were identified even by parents themselves as being negligent in three ways: Firstly, they were seen as not fulfilling the role of educating their children in terms of sexual behaviour and advice regarding the avoidance of sexuality. Secondly, they were seen as uncaring about the children's welfare due to domestic concerns, Thirdly, they were seen as setting poor examples for the children in terms of their own sexual behaviour.

Dubbe in Rozema (1986) discovered that adolescents also experience difficulty communicating with their parents about sex. He maintains that sexuality is one single topic adolescents found most difficult to discuss with their parents, for the following reasons: fear, nagging, and feeling condemned. These create a defensive communication climate (Gibb in Rozema, 1986) which occurs when a person feels threatened by others. A study conducted by Kekovole et al. (1997) in Kenya, corroborates this view. Adolescents reported feeling uncomfortable talking to their parents about sexual issues. Out of eleven choices that were listed in the questionnaires, parents were highlighted as the ones the adolescents were most uncomfortable talking to. They preferred friends, siblings and health workers. It seems a similar situation could be operating in South Africa. A finding that may be supportive of this, though its external validity is questionable, is a telephone survey conducted on "FRESH" a youth programme on sexuality held on the 4th of May 2000 ("FRESH", 2000). The question asked was whether young people could talk to their parents about sex. About 64% of the callers voted against this notion whereas only 34% were for this idea. This therefore suggests that the majority of young people that called in are not comfortable talking to their parents about sex. Uslander in Rozema (1985) attributes this to the fact that parents tend to think of sexuality in moral terms and therefore tend to patronize, preach or even condemn their children when questioned about human sexuality.

In contrast to the above argument, Kaufman and Levin in *loveLife* (2000), state that most young South Africans want to learn about sex from their parents, (corroborating a study by Webb, 1997), but most in fact learn about sex from their friends or older siblings. This

notion is given expression in loveLife campaigns with slogans such as: 'Children want to hear from you (parents) about sex' and 'Love them enough to talk about sex' thus putting the primary responsibility of educating children about sex onto parents. This may be valid in certain contexts but this approach tends to be reductionistic in that it focuses on one aspect, forgetting that children do not exist solely in the confines of their homes but do obtain influences from outside sources. Furthermore in certain instances parents are absent due to domestic and economic concerns.

Lear (1997), in a study conducted in America explored family-based and school-based sex education and its perceived effectiveness on participants. It was discovered that in virtually all cases parents had not established a pattern of open communication about sexuality. Advice about sex was usually limited to vague warnings to be careful. Given the lack of foundation for discussion about sex, by the time parents became willing and attempted to discuss the issue, young people were often reticent to participate preferring privacy while exploring their sexuality.

There are some indications of initiatives by some parents of trying to break this vicious cycle. For instance, in Zaire some mothers have broken the taboo, which prohibits discussions of sexual subjects with unmarried children, in order to help them understand the need for condom protection. Others even supplied teenagers with condoms. Fathers, while not taking similar action, tended to approve of their wives' initiatives in this respect. (Schoepf & Walu cited in Bolton & Singer, 1992).

The lack of organized efforts to adequately prepare young people for the psychological and physiological events associated with sexual maturity increases the likelihood that they will turn to experimentation or peers for information (cf. Lear, 1997).

2.1.2 Peers

In many contexts, peers have always been influential in providing sex information. This is corroborated by numerous studies including an American study by Thornburg (1981), which identified peers as the primary source of sex information for the majority of teenagers, followed by the media/literature, and then mothers (Moran & Corley, 1991).

Reed and Weinberg (1984) did a re-evaluation of the data collected by the Kinsey Institute for Research, by looking at the changing norms of what they term “Scripts” of young people. Their results indicate that much of what young men and women do is influenced and entrenched by what others similar to them are doing. This therefore suggests that the norms of adolescent peers are very influential. More attention needs to be paid to the way the fact that adolescent sexuality is a complex socially negotiated process, embedded with norms and values rather than the result of informed decision making. This study therefore aims to look at how influential peers are in this community.

2.1.3 Siblings

loveLife (2000) highlights that most young people in South Africa learn about sex from their friends and older siblings. The influence of siblings in adolescent sexual behaviour is therefore very important. Siblings of a similar age are said to be more likely to have direct intervention-type behaviour influences on each other (e.g. inviting a younger sibling on a double date) than siblings who are further apart. Siblings that are far spaced tend to become role models (Rodgers & Rowe, 1988). Siblings therefore seem to play a major role both directly and indirectly in the sexual socialization of their brothers and sisters.

2.1.4 Cultural influences

Within the Xhosa culture, as this is the culture of the participants in the research, there used to be puberty initiation ceremonies for girls called ‘Intonjane’. In these ceremonies girls were taught about sexual behaviour and the fundamentals of womanhood. There are few, if any, communities that still perform these ceremonies. The reason for their decline has been generally attributed to the assumption that Africans are becoming more westernized. However, Webb (1997) raises an interesting point about the decline of similar rituals in Zambia. He cites that because people are no longer getting married at an early age, and the extended time gap between initiation and marriage, it is presumed that the initiated girls would be keen to experience what they have learned. Furthermore, these girls are also perceived to be more attractive to males as they are officially sexually ‘aware’. This therefore suggests that these rituals have been done away with in order to keep girls ignorant about sex for longer periods. Delius and Glaser (2001) however

ascribe the decline of these ceremonies to the introduction of Christianity. If these initiation ceremonies were still in place, they would serve as a useful resource for introducing HIV/AIDS education and sexual negotiation skills.

2.1.5 Media

In America the media is said to have been instrumental in breaking the culture of silence about sexuality. Sex is used to sell all types of products (Tatum cited in Cassell & Wilson, 1989). However at the beginning the media absolved itself of responsibility by claiming that it is not a responsible educator and that its purpose was only to sell and entertain. This viewpoint has since changed, because the media realised how influential it is, and as a result, it has taken it upon itself to educate the public on certain sexual issues. A similar development has been observed in South Africa. Previously in South Africa the media, which had been an influential medium, and television in particular did not hold open discussions on sexuality. Sex was portrayed implicitly in soap operas and advertisements. This view is based on subjective observation.

The media has now taken a direct stance in promoting openness about sexuality. One of the first programmes dealing directly with sexuality was "JIKA- JIKA" screened in mid 1999. Subsequent to this two other programmes have emerged namely, "FRESH " and "SCAMTO". These programmes have included open discussion on sexuality. All these efforts have however, been initiated because of the AIDS pandemic, in an attempt to get people to talk about sex.

The media provides young people with a great deal of sexual stimulation. It suggests that adults and teens alike have sexual intercourse when they feel like it and without realistic consequences (Tatum cited in Cassell & Wilson, 1989). Young people then need a rational perspective to help counterbalance the sensationalism and distorted images around them (Brown, 1981). This therefore calls for the development of well-structured and well-researched sexuality programmes.

2.1.6 School

For years schools in South Africa did not have sex education as part of their curriculum. Instead sex education formed part of Guidance and Biology, and the emphasis was mainly on the technical aspects of sex content (i.e. human physiology and facts of nature) rather than on the social and emotional aspects. This has changed drastically to the extent that sexuality education in the Outcomes Based Education curriculum is introduced as early as in Grade 1. The focus is not only on the content (i.e. providing accurate information) but also on equipping learners with skills and an opportunity for exploration and development of values, attitudes, feelings and emotional needs (Vergnani & Palmer, 1998). Sex education programmes are often expected to emphasise abstinence in spite of the fact that the average age of sexual debut is around 16 years (Lear, 1997). Factors like this (i.e. peoples' expectations) need to be taken into consideration when developing programmes because if they are ignored that could lead to the failure of such ventures.

2.1.7 Church

The church has for years been opposed to certain aspects of sex education on moral grounds since discussion of these issues were considered to expose young people to facts they would otherwise not have been aware of and therefore unable to experiment with. Many changed their viewpoint due to the HIV/AIDS pandemic (cf. Bolton & Singer, 1992). The same pandemic, however, particularly in its early stages, provided ammunition to both the conservative and progressive sectors of the church in the struggle over sexuality. It offered conservative moralists a weapon, where "God's Wrath" was asserted as the cause of AIDS (Bolton & Singer, 1992) and strengthened their determination to keep the sexual instruction of the youth on the strictest religious basis and to a minimum. The progressive elements, on the other hand, were more tolerant of the increasingly permissive society in which we live and focus on the dual goals of prevention of pregnancy and disease and the religious and moral aspects of sexuality. Pre and extra-marital sexuality in general and homosexuality in particular have posed enormous difficulties for religious leaders faced by the apparent discrepancies between social realities and traditional theological doctrines on sexuality. Liberal churches in

America have moved in the direction of accepting non-marital sex whether homosexual or heterosexual. But the ideal in almost all cases continues to be one of fidelity and love within a monogamous relationship and “recreational” sexuality continues to be condemned (Bolton & Singer, 1992, p157).

In many areas of the world, the church has become proactive in educating its congregation about sex. Seemingly the church is now aware that a religion that ministers and guides people throughout life, from the womb to the tomb, cannot avoid dealing with sexuality, which is so critically involved in all of life's major events as well as in the day to day activities (Genne cited in Brown, 1981). Youth groups hold open discussions about sex but they are still based on religious principles.

It needs to be acknowledged that some churches are still conservative on the issue of sexuality. In those churches, sex is taught within the context of strict moral values, a temptation to be resisted and overcome. An image of sexuality as a positive, voluntary expression of desire or emotional commitment is absent (Bolton & Singer, 1992). For instance, the recent announcement by Catholic Bishops condemning the use of condoms on moral grounds because they believe condoms promote promiscuity but more importantly for theological reasons to do with the church not even approving of contraception. This brings to mind Mbetse's (2001) comment that Christians have “heavenly models”, which are “earthly, useless”. The bishops might be within their right to assert their own cultural preference for their congregation in the struggle against HIV/AIDS, which is abstinence and faithfulness. This approach is based on the assumption that by condemning the use of condoms all the members of the congregation will be faithful. This assumption is however fallacious in that some of its members engage in premarital and extramarital sexual relationships. Given this the transgressors to the churches' rule are left in a dilemma as to whether by using condoms in their sexual endeavors they could be committing a double sin. It would be understandable if the church made it clear that it is the promiscuity associated with condoms to which they object rather than the condoms per se, as needing to use a condom suggests that one is not leading a holy life. At the same time the church has to acknowledge that some of its

congregates might deviate from the 'law'. In such instances it has to allow the use of condoms in order to prevent HIV transmission.

In South Africa Pastor Khathide of the Pentecostal church ("MAMEPE", 2002) has broken the taboo of silence in the church about sexuality. He holds seminars for married couples and teaches them about the pleasures of sex. He has even released a number of CD's and tapes on the same topic and his target audience is married people. He firmly believes that the taboo of sex needs to be demystified as this could encourage parents to talk openly to their children about sex. Like most religious leaders Pastor Kathide believes that sex should only be enjoyed within the confines of marriage. However, he does not shy away from the reality that children and young people are sexual beings. He even makes an example that young people need to be told that there is nothing wrong in being sexually aroused as this is a natural phenomenon, but that they need to wait until the time is right to have sex and then only with the 'right' person ("MAMEPE", 2002). Pastor Kathide has met a lot of criticism within religious circles and among Black people as they feel what he does is "against their culture". This does not deter him in that he understands that reactions like this are to be expected when one deviates from the norm.

Bolton and Singer (1992) identify sexual hypocrisy as the worst enemy of AIDS prevention. They argue that the threat of AIDS will not reverse the sexual revolution, but that it has resurrected traditional fears and guilt surrounding sexuality. Shernoff and Bloom in Bolton and Singer (1992) argue that we need to support the right of each person to choose for him/herself the fullest expression of their needs. This right is at the heart of any healthy community. The effect of AIDS education will be crucial in determining whether the ultimate legacy of the AIDS tragedy, in which so many lives are being lost, will be a revival of a restrictive sexual order in which individual rights are severely circumscribed, or the emergence of a new sexual culture based on the values of freedom, choice, creativity, honesty and responsibility.

The literature covered thus far suggests a trend towards openness in sex communication, which has been promoted as a response to the HIV/AIDS pandemic.

2.2 Mediating factors in sexual communication and education

Within the African context, the introduction of Christianity (Delius & Glaser, 2000; Halperin, 2000; Allen, 2001) and the breakdown of communication between generations (Webb, 1997) have been highlighted as reasons why sex education has been neglected. Explanations for the breakdown are, however, contradictory. On the one hand, sex is seen to be a cultural taboo and therefore not discussed openly, and on the other, the traditional approach to sexual education through extended family and community heads are said to have broken down. The latter has been facilitated mostly by urbanization and migrant labour (cf. Webb, 1997).

2.2.1 Migrancy

The phenomenon of migration of people and families in search of better opportunities has been characteristic of many societies for a very long time. Of particular interest to us is migrant labour and its implication for the sexual communication and education context. In SA apartheid policies such as influx control restricted the African population from voluntary migration out of their designated areas, which were put in place by group-areas legislation. The legacy of this era is that these areas still have some of the lowest levels of services, infrastructure and employment in the country (The State of South Africa's Population Report, 2000). The site of study is one such area. People from these areas have little option but to migrate in search of employment opportunities.

Delius and Glaser (2000) in their attempt to understand the sexual socialisation of African societies identify migrant labour as one of the mediating factors to this process. High incidence of migrant labour in these communities ensured that fathers were often absent figures and this resulted in diminished parental control over their children's sexual activity. This was further perpetuated by mothers who also had little option but to search for employment or income in towns. They further relate that in the early stages of migrant labour a man's first trip to the town was usually delayed until after initiation, but by the twentieth century it was common for boys to leave for work long before they were

circumcised. As a result, they were unable to be included in traditional rural youth organisations, which were arenas for sexual education. For many of these young men, the harsh and often violent world of the hostels in which they resided became a substitute locality for learning sexual values. When these young men returned home they were often relatively affluent and independent of both parental control and the pressure exerted by local peers. Instead they became the pace-setters for young people in their communities and their values and style became a powerful counterpoint to the values that elders attempted to instill (Delius & Glaser, 2000, p.10).

Caldwell, Anarfi and Caldwell (1997) argue that migration has always facilitated the spread of any infectious disease and this also applies to HIV/AIDS. The State of South Africa's Report (2000) cautions us about making assumptions of this sort because migration could easily be construed as being the problem, whereas in reality, it is rather the manifestation of a greater sociological problem. But Caldwell et al. (1997) explain their point by stating that with regards to both sexual and other behaviour, migration takes individuals away from their home places where their actions are often monitored and controlled, to distant places where no one feels individual responsibility for exerting much influence over them.

Webb (1997) highlights one of the significant effects of migrant labour, namely, family disintegration. It separates families both spatially and emotionally, and this condition causes intra-family communication problems. In a family where there is poor communication, broaching the subject of sexuality is obviously less likely to occur.

2.2.2 Gender as a mediating factor

Gender and sexuality are significant factors in the sexual transmission of HIV and are therefore paramount in the planning of sexuality programmes (Nahom et al., 2001). Gupta (2000) alerts us that gender is not a synonym for sex. It is therefore necessary that we make this distinction clear. Mendoza (1997) provides a definition that captures our meaning of gender in this context:

Gender is what it means to be a male or a female and how that defines a person's opportunities, roles and responsibilities. Gender is a socio-cultural variable and refers to the roles, behaviour, and personal identities that the society and culture prescribes as proper for women and men. These attributes, opportunities and relationships are socially constructed and learned through socialisation processes. Gender roles vary across determinants such as race, culture, community, time, ethnicity, occupation, age, and level of education. While sex is biological, gender is socially defined (p. 1 in Airhihenbuwa & Obregon, 2000).

This differentiation between the sexes brought about inequalities. In many cultures men are considered to be superior to women and in those contexts the way women behave and interact with men is largely defined by men. Esu-Williams's (2000) definition of what a good African woman is depicts this inequality. She stipulates that women have allowed men to determine this and they (women) have tried very hard to live up to this definition. She states that men prefer women who can bear heavy loads, be a caregiver, be a great cook, and after all that is done, provide sexual satisfaction on men's terms alone. Paradoxically, a woman who is a really good sexual partner is suspect. So enjoying sex has been relegated to men and women outside the home.

This is closely linked to the sexual components identified by Gupta (2000) which she terms the 5 P's of sexuality i.e. practices, partners, pleasure/pressure/pain, procreation and power. The first two refer to the aspects of behaviour- how one has sex and with whom, while the second two refer to the underlying motives. The fifth P is the most important and refers to the power underlying any sexual interaction, heterosexual or homosexual and determines how all the other Ps of sexuality are expressed and experienced. Thus power determines whose pleasure is given priority and when, how, and with whom sex takes place (p.18). Power is thus fundamental to both sexuality and gender. This therefore suggests that unequal power balance in gender relations that favours men, translates into an unequal power balance in heterosexual interactions, in which male pleasure supercedes female pleasure and men have greater control than women over when, where, and how sex takes place. An understanding of individual

sexual behaviour, male or female thus necessitates an understanding of gender and sexuality as constructed by a complex interplay of social, cultural, and economic forces that determine the distribution of power (Gupta, 2000).

Gupta (2000) further sums up some of the most crucial factors fuelled by these power imbalances that mediate both male and female vulnerability to HIV/AIDS. These factors are drawn from various international studies. Attention is first paid to the factors that are associated with women's vulnerability to HIV.

Firstly, in many societies there is a culture of silence that surrounds sex, which dictates that "good" women are expected to be ignorant about sex and passive in sexual interactions. Gupta, Weis and Mane (1996) contribute to these findings by suggesting that female ignorance of sexual matters is often viewed as a sign of purity and innocence while having "too much" knowledge about sex is a sign of "easy virtue". This attitude makes it difficult for women to be informed about risk reduction and even when they are informed it is difficult for them to be proactive in negotiating safer sex (Gupta & Weis, 1989; Parker & Gagnon, 1995; Donovan & Ross, 2000).

Secondly, the traditional norm of virginity for unmarried girls that exists in many societies, paradoxically, increases young women's risk of infection because it restricts their ability to ask for information about sex out of fear that they will be thought to be sexually active. Virginity also puts young girls at risk of rape and sexual coercion in high prevalence countries because of beliefs that having sex with a virgin will cleanse a man of infection, although it is not clear how widespread these beliefs are. In addition to this, in cultures where virginity is highly valued, research has shown that some young women may engage in risky sexual practices, such as anal sex, in order to preserve their virginity, thus placing themselves at increased risk of contracting HIV (Rivers & Aggleton, 1999).

Thirdly, because of the strong norms associated with virginity and the culture of silence that surrounds sex, accessing treatment for sexually transmitted diseases could be highly stigmatising for women. For example, in a study conducted in Tanzania it was found that there were gender differences in the decision making that led to the use of HIV voluntary counselling and testing services. Men made the decision to seek voluntary counselling and testing independently, women on the other hand felt compelled to discuss

the issue with their partners before accessing the service, thereby creating a barrier to accessing these services (Rivers & Aggleton, 1999).

Fourthly, in many cultures because motherhood, like virginity, is considered to be a feminine ideal, using barrier methods or non penetrative sex as safe sex options presents a significant dilemma for women. Fifthly, women's economic dependence on men increases their vulnerability to HIV. Research has shown that the economic vulnerability of women makes it more likely that they will exchange sex for money or favours (Kelly & Parker, 2000; Fuglesang, 1997), less likely to succeed in negotiating protection, and less likely that they will leave a relationship they perceive to be risky. Balmer et al. in Rivers and Aggleton (2000) observed a similar dynamic in Kenya where young girls report that they are courted by older men who seek sex. This puts them in compromising situations where it is difficult to negotiate a way out of the relationship. He also discovered that young women felt that they did not have control over their sexuality instead girls learned that sex was something that happened to them. It was thus not something they could initiate or actively participate in. Finally the most disturbing form of male power, violence against women, contributes both directly and indirectly to women's vulnerability to HIV.

It is clear that dominant ideologies of femininity promote ignorance, innocence and virginity, whereas dominant versions of masculinity encourage young men to seek sexual experience with a variety of partners (Rivers & Aggleton, 1999). Let us now look at the ways in which the unequal power base in gender relations increases men's vulnerability to HIV infection, in spite of, or rather because of their power.

Firstly, the prevailing norms of masculinity which expect men to be to be more knowledgeable about sex, put young men at risk of infection because they prevent them from seeking information or admitting their lack of knowledge about sex or protection (Rivers & Aggleton, 1999). This then compels them into experimenting with sex in unsafe ways and at a young age to prove their manhood. So while young women risk their sexual health because they must appear to be ignorant and thus cannot seek information, young men risk their sexual health because they must appear to be knowledgeable and so cannot openly seek information either (Rivers & Aggleton, 1999).

Secondly, in many societies it is believed that a variety in sexual partners is essential to men's happiness and a natural necessity. For example in Nicaragua, where virginity is highly valued in young women, having multiple sexual partners is seen as a sign of virility in young men (Zelaya et al., 1997). Berglund et al (1997) further note that in this community the pressure to be sexually active for young men and to have as many partners is very great to the extent that those who do not conform to this expectation are openly ridiculed by their peers for not being real men. In South Africa, for example, having many sexual partners is reported to be equated with popularity and importance among young men.

Thirdly, notions of masculinity that emphasize sexual domination over women as the defining characteristic of malehood, contribute to homophobia and the stigmatisation of men who have sex with men. This forces men who have sex with men to hide their sexual behaviour and deny the risk involved, thereby increasing their own risk as well as that of their partners, male or female.

Fourthly, in many societies men are socialised to be self-reliant, not to show their emotions, and not to seek assistance in times of need and stress. This expectation of invulnerability associated with being a man is contrary to the expectation that men should protect themselves from potential infection and encourages the denial of risk.

It appears that these gender based power inequalities perpetuate both male and female vulnerability to HIV infection, it is therefore crucial that attempts be made to address these imbalances. Gupta (2000) suggests that there is an urgent need to break the silence surrounding sexuality because talking openly about sex is the first step in reducing denial and bringing about acceptance of collective vulnerability. Gupta and Weiss (1995) further suggest that opportunities should be created for women to talk openly about sex. This could be an important step in overcoming the social norms that define a "good" woman, as one who is ignorant about sex and passive in sexual interaction and those that label inter-partner communication on sex, particularly when initiated by a woman as taboo. They further contend that norms and beliefs like these make negotiating the use of condoms or raising the issue of monogamy a very difficult task. It is therefore the gender system that needs to be addressed not just women because seeking to change female

behaviour without taking into account its relationship to male behaviour could prove meaningless as women are still unempowered (Gruinseit, 1997). Mann and colleagues in Donovan and Ross (2000) suggest that the removal of gender inequalities could be the single most effective step in preventing HIV transmission given the powerlessness of women to negotiate sexual safety in many societies. However, the chances of achieving effective change are very slim as this would require changing the entire cultural mindset and religious ideologies.

2.2.3 Poverty

There is a global understanding that the HIV/AIDS epidemic is less about infection and more about social factors (Urdang, 2001, p. 24). Poverty is one such factor. In many African countries poverty plays a central role in the transmission of HIV in that among poor communities there is generally less perception of risk. For people struggling for daily survival, a disease like AIDS, which may or may not kill them in future can seem unimportant (Finger in Rivers & Aggleton, 1999). In South Africa, for example, children and young people living on the streets of urban areas do not commonly list HIV/AIDS as an overriding concern. Instead, the day to day need for shelter, food, and clothes take higher priority (Swart-Kruger & Ritchter, 1997).

Young people living in poverty or facing the threat of poverty may be particularly vulnerable to sexual exploitation through the need to trade or sell sex in order to survive (WHO, 1998 in Rivers & Aggleton, 1999). For example, in South Africa, more than half of 141 street children interviewed report having exchanged sex for money, goods and protection and several indicated that they had been raped (Swart-Kruger & Ritchter, 1997). Similar patterns prevail in other countries. For instance, in Zimbabwe, Kenya, Zaire, and South Africa, the increasing financial insecurity that exists among a large number of female headed households make transactional sex a “rational means of making ends meet” (Rivers & Aggleton, 1999; Kelly & Parker, 2000)

This close relationship between HIV/AIDS and poverty initiated a controversial debate in South Africa, where one faction asserted that poverty was the cause of AIDS and not HIV

per se. President Thabo Mbeki was among the people who spearheaded this debate. This was a very heated debate and President Mbeki drew opposition from numerous circles within the country and abroad including AIDS activists, politicians and medical experts. As a result of this view in 2000, poverty eradication and accelerated socio-economic development were number one points in the National Strategic Intervention to curb HIV/AIDS (The State of South Africa's Population Development Report, 2000). However, the possibility of these objectives being achieved in the near future is very small. It is therefore suggested that open communication about sexuality should be given priority as this could be achieved with minimum resources being put in place. It has been proven in other countries that the possibility of beating the scourge of the HIV/AIDS pandemic can be achieved by talking openly about sex.

It is now necessary to turn to the theories and models developed for health communication, and to look at them in the light of the challenges outlined above.

2.3 Theories and models of health communication and their impact on behaviour change

An effective communication strategy is a critical component of the global efforts in HIV/AIDS prevention and education due to the absence of a cure or vaccine against the disease (Airhihenbuwa & Obregon, 2000). Such a strategy therefore needs to be grounded in theory so that the resulting framework is flexible enough for application in different regional and cultural contexts. Piotrow et al. (1997), provide a summary of some of these theories and divide them into five categories namely:

(i). Stage or step theories (diffusion of innovation, the input or output persuasion model and stages of change theory); (ii) Cognitive theories (theory of reasoned action and social cognitive learning theory); (iii) Social process theories (social influence, social compassion and convergence theories); (iv) Emotional response theories and (v) Mass media theories (Cultivation theory of mass media).

The most commonly used theories and models in HIV/AIDS communication are the (i) The Health Belief Model (ii) Theory of reasoned action (iii) Social learning or cognitive

theory, (iv) Diffusion of innovation theory and (v) Social marketing. Underlying assumptions of these theories will be highlighted briefly.

2.3.1 The Health Belief Model (Becker, 1974)

The Health Belief Model (HBM) is based on the premise that health behaviour is a function of an individual's socio-demographic characteristics, knowledge, and attitudes (UNAIDS, 1999). According to this model behaviour change is only possible if the person (i) perceives him or herself to be susceptible to a particular health threat, (ii) understands the seriousness of the condition, (iii) believes that adopting a new behaviour could decrease ones vulnerability to contracting the disease, (iv) has had something happen that required him to take action, and (v) understands the benefits of taking preventative action and also acknowledges the barriers to taking that particular action. For change to occur the benefits must outweigh the disadvantages (UNAIDS, 1999). In the context of HIV/AIDS for example, the likelihood of a condom being used as a means to prevent HIV infection will be greater when people perceive themselves to be susceptible to contracting HIV, perceive the consequences of infection as very severe, perceive taking preventative action as very effective, see few costs or barriers to self protection (such as embarrassment over acquiring condoms) have a cue to action (e.g. are reminded of protective behaviours when dating) and are able to protect themselves (e.g. have the opportunity to obtain condoms) (Valdiserri, 1989, p. 51)

The main criticism that has been lodged against the HBM is that it is a rational cognitive model and assumes that decision makers are rational. This does not hold true for most adolescents and adults as they do not seem to approach the AIDS issue from a rational or logical perspective but seem quite capable of discounting risks and optimistically perceiving themselves as invulnerable to harm (Friedman cited in Airhihenbuwa & Obregon, 2000).

2.3.2 Theory of reasoned action (Fishbein & Ajzen, 1975)

This theory is based on the assumption that the adoption of certain behaviours is based on personal intent. This intent is determined by a person's attitude (beliefs and expected

values) towards performing the behaviour and by perceived social norms (importance and perception that others expect a certain behaviour) (Fishbein & Ajzen in Piotrow et al., 1997). For example, in the context of HIV/AIDS prevention a person may start to use condoms if his or her attitude is “having sex with a condom is just as good as having sex without a condom” and the social norm could be “most of my peers are using condoms so they would expect me to do so as well” (UNAIDS, 1999).

This theory also assumes that individuals are rational in their decision making processes. This is an assumption that may not be entirely true for HIV/AIDS related behaviours that are heavily influenced by emotions (Michal-Johnson & Bowen in Airhihenbuwa & Obregon, 2000). Furthermore individuals evaluate information that may result in action within external constraints, which are mediated by power relations in a society (Yoder in Airhihenbuwa & Obregon, 2000).

2.3.3 Social learning or cognitive theory (Bandura, 1986)

The social cognitive or learning theory is based on the assumption that new behaviours are learned either by modeling the behaviour of others or by direct experience. It focuses on the important roles played by vicarious, symbolic and self regulatory processes in psychological functioning and looks at human behaviour as a continuous interaction between cognitive, behavioural and environmental determinants (Bandura in UNAIDS, 1999). Central to this theory is the concept of self efficacy which is a belief in ones ability to implement the necessary behaviour and outcome expectancies which are mainly beliefs about what the outcome of implementing that particular behaviour might be (UNAIDS, 1999). A person with a high self efficacy will be more likely to adopt safe sex behaviours (for an example insist that their partners use condoms) compared to those with low self efficacy. The main argument against this theory is that it is an individual psychology model and programmes based on this model are not relevant in cultures where individual decisions are the result of group norms (Freimuch et al., in Airhihenbuwa & Obregon 2000).

2.3.4 Diffusion of innovation theory (Rogers, 1983)

This theory focuses on the communication process by which a new idea or product becomes known and used over time by members of a given population (Airhihenbuwa & Obregon, 2000). This theory asserts that people are most likely to adopt new behaviours based on favourable evaluations particularly if the idea is communicated to them by people they respect (Keagles in UNAIDS, 1999). Central to this theory are four essential elements: the innovation, its communication, the social system, and time. Of these elements two are widely used in HIV/AIDS campaigns and these are creating HIV awareness and opinion leaders to influence attitudes and behaviours (Rogers in Airhihenbuwa and Obregon, 2000). The use of opinion leaders helps to shape culturally appropriate strategies. This is particularly important since the content, context and language will be a factor in the outcome of HIV/AIDS prevention and care. That is, the context is contingent upon each community's interpretation of what comprises a disease. Context refers to the relationship and negotiation in families and communities and language of communication refers to codes of elasticity of usage where relevant (Airhihenbuwa and Obregon, 2000).

This theory has been criticized for being too linear and for having a pro-innovation bias. It has also widening the gap between the "information haves" and "have nots" in a social system, a gap which has been observed in AIDS awareness and knowledge (Freimuth in Airhihenbuwa and Obregon, 2000).

2.3.5 Social marketing (Kotler and Zaltman, 1971)

Social marketing is an organised approach geared at promoting acceptability of a social idea (Airhihenbuwa & Obregon, 2000). This concept is derived from the field of commerce and advertising. Andreason in Piotrow et al. (1997) defines social marketing as the application of commercial technologies to the analysis, planning, execution and evaluation of programmes designed to influence the voluntary behaviour of targeted audiences. Social marketing focuses primarily on influencing targeted audiences' behaviour by emphasizing the four P's: i.e. product, price, place and promotion (Piotrow

et al, 1997). These four P's have been applied extensively in HIV/AIDS prevention to promote condoms. A fifth P has been recently added to indicate positioning with regards to recognition of competing campaigns on the same subject in the same location (Airhihenbuwa & Obregon, 2000).

Social marketing in HIV/AIDS communication has been criticized on ethical grounds in that sometimes it employs manipulation such as fear in promoting condoms (Gutman, in Airhihenbuwa & Obregon, 2000). Furthermore it is believed that social marketing applies a simple solution (such as condom distribution) to a complex problem without addressing the social conditions that cause the spread of HIV (Freimuth, in Airhihenbuwa & Obregon, 2000). Evaluation of social marketing undertaken by Smith's in 1998 stresses this point, in that product social marketing has been widely used and praised whereas little has been done with regards to behaviour social marketing (using social marketing to change and maintain behaviour) and almost nothing has been done in the area of policy social marketing (using social marketing to influence policy to support HIV research and protection of persons living with HIV/AIDS) (Airhihenbuwa & Obregon, 2000).

All these theories are said to be effective in initiating behaviour change, but they have limitations when applied in contexts different from those for which they were developed. For example, the social cognitive theory is said to be very effective in changing behaviour in America but has failed to yield similar results when applied in Africa (Airhihenbuwa & Obregon, 2000). This is mainly because these theories were designed to address health prevention from an individual, linear, and rational perspective, hence their failure when applied in different contexts. Mhloyi in Esu-Williams (2000) clarifies this point when he points out that years of implementation of prevention paradigms that are focused on the individual rather than the social structures and family have not worked for us in Africa.

In response to these limitations UNAIDS developed a new communication framework for HIV/AIDS. This framework moves from the focus on the individual to focus on five domains of contexts that influence behaviours; i.e. government policy, socio-economic

openly about sex. Community mobilisation is not synonymous with social mobilisation. A distinction has to be made between the two. Social mobilisation involves actions that reach and influence all relevant segments of society and a much broader sphere of players, from the highest levels of government to the poorest citizens at community and household levels. Community mobilisation on the other hand tends to be limited to the decisions and activities that occur at community level (Baueme et al., n.d.).

Community mobilisation is motivated by respect for the community and its needs. It strives to be culturally appropriate and sensitive. It is also flexible, adaptable and consensus-oriented (Baueme et al., n.d.), hence it has proved to be a success in many countries. Baueme et al. (n.d.) highlight a number of reasons why this approach is an effective HIV/AIDS prevention strategy for promoting behaviour change, namely:

- (i) Participation by people who serve a variety of roles within a community improves the probability that the campaign will reach a broad audience. In Uganda for instance it was discovered that active participation and involvement of community members was paramount in determining personal responsibility for prevention (cf. UNAIDS, 1998).
- (ii) Community mobilisation contributes to sustained behaviour change. It encourages local capacity building and promotes ‘investment’ in the campaign objectives, thus ensuring the sustainability of prevention efforts. When the local involvement in a campaign has involved many participants it is likely that community members will continue to spread its message deliberately or due to habit.
- (iii) Community mobilisation uses the language of the people and as a result the messages are understandable, relevant and acceptable.

In designing intervention programmes, community mobilisation can utilise either naturally-occurring networks (e.g. women gathering at well), formally organised existing networks (e.g. schools, youth groups), or formal organisations newly created to fulfill a specific need. It can also facilitate coalitions of formal organisations. This is deemed to be important because if certain groups are left out of an intervention they can thwart it

(Baueme et al., n.d.). Many communities use existing organisations, groups and structures for education and support and through these, create networks and alliances that are successful in increasing community awareness and which develop high levels of responsiveness to new issues as they arise. The key elements in these relationships are communication, trust, and willingness to work together. In many countries, community initiatives create the stimulus for broader community involvement and a response to the HIV epidemic at a national level (UNAIDS, 1998). Despite the attractiveness of using existing community networks to promote a new practice, Baueme, et al. (1994) point out some of the limitations of this approach. These include the following:

- The strategy is very labour intensive and must be replicated anew in each community where it is to operate.
- The community may have more urgent priorities than the activity of interest to the implementing agency.
- Existing networks come with ongoing rivalries and power struggles.
- Attempts at restructuring resource allocation can lead to conflict or violence.
- Political forces within the community may take over the activity for other purposes.
- A new activity may strain the already scarce resources of a community.

In spite of these limitations this is a valuable framework to draw upon as its benefits in our context outweigh its disadvantages.

The preceding discussion has revealed that sex is no longer considered a taboo in many sectors of the society and there appears to be a growing trend, which is indicative of openness in communicating and educating about sexuality. This has been facilitated mostly by the HIV/AIDS pandemic. A great range of stakeholders have taken it upon themselves to address the issue of sexuality education directly. However, as discussed above there are still obstacles to this process and some of which are not easily amenable to solutions. There is therefore a need to understand and explore these issues further fully cognisant of the fact that there is no general formula or recipe which is culture and context independent. The following chapter will address the methodological considerations that guided the present investigation.

CHAPTER THREE

3 METHODOLOGY

3.1 Research questions

This study aims to describe intergenerational differences in how people acquired and are in the process of acquiring information about sex and patterns of sex communication in early adolescence. This involves developing an understanding with respect to three aspects: firstly, an understanding of the changing dynamics of sex education and communication within a particular community; secondly an understanding of the factors driving trends in this area; and finally an understanding of how this community is responding, communicatively speaking, to HIV/AIDS. This enquiry is guided by an interest in the following issues:

- i) the form and nature of communication (e.g. direct or indirect, individual or within a group);
- ii) the content of communication (e.g. normative sex practices, sex debut, birth control and HIV/AIDS);
- iii) affective responses to different forms of sex communication;
- iv) the impact that different sources of information have on recipients;
- v) different levels and phases of communication.

3.2 Methodological orientation

Cross-generational interview and focus group research designs were employed in this research endeavour.

Interviewing provides access to the context of people's behaviour and thereby provides a way for researchers to understand the meaning of that behaviour. A basic assumption in in-depth interviewing research is that the meaning people make of their experience provides an understanding of how they act. Interviewing thus allows us to put behaviour

into context and provides access to understanding actions. It affirms the importance of the individual without overlooking the fact that meaning is often shared and created by associations between people (Seidman, 1991). Since interviews look at behaviour in context, culture is also taken into consideration. Culture is about how people interpret the world around them by developing shared understanding. Culture thus provides people with rules about how to operate in the world in which they live and work (Rubin & Rubin, 1995).

The focus group discussion is intended to encourage participants to speak freely and completely about their behaviours, attitudes and opinions. Interaction among and between group members, structure discussions in which group members react to comments made by each other. In this way one gains an understanding of how meanings are negotiated and contested within groups, between ages, and across other social differences represented in the group membership. Thus the interaction in focus groups of ten creates a living phenomenon that has the potential to extract more information than would be gained from individual utterances (Morgan & Krueger in Morgan 1993). Each method has its own strengths and weaknesses. Individual interviews provide good access to biographical material and subjective perspectives, but often do not reflect the social dynamics of meaning. Focus group discussion provide good access to the latter but are often weak in providing understanding of details and nuances that motivate individual behaviour.

A total of twelve interviews and two four-person focus groups were conducted. The interviews were conducted in Xhosa, which is the home language of the respondents.

3.3 The study site

The study site is the Amatole basin, which is a cluster of 13 villages between Alice and Hogsback in the former Ciskei area. This is an isolated, deep rural community with a strong tribal authority base. Access to this site is by dirt roads and there is little development of infrastructure. There is no electricity and only limited piped water.

Housing ranges from permanent brick, to wattle and daub structures. There are no permanent health facilities besides a daily clinic that is mainly staffed by 'out of town' nurses. There is only one high school and a number of primary schools. There are few youth facilities and there are virtually no employment opportunities in this area. Due to this situation there is a high degree of migrant labour. Community members graze cattle and goats and there is little other subsistence agricultural activity (Kelly, 2000; Kelly & Parker, 2001 & Ntlabati, Kelly & Mankayi 2001).

3.4 Sampling and recruitment

The sample was drawn from a cluster of villages in the Amatole Basin, a deep rural area near Alice in the former Ciskei. Purposive sampling was employed here. This sampling procedure is often criticized for its lack of external validity. However, Hallway in Lewis (1999) points out that in order to gather meaningful data when conducting research in sexual matters, it is important to recruit people that are not only willing to talk about their behaviours but are also willing to provide insight into their attitudes and motivations.

In this study the following criteria was applied in recruiting respondents:

- Participants for the interview study included: two females and two males between the ages of 55 –65 years old; two females and two males between the ages of 35-45 years old; and two females and two males between the ages of 18-24 years old.
- Participants of the two focus groups included four females between the ages of 10-12 and four males between the ages of 10-14.
- Individuals that qualified for inclusion in this study had to have been born and brought up in the area.

Participants were recruited with the assistance of a local pre-primary school teacher and the Chairman of the Resident's Association, who have assisted in the Kelly (2000) study and who understood the background to the research and the social structure of the community in question.

Participants were told that their participation was entirely voluntary and that they were free to refuse to answer any questions asked of them should the questions make them feel uncomfortable. Each participant was required to sign a consent form written in his or her home language (Xhosa). The contents of the consent form included confidentiality and anonymity clauses and this was discussed with them (see appendix). In the case of children under 18 years parental consent was sought. Parents were also required to sign consent forms on their children's behalf. On completion of the interviews respondents were given a gift as a token of appreciation for their participation. On deciding on a suitable gift for adults it was felt that it should be something practical. Money was therefore deemed as a viable option. Adults were thus given R40.00 each and HIV/AIDS awareness badges. Children on the other hand were given T-shirts and caps bearing HIV/AIDS logos as well as sweets.

3.5 Data collection

Data collection was done by the researcher and a co-researcher who is doing related research. About half of each interview was devoted to enquiring into the topic at hand, and the other half was devoted to the topic of sex debut.

Respondents were interviewed using a semi-structured interview format, which looked at how they learned about sex in their early adolescent years and their responses to the same. The interviews were guided by the following questions:

SEXUAL COMMUNICATION AND EDUCATION

- Early sexual communication and education patterns, i.e. how the participants received information about sexuality.
- Games that were played that had sexual connotations.
- Whether there are any changes nowadays as to how this subject is broached.

SEXUAL DEBUT

The following aspects were covered.

- Age at first coital experience, looking at the present and past age differentials, is the age the same for girls and boys.
- Early relationships or dating.
- Stage of sexual experimentation.
- Norms about sexual experimentation.
- General relationship patterns (e.g. concurrent or serial monogamy).
- Boys and girls sexual initiation and negotiation.
- Each participants' first sexual experience (age, setting, whether it was by choice and also how it was like for their peers; how they dealt with risks such as pregnancy and STDS).

Respondents were encouraged to describe their experiences in detail and to give as much background data around sex communication contexts as they could. Interviews were conducted in Xhosa and were audio recorded. The interviews were held in the premises of the Chairman of the Residents' Association. Two houses were allocated for this purpose. The interviews went relatively well given the sensitive nature of the subject covered. All the participants were very co-operative although a few initially experienced some level of difficulty in opening up on certain issues. However the interviewers' psychology background (i.e. experience in dealing with sensitive issues) was helpful in alleviating the interviewees' anxieties. The interviews lasted for approximately 40 minutes to an hour each.

Two separate structured focus groups (Morgan, 1993) for boys and girls were also used to collect information about what respondents knew about HIV/AIDS, how they have learned this, and their affective responses to different sources of communication. The focus groups commenced with a game in order to get the children to relax. After that the group members were asked what they normally did when they did not have school. This was geared at getting the members to talk about the games they played and to see whether any of them had any sexual connotations. Members of both groups were very shy in broaching the subject of sexuality. There was a sense that the topic at hand was not something that is normally talked about and thus there was an element of surprise that

someone called upon them to discuss it. However, there were members in both groups who were instrumental in getting the others to talk. The focus groups lasted for approximately 40 minutes.

3.6 Data analysis and interpretation

The audio recordings were listened to by the researcher and verbally translated into English onto a second audio tape, sentence by sentence. Thereafter the recordings were professionally transcribed. The researcher later made corrections on the transcribed document.

The data was then entered into a format for analysis using Atlas.ti, which is an advanced software package for the analysis of data using Grounded Theory methodology (Strauss & Corbin, 1990). The thematic analysis of the data generated using this method was further interpreted in relation to data already available on this sentinel site (Kelly, 2000). The material was also interpreted in drafting the discussion section of this thesis in relation to literature on culture, sexuality and health communication. Finally, the findings were interpreted further to attempt to understand the implications, in the context of the need to develop better HIV/AIDS responses, in this area.

The final product is grounded, in that it reflects the categories of experiences reflected by the participants' accounts, and is theoretical to the extent that it reflects an account, which cuts across participants' experience. To the latter extent, an account that emerges represents both the participants' experience and an explanatory framework.

CHAPTER FOUR

4. PRESENTATION OF RESULTS

4.1 Summary profile of participants

Participant 1: A 56 year old married man with children. His knowledge of sexual matters developed through experimentation by playing games like 'Undize' (hide and seek with some form of sexual exploration) and the act of 'Ukuradisa' which is initiation to non-coital sex by older girls. He never received formal sexual education and his parents did not communicate with him about such matters. As a result of this, he does not feel comfortable talking to his children about sex. He has some knowledge of AIDS but seems to have misconstrued facts about how one contracts the virus.

Participant 2: A 60 year old married man with five children. He received sexual information from his grandfather at the age of 15. He has not, however, imparted this information to his own children as he feels they are more advanced than he was at their age. At his home, the role of talking to the children about sexuality seemed to have been left to his wife. He prides himself on the fact that though he worked away from home for years, he has no illegitimate children. He owes this to the information his grandfather shared with him. The participant seems to be well informed about AIDS, as he has attended extensive courses on HIV/AIDS at his workplace and was later appointed as an AIDS educator to his co-workers.

Participant 3: A 57 year old widow with five children. She grew up in a very strict home where there was no mention of sex. Due to this lack of communication with her family, she reports that the first time she had sex she fell pregnant, as she did not know what to expect. Subsequent to her pregnancy her parents began to talk to her younger siblings about sex. She does not feel comfortable talking to her children about sexuality, instead she sent her daughters to the clinic for contraceptives once she noticed that they were involved with boyfriends.

Participant 4: A 55 year old married woman. Her husband works in a seaside town and only comes home during the holidays. She has a good idea of how HIV is contracted. She was raised by her grandmother as her father passed away and her mother was thus forced to leave home and seek employment to support the family. She received sexual information from her grandmother and by observing friends and sharing experiences with them. She has shared this information with her own children and has also taken a proactive step in taking them to the clinic for contraceptives.

Participant 5: A 43 year old male. He was once traditionally married but has since separated from his wife. He has two children from different mothers, one of which was a product of his marriage. His introduction to sex came through experimentation and by observing his older siblings. He is well aware of AIDS and as a result reports that he tends to be faithful to his partner.

Participant 6: A single 35 year old man with one child. His parents never communicated with him about sexuality and his knowledge about these matters came primarily from experimentation and observing his siblings' behaviour. He is aware of AIDS but has some misgivings about using condoms.

Participant 7: A 35 year old married woman with three children. Her husband works in a rural town about 200km away and visits home once a month. Her initiation to sexuality came through listening to friends' conversations about their boyfriends. She has not yet talked to her children about sex as she feels they are still very young. She is well informed about AIDS and is concerned that she might be at risk of contracting it as her husband works away from home and she is not certain whether he is faithful or not.

Participant 8: A 40 year old married woman with four children. She received information on sexuality from various sources. Her primary knowledge, however, came from experimentation through childhood sexual games (Undize). She has attempted to talk to her daughter about sex but she felt the best way to ensure that her daughter did not fall

pregnant was to send her to the clinic for contraceptives. She is aware of AIDS and as a result warns her children about the danger of contracting the virus.

Participant 9: A 23 year old single man. He has a steady girlfriend as well as other girlfriends on the side. In all his sexual encounters he admits to never having used condoms but professes to be aware of HIV/AIDS. His knowledge about sexual issues came primarily from direct experimentation and from instructions from his older brother.

Participant 10: A 20 year old male with no children. His first knowledge of sexual issues was gained from experimentation as well as from his older peers. He has had some formal sexual education, which he received at school from nurses. He is well informed about HIV/AIDS and states that he uses condoms during all of his sexual encounters. He has had three girlfriends thus far and is very boastful of his sexual conquests and knowledge.

Participant 11: An 18 year old female currently doing standard 9. She is the second born of five children (one brother and three sisters). She seems to know all the facts about HIV/AIDS but her first sexual encounter was without a condom. She, however, reports to have used condoms during subsequent sexual acts. She seems to be one of the more assertive females in this study. She is well informed in matters of sexuality and her mother played a major role in her sexual socialization. She is one of few participants to have had information from various sources.

Participant 12: A 19 year old female. She has never communicated with her parents about sexuality but would like her mother to talk to her about sex. She learned about sexuality primarily from observing her older sibling's behaviour and from conversations with peers. She is well aware of HIV/AIDS but reports that she has never used condoms in any of her sexual encounters. She would like to make use of condoms but says that her partners refuse to use them.

Female focus group –The group comprised of three 11 year olds and one 12 year old. Although we initially aimed for a more diverse group with ages ranging from 10 to 14 years, this was however not possible due to the difficulty in obtaining suitable candidates. The girls were very shy and not forthcoming. Two of them however eventually warmed up and contributed and helped the others to open up. All the girls report to have heard about HIV/AIDS but their perceptions of the facts were very distorted. They all learned about HIV/AIDS as well as other aspects of sexuality from the nurses who made school visits and gave talks on these subjects. The only information the participants received from their mothers was in the form of warnings about pregnancy and threats made to persuade them to refrain from sex. Their primary socialization in sexuality, however, was from experimentation through childhood sexual games such as ‘Undize’.

Male focus group - This group was composed of four boys aged 10 to 13 years. Three of the boys were very shy and surprisingly, it was the youngest that was forthcoming and encouraged the others to talk. They had all heard about HIV/AIDS although they did not have all the facts correct. They all report to have been initiated to sexuality by older girls while playing ‘Undize’. Thus their knowledge about sexuality came primarily from direct experimentation.

4.2 Analysis of Results

This study has been undertaken mainly to understand how people in this community learned about sex and to determine whether there are any intergenerational differences to how they acquired this information. From the analysis of the participants’ responses several themes emerged and these will be discussed in detail below.

4.2.1. Learning about sex (Trends in acquisition of sexual information)

The sources of sexual information identified in this study, arranged in their relative degree of influence are (i) Direct experimentation through childhood sexual games; (ii)

Peers; (iii) Observing others; (iv) Health educators; (v) Schools; (vi) Parents; (vii) Partners and (viii) the Church.

(i) Childhood sexual games

For most respondents regardless of age, sexual initiation in this community was in the context of games. There are however differences when these games were played in the past compared to how they are presently performed. 'Undize' is one such game, which has been identified by almost all the respondents as the one that initiated them to sex. This game is like hide and seek but it tends to move beyond merely seeking and finding in that it involves some form of sexual exploration. There are, however, intergenerational differences on how this exploration has been practiced. The old generation reports that in this game the only thing that happened while in hiding is touching, getting close to a girl, and pretend sex but girls "would have their panties on". Nowadays this game involves taking off of panties, and real penetration but this is not viewed, by those participating in the game, as intercourse.

The following extract with a 23 year old male illustrates this view;

INTERVIEWER: Could you tell me how far you had gone in Undize. What had you been doing?

RESPONDENT: Well I had been having sexual relations, although I wouldn't say it was the real thing. Sure, I was sleeping with girls but to, let me put it this way, there was no ejaculation. You would just have sex with her but you wouldn't come or anything like that. It was the real thing in all respects except for the fact that we didn't ejaculate.

INTERVIEWER: Did the girls have their clothes off.

RESPONDENT: Yes, we had our clothes off. We had sex, actually, actual sex, but the difference was that you didn't get to come. You just did what you did until you got tired of it and then you would get up and go.

INTERVIEWER: Did all this happen in Undize?

RESPONDENT: Yes, it was in Undize.

The following interview with a 37 year old woman adds to the above account;

RESPONDENT: We got this information from playing Undize with the boys. They used to chase us and it is then that I noticed that we were different.

INTERVIEWER: What actually happened when you play this game?

RESPONDENT: In this game we would sleep with the boys in the bushes when we go hiding. What used to happen is that if it happens that you hide in the same spot with a boy, he will then sleep with you.

INTERVIEWER: You said you would sleep with them, can you explain this to me, like just give me a clear picture of how this would start?

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 would start 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 taking off your panties?

RESPONDENT: Yes there was penetration but as I said to you it was not really serious.

INTERVIEWER: And when you were doing this what did you call it?

RESPONDENT: This was just part of Undize. We used to say we're playing Undize when we do that.

It is interesting to note that both males and females viewed the sexual exploration evident in this game as nothing serious but 'just play' although it involved penetration. Even the youngest participants in this study are very aware of this game and their description of what used to happen in this game is commensurate with the above.

Another game, which was mentioned by the younger age groups, is that of playing 'mommy and daddy'. In the words of an 11 year old in this game they would do 'dirty things' which imply having sex. From the participants' description of this act it appears that this was penetrative sex (i.e. "They say a penis should enter the vagina") though it is done in the context of playing.

There is also another game which was mentioned by only one respondent (Man aged 55) called 'Ukuradisa', which is a form of thigh sex with an older girl. The girls who normally participated in this act were those whose boyfriends were away at the mines. The girls would apparently ask the younger boys to be their 'kids' and later instruct them on how to perform thigh sex, thus initiating them to sex. It could be hypothesized that the reason this act was only mentioned by one respondent is due to the fact that the girls were very discreet in their selection of 'kids'. As in the words of the same man, "the girls would choose those boys they know would not tell".

In this community, it seems there has not been a strong taboo on sexual experimentation. There used, however, to be a distinction between sexual experimentation and sexual intercourse, and this was strictly regulated. The above accounts suggest that in the

younger age groups this distinction was overlooked, but that in the older group it seems to have been clearly in place. For example in the words of a 55 year old woman: "We all knew that we were not supposed to let our man anywhere near us, you could allow a man to go as far as the thighs, but no penetration was allowed. 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". This distinction appears to have blurred to the extent that sexual experimentation rapidly evolves into intercourse in recent years. 'Undize' now involves sexual penetration whereas in the past this was not the case. Thus the "play" now tends to move towards "the real thing", although as is seen above, respondents sometimes do not consider this to be real sexual intercourse even when penetration takes place.

(ii) Observation of others

Observation of others' behaviour particularly older siblings and peers has been another common manner in which most of the respondents report to have learned about sex. Older siblings tend to provide a role model influence over their younger siblings. For example in the words of an 18 year old female: "Well about boys we learned from our sisters, we used to observe what they were doing and because we were curious we then imitated what they were doing." In some instances the siblings move beyond being mere models and played a direct role by imparting information to their younger brothers and sisters.

This interview with a 19 year old female supports this claim;

RESPONDENT: Yeah, I was much younger when I first heard of such things, and it was mainly from my older sister.

INTERVIEWER: How old was your sister?

RESPONDENT: I'm not really sure but she's 23 years old now. 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, I mean she was open about it and it eventually came to a situation where she would go out at night and even then I was quite aware of what was happening, she didn't keep it secret from me.

INTERVIEWER: So you knew about boys, before you even had one yourself.

RESPONDENT: Yes I knew.

There are indications that this initiation and education has been divided along the sexes, in that there is no respondent who reports to have been verbally initiated to sexuality by

an opposite sex sibling. Two respondents allude to this dynamic. A woman aged 55 reports that she only had older brothers in her family so she had no one to talk to about issues of sexuality and a man aged 20 said: "My older siblings were all girls thus I could not talk to them about such things". Based on these accounts, it appears that in this community communication about sex in mixed company is not normative or condoned.

(iii) Peers

Through all the age groups peers are highlighted as one of the most influential sources of sexual information. There are, however, subtle differences between the sexes regarding how they communicate and what they talk about. Females, particularly the old generation, seem to have been more explicit in their conversations than males. Within the older generation there are indications that females shared advice on how to prevent conception, such as ensuring during sexual intercourse that a man does not ejaculate inside them or not allowing penetration at all, e.g.; "you only allowed a man to go as far as the thighs". The younger age group tends to advise each other about contraceptives. On the other hand, with males, there seems to have been some secrecy around details of early sexual experience apart from boasting about their sexual conquests and the number of their girlfriends. For example, when the interviewer asked; "what about friends" (referring to talking about sex), the respondent answered: "No, not really, we did not talk about things like sex, no, no we did not talk about those things" (male 60 years) and a 35 year old male respondent in a similar fashion: "No, the way I see it we all had secrets". With females it could be argued that their open communication has been facilitated by the amount of responsibility placed upon them to prevent pregnancy. As one 55 year old woman puts it "We were expected to take care of things".

As has already been mentioned peers also act as models for their fellows. There seems to be an atmosphere of acceptance regarding discussions of sexuality amongst peers, however HIV/AIDS is seldom discussed. The risk of contracting HIV and its prevention is rarely touched upon and where it is mentioned there seem to be negative insinuations about the use of condoms, particularly from male respondents. These males seem to be

more concerned about immediate gratification than the long-term consequences of their actions. The following extract with a 23 year old man illustrates this:

RESPONDENT: Well I'll be honest with you. I know about AIDS. I'm aware that it's a disease that kills. But so far I have never used a condom and I think even among my peers it's quite common that a condom is not used because we do sit and talk about these things. We know AIDS is there but you know we haven't used condoms no, I'll be honest with you.

INTERVIEWER: Are we talking about not using a condom now or is it a question of never having used a condom before?

RESPONDENT: No, I've never, in fact most of us have never used a condom, not ever.

INTERVIEWER: So it's not a question of having used it and not liked it, you just have never even tried it?

RESPONDENT: Ya, we've never tried it, in fact I have never and most of my friends haven't ever tried it. In fact among my peers I've never heard anyone saying they've ever used a condom. No, we just don't use it, we've never tried it.

In this context it seems "none of my friends use condoms" becomes a mediating factor in deciding whether to use a condom or not. It further indicates the extent to which peers can influence one another's' behaviour.

(iv) Health educators and schools

Health educators and schools seem to be relatively new sources of sexual information, in that the old generation does not identify either informant as having played a valuable role in their sexual socialisation. This may be due to the fact that in their time education was predominantly informal and clinics were mainly there to render primary health care services. The younger age groups identify health educators (nurses) as more proactive in providing sexual information than schools. But neither source provides a supportive environment where open discussion of topics covered is facilitated. Topics covered by nurses include puberty, STDs, HIV/AIDS and birth control. It appears that what is delivered during these talks (particularly information about HIV/AIDS) is not assimilated by the recipients but tends to be superficial knowledge; e.g., "I know about AIDS. I'm aware that it's a disease that kills. But so far I have never used a condom and I think even among my peers it's quite common that a condom is not used". This may be due to the fact that these talks are often held only once and there is no follow-up to ascertain whether what has been taught is put into practice. Furthermore the mere manner in which

these talks are presented tends to be didactic, thus chances of them being met with resistance are high. These talks tend to prescribe ideal ways of sexual conduct and seldom take into account already adopted behaviour patterns. It further appears that the ethics and behaviours that should be conveyed to the learners is not incorporated into their value systems

There are, however, indications that nurses attempt to involve parents in their children's sexuality by insisting that they accompany their daughters the first time they come to the clinics for contraceptives. This tends to be only partially beneficial, as parents feel their responsibility is over once their children receive "the injection".

Schools are said to cover only basic concepts of human physiology. These are not topics on their own but are touched upon by virtue of being a small part of the Biology syllabus. This contrasts with the OBE system's objective, which encourages the inclusion of life skills based education in the curriculum as early as Grade One. This therefore suggests that this community is lagging behind in this development or else the Department of Education has not yet successfully implemented these system policies.

(v) Communication between parents and children

Over the past forty years there have not been great changes in patterns of sexual communication within families as there is still little discussion of sexual matters in the home. Parents tend to experience difficulty communicating with their children about sex though they are aware that this is what is expected of them and that there is a need for such discussion. The reasons some parents cited for their lack of involvement are that: (i) "It was not done for them." (ii) "Children know more than them so there is no point". (iii) "Afraid they will do the opposite of what they tell them". (iv) "Afraid of being perceived as giving them permission to have sex". (v) "Afraid of putting ideas in their childrens' heads. Parents are not the only ones that experience difficulty in discussing sexual issues with their children but children themselves also sometimes feel too reluctant and uncomfortable to open up to parents about this subject. Instead they prefer talking to

other significant figures like aunts or siblings. This may be due to the contention that parents tend to preach when talking about sex.

The following interview with a 19 old female supports this view:

INTERVIEWER: Ya, can we talk now about the parents, your mothers actually, do you discuss everything with your mother? I mean boyfriend stuff, everything.

RESPONDENT: Well I personally have never discussed anything like that with my mother because whenever I have a problem I have my sister to talk to, so I have no reason to go to my mother with anything like that.

INTERVIEWER: So you have no problem discussing everything with your sister?

RESPONDENT: Ya

INTERVIEWER: You mean everything?

RESPONDENT: Mm hmm.

INTERVIEWER: And does your sister discuss things with your mother?

RESPONDENT: Ya, she has no problem, she speaks about everything with my mother, but I'm not comfortable doing the same thing.

INTERVIEWER: Why is that? What do you think is the reason behind the difference?

RESPONDENT: Well I think my mother is...well I'm not comfortable talking about it but my sister because she's older, she's more comfortable talking to my mothers about these matters, I don't know why but I'm not.

INTERVIEWER: When did your sister start feeling comfortable enough to talk to your mother about such things?

RESPONDENT: No, just recently when she was my age she was not comfortable either; she's only just now started talking to my mother about everything

From this account it appears that a certain level of maturity is expected before communication about sexuality can take place. Thus age seems to be a mediating factor to this process. There is, however, support for parent -child communication from young people about sex although they often experience difficulty initiating these discussions.

The latter part of the same interview illustrates this:

RESPONDENT: No, I would like her 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.

On the basis of data gathered it can be said that the primary concern of parents has always been the prevention of pregnancy and their communication therefore tended to centre on this topic. However the way this has been dealt with previously is slightly different to today's' approach. There is evidence that in the past mothers used to sit down



with their daughters at the onset of menarche and warn them about the risk of pregnancy. Sons were also not neglected as fathers, together with mothers, used to warn their sons about making a girl pregnant but this is no longer the case. One of the contributing factors to this breakdown appears to be the introduction of injectable contraceptives, as well as leniency in the custom of 'Ukuhlawulisa' (a fine in the form of cattle imposed for impregnating a girl). Since this is no longer a threat, fathers, some of whom are absent, have taken a back seat in educating their sons who are thus left to fend for themselves. Responsibility is now largely placed on girls.

In this community mothers seem to be more involved than fathers in educating their children both males and females about sex. Their involvement, however, is minimal. In recent years, fathers' involvement in the sexual education of their children tended to be in the form of admonishments and threats of beatings should children be sexually active. Although mothers communicate with their daughters this is often not done in a supportive environment, as the communication tends to be instructive, or threatening. They frequently warned them of the dangers of sex and expected them to abstain from sexual activities.

Parents tend not to prepare their children in advance for what might happen to them. Communication takes place only at the onset of menarche, and not before, and the daughters are taken for administration of injectable contraceptives once the parents believe they are sexually involved. This has been the norm in all the age groups but contraception was not readily available for the older generation. Rather strict measures were put in place to ensure that they did not deviate from the prescribed modes of conduct. All these parental efforts seem to have been motivated primarily by the desire to prevent pregnancy. HIV/AIDS does not seem to be a motivating factor for their actions. If parents rechannelled their efforts and emphasised the prevention of HIV/AIDS rather than pregnancy, this may drastically reduce the number of young people who get infected with HIV.

(vi) The church

There are few respondents who report having heard anything related to sexuality at church. The reasons they provided for this lack of input is that most of them are not church goers and those who do attend claim there is silence surrounding this topic. The few who report having heard something from church report that the church tends to take a moralistic stance in that they condemn premarital sex. Apparently few churches touch on this subject and those that do focus on “rebirth”. In these churches young people are actively encouraged to abstain from sex because sex before marriage is a sin. The following extract illustrates this point:

INTERVIEWER: And from the church side, was there anything that you learnt there?

RESPONDENT: Not much but I remember at church there used to be this rule that a member of the congregation cannot marry outside the church. But that’s not something that’s sort of respected. Also when maybe someone is to be promoted to be a deacon they wouldn’t be allowed that privilege unless they are married and things like sex were not talked about in my church. I used to hear about those things in those churches where people say they are born again Christians and when they talk about sex they will be totally against it. They would quote from the scriptures that premarital sex is a sin, which is quite funny for me because God created it and it’s quite a natural thing. [18 year old female]

A 57 year old woman takes this further and reports that before she was accepted to the women’s fellowship she had to stand up in front of everyone and confess her sins. She admitted to being disobedient because she fell pregnant out of wedlock.

It appears that the church has not played a major role in the sexual socialisation of this community apart from asserting its values.

(vii) Communication between partners

Fifty years ago communication between partners always centred on the prevention of pregnancy. This was the primary concern of most couples. This was a very serious issue due to the negative effects an unwanted pregnancy would have on both sexes. The topics they discussed were mainly things like playing outside (i.e. thigh sex), external ejaculation (i.e. withdrawing before the males come) as well as the fear of virginity testing for those this was still a practice when they were growing up. This has, however,

changed drastically in that males are responsible nowadays for ensuring that their girlfriends are using contraceptives. This is the limit of their involvement in sexual reproductive health issues. In the 1950's females tended to be more empowered than their male counterparts in that they were well informed about safe sex practices and were not afraid to communicate this to their partners. In the words of a 55 year old man: "It was the girls who told us about these things (i.e. to play outside) and we respected our girls and did things accordingly". Nowadays this is not the case as there are reports of girls being coerced or tricked into sexual intercourse. For males it seems when a girl says 'yes' to a relationship it is translated as agreeing to having sex. Communication now between partners tends to be simple and informative and covers the following information (i) whether the girl is on contraceptives; (ii) at what time the male should pick her up at night. The communication that used to happen about safe sex now is lost. There is a trend, which indicates that young men in this community have lost respect for their women and do not value their relationships. This is illustrated clearly by the comment made by one male respondent that of pricking condoms so that if they (males) are HIV positive they can infect their partners but remain protected if their partners are HIV positive.

In partners' discussions, condoms and HIV/AIDS are not talked about and these subjects tend to be avoided. Females are, however, concerned about the risk of contracting STIs and AIDS and are eager to protect themselves but are not assertive enough to demand that their partners use condoms; e.g., "I would like to use condoms but my partner refuses" (19 year old female) and "I had a condom with me but my boyfriend refused to use it" (Female 18 years). Although some of them know that their partners have or have had other partners, they are unable to insist that a condom be used. This, therefore, suggests that females in this community are disempowered in their sexual relationships and are thus vulnerable to contracting HIV despite their attempts to protect themselves. This is particularly more difficult for married women who do not live with their husbands and are suspicious that they might be involved with other people where they work.

The following passage pertains:

INTERVIEWER: How do you feel about the possibility of him (husband) being involved with other women? How does that make you feel when you consider that he might be.

RESPONDENT: Ya, I get quite worried, especially with the diseases that he might bring home' now that he is staying there he'll bring AIDS or something and there's nothing I can do about it. It does really get me worried. [35 year old woman]

This clearly illustrates an overwhelming sense of helplessness experienced by females regarding this issue, which could be attributed to their subjugated status.

4.2.2. Contents of sexual communication and education

Here attention will be paid to the topics that were identified by the respondents as those that are often covered in sexual communication and education. We also look at the trends among the different age groups on how these matters have been broached. The form and nature of these discussions, affective responses and their impact on recipients, will also be commented upon.

(i) Prevention of pregnancy and contraception

Across all the age groups prevention of pregnancy is one subject that all the respondents (both males and females) are well informed about. This topic is brought up in various contexts e.g. the family, among peers, between partners and by the health workers. In many contexts it is the only subject of concern and after it has been dealt with, the communication tends to end there. There are various reasons this topic has been given priority. With the older generation the parents were very concerned about the stigma associated with having a child out of wedlock and nowadays parents want their children to be educated.

Mothers are very active in imparting this information and girls are often recipients of it. However, the mother-daughter communication is often not intended to produce mutual agreement regarding the choices available. It is instructional rather than dialogical. Fathers are seldom involved. They tend to disapprove of these discussions but at the same time they do not want their daughters to fall pregnant. For example: "My father never talked to us about sex and we were never comfortable talking to him about anything. The only person we were comfortable with was our mother. Our father was very strict and I

remember when I started dating and having boyfriends he used to hit me and he was even against my mother talking to us about sex as he believed she was condoning a bad behaviour and setting a bad example for us. He also felt that if it happens that we fall pregnant he will be the one who will have to be responsible and not our mother” (Female, 18 years).

In the 1950’s children were given culturally approved outlets for dealing with their emerging sexuality, e.g. “panty” or thigh sex was permissible. The following statement from a 60 year old man pertains: “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 girl’s family’s wealth in the form of cattle. So I kept that knowledge and whenever I played with a girl, we played 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”. This suggests that males were also responsible for the prevention of pregnancy.

In the past mothers were continuously involved in their daughter’s sexuality by regularly interrogating and monitoring their daughters. For example: she (mother) would keep on asking if you’d been on your periods. She’d be worried about this all the time and she would ask how long ago it was and she would count the days”. Nowadays this is no longer the case. Instead when mothers notice that their daughters are sexually active they send them to the clinic to get contraceptives. For example in the words of a 55 year old woman: “With my child, the minute she went on her periods I took her to the clinic for family planning ... and that helped because she got pregnant in her 20’s”. The following statement further illustrates: “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 be disrupted by pregnancy. It is interesting to note that the primary concern of these mothers is to get their children educated and that HIV/AIDS does not feature strongly. Two mothers, however, report having imparted information about traditional contraception methods to their children such as ‘outcourse’ (playing outside) and said they felt contraceptives were a sure way to ensure that their daughters did not fall pregnant. They highlighted two reasons for opting for this choice namely: (i) they felt children of today

are unable to take care of themselves and (ii) they felt that boys are reluctant to perform thig sex but rather insisted on the real thing.

Between partners contraception is an SRH topic that is often brought up, but it is not discussed. The boys only ask whether their girlfriends are on contraceptives and then take no further interest in the matter. This is different to how things were previously between partners as both parties were responsible for taking precautions. There is also the expectation that girls should be accountable in preventing pregnancy and boys tend to pressurise their girlfriends to use injectable contraceptives if they are not currently practicing this method. The boys seemingly do not want to compromise, e.g. opt for mutual masturbation or panty sex, but insist on penetration. They also seem to be unconcerned about the dual protection offered by condoms (i.e. contraceptive as well as its prophylactic properties) and the fact that they are a suitable alternative.

Health workers also play a major role in imparting information about the prevention of pregnancy. They offer talks on contraceptives and encourage their use. Almost all the sexually active female respondents have responded to this call in that they use some form of contraception.

(ii) Puberty

Puberty is rarely discussed in isolation even by health workers and when it is brought up explanations regarding what should be expected, are vague. Across generations menarche in girls is one aspect of puberty that is often discussed and it is dealt with in relation to the prevention of pregnancy. Girls are often not prepared to expect this developmental change and how to deal with it. Instead it is explained when it happens. For example: "I remember at one time when I started having my menses, I was so shocked and I didn't know what was going on. I went to my mother and told her what was going on and she asked me to sit down with her and she explained everything to me, that is, this is something that happens monthly and that I have to take care of myself and make it a point that I hide it from other people". It could be argued that puberty for these respondents is a developmental stage that could have passed by without being noticed if it

was not for its relation to pregnancy. In this study there is no mention of parents sitting down with boys to explain to them the physiological changes that occur in their bodies.

The health workers seem to be the only ones that go beyond merely explaining the onset of menarche and focus on other aspects of this developmental stage; e.g.: “they (nurses) said that when someone has pimples only on their forehead then that means they are reaching puberty ... and when there is blood coming out of us we should tell our mothers” (focus group- girls). For most respondents this stage is something they discovered and explored on their own. In instances where there were things they did not understand they inquired about them; e.g., “I was 17 and it was the first time I had an ejaculation. I was very shocked and then I asked others and they explained it to me...” (Male, 35). This therefore suggests that it is something they negotiated and mastered through trial and error.

(iii) AIDS, Sexually transmitted infections (STIs) and condoms

Health workers are the major providers of information about these topics, as almost all the respondents who are aware of these subjects report to have gained the information primarily from nurses. For example: “We used to have nurses who would come and give talks on sex and more especially about AIDS and STDs. They would teach us about how to use a condom and also warn us about promiscuity. They also encouraged us to take good care of our bodies. When we notice something funny or different on our private parts, to go to the clinics because it might develop to something serious or make us more vulnerable to contracting AIDS”(Female, 18 years). Other than the nurse’s input these subjects are often referred to in passing or in the form of a threat. Children are often warned by their parents about the existence and danger of contracting HIV but there is seldom detailed explanations and advice to them on how they should protect themselves “it was said that we should not sleep with boys because we can get diseases” (12 year old girl).

There is sometimes mention of AIDS and condoms between peers, but this is not a subject they tend to take seriously. Among males, particularly the younger age groups,

condoms are not viewed positively and are often discredited, with comments like “they have holes” and that “they are tight and prevent free ejaculation”. The contraceptive value of condoms is another reason they are not popular among males. For example a comment made by a 23 year old male highlights this point; i.e.’ “Most of us regard it (condoms) as a waste in that you know you will have sex and you will ejaculate but it’s like you’re throwing your babies away because they end up in that sack like thing and you eventually have to throw it away, so what is the point? It’s such a waste”. This is strange given the fact that the respondents who hinted to this both insisted that their partners should be on contraceptives, thus the chances of conception with or without a condom were virtually impossible. This brings to mind the distinction males in this study made between sexual relations that took place in ‘Undize’ and the ‘real’ thing, since in the latter there is ejaculation this suggests that many males equate having intercourse to ejaculation and it implies that in order for the act to be psychologically gratifying the semen should be retained by their partners and not thrown away. If this does not happen they feel that they did not have sex (i.e. the ‘real thing’) but were just playing. Females on the other hand, as stated previously, recognise the benefits of using condoms and are eager to introduce them into their sexual relationships but are not assertive enough to demand that their partners use condoms.

All the respondents in this study are aware of STIs and condoms but while the extent of their knowledge varied, most of them had a superficial grasp of the facts. Some of them, however, particularly the youngest age group have misconstrued facts, which suggest a degree of misinformation or a lack of understanding of what they had been told.

(iv) Sexual relations

In almost all the age groups discussions about this topic were held among peers of the same sex. There is no mention of any scenario where communication about this topic in mixed company took place. There is thus a clear division in this regard. As has been stated previously females tend to be more explicit in their discussions than males. Among females there is mention of advice shared between them about external ejaculation and avoidance of intercourse when one is menstruating.

Between partners this is not a subject that is talked about, before or after the act. Thus there is a sense that sex is something that is done and not talked about. Further it could be said that sex is something that males do to females and not something that both parties engage in together and enjoy. Females refer to just “giving in” to sex or being forced to engage in sexual intercourse. None of the female respondents report to have initiated sex with their partners. In most instances they engage in sexual relations despite their own misgivings simply to please their partners.

The following extract endorses this view:

INTERVIEWER: How did your boyfriend introduce the topic of you sleeping together?

RESPONDENT: He said nothing, he just undressed me and he had sex with me.

INTERVIEWER: You talk as if you were not for this idea

RESPONDENT: You can say that. The whole time I was just wondering what he was doing on top of me.

This extract illustrates some of the compromising situations women find themselves in. As is depicted above no prior communication took place about the sexual act. In situations like this the possibility of negotiating condom use is almost impossible.

4.2.3. Contextual mediators to sexual communication and education

(i) Introduction of injectable contraception

Previously in this community, sexuality was a regulated act. The family and the community at large were involved in ensuring that young people adhered to the prescribed modes of conduct. Children were given instructions on how to avoid pregnancy. There used to be references to instructions like “playing outside” and warnings to abstain from sex. Random vaginal inspections were common practice to ensure that young people did not deviate from the rules and indulge in sexual activity. For those who were discovered to have broken the rules there were dire consequences. Both parties involved were held responsible, particularly if pregnancy resulted. For example if this occurred, the elderly women of the community would come together, sing and march to the responsible boys home to demand payment of a fine in the form of cattle from the boys family. This process was called “Isihewula”. All this was done with much fanfare

and the boys family not only had to pay immediately but also had to live with the humiliation their son had brought upon them. The girl and her family were also subjected to shame due to the stigma attached to premarital pregnancy. The peers of the pregnant girl were also subjected to scrutiny and would be inspected. The peers would go into a period of mourning for the girl who had fallen pregnant. The driving force for almost all these efforts has always been the prevention of pregnancy, as virginity in itself is not portrayed as a treasured and celebrated thing. This therefore necessitated that parents, grandparents, and other family relatives sit down with their children and instruct them on acceptable ways of behaviour.

Since the advent of injectable contraceptives this instruction ceased to exist. Contraceptives provided an easier way of dealing with these problems. They took away the fear of pregnancy for girls and the possibility of being fined for boys. It also took away the communication that used to take place between partners and mothers and their daughters at menarche. This has thus had negative implications for young people in that the age at sexual debut decreased significantly. As it has previously been highlighted children as young as 11 years engage in sexual intercourse because they know that they are protected from conception.

(ii) Subjugation or disempowerment of women

It has already been established that females in this community are very disempowered with regard to their intimate relationships. This, therefore, affects their ability to negotiate safe sex practices with their partners. They are unable to protect themselves from contracting STIs although they would like to do so. There is an indication that in close relationships there is unequal power sharing. Males are the dominant sex and things go according to their wishes and women's wishes are largely ignored. For instance, the majority of females in this study voiced a desire to use condoms in their sexual encounters but few in fact report having successfully introduced them into their sexual relationships. This is mainly due to the fact that they are not assertive enough to demand condom use by their partners. This difficulty is further exacerbated by the coercive and violent nature of some of their sexual encounters. Furthermore raising the subject of the

use of condoms is perceived by the males as questioning their fidelity (and perhaps the women's fidelity). Even in cases where women are aware that their partners are unfaithful they are powerless to insist that condoms are used. This is even more difficult in the case of married women. In this community it seems women are taught to be subservient to their mates as it is clear that multiple partnering for males is acceptable but is frowned upon for females. There is thus a double standard in this community when it comes to sexuality. Males boast freely about the number of girlfriends they have whereas when a girl has more than one partner she is considered to be a "whore". Girls were even expected to wait for their boyfriends when they go away to the mines and not court someone else although this did not hold true for boys. There are also indications that the community and the females themselves perpetuate these double standards. As one male respondent said, "girls often view those who have more than one boyfriend as whores", thus perpetuating this double standard.

(iii) Challenge of parenting

Most of the participants in this study report that their parents never communicated openly with them about sex and as a result the participants that are parents have not communicated with their children either. This initially appears to be an excuse or reluctance on their part to broach this sensitive subject because of their own discomfort. But when one pays close attention to what some of these parents are saying, it becomes clear that they are conveying their sense of inadequacy in dealing with this subject. Since they did not experience such communication they lack the skill necessary to deal with this issue. Parents instead resort to playing a game of pretence with their children. They act as if they are not aware of what their children are up to and their children maintain this pretence by hiding what they are doing from them. For example, there are reports of couples meeting in secluded spots where they are not seen by older people and when they happen to meet in the community they part at the sight of an adult. At the same time the same parents allocate outside rooms to their teens once they suspect that they are involved in sexual relationships. Parents thus almost deliberately tend to turn a blind eye to what is happening under their noses, as the alternative is very difficult for them to contend with.

(iv) Breakdown of family structure

The breakdown in family structures has been facilitated mainly by migrancy and the prevalence of nuclear family households in this community. Previously the upbringing of children used to be a shared responsibility with the extended family. There used to be reliance on grandparents and aunts, to help where parents fell short. These people used to play a pivotal role in the sexual socialization of young people. Since this is no longer the case, the role they used to play is now left vacant. This is mainly a cause for concern as some of the heads of these households are working. Some of them work away from home for a substantial amount of time ranging from a week to a year. In some families it is mothers and or fathers that have to leave the home to seek employment, as there are no employment opportunities within the community. Thus these parents are not able to tend to their children's developmental needs sufficiently. Those who are fortunate to work nearby return home very late and are often too tired to fulfill these parental roles.

(v) Lack of developed structures and ongoing sexuality education efforts

In this site as it has previously been pointed out, that there has not been ongoing sexuality education efforts except for periodic presentations by nurses. These are often once off lectures with no follow up. Without ongoing communication and education there is often no opportunity for children to assimilate what has been taught.

The nurses are highlighted as worthy providers of sexual information. However, there are insinuations that in certain instances, they tend to be judgemental when dealing with young people. For example, there are reports of girls that are turned away when they come to the clinic for contraceptives because they are considered to be too young and in some instances nurses frown upon young people that bring the younger ones to the clinic for contraceptives.

There is a clinic in this community but it does not seem to be a well utilized resource, and young people only visit it to get contraceptives. There is a sense among young people that the clinic specialises in providing contraceptives. By the same token it is acknowledged

that information about HIV/AIDS, STIs and condoms is freely available (e.g. “these days you can get all kinds of information from the clinic”), but it seems the latter is not common knowledge or advertised by the clinic staff.

It appears that the above factors have had an immense role in influencing the knowledge, attitudes and behaviour of young people with regard to sexual practices. Firstly, the introduction of injectable contraceptives has resulted in a marked shift in emphasis on avoidance of pregnancy to uninhibited, free sexual exploration, more especially on the part of men. Secondly, the tendency to patriarchal dominance has manifested itself in such a way that many women feel absolute lack of control over their bodies. This arises from men’s tendency to behave as though they own their spouses or partners’ bodies. Thirdly, the rapid breakdown of family structure has produced children who do not get sustained, in-house, value based sexual education from their parents and elder members of the family unit. Finally and closely connected with the third point mentioned above, boys and girls have filled the gap created by the absence of family educators through peer substitutes often with disastrous consequences.

CHAPTER FIVE

5. DISCUSSION OF RESULTS

5.1 Intergenerational modes of learning about sexuality

The majority of studies conducted in South Africa suggest a high degree of silence surrounding issues of sexuality (Glaser & Delius, 2001; Kelly & Parker, 2000 & 2001; Webb, 1997). This study is no exception. It appears that, in the community under investigation, sexuality has never been an openly discussed subject. Warnings and threats to refrain from sex due to the risk of pregnancy are the main form of instruction to children. This is somewhat contrary to the sexual socialisation historically seen in some Black cultures of Africa where there is a tradition of open communication (cf. Delius & Glaser, 2001) and formal sexuality education efforts (Allen, 2001). The Kgatla community of Botswana and the Sukuma people of Nigeria serve as valuable examples. In these communities sexuality was never a subject that needed to be veiled to the extent that it was not uncommon to find both males and females engaged in sexual discussions.

In the community studied here, however, there are subtle indications that before 1950 there used to be informal but culturally supported sexual socialisation activities but these collapsed before our respondents' time. As one respondent points out, the school going youth were prohibited from attending 'imitshotsho' (overnight gathering characterised by singing and dancing, held to bid farewell to the boys leaving for the initiation school), which were perceived to be uncivilized and were known to have been an arena for sexual exploration. It could therefore be hypothesised that the influence of missionary Christian values may have been already operational in this community. Mayers in Delius and Glaser (2001) stipulates that among the Xhosa there were distinctions between the communities that adopted these values and those that refused to accept them. He cites the experience of the 'Red', conservative Xhosas and the 'school' Christianity influenced Xhosas. In the former the traditional ways of educating young people about sex were maintained. Here, initiation ceremonies for both girls and boys, youth organisations and

the opportunity for limited intercourse as a means of sexual expression were permitted. In the latter communities, these practices were regarded as obscene and uncivilized and were done away with. This bore undesirable consequences for its followers as Christianity stigmatised traditional methods of dealing with sexual matters but failed to curb the heightened sexual impulses of prepubescent youth. Although this community could to some extent have adopted Christian values, it continued to uphold some of its own practices, as it appears that sexual experimentation was acceptable.

Sexual experimentation has been the primary mode of learning about sexuality across generations in this community. Games like 'undize' have been played by many generations of children and it was common knowledge that they involved some form of sexual exploration. There were, however, certain limitations that had to be observed. Nowadays these limits have broken down to the extent that sexual experimentation rapidly develops into intercourse in a seamless way without any mediating influences to distinguish between games and "real sex". The consequence of this change is that young people engage in sexual experiences early in life without making an informed decision as to when to become sexually active.

It is interesting to note that each age group perceives the next generation to be more sexually advanced at an earlier age than their own. Many respondents maintained that children these days start having sex at an earlier age than they had, whereas investigation reveals that the majority of respondents become sexually active at similar ages. Only the respondents in the 55+ group were significantly older. This could be due to the fact that in their time sexuality was regulated by community traditions. It is regrettable though, that none of the members of this age group (i. e. 55+) understand that the present early age of sexual debut may be partly due to the fact that no one now communicates with young people with regard to socially accepted sexual behaviour patterns, but rather to simply encourage the use of contraception. This early age of sexual debut is to be expected as Hedgepeth and Helmich (1996) point out that in a culture that lacks any formal initiation into adulthood the onset of sexual activity often provides a substitute. Although male initiation is still practiced in this community, it is somewhat different to

the way it was done in previous years. It seems emphasis is now placed on the circumcision procedure than overall initiation to adult male roles. As one male respondent concludes, "there is nothing much that is taught in the circumcision schools other than carry out the procedure". Females on the other hand are largely ignored in that the female initiation rituals called 'intonjane' are no longer practiced. There are indications, however, that it is not only the community studied that has done away with these rituals. Webb (1997) in a study he conducted in Zambia also noticed the decline of these rituals.

In this context it appears that information about sexuality is given after the fact, e.g., at the onset of menarche and when young people are observed to be involved with the opposite sex. This input does not prepare young people in advance on how to handle these difficult situations. In most instances, by the time this input is given there is an already adopted mode of behaviour, which is not based on informed decision making, but rather on external influences such as peer activities e.g. "I saw my friends doing it (sex) so I decided to do it too". Personal values and attitudes (cf. Vergnani & Paler, 1998a; 1998b) do not play part in these decisions, as foundation for these values have never been laid. This situation needs to be addressed because it might have undesirable consequences for the HIV/AIDS pandemic. Lear (1997) alerts us to the effects of this delayed communication. In a study she conducted in America she discovered that where foundations for discussions about sexuality have been absent, by the time attempts are made to discuss the issue young people are often reticent, preferring privacy while exploring their sexuality. Efforts then have to be made to prevent the development of attitudes and behaviours which are seen as undesirable within the given community towards sex and sexuality.

The driving force behind the provision of the limited information provided for young people has been and continues to be the prevention of pregnancy while HIV/AIDS does not feature strongly. Parents, particularly mothers are the primary sources of this information but nurses and teachers also touch on this subject. This could be due to the expectation that parents should be the primary providers of sexual information, yet for a

number of reasons this does not happen, as it is the case in the study in question. As Ezeil (cited in Brown, 1981) puts it, parents cannot choose whether to give sexual instruction, they can only choose whether to be helpful or neglectful in this matter. This contention fails to consider that in most instances it is not only a matter of choice but that circumstances beyond the parents' control might be contributing to this lack of communication. For example in many cultures parents are not necessarily central to their children's socialisation. In situations of migrancy for instance, as it is the case with this community, this role is played by siblings and grandparents or other family members. Furthermore many parents have never experienced any form of sexual instruction themselves therefore they lack the skill necessary for handling this sensitive subject. What parents tend to do in this community is to send their daughters for contraceptives, threaten them to prevent them from having sex and play a game of pretence with their children whereby both parties act as if they do not know what the other party is doing in private. Their primary motive for putting their daughters on contraceptives is to ensure that they proceed with their studies without the interruption of pregnancy. The dangers of contracting HIV are largely ignored. Parents fail to realise that the education they are so keen for their children to have would be useless should they die early from AIDS.

Information on HIV/AIDS is mainly provided by health workers. Their input, however, is also limited in that it is often through sporadic presentations, which are often once-off with no follow up. This community is not alone in this situation as Webb (1997) made similar observation in a study he conducted in Soweto (a township in Johannesburg, South Africa). This, therefore, calls for concerted efforts from both the government and the communities at large to ensure that there is ongoing education about HIV/ AIDS and sexuality education, as providing the former without the latter would not be beneficial. As Cassell and Wilson (1989) point out, that it would be a mistake to bombard people with information on AIDS in a vacuum without the balance of a comprehensive sexuality education programme.

On the home front, young people are only warned about the existence of AIDS with little explanation as to how to protect themselves. This is mainly due to the fact that the latter

part requires an explicit dialogue about the sexual act, which parents tend to shy away from. All the participants in this study know or have heard about AIDS although some have distorted ideas about how the disease is contracted and its symptoms. Among young people of this community there is generally high levels of concern about contracting HIV but with little effort to prevent contamination (Kelly et al., 2000). It is therefore crucial that young people are better informed, as a realistic perception of the risk factors are a critical step in the process of behaviour change (cf. Calderone, 1989).

It appears that sexuality has never been an openly discussed subject in this community. The difference is that previously it was regulated in that certain modes of conduct were put in place and had to be observed. But due to a number of factors, which will be discussed extensively in the following section, these regulatory practices have since broken down.

5.2 Mediating factors in sexual communication and education

5.2.1 Introduction of injectable contraceptives

Injectable contraceptives are said to have played a major role in the breakdown of traditional methods of educating young people about sexuality, which were evident in the 1950's. There are indications that in this community, mothers used to sit down with their daughters at the onset of menarche and warn them about the dangers of pregnancy. Sons were also not neglected as pregnancy bore undesirable consequences for both sexes. Young people were given culturally sanctioned ways of expressing their sexuality such as thigh sex. There was also a need to continuously monitor that they do not deviate from the prescribed modes of conduct. Periodic vaginal inspections were thus performed for this purpose.

Injectable contraceptives became a substitute for all these efforts and demanded less responsibility from the parents who previously had to bear the shame should their daughters fall pregnant or their sons impregnate a girl. Girls are now taken to the clinic for contraceptives with minimal discussion. This has had a marked effect on the sexual

culture of this community. Girls as young as 11 years become involved in sexual relationships because they know that they are protected from pregnancy. Furthermore, this form of contraception absolved males of all responsibility in sexual reproductive health (SRH) issues. In this community before the advent of injectable contraceptives there were societally sanctioned norms that helped to ensure that males took responsibility in SRH matters. The process of 'Isihewula' is an example of the practices that were performed to enforce these norms. Males were publicly denounced when they impregnated a girl. These practices have since broken down and now too much responsibility is placed on females. A similar dynamic was also evidenced by Mfono (1998) in a study which looked at teenage contraceptive needs in urban South Africa where boys indicated that it is the girls responsibility to seek protection and that they (the boys) routinely assumed that their partners were protected from conception.

In their inception contraceptives were mainly seen as a form of empowering women to decide on how many children they want to have thus avoiding the burden of having to care for children on their own while fathers could easily abandon them. This was perceived as something a woman could do on her own without having to seek her partners consent (The State of South Africa's Population Report, 2000). But since the beginning of the HIV/AIDS pandemic the same injectable contraceptives, which were once viewed as beneficial, may be perpetuating women's vulnerability to contracting the disease. In this community it has negated the need for the adoption of condoms as a method for preventing sexually transmitted infections. Males blatantly refuse to use condoms fully aware that there will be no adverse consequences for them. A comment made by a male respondent about what some males in this community say they do with condoms illustrates this point. He states that they would pierce a hole right at the tip of a condom so that if they are HIV positive they can pass the virus to their girlfriends and at the same time remain protected if their girlfriends have the virus. It is possible that this could be just macho talk on the part of males, but statements like this cannot be taken lightly not unless they are proven otherwise. If males have such attitudes then females in certain situations are very vulnerable to contracting the disease and there is relatively little they can do to protect themselves. Consequently, attempts to empower women

through safe sex practices would prove meaningless in that they would continue to be at risk in spite of all their efforts to the contrary.

It has already been pointed out that male involvement in SRH matters in this community is minimal. It is therefore crucial that attempts be made to involve them and at the same time appeal to their consciences. It is acknowledged that not all males think in this manner or are this devious but it is necessary that efforts be made to address this mindset, as there are indications that this is something that is common knowledge in the studied community but may be as a myth. One cannot help but wonder whether this kind of mentality is prevalent in other areas of South Africa. Involvement of males in programmes that promote the concept of sexual health could be very beneficial to counter against this notion. In these programmes males could learn to love and value themselves, remain healthy and build equitable and loving relationships (cf. Goldman, 200). This could, therefore, help them to develop a positive attitude about themselves and result in their treating members of the opposite sex with respect instead of deliberately jeopardize their health.

It is, however, acknowledged that injectable contraceptives are not entirely detrimental as they provide certain benefits such as decreasing the number of unplanned and unwanted pregnancies. In this study the negative aspect of this method of family planning is the one that is of concern because it has had a significant impact on the sexual culture of this community. By saying this, we are nonetheless not attempting to down play the benefits this form of contraception offers. It is therefore the recommendation of this study that condoms be made the contraceptive method of choice for young people. This is advisable because of their dual protective properties. At the same time it is worth mentioning the possibility that like the injectable contraceptives, the condoms we are trying to promote may well bear undesirable consequences of their use in the future, but at present they are a viable solution. For example, Kelly and Parker (2000) in a study conducted in an urban South Africa township discovered that condoms were linked to early sexual debut in that they removed the threat of pregnancy due to their contraceptive properties. In light of this

they caution us about the introduction of health technologies in place of developing culturally supported responses to health crises.

5.2.2 Gender Inequality

Hedgepeth and Helmich (1996) raise an important point in that many sexuality and HIV/AIDS education programmes are based on the assumption that all individuals are able to choose their behaviour freely within the context of a co-equal partnership or that they are committed to maintaining their own good health. This assumption is often fallacious, as is the case in community being studied. In this community there is uneven distribution of power within sexual relationships with males being the dominant sex. This significantly impacts on sexual negotiation, as the males' desires take precedence over the females. The practice of 'dry sex', practiced in many Southern African countries serves as a valuable example. This practice involves women inserting herbs, powders, and other foreign substances to tighten and dry their vaginas in order to enhance their partners' sensation by increasing friction thereby heightening their sexual pleasure. This practice has resulted in a sexual culture in which female lubrication is typically not encouraged (Halperin, 2001).

This is, however, undesirable in that women who practice dry sex are at great risk of contracting HIV, as they are prone to vaginal tears, furthermore this form of sex is unpleasant to women.

Donovan and Ross (2000) highlight that many African women have little power to decline sex or to insist on safer sex although they have often been the focus of HIV education campaigns. The coincidence of sex with power structures that are commonly based on gender makes it clear that social justice and HIV prevention are intimately intertwined. For instance, in the study being conducted at present, females were found to be powerless and thus unable to negotiate safe sex practices with their partners, e.g. "I would like to use a condom but my partner refuses" and "I had a condom with me but my partner refused to use it". This seems to be a common problem due to the fact that females are not assertive enough to enforce condom use in their sexual relationships. Even in situations where women are aware that their partners are unfaithful which is

presumably enough ground to demand condom usage, they are unable to insist on this. This dynamic mirrors Gupta and Weiss's (1989) research findings that women's ability to negotiate condom use or ensure fidelity in partnerships is largely dependent on men because socio-cultural norms give priority to male pleasure and control in sexual relationships. Gruinseit (1997) provides a detailed explanation regarding what might contribute to this state of affairs. She states that women are called upon to demand protected intercourse when the odds appear to be against their success. She contends that women are asked to step out of their gender stereotype of passivity and guide the sexual encounter to safety with respect to disease transmission. There is, therefore, an inherent contradiction in this expectation (that is asking women to ensure the use of condoms or discourage penetrative sex practices) when in most cultures their culturally legitimised role is that of passivity (Waldby, Kippax & Crawford, 1993; Ehrhardt, 1991 in Parker & Gagnon, 1995) and they have little power to influence events.

Gupta and Weiss (1995) assert that opportunities should be created for women to talk openly about sex. This could be a crucial step in overcoming the social norms that define a "good" woman as someone who is ignorant about sex and passive in sexual interaction and the prejudiced beliefs that label inter-partner communication on sex, particularly when initiated by a woman as taboo. They further contend that norms and beliefs like these make negotiating the use of condoms or raising the issue of monogamy a very difficult task. It is, therefore, the gender system that needs to be addressed and not just the lack of empowerment that women experience. Because seeking to change female behaviour without taking into account its relationship to male behaviour could prove meaningless (Gruinseit, 1997).

Mann and colleagues in Donovan and Ross (2000) suggest that the removal of gender inequalities could be the single most effective step in preventing HIV transmission given the powerlessness of women to negotiate sexual safety in many societies. However, the chances of achieving this are very slim, as this would require changing the entire cultural mindset and religious ideologies that exist in our society. In many sub cultures, for instance, both men and women believe that a variety of sexual partners is natural for men

but not appropriate for women (cf. Gupta & Weis, 1989; Gupta, 2000; Heise, 1995). This double standard is evident in the present study, for example, males could freely boast about the number of girlfriends they have but when a woman has more than one partner she is labeled a 'slut', even by fellow females.

The meaning women attach to sex is different to that of men which could be another reason women put themselves in situations whereby their health can be compromised. In Kenya, Kekovole et al. (1997) discovered that the main reason boys cite for engaging in sexual relations is to enjoy themselves whereas girls mention the demonstration of love as their main objective. For example, in the present study there is no mentioned scenario where a woman initiated sex and most in fact engaged in sexual intercourse despite their misgivings to please their partners. This discrepancy is clearly outlined by Kelly (2000) in a study he conducted which addressed the question "Do you like sex?", in the same community under investigation. About 47% of females said 'Yes' to this question compared to 83% of males. Only 6% of males answered 'Unsure' compared to 19% females. Only 11% of males answered 'No' while 34% of females admitted to disliking sex. It is worth noting that all these respondents had been in sexual relationships. This therefore shows a degree of ambivalence that female respondents have about sex and throws into question the nature of their involvement in sex. This further provides insight into the thoughts and feelings of young women who have these negative sentiments to sex yet feel obliged to engage in sexual activities (Kelly, 2000). There is therefore a need to promote a culture that asserts equality between men and women including the assertion of sexual reproductive rights. This is necessary in order to challenge these current norms and the devastating consequences they have for the sexual health of the current generation of young people (Kelly, 2000).

5.2.3 The challenge of parenting

It is often assumed that parents should be the primary sources of sexual information for their children but for a number of reasons parents do not necessarily lead the way. This has been the experience of most of the participants in the present study. For the few that have been fortunate enough to have had any input from their parents, this input was

nothing more than instructions and threats to avoid sex due to the risk of pregnancy. Besides this, there is relatively little information conveyed. The parents who took part in this study admit that they have not communicated with their children, although a few hinted to that “now there is a need” and “they are encouraged to do so”. The reasons these parents gave for their lack of input are similar to the anxieties highlighted by Gordon (cited Brown, 1981) which parents tend to have when faced with this responsibility. Hedgepeth and Helmich (1991) add an interesting point, which highlights the reality of the problems these parents find themselves faced with when they have to broach this subject. They point out that since most parents have never experienced formal sexual education they have narrow and often distorted views on the topic. Some fear it means teaching children how to have sex.

Parents are seen as primary socialising agents but they claim to be ill equipped to handle this responsibility. If parents are expected to contribute in this way and are unable to do so, then something has to be done to help them develop the skills necessary in order to broach this sensitive topic. The recent initiative by loveLife South Africa of establishing a help line for parents on how to handle this subject and helping them with any questions they might have, may be a good start. Helplines generally provide a vital interactive element and are often the simplest course of action for addressing questions, providing access to resources, obtaining counselling support and referral to local services (Kelly et al., 2001). However a majority of South Africa, particularly rural communities, would not be able to utilise this resource, as most of them do not have access to telephones. For instance, at the time we conducted the study at Amatole, there were no telephones or public call boxes in the area. This calls for initiatives at grassroots level that could benefit everyone. This alone will not be enough in that if there has never been a climate of communication in the home all these efforts would be pointless.

Parents need first of all to be helped to develop a warm and accepting atmosphere between them and their children, which will be facilitative of communication in general. It is the contention of this study that the dialogue should start at an early age by mainly dealing with age appropriate questions the children might have. As Goldman in Cassell

and Wilson (1989) points out, children are not sexual in the same way that adults are. They have their own stage appropriate ways of experiencing and thinking about sex, which is integral to other areas of their development. They therefore need the conversation to be kept going as they move toward a more mature understanding of the complexities of the world and its people (Calderone, 1989). For example asking a 3 year old how her day at play school was might be a good start to facilitating communication thus establishing a daily pattern of communication, which could take place at suppertime. It is, however, acknowledged that many parents in this community, as is the case in other areas of South Africa, are working although not necessarily employed. Some work far away and those that are around often commute to and from work and arrive home very late. This necessitates that the significant figures that play the parenting role in their absence should be the ones who should be taught these skills. Those parents who are fortunate enough to work closer to their families need to be encouraged to set aside time for their children. For example, they could set aside two hours for their children on weekends, which would serve as family time to catch up on what their children have been doing during the week.

In order to successfully broach the subject of sex Calderone (1989) advises that parents need first and foremost to be taught to be comfortable with their own sexuality. They also need to be made aware that truth and communication are the basis for helping children understand the world they inhabit. Furthermore they need to be taught to bless, honour, dignify, conserve and celebrate their children's sexuality. Instead, what has been observed in this community and other studies is that the negative aspects of sex are emphasised with little or no mention of the positive sides. Parents need to balance the two, as while they focus on the negatives young people's communication with their peers tends to focus on the positive aspects. Sex is made to be such an appealing and wonderful thing for example, "They (friends) made it sound so good" and "It (sex) was definitely not portrayed as something painful, but rather as something enjoyable so much that we wanted to find out for ourselves". If caregivers or parents could learn to balance the two (i.e. negative and positive aspects of sex), young people would be able to make informed decisions on whether to be sexually active instead of just being influenced by others. As

Gupta and Weis (1995) point out, educating young people about their bodies may help limit the practices of certain high risk sexual behaviours because if they are well informed they will know the consequences of their actions. In addition to this Lawrence, Kanabus and & Rogers (2000) advise that young people need to be equipped with communication skills because they may know about safe sex practices but be unable to communicate this with their partners.

5.2.4 Breakdown of family structure

In many societies, the family and the immediate community traditionally provided young people with information and guidance about sex and sexuality (Rivers & Aggleton, 1999). In some African societies, namely, the Kgatla community of Botswana (Delius & Glaser, 2000) and the Sukuma people of Nigeria (Allen, 2001), education about sexuality used to form part of initiation into adult roles. In many developing countries with South Africa as part of them, urbanisation and migration made the continuation of these rituals almost impossible in that families and community networks became more widely dispersed (Rivers & Aggleton, 1999). In the study in question, labour migrancy is identified as having been a contributory factor in the disintegration of families, which in turn significantly affects the communication context. As Webb (1997) points out, migrant labour separates families both spatially and emotionally and this leads to intra-family communication problems. Given the fact that there is poor communication in these families, it is to be expected that broaching the subject of sexuality is less likely to happen.

Furthermore, migrant labour is said to have facilitated the decline of the traditional multigenerational extended families and these are increasingly replaced by nuclear families, single parent families and in some cases complete absence of parents (Fuglesang, 1997). This holds true for our community of study. However, it is worth mentioning that labour migrancy is not a new phenomenon in this community. The difference is that previously there used to be reliance on members of the extended family, which is no longer the case to the same extent. The consequence of this is that children do not get sustained, in-house, value based sexual education from their parents and elder

members of the family unit. Runganaga and Aggleton in Rivers and Aggleton (1999) made similar observations in a study they conducted among the Shona community of Zimbabwe. In this community some of the children whose parents have to work are left in the care of siblings and without consistent adult supervision, thus increasing opportunities for sexual activity.

Given the implications of parental absence in children's upbringing, it is crucial that intervention programmes designed for communities attenuated by migrancy be handled differently. Certain measures thus need to be put in place because the dynamics that operate in these communities are different from those without this problem.

5.2.5 Lack of developed structures and ongoing sexuality education efforts

Kelly et al. (2001) are of the opinion that if there is a single factor that hinders effective response to HIV/AIDS in South Africa, it is the lack of an adequate supportive service environment. Such an environment begins with the provision of health promotion education and life skills training services and extends to other appropriate services. A comment made by a male respondent in this study may be illustrative of this point. He states that he is aware of AIDS and is cognisant of the fact that it is a disease that kills, but in spite of this knowledge he has not used condoms to protect himself from contracting the disease. This suggests that the awareness is there but no behaviour change has taken place. This is somewhat related to the pattern noted by Kelly (2000) in the same community where he observed that young people were very worried about the risk of contracting HIV but were not doing much to protect themselves. Given the above argument, this is to be expected in that the findings of the present study suggest a lack of ongoing SRH communication programmes in this community. The only input of note are the sporadic presentations offered by health workers. The emphasis of these presentations is mainly on health related issues (e.g. HIV/AIDS and contraception) and do not incorporate community values, beliefs and attitudes.

This calls for a concerted effort by the stakeholders involved in delivering these services to take action. In this community the clinic is central in the provision of health related

services and information but there are indications that it is not fully utilised. The judgemental attitude of the staff may be a contributing factor in young people's reluctance to utilise this resource. There are reports that at times nurses chase away young people they perceive to be 'too' young when they consult the clinic for the administration of contraceptives. This community is not alone in this problem in that studies conducted in other areas also noted the nurses' judgemental attitude (Mfono, 1998; Kelly et al., 2001; Barnett & Schueller, 2000). For example, in a study conducted in Tanzania, it was discovered that young people infected with STDs and who were aware of this were reticent to go to public clinics or hospitals but were more likely to treat themselves with over the counter medicines (Fuglesang, 1997). Rivers and Aggleton (1999) provide a plausible explanation for this state of affairs. They point out that health services are seldom designed specifically to meet the needs of young people, and that health workers only occasionally receive specialist training in issues pertaining to young people's sexual health. In South Africa however, loveLife has introduced a National Adolescent Friendly Clinic Initiative (NAFCI). NAFCI is a health service quality improvement accreditation programme, which aims to improve the quality of adolescent health services at the primary care level (loveLife, 2001b). This appears to hold promise for development of the public sector adolescent reproductive health environment (Kelly et al., 2001). The key objectives of this programme are:

- To improve the accessibility of health care services for adolescents;
- To establish national standards and criteria for adolescent health care in clinics throughout the country and
- To build the capacity of health care providers in order to improve delivery of adolescent friendly services.

The programme also identifies characteristics of adolescent friendly health care providers who: treat adolescents with respect and dignity, are friendly and have non judgemental attitudes, maintain privacy and confidentiality, promote free and informed choice, have the knowledge and skills to manage common adolescent health problems. Specific standards of service are also outlined as well as standards for management, training and physical environment of the clinic (loveLife,2001b; Kelly et al., 2001).

If the clinic in this community could adopt this strategy, it could serve as a valuable resource for its members instead of it just being utilised for the administration of injectable contraception, as is currently the situation.

5.3 Community mobilisation as a response to the HIV/AIDS pandemic

When this study was first undertaken, the aim was to ascertain where would it be best to place sexual communication and education activities in this community. This section attempts to answer this question. It is important before starting with the task at hand to elucidate what is meant by 'community mobilisation as a response to HIV/AIDS' lest any two pieces of information appear contradictory. One of the main objectives in undertaking this study was to help make sexual communication and education the primary focus of intervention programmes and HIV/AIDS to form part of it, instead of the norm with most programmes whereby the former is discussed in the context of the latter. The main concern about this approach is that when attention is paid to a particular SRH issue and a remedy is developed for that problem a sense of complacency develops. Take for instance the role played by injectable contraceptives in reshaping the sexual culture of the community in question after the threat of pregnancy was removed. Let us now say for arguments' sake that HIV/AIDS ceases to be such an enormous threat should a cure be discovered or a vaccine be developed. It seems possible that the attention given to educating about sexuality may diminish. If this were to happen a future epidemic would place us back in the same position in which we found ourselves when the scourge of AIDS first hit us. For these reasons, it is the contention of this study that sexuality education forms part of enculturation so that people develop into well-rounded human beings with vested knowledge about all aspects of their bodies. Having said all this, a need to take action often arises from a pressing issue, which at this stage happens to be HIV/AIDS. It is for this purpose that we adopt this stance as it would be a very difficult task to mobilise people to communicate openly about sexuality without such an incentive.

Our community of study has a strong tribal authority and a relatively high community spirit. There are a number of spoken and unspoken rules that are disseminated among

members, which serve to regulate behaviour. For example, in this community there is the practice of allocating outside rooms or houses to both males and females once they are observed to be involved in sexual relationships. There are indications that parents do this in order to maintain the disguise that they do not know what their children are doing in private. The children on the other hand are aware of this but choose to participate in this game of pretence. This is a very interesting dynamic which is indicative of a culture that maintains the pretence that sex does not happen thus unconsciously absolving the parties involved from addressing sexuality. This is a very dangerous approach given the era we live in and calls for more appropriate responses in dealing with sexuality. Given the prevailing community culture of collusion surrounding sexuality, it is deemed necessary that any intervention introduced in this context should target the entire community, hence the adoption of the community mobilisation framework.

Community mobilisation in response to HIV/AIDS has been shown to be an effective way to change attitudes and behaviour within communities, to provide care and treatment to community members and to design and implement prevention programmes with a lasting impact (Malcom & Dowsett, 1998). For an example in Uganda, it was discovered that taking personal responsibility for HIV prevention was contingent upon the active involvement and participation of the community (Madraa & Ruranga–Rabaranira cited in Malcom & Dowsett, 1998). It has already been pointed out that this community has a strong tribal authority. It is therefore paramount that the chief is involved in the planning and implementation of the programme because failure to do so may significantly affect the community's commitment and approval of such a venture. The involvement of community leaders in any intervention is crucial because they already belong to and lead an existing community and thus enable them to play a catalyst role in mobilisation and sensitisation (Malcom & Dowsett, 1998). It is contended that local leaders would provide credibility and lend a positive influence to such a programme in a way that would not be possible by externally imposed structures or 'outsiders' (Baueme et al., (n.d.)). Furthermore gathering the support of local leaders from diverse backgrounds builds a strong foundation, which assures that activities will continue even if external assistance is cut back (Gottert in Baueme et al., n.d.).

Community response to HIV/AIDS requires the involvement of every sector in which each assumes a level of responsibility in addressing certain aspects of the epidemic (Malcom & Dowsett, 1998). For example, the church can specialise in care and support of people living with HIV/AIDS and the schools may focus on educating about sexuality and the disease. In the present study a number of community based sources of sexuality information were identified and these could be useful resources for mobilisation. These could be utilised as they are and serve as already existing networks. Baueme et al., (n.d.) highlight some of the benefits to using such networks which are: i) these networks are already operational when mobilisation efforts begin so that programme activities can take advantage of existing momentum. ii) at times these networks have a preexisting hierarchy with recognised leadership that others will readily follow. Examples of these networks in this context are:

- **Schools**

Learners spend a majority of their time at school it is therefore plausible that sexuality education be introduced in schools. This should be introduced at an early age before children are sexually active or reach puberty instead of the norm, which has been noted in this study, that of reacting after the fact. It is important that the education be 'sex positive' and 'sexuality positive'(McCallum & Baxter, cited in Malcom & Dowsett, 1998) and it should adopt the language that is acceptable and known to the community. The OBE curriculum is fortunately supportive of this argument in that it stipulates that sexuality education be introduced in Grade one. It is clear though, that this community is lagging behind in this development. It could be hypothesized that the schools are mirroring the community's response to the subject. It is therefore necessary that structures be put in place to implement the OBE policy. Since this is a new development, teachers need to undergo extensive training on how to approach this subject. Government involvement in this respect needs to be sought.

It is the assertion of this study that teachers' participation in these programmes should be voluntary and not per their subject expertise (e.g. guidance teacher) or by virtue of being

a teacher of a certain grade. It is therefore the recommendation of this study that sexuality or lifeskills education be the responsibility of a teacher who has freely volunteered to undertake this responsibility. The teacher should be dedicated to imparting this sort of information. This will prevent someone, who for instance, does not approve of sex education in schools from being forced to provide this information and possibly presenting the subject with negative feelings which the learners may sense.

▪ Churches

The findings of this study suggest that the church has not played a significant role in the sexual socialisation of members of this community. Churches need to move beyond sermonising and empower its congregation with information about sexuality. As Genne (cited in Brown, 1981) points out, a religion that ministers and guides people throughout life, from the womb to the tomb, cannot avoid dealing with sexuality, which is so critically significant in all of life's major events as well as in the day to day routines. In South Africa, Pastor Khathide of the Pentecostal Church has paved the way as far as broaching the subject of sexuality in the church by holding talks and seminars on this topic.

In this context the church could serve as a very valuable resource in that it has potential to reach a diverse audience of both young and old people. Furthermore, it can facilitate positive behaviour changes due to the status that church leaders or ministers are awarded. For example, if the community members feel the church supports open communication about sexuality this may encourage those who were reticent, to open up to this possibility.

▪ Peers

In the present study, peers are identified as the most influential source in the provision of sexual information. For this reason peers could be used to form a valuable network, for example a youth group. McCallum and Baxter (cited in Malcom & Dowsett, 1998) assert that education designed and delivered by peers is likely to be more effective than education developed and delivered by other external agencies. Furthermore peers are said to be a very powerful influence in determining whether an individual will practice safe sex or not (cf. Lear, 1995). For example “none of my friends are using condoms”, for

males in this study becomes a mediating factor in determining whether a condom is used or not. It is therefore paramount that peers be involved in mobilisation activities owing to their level of influence among its cohorts.

The primary focus of the youth group needs to be on developing a sense of personal responsibility in SRH matters, as this appears to be lacking. This could be achieved through the use of plays, dance, music and discussions, all promoting the concept of openness about sexuality. This could portray different scenarios, drawing comparisons between contexts where open communication about sexuality has taken place and where there has been no discussion. This would illustrate the necessity of communication in this matter. The youth group could have sub-groups based on the age or level of maturity of its members, thus dealing with age appropriate challenges. These subgroups could assist in re-establishing the concept of grouping, which was previously present in this community. For example, there are reports that both males and females were divided according to their age. There were certain rules that governed each cohort and determined the age range of their potential mates. There was also a sense of togetherness where all the parties belonging to a certain group did things at the same time e.g. start dating. If these youth sub-groups could be put in place they could help overcome the sexual predation of young girls observed by Kelly (2000) in this community. The courting of girls within certain age groups would then not be permissible.

It is recommended that discussions about sexuality be generally held in groups comprised of both males and females. This will reduce the difficulty associated with initiating discussions about sex particularly between partners, as they already have experience in talking to the opposite sex. Opportunities will then be created whereby these groups will be divided particularly when dealing with sensitive issues. Female groups may focus on empowering women in matters related to their SRH, which would in turn enhance their self-esteem. This however will not be beneficial enough as numerous studies have shown that programmes that focus on empowering women but which disregard the culture that promotes male dominance over females, does not do much for women. It is for this purpose that males should be involved. Hedgepeth and Helmich (1996) advises that

intervention programmers should be introduced early to young boys as they are the ones that are likely to grow up to be abusers. In male groups on the other hand, emphasis should be placed on encouraging a sense of responsibility. Young people in this community have indicated readiness and willingness to discuss sexuality so something definitely needs to be done.

This network should co-operation with other networks present in the community particularly the school. This is very important in order to ensure that they do not deliver contradicting messages, thus confusing young people. Their activities need to be coordinated as they are serving the same community but in different contexts i.e. the school in a formal and youth organization in a less formal setting.

▪ **Health workers/ Clinic**

Nurses in this community have taken a lead as far as educating about sexuality. Although their input is minimal they are a valuable resource for mobilisation. Steps now need to be taken to ensure that the education they offer is ongoing and that their service is easily accessible to young people. It is therefore recommended that nurses receive training in dealing with young people's issues. The adoption of the NAFCI approach discussed in section 5.2.5 would be very beneficial.

▪ **Parents /Caregivers**

It has already been stipulated that communication between parents and children about sexuality is lacking. This is mostly due to the anxieties both parties experience when faced with broaching this sensitive subject. However, parents and children alike have indicated that there is a need for this communication but there are a number of obstacles to this process that need to be overcome. Attempts then have to be made to equip the parties involved with necessary skills needed in handling this responsibility. Parents or caregivers as most parents are absent in this community, need to be trained on how to initiate sexual discussions with children. Programmes encouraging greater communication about SRH issues need to be developed. Fathers also need to be targeted and involved because the responsibility of educating children about sexuality in this

community has been left in the lot of mothers. Communication or education has to target both sexes equally so as to encourage a sense of shared responsibility in SRH matters.

The findings of the present study particularly the role played by injectable contraceptives in perpetuating young peoples vulnerability to HIV/AIDS, need to be communicated to caregivers. It is hoped that once they are aware of this they would start to appreciate the value of communication and realize that pregnancy is not as serious as HIV/AIDS.

In sum, the above discussion looked at the trends in the mode of learning about sexuality as well as mediating factors to this process. Recommendations are then made of possible intervention strategies that could facilitate open communication about sexuality.

6. CONCLUSION

6.1 Overview

The present study explores the nature of sex communication and education over a period of fifty years from 1950 to the present. It adopts an historical, biographic perspective in attempting to understand how the sex communication context has changed over the years. Major trends in sexual communication and education were discussed by mainly looking at various sources of sexual information. Theories and models normally employed in health communication for HIV/AIDS were first described and then criticised.

The findings of the present study suggest that sexuality has never been an openly discussed subject in this community. In the 1950's, however, there were culturally sanctioned community norms that served to regulate sexual behaviour. The process of 'Isihewula' and random vaginal inspections are examples of the practices that were performed to ensure that young people adhered to the prescribed modes of sexual conduct. Education about sexuality has always been limited to warnings and threats to refrain from sex due to the risk of pregnancy. Previously, this responsibility fell solely in the lot of parents/caregivers, and mothers in particular. Fathers were also involved but

their involvement was minimal. In recent years, parents seem to have taken a backseat and health workers have become leaders in the provision of sexual information. Their input, however, is often after-the-fact and thus has not served to prepare young people for how to deal with sexual developmental challenges.

The introduction of female injectable contraceptive methods played a major role in reshaping the sexual culture of the community under investigation. It led to the breakdown of traditional regulatory practices that governed sexuality since pregnancy was no longer a threat in the social sense. Injectable contraceptives served as a new medical regulatory mechanism, and appeared both on the surface and in socio-economic terms to be an appropriate, practical and sensible approach in the context of the risk of unwanted pregnancy (Ntlabati et al., 2001). It has, however, had a marked effect on the sexual communication and negotiation context. It had the effect of absolving males of all responsibility in SRH matters and as a result most such responsibility rests on women. Young men now focus on ensuring that they get maximum satisfaction and pleasure from their sexual encounters. They are reluctant to use condoms because they perceive them as interfering with their pleasure. This in turn has serious implications for the HIV/AIDS pandemic. Given the above argument, condoms are recommended as a contraceptive method of choice for young people by virtue of their dual protective properties. Before the inception of injectable contraceptives there are indications that sexual responsibility was shared between the sexes, in that pregnancy bore undesirable consequences for both males and females. As a result, men were prepared to compromise and accepted the need to practice non-penetrative forms of sexual relations.

Further contributing factors found to have played part in the breakdown of traditional methods of educating young people about sexuality were: (i) gender inequality, (ii) the increasingly difficult challenge of parenting caused mainly by labour migrancy, (iii) the breakdown of family structures and (iv) the lack of developed and ongoing programmes that educate people about sexuality.

There was also a culture of collusion surrounding sexuality within this community between adults and children, which absolved both parties from addressing sexuality. Given this, recommendations have been made for possible intervention programmes geared at facilitating openness about sexuality. The community mobilisation framework was deemed a suitable approach in ensuring such programmes would be a success owing to the high community spirit evident in the site under investigation, due in part to the geographic isolation of this community.

6.2 Recommendations for further research

The present study yielded similar results to other studies (Webb, 1997; Delius & Glaser, 2001; Kelly & Parker, 2000, 2001) conducted in the field of sexuality with regards to the silence surrounding the topic of HIV/AIDS. There are, however, some findings that were not present in a majority of these studies, principally the role of injectable contraceptives, and the culture of collusion between children and adults surrounding sexuality.

In the present study a statement was made about pricking condoms. Although this could just be a myth it cannot be simply dismissed given the widespread belief that such practices take place. It is for this reason that it is recommended that this be investigated further as this may be a contributing factor in perpetuating women's vulnerability to contracting HIV/AIDS.

As highlighted above, it was recommended that condoms be made a contraceptive method of choice for young people. In this study, however, two male respondents hinted that this aspect of condoms was the reason they are not keen to use them. At face value, this appears to be a contradiction in that both respondents insisted that their partners use other forms of contraception. It could be argued that their lack of enthusiasm may be a reflection of a culture that is supportive of fertility. To quote one respondent "I want my family name to continue long after I'm dead". In a study conducted in South Africa, Preston-Whyte and Zondi (1991) and Abdool-Karim et al. (1992) came to similar conclusion. They discovered that one of the barriers to the use of condoms was that girls

have to prove their fertility before marriage and that condoms were perceived to be incompatible with male notions of masculinity. It is therefore necessary to understand to what extent the contraceptive nature of condoms is a contributory factor to their non-use. At the same time it is important to gain such insights in order to come up with relevant approaches for convincing people to use condoms. It is hoped that addressing these issues may assist in combating the spread of HIV/AIDS.

6.3 Limitations of the present study

This study has generated valuable insights into understanding how people are learning about and dealing with sexuality and how this prepares them, or not, to face the crisis of HIV/AIDS in their community. However, a number of issues were left hanging due to time constraints and the sensitive nature of our topic of investigation. Caution had to be practiced to ensure that too much probing did not result in making the respondents uncomfortable.

Another limitation of this investigation lies in the sampling method adopted. This method does not allow the freedom required to make generalisations regarding issues other than the one for which it was developed. While it is acknowledged that the findings of this research cannot be generalised, they nevertheless provide valuable insights about the dynamics that may be operational in many rural communities of South Africa.

It is hoped that this study has made a valuable contribution in the area of sexuality education, communication and HIV/AIDS prevention work, as was the intention at its inception.

LIST OF REFERENCES

APPENDIX 1

APPENDIX 1
CONSENT FORM

I/ I the parent of have been informed that the present investigation falls under the auspices of the Department of Health, which is aimed at developing an understanding on changing perspectives in sex communication and its relation to HIV/AIDS. I have given consent to take part in this investigation, well aware of the fact that my name/ my child's name will not be used in the report and that everything that has been said will be kept confidential.

Signed by (In person/ the parent)

LIST OF REFERENCES

- Abdool-Karim, S.S., Abdool-Karim, Q, Preston-Whyte, E. & Sankar, N. (1992). Reasons for lack of condom use among high school students. *South African Medicine Journal*, 82, 107-110.
- Abdool-Karim, Q.A., Abdool-Karim, S.S. & Nkomokazi, J. (1991). Sexual behaviour and knowledge of AIDS among urban Black mothers. Implications for AIDS intervention programmes. *South African Medicine Journal*. 80 (7), 340-343.
- Allen, D.R. (2001) Learning the facts of life: Past and present experiences in a rural Tanzanian community. *Africa Today*, 47, July 23, 2001, <http://www.indiana.edu/~iupress/journals/africatoday/aft47-3.html>.
- Airhihenbuwa, C.O., Makinwa, B. & Obregon, R. (2000). Toward a new communications framework for HIV/AIDS. *Journal of Health Communication*, 5, 101-112.
- Airhihenbuwa, C.O. & Obregon, R. (2000). A critical assessment of theories/ models used in health communication for HIV/AIDS. *Journal of Health Communication*, 5, 5-16.
- Bailey, P. (2001). Rethinking differences in sexual education and reproductive health: A training manual for health care providers. *Family Health International*, October 11, 2001, <http://www.fhi.org/en/fp/fpothor/genderguid.html>.
- Barnett, B. & Schueller, J. (2000). *Meeting the needs of young clients: a guide to providing reproductive health services to adolescents*. NC: Family Health International.
- Baueme, C., Gilborn, L., de Negri, B. & Gara, C. (n.d.). Overview of community

mobilization. Unpublished document, Centre for Communication Programmes, Johns Hopkins University, Baltimore.

Bolton, R & Singer, M. (Eds.) (1992). *Rethinking AIDS prevention: Cultural approaches*. Yvedan: Gordon & Breach Science Publishers.

Brown, L. (Eds.) (1981). *Sex education in the eighties: The challenge of healthy sexual evolution*. New York: Plenum Press.

Buga, G.A., Amoko, D. H. A. & Ncayiya, D. J. (1996). Sexual behaviour, contraceptive practice and reproductive health among school adolescents in rural Transkei. *South African Medical Journal*, 86(5), 523-527.

Calderone, M, S. (1989). Family education for sexuality. In Cassell, C. & Wilson, P. M. (Eds.). *Sexuality education: A resource book* (pp. 3-12). New York: Garland Publishing.

Caldwell, J. C, Anarfi, J.K. & Cladwell, P. (1997). Mobility, migration, sex, STDs and AIDS: An essay on Sub-Saharan Africa with other parallels. In Herdt, G. (Eds.) *Sexual cultures and migration in the era of AIDS: Anthropological and demographic perspectives* (pp. 41-54). New York: Oxford University Press.

Cassell, C & Wilson, P. M. (Eds.) (1989). *Sexuality education: A resource book*. New York: Garland Publishing.

Chilman, S. (1990). Family life education: Promoting healthy adolescent sexuality. *Family Relations*, 38, 123-131.

Delius, P. & Glaser, G. (2000). *AIDS in context*. A paper presented at the XII International AIDS Conference, Durban, South Africa.

De Vos, A. S. (1998). *Research at grassroots level: A primer for the caring professions*.
Pretoria: JL Van Schaick Publishers.

DiIorio, C., Resnicow, K., Dudley, W. N., Thomas, S., Dongqing, T. W., Van Marter, D.
et al, (2000). Social cognitive factors associated with mother-adolescent
communication about sex. *Journal of Health Communication*, 5, 41-52.

Diop, W. (2000). From government policy to community –based communication
strategies in Africa: Lessons from Senegal and Uganda[Electronic version] .
Journal of Health communication, 5, 113-118.

Donovan, B & Ross, M. (2000). Preventing HIV: Determinants of sexual behaviour.
Lancet, 355 (9218), 897- 901.

Esu-Williams, E. (2000). Gender and HIV in Africa- Our hope lies in the future. *Journal
of Health Communication*, 5, 123-127.

Fuglesang, M. (1997). Lessons for life- Present and past modes of sexuality education in
Tanzanian society. *Social Science and Medicine*, 44(8), 1245-1254.

Gebhard, P. H. (1997). The acquisition of basic sexual information. *The Journal of sex
Research*, 13, 148-168.

Genne, W. H. (1981). Sex education in religious Settings. In Brown, L. (Eds.), *Sex
education in the eighties: The challenge of healthy sexual evolution*(pp. 127-
136). New York: Plenum Press.

Gordon, S. (1981). Preteens are not latent, adolescence is not a disease. In Brown, L.
(Eds.). *Sex education in the eighties: The challenge of healthy sexual evolution*
(pp. 83-100). New York: Plenum Press.

Gruinseit, A. (1997). *Impact of HIV and sexual health education on sexual behaviour of young people : A review update*. Geneva: UNAIDS.

Gupta, G. R. & Weiss, E. (1995). Women's lives and sex: Implications for AIDS prevention. In Parker, G. R. & Gagnon, J. H. (Eds.). *Conceiving sexuality: Approaches to Sex Research in a Postmodern World* (pp.259-272). New York: Routledge.

Gupta, G. R. (2000). Gender, Sexuality and HIV/AIDS: The what, the why and the how. *In News & Views. Newsletter of the Women Health Project*.36, 18-21.

Haffner, D.W. (1989). The AIDS epidemic and sexuality. In Cassell, C & Wilson, P. M. (Eds.) *Sexuality education: A resource book* (pp. 257-268) New York: Garland Publishing.

Halperin, C. (2000). *Is poverty the root cause of Southern African AIDS?* A paper presented at the XII world AIDS Conference, Durban, South Africa.

Hedgepeth, E. & Helmich, J. (1996). *Teaching about sexuality and HIV: Principles and methods for effective education*. New York: New York University Press.

Heise, L. L. (1995). Violence, sexuality and women's lives. In Parker, G. R. & Gagnon, J. H. (Eds.). *Conceiving sexuality: Approaches to Sex Research in a Postmodern World* (pp. 109-134). New York: Routledge.

Kalicham, S. A. (1998). *Preventing AIDS: A source book for behavioural interventions*. (1st ed.). New Jersey, London: Lawrence Erlbaum Associates Publishers.

Kekovole, J, Kiragu, K, Muruli, L. & Josiah, P. (1997). *Reproductive health communication in Kenya: Result of a National IEC Situation Survey Country Report*. Baltimore: Johns Hopkins Centre for Communication Programs.

- Kelly, G. F. (1981). Parents as Sex Educators. In Brown, L. (Eds.), *Sex education in the eighties: The challenge of healthy sexual evolution* (pp. 101-114). New York: Plenum Press.
- Kelly, K. (2000). *Communication for action: A contextual evaluation of youth responses to HIV/AIDS*. Research monograph. Pretoria: Department of Health.
- Kelly, K. & Parker, W. (2001). *Communities of practice: Contextual mediators of youth responses to HIV/AIDS*. Beyond Awareness Campaign, Department of Health, South Africa.
- Kelly, K., Parker, W. & Oyosi, S. (2001). *Pathways to action: HIV/AIDS, children and young people in South Africa- A literature review*. CADRE, Save the Children, South Africa Programme.
- Kirkendall, L. A. (1981). Sex education in the United States: A historical perspective. In Brown, L. (Eds.). *Sex education in the eighties: The challenge of healthy sexual evolution* (pp. 1-118). New York: Plenum Press.
- Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. Thousand Oaks CA: Sage Publications.
- Lawrence, J., Kanabus, A. & Regis, D. (2000). *A survey of sex education in secondary schools*. West Sussex: AVERT.
- Lear, D. (1995). Sexual communication in the age of AIDS: The construction of sexual risk and trust among young adults. *Journal of Social Science and Medicine*, 41, 1311-1323.
- Lear, D. (1997). *Sex and sexuality: Risk and relationships in the age of AIDS (1st ed.)*. Thousand Oaks, London: Sage Publications.

Leclerc-Madlala, S. (1998). Safe sex in the Rambo or Bimbo divide: A look at the gender imperative of AIDS. *PINS*, 24, 92-94.

Lewis, G. (1999). *A phenomenological-hermeneutic enquiry into the factors that mediate sexual risk taking in the context of HIV/AIDS*. Unpublished Honours Thesis, Rhodes University.

loveLife (2000). *Love them enough to talk about sex*. LoveLife, South Africa.

loveLife, 2001a. *Hot prospects, cold facts: Portrait of young South Africa*. loveLife, South Africa.

loveLife, 2001b. *National Adolescent Friendly Clinic Initiative (NAFCI)*. LoveLife, South Africa.

MacPhail, C. (1998). Adolescents and HIV in developing countries: New research directions. *PINS*, 24, 69-87.

Madraa, E. & Ruranga-Rubiramira, M. (1998). Experience from Uganda. In Malcom, A. & Dowsett, G. (1998). *Partners in Prevention: International case studies of effective health promotion practice in HIV/AIDS* (pp. 49-57). Geneva: UNAIDS.

Malcom, A. & Dowsett, G. (1998). *Partners in Prevention: International case studies of effective health promotion practice in HIV/AIDS*. Geneva: UNAIDS.

Mbetse, D. (2001). Breaking educational and religious taboos in the provision of sex education Personal experiences of a schoolteacher and pastor. AIDS in Context Conference: University of the Witwatersrand, Johannesburg, South Africa.

McCallum, L. & Baxter, D. (1998). Experience from Australia. In Malcom, A. &

Dowsett, G. (1998). *Partners in Prevention: International case studies of effective health promotion practice in HIV/AIDS* (pp. 10-23). Geneva: UNAIDS.

Mfono, Z. (1998). Teenage contraceptive needs in urban South Africa: A case study. *International Family Planning Perspectives*, 24, 180-183.

Moran, J. R. & Corley, M. D. (1991). Sources of sexual information and sexual attitudes and behaviours of Hispanic Adolescent males. *Adolescence*, 26, 857-863.

Morgan, D. L. (1993). *Successful focus groups: Advancing the state of the art*. California: Sage.

Mueller, K.E. & Powers, W.G. (1990). Parent-child sexual discussion: Perceived communication style and subsequent behaviour. *Adolescence*, 15, San Diego: Libra Publishers.

Nahom, D., Wells, E., Gillmore, M. R., Hoppe, M., Morrison, D. M., Archibald, M., et al, (2001). Differences by gender and sexual experience in sexual behaviour: Implications for education and prevention. *Journal of School Health*, 71(4), 153-158.

Ntlabati, P, Kelly, K. & Mankayi, A. (2001). *The first time: An oral history of sexual debut in a deep rural area*. AIDS in Context Conference: University of the Witwatersrand.

Parker, G. R. & Gagnon, J. H. (1995). *Conceiving sexuality: Approaches to Sex Research in a Postmodern World*. New York: Routledge.

Parker, R.G. (1995). The social and cultural construction of sexual risk, or how to have

(sex) research in an epidemic. In Ten Brummelheis & Herdt (Eds.), *Culture and sexual risk: Anthropological perspective on AIDS* (pp. 257- 269). The Netherlands: Gordon & Breach Publishers.

Parker, R. & Aggleton, P. (1998). *Culture, society and sexuality*. London: Routledge.

Perlman, H. (1998). *Bodywise: Sex, education, health and advice for South African youth*. Cape Town: Maskew Miller Longman.

Piotrow, P.T., Kincaid, D.L., Rimon, J.G., Rinehart, W. (1997) *Health communication: Lessons from family planning and reproductive health*. Westport, Conn.: Praeger.

Reed, D. & Weinberg, M. (1984). Premarital coitus: Developing and established Sexual Scripts. *Social Psychology Quarterly*, 42(2), 129-138.

Rimon, J.G. (1999). Communication and behaviour change: Enhancing HIV/AIDS programmes. *Global AIDS Newsletter*, 55 (7), 14-16.

Rivers, K. & Aggleton, P. (1999). Adolescent sexuality, gender and the HIV/AIDS epidemic. New York: UNDPH HIV and Development Program.

Rodgers, J.C. & Rowe, D.C. (1988). Influence of siblings on adolescents sexual behaviour. *Developmental Psychology*, 24, 722-728.

Roper, M. in Cassell, C & Wilson, P. M. (Eds.) (1989). *Sexuality education: A resource book*. New York: Garland Publishing.

Rozema, H.J. (1986). Defensive communication climate as a barrier to sex education in the home. *Family Relations*, 35, 531-537.

Rubin, H.J. & Rubin, I. S. (1995). *Qualitative interviewing: The art of hearing data*.

London: Sage Publishers.

Rubinstein, E. A. Television as a Sex Educator. In L. Brown (Eds.), *Sex education in the eighties: The challenge of healthy sexual evolution* (pp. 115-126). New York: Plenum Press.

Seidman, I. E. (1991). *Interviewing as qualitative research: A guide for researchers in education and social sciences*. New York: Teachers College Press.

South African Broadcasting Cooperation (2000, May 4). *FRESH* [TV Programme], Channel 1.

South African Broadcasting Cooperation (2002, March 23). *MAMEPE* [TV Programme], Channel 2.

Schoepf, B.G. (1992). AIDS, sex and condoms: African healers and the reinvention of tradition in Zaire. In Bolton, R & Singer, M. (Eds.) *Rethinking AIDS prevention: Cultural approaches* (pp. 87-104). Yvedan: Gordon & Breach Science Publishers.

Strauss, A. & Corbin, J. (1990) *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Steward-Buchanan, A. (1997). From "Youth Speak Out" to "Talking to each other". *AIDS Bulletin*. May-June, 6, p.37-38.

Swart-Kruger, J. & Richter, L.M. (1997). ADS related knowledge, attitudes and behaviours among South African street youth: Reflections on power, sexuality and the autonomous self. *Social Science Medicine*, 45(6), 957-966.

Tatum, M.L.(1989). Overview: A perspective on school programs. In Cassell, C &

Wilson, P. M. (Eds.) *Sexuality Education: A Resource Book* (pp. 95-105). New York: Garland Publishing.

The State of South Africa's Population Report (2000). *Population, poverty and vulnerability*. Department of Social Development: The national population unit.

Urdang, S. (2001). Women and AIDS: Gender inequality is fatal. *Women's International Network News*, 27 (4), 24-25.

Valdiserri, R. (1989). *Preventing AIDS: The design of effective programs* (1st ed.). New Brunswick: Rutgers University Press.

Vergnani, T. & Frank, E. (1998a). *Sexuality education for senior phase teachers*. Sandton: Heinemann.

Vergnani, T & Palmer, L. (1998b). *Sexuality education for foundation phase teachers*. Sandton: Heinemann.

Webb, D. (1997). *HIV/AIDS in Africa*. Illions, USA: David Phillip Publishers.

Zelaya, E., Marin, F.M., Garcia, J., Berglang, S., Liljestrand, J. & Persson, L. A. (1997). Gender and social differences in adolescent sexuality and reproduction in Nicaragua. *Journal of Adolescent Health*, 21, 39-46.

