

Constructions of sexuality and HIV risk among young people in Venda: Implications for HIV prevention

by

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Declaration

I declare that this dissertation is my own unaided work. It is submitted for the degree of Doctor of Philosophy to the Department of Psychology at the University of Pretoria, Pretoria. It has not been submitted before for any degree or examination in this or any other University.

Ethics Statement

The author, whose name appears on the title page of this thesis, has obtained, for the research described in this work, the applicable research ethics approval. The author declares that he/she has observed the ethical standards required in terms of the University.

Abstract

Young people are increasingly engaging in sexual risk behaviours despite continued HIV and AIDS prevention interventions. Literature indicates that no successful prevention strategy for young people is currently available, as certain factors render preventive strategies ineffective amongst young people. This indicated a need for context-specific and culture-specific prevention interventions. The present study explored constructions of sexuality among young people of Venda. Discourse analysis was conducted using focus group discussion data of young people (learners from Grade ten to twelve) and community leaders in rural and urban areas of Venda. The impact of the discourse on young people's sexual behaviour may inform more successful future HIV prevention interventions.

Four predominant discourses were identified from the young people's constructions: Firstly, the male sexual drive discourse implies that young men need sex to satisfy an uncontrollable biological drive, while young women's sexuality is enmeshed with love, emotions and relationships; secondly, sex is a commodity. Young women has sex for material gain for own or family survival or in pursuit of modernity; thirdly, traditional hegemonic masculinity implied that sex is a means to attain the status of a *real man*; and finally, HIV and AIDS was normalised as any other illness and not regarded as a threat significant enough to influence sexual risk behaviours. HIV preventive messages did not influence young people's sexual risk behaviours. Community leaders constructed young people's sexual behaviour as immoral. For them, young people's sense of freedom and human rights lead them to dishonour cultural rules and to engage in risk behaviour. Parents felt disempowered to influence young people's sexual education and behaviour.

Recommendations for more successful prevention interventions include: An abstinence programme aimed at young people in primary schools before they start engaging in sex. Safer sex programmes aimed at young people in secondary schools which include comprehensive sexuality education. Context-specific HIV and AIDS prevention interventions developed with the participation of young people and adults in the community. Combination interventions that include TMC, comprehensive sexuality education and discussions aimed at deconstruction of gender roles. This should run concurrently with parental skills programmes to educate parents on positive parenting and building supportive relationships with their children. The improvement of access to HIV intervention resources through the involvement of local government and traditional kings is recommended.

Key Terms

Young people, sexuality, HIV and AIDS, prevention interventions, culture, Venda, sexual risk behaviours, social construction, discourse analysis.

Dedication

For my sons
Dembe Alexander Makamu
Denzhe Lawrence Makamu

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I would like to express my sincere gratitude to:

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List of Acronyms and Abbreviations

ABC	(Slogan originally proclaiming:) Abstain, Be faithful, Condomise but later rephrased in different ways)
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy / treatment
ARV	Antiretroviral (drugs)
DP	Discursive Psychology
Eish!	Cross cultural South African expletive (Not profane!) Orig. isiXhosa
FDA	Foucauldian Discourse Analysis
HAART	Highly active antiretroviral therapy (a combination of three or more appropriate drugs)
HBM	Health belief model
HIV	Human immunodeficiency virus
HSRC	Human Sciences Research Council
LO	Life orientation (a school subject)
MC	Male circumcision
MMC	Medical male circumcision
MCP	Multiple concurrent partnerships
NAPWA	National Association of People Living with HIV and AIDS
PEP	Post-exposure prophylaxis
PMTCT	Prevention of mother to child transmission
PrEP	Pre-exposure prophylaxis
SEM	Social ecological model
STI	Sexually transmitted infection
TAC	Treatment Action Campaign
TasP	Treatment as prevention (by curtailing transmission of pathogens to others)
TBVC	Transkei, Bophuthatswana, Venda and Ciskei (self-governing homelands in South-Africa prior to 1995)
TBP	Theory of Planned Behaviour
TRA	Theory of Reasoned Action
TMC	Traditional male circumcision
UNAIDS	(The joint) United Nations programme on HIV/AIDS
VCT	Voluntary counselling and testing
WHO	World Health Organisation

Glossary

Note: Some uncertainty exists regarding certain terms used in relation to HIV and AIDS. The definitions suggested by the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2009) are given in appendix 1. These terms are important in understanding the epidemic and are used in this study. Some other terms used in the study are the following:

AmaXhosa	Xhosas. IsiXhosa-speaking people of South Africa
AmaZulu	Zulus. IsiZulu-speaking people of South Africa
Bushbuckridge	(a.k.a. Bosbokrand) Town in Mpumalanga
CD4 count	Indication of concentration of T lymphocytes in blood
Domba	Age group rite of passage for Vhavenda youth (Chapter 3.2.5)
Edutainment	Education presented as entertainment through media
Giyani	Town in Vhembe district of Limpopo
Gondeni	Rural area with small villages in Venda
Hogo(ni)	Initiation school/rite of passage for boys
Ingagara	“Real man” (i.e. <i>top dog</i>)
Isinyama	(the propensity for) bad luck
Isithipa	Loner. Man without girlfriends. Washout
IsiXhosa	Language of the AmaXhosa
IsiZulu	Language of the AmaZulu
Kahungo	Disease which is contracted by a man who have sex with a woman who miscarried and has not been purified traditionally in the Tonga people of Zambia.
Kusasa fumbi	Removing dust (Malawian expression indicating sexual debut)
Kwazulu Natal	Province of South Africa
Limpopo	Province of South Africa
Lobola	Bride-price
Mahundwane	Traditional cultural ceremony of the Vhavenda involving play-acting of family roles
Malamulele	Town in Vhembe district of Limpopo
Maniini	Semi-rural suburb of Thohoyandou in Venda
Matangari	Rural area in Venda
Marude	Area near Thohoyandou in Venda
Milayo	Secrets of womanhood
Mpumalanga	Province of South Africa
Munna ndi ndou...	A man is an elephant... (Saying in support of multiple concurrent partnerships)
Muroho	Food/(traditional) vegetables
Murundu/Mula	Age group rite of passage for Vhavenda youth (Chapter 3.2.3)
Musevhetho	Age group rite of passage for Vhavenda youth (Chapter 3.2.1)
Nguni	Large group of languages in South Africa which includes isiZulu, isiXhosa, Ndebele, Swazi and related languages
Othering	Perceiving another person or group as entirely different from one self
PEN-3	A culturally sensitive health behaviour theory

Serodiscordant	Of mixed status; i.e. where only one member of a couple is HIV positive
Shebeen	(Informal) provider of alcohol/bar/pub
Shuvhuru	Derogatory term designating men who have not attended initiation schools and/or have not been circumcised
Sibasa	Town in Vhembe district of Limpopo
Soshanguve	Town in Gauteng province of South Africa
Sotho	Group of languages in South Africa, Botswana and Lesotho including languages such as Sepedi and Sesotho
Stoep	Porch
Thusula	Sexually transmitted disease
Thohoyandou	City in Venda
Tshikanda	Age group rite of passage for Vhavenda youth (Chapter 3.2.4)
Tshitambo	Age group rite of passage for Vhavenda youth
Tshiukhuvha	Porch
Tshivenda	Language of the Vhavenda people of Venda in Limpopo
Tswia	Tripod for cooking
Ukusoma	Thigh sex
U vhofha	A traditional way of preventing pregnancy that is done by mixing menstrual blood with traditional medicine (usually done by a traditional healer)
Venda	Region in the Limpopo Province of South Africa. Also English contraction for the language and people of Venda
Vhavenda	Tshivenda speaking people from Venda in Limpopo
Vhembe	The district of Limpopo in which Venda falls
Vhukomba	Age group rite of passage for Vhavenda youth (Chapter 3.2.2)
Vhulwadze ho tangananaho	Compound disease. Lit. <i>Mixture of diseases</i>
Vhusha	Age group rite of passage for Vhavenda youth (Chapter 3.2.2)
Vhutambo	Age group rite of passage for Vhavenda youth
Western Cape	Province of South Africa

Chapter 1

Background

1.1 Introduction

While HIV and AIDS prevention programmes seem to be reasonably effective for some groups of people in some geographic areas, they are ineffective in other areas, especially amongst certain gender and age groups.

In some sectors of society in South Africa such programmes have been unsuccessful in reducing the HIV and AIDS infection rate or prevalence. In South Africa young people and especially young women, remain a high risk group. In their study Shisana et al. (2014) found that 24.1% of all new infections in the country occurred in young females aged 15 to 24 years. Shisana et al. (2009) also recorded that HIV prevalence is increasing in provinces such as Mpumalanga and Kwazulu Natal whereas it is decreasing in other provinces such as Western Cape.

The spread of HIV and AIDS is thus complex and subject to various context-specific factors. Based on this complexity, Taylor (2004) criticised the use of generic HIV and AIDS prevention programmes as different geographical areas, cultural and age groups may have different norms, beliefs and constructions of sexuality which contribute to different behaviour patterns. In an effort to contribute to the development of HIV prevention interventions, the researcher interacted with young people in Venda, in Limpopo province, to understand their constructions of sexuality and the influence of these constructions on their sexual risk behaviour.

In this chapter (Chapter 1) an overview is given of the extent of the HIV epidemic in South Africa and of risk behaviours prevalent among young people. The overview is followed by a description of the context of the study, which includes brief background information to introduce the researcher's reasons and motivation for doing this study. The researcher's commitment and the aims of the study are explained. The chapter concludes with an outline of the study.

1.2 Overview of HIV in South Africa

1.2.1 HIV prevalence

HIV infection has developed from a virtually unknown disease into a worldwide pandemic during the past four decades. It was estimated that in 2014 36.9 million people were living with HIV globally. Of the global number of people living with HIV, 25.8 million are from sub-Saharan Africa. Women account for 58% of the total number of people living with HIV globally (UNAIDS, 2015) and 80% of women living with HIV are from the sub-Saharan region (UNAIDS, 2014). Fifteen percent of those living with HIV are between 15 and 24 years old. It was estimated that more than 80% of the children living with HIV globally are from sub-Saharan Africa. In the sub-Saharan region in 2013, South Africa accounted for 25% of people living with HIV followed by Nigeria at 13% and then Kenya at 6% (UNAIDS, 2014). The high number of people living with HIV in South Africa is partly as a result of the increase in the roll-out of ART which prolong the lives of those living with HIV.

According to the Human Sciences Research Council (HSRC) 2012 survey, overall HIV prevalence in South Africa has increased from 10.9% in 2008 to 12.6% in 2012 (Shisana, et al., 2014). In line with the global prevalence, Shisana, et al. (2014) found that females in South Africa have a significantly higher HIV prevalence rate than males (14.4% vs. 9.9%). The higher prevalence among women is already evident in the 15 to 19 year age group. UNAIDS (2013) reported that HIV prevalence among adolescent girls aged 15 to 19 years is unacceptably high. This can be ascribed to factors such as gender inequality, culture and biological vulnerability.

HIV prevalence is increasing in provinces such as Mpumalanga and Kwazulu Natal whereas it is decreasing in other provinces such as Western Cape and Limpopo (Shisana et al., 2014). There was a 2.7% increase in HIV prevalence from 2005 to 2008 among young people in Limpopo (Shisana et al., 2009) followed by a decline in 2012 (Shisana et al., 2014).

While HIV prevention interventions were increasingly rolled out and made available to most people in South Africa for the past three decades, it is still uncertain why HIV prevalence among young people, especially females, is not decreasing. One reason may be that prevention interventions implemented are mostly generic in nature and not directed at the

specific needs of identified groups. There is an obvious need for research in this regard and for the development of HIV prevention interventions that specifically target factors which influence young people's sexual behaviour.

1.2.2 New HIV infections

It is estimated that 2.0 million people were newly infected with HIV globally in 2014. Sub-Saharan Africa accounted for at least 66% of new infections in 2014. A large proportion of new infections in sub-Saharan Africa occur among young women and adolescent girls (UNAIDS, 2014).

As high as the incidence rate is, new HIV infections are said to have declined between 2000 and 2014. South Africa accounted for the largest decline in new infections with 98 000 fewer new infections in 2010 (UNAIDS, 2014). Despite the decline in HIV new infections, South Africa still has the highest rate of new infections compared to other countries in sub-Saharan Africa. South Africa accounts for 23% of new infections, followed by Nigeria at 15% and Uganda at 10% (UNAIDS, 2014). The Department of Health (2011) indicated that there were at least 4181 new infections in children aged 0 to 14 in Limpopo in 2009. Incidence among young people aged 15 to 24 was 1.5% in 2012. Shisana et al. (2014) reported that there was a 2.5% of HIV incidence among young females aged 15 to 24 years. This was indicated as a special concern (Shisana et al., 2014).

As indicated above, HIV prevalence and infections differ across geographic areas, contexts, gender and age groups. Some groups, especially young women, are more vulnerable to HIV infection than others. The differences in context and vulnerability curtail the effectiveness of generic HIV prevention interventions. It is therefore important to consider contextual factors and culture in the development of HIV prevention interventions.

1.2.3 Motivation of focusing on constructions of sexuality and Venda

As HIV prevalence and incidence are not uniform across board, HIV-risk behaviours are also not uniform across various groups of the population (Latkin & Knowlton, 2005). Risk

behaviours are influenced by different factors in different societies. These factors include gender inequality, societal norms, poverty, culture, peer pressure and personal choice. Risk behaviours are not always rationally based on knowledge of HIV and AIDS and suitable avoidance strategies (Campbell, 2003). Risk behaviours are socially constructed in each society and are inter alia dependant on norms and beliefs that influence behaviour in each society. Rather than offering generic HIV prevention interventions, it is important to consider constructions of sexuality and risk behaviours prevalent in a specific area, age group and/or context and structure HIV prevention interventions accordingly. Statistics, such as the following, may support such a process.

In the National Youth Risk Survey (Reddy, et al., 2010), 38% of learners in Grade 8 to 11 reported that they were sexually active and only 31% of them reported consistent condom use. High levels of unprotected sex are, therefore, reported among young people. It is therefore important for this study to focus on young people from Grade 10 to Grade 12 (the 15-19 age group) in order to change their behaviour but also to develop safety behaviour patterns that can eventually influence their sexual behaviour positively when they leave school. Reddy et al. (2010) indicated that 22.0% of sexually active young people in Limpopo have been pregnant or made someone pregnant. The latter statistic is the second highest of all the provinces in South Africa, with Eastern Cape being the highest (25.4%). Reddy et al. (2010) revealed that 49.9% of sexually active young people in Limpopo reported that they had had one or more sexual partners in the previous three months.

Shisana et al. (2014) related that the percentage of youth in Limpopo who reported multiple sexual partners did not change between 2002 and 2008 or since then up to 2014. They also recounted that early sexual debut in Limpopo increased from 10.1% in 2005 to 11.2% in 2008 and 11.8% in 2012. Shisana et al. (2014) further noted condom use at the last sexual encounter among young people in Limpopo decreased from 52.6% in 2008 to 39.3% in 2012. This indicates that young people in Limpopo are increasingly engaging in high risk sexual behaviours that place them at risk of HIV infection. (The 2014 HSRC report is currently the latest national report; research for the next report is in progress).

Young people are vulnerable to HIV infection as they are at an age of sexual experimentation. Lack of sexual knowledge places young people at risk of HIV and other sexually transmitted

infections (Malisha, et al., 2008). The South African Demographic Health Survey (2006) revealed that, among age groups, youth reported the weakest knowledge about ways to prevent HIV transmission. Shisana et al. (2014) reported that there was a decrease in knowledge about HIV transmission among young people between the 2008 and 2012 surveys. Shisana et al. (2014) also reported that, between the provinces, respondents from Limpopo had the least knowledge of HIV transmission and prevention interventions. This further indicates that there is a need for more research to be conducted among young people in South Africa, specifically the young people of Venda.

Limpopo province was the last province to roll out ARV drugs in South Africa. By the end of 2005, Limpopo had reached only 12% of its target in the national ARV roll-out plan (McNeil & Niehaus, 2009). Limpopo is also said to be one of the provinces that is neglected with regard to HIV and AIDS education, prevention programmes and treatment and care (McNeil & Niehaus, 2009). “The lack of activity in the region by organisations such as the Treatment Action Campaign (TAC) and the National Association of People Living with HIV and AIDS (NAPWA) has meant that there are currently no support structures to encourage or enable people to fully disclose their status” (McNeil & Niehaus, 2009, p. 68). At that stage (2009) HIV prevention in Limpopo were not on par with the other provinces, which were not satisfactory either. A lack of literature on subsequent development in this field in Limpopo is therefore disturbing as it may be indicative of a worsening situation.

Young Vhavendas were recruited as participants in the study, as the literature study has revealed that limited research had been conducted on HIV and AIDS among young people in Venda. Examples of literature regarding HIV prevention which employs Tshivenda as language medium are rare, as are incidences of media reporting in the language and on the subject (McNeil & Niehaus, 2009). This might have an impact on young people from Venda’s knowledge of HIV and AIDS, prevention, interventions and risk. It was, thus, important for the study to be conducted among young people in Venda.

1.3 Context of the study

1.3.1 Venda

Venda was one of the TBVC (Transkei, Bophuthatswana, Venda and Ciskei) homelands in South Africa that was self-governing prior to 1995. It was a traditionally governed state. Venda applied to be part of South Africa in 1991 and the homeland policy was dissolved in 1994. Currently, Venda is one of the rural areas in the Limpopo Province. Limpopo is situated at the border of South Africa and Zimbabwe and is one of the poorest provinces in South Africa.

Venda has just over one million people and it constitutes the second smallest ethnic group in South Africa (McNeil & Niehaus, 2009). Tshivenda is the language spoken by the Vhavenda people. Most people in Venda, especially the elderly and school children, including young people who were participants of the present study are only fluent in Tshivenda. Tshivenda is totally different from languages of Nguni and Sotho origin in South Africa, as its influence and origin are from languages in Zimbabwe and Zambia (McNeil & Niehaus, 2009).

Venda has high levels of unemployment, mortality and welfare dependency. The importance of kinship for social organisation is highly emphasised. McNeil and Niehaus (2009, p. 67) in their ethnographic study in Venda, stated that:

“Official attempts have been made to increase the number of headmen under chiefs and initiation schools under the control of the royal house. By reinstating forgotten ‘knowledge’ at the core of royal institutions, these have served to bolster the generational and patriarchal authority, not only of traditional leaders, but also of older women as ritual experts”.

When chiefs in Venda were re-empowered for political reasons, it was also aimed to ensure that young women attend initiation schools. The number of initiation schools were consequently increased in concert with the number of headmen.

Traditionally, young people in Venda are taught about sexuality, morals, responsible behaviour, respect and leading by example during different rites of passage for young girls and boys. The rites of passage are tailor-made for specific age groups and with specific knowledge imparted to prepare them for the next stages of their life. Of note is that most rites of passage are intended for girls. Musevhetho, Vhusha, Vhukomba, Murundu/Mula, Tshikanda and Domba are the rite of passages that are done for young people at different age groups. More details about rites of passage will be discussed in Chapter 2.

Due to societal changes and globalisation, the above rites of passage are losing traction in Venda. An unfortunate consequence of the decline of rites of passage is that elders are no longer instructing youngsters on sexuality, morality, parenthood, good citizenship and responsible behaviour. This omission creates a hiatus in the upbringing and knowledge of youth. In the HIV and AIDS context this has severe implications.

1.3.2 Motivation of the study

In conducting research, the researcher's beliefs, attitude, values and experiences contribute to the selection of a research topic; methods of doing research and the analysis of data (Mauther & Doucet, 2003). The researcher's interest in young people's sexual behaviour originates from the researcher's work at a community clinic in Soshanguve where young people were referred for counselling regarding HIV and AIDS and sexually transmitted diseases. Through counselling interactions, the researcher became aware of sexual risk behaviours that were prevalent among young people which place them at risk of HIV. The researcher also learnt that there are many complex pressures that place young people at risk of HIV. Peer influences, the need to belong and family circumstances such as poverty and lack of close parental influence were factors that influenced young people's sexual risk behaviours.

The researcher was born and lived in Venda until she entered tertiary education. As a trained clinical psychologist in the city, it became apparent that Venda was not on par with other areas in South Africa when it comes to HIV and AIDS education. Through personal experience and following interactions with people in Venda, she learned that elders are concerned about young people's sexual behaviour as it deviates from traditionally accepted norms and practices.

Young people used to attend initiation schools where they learned about respect and about positive sexuality. They were instructed in being well-mannered in conducting relationships and to abstain from pre-marital sex. Currently, young people have a choice to attend traditional initiation schools or not and most of them choose not to attend. Elders believe that young people are not behaving appropriately because they lack the education of traditional initiation. Young people, adults and elders disagree on what suitable behaviour should be. This encouraged the researcher to explore the behaviour of young people, sexuality and HIV and AIDS in the context of the Venda culture.

1.3.3 Suitability of social construction theory for this research

Previous literature shows that HIV prevention interventions are not equally effective in all contexts (Taylor, 2004; Taylor & Gahagan, 2004). This influenced the researcher to select social construction theory as point of departure. Social construction theory is mainly concerned with the idea that every society develops joined constructions that determine its own way of being. Constructions are formed through interaction among people within the society and these constructions shape their behaviour (Burr, 1995). In relation to this study, sexuality is a social construct that is derived from discourse within a society (Foucault, 1978). Interactions among young people in Venda influence whether they have sex or not, how they have sex and with whom they have sex. Social construction theory (Gergen, 1985) also assisted the researcher to analyse text in a relational manner to determine how interaction among young people and interaction between young people and adults in the community influence young people's sexual behaviour. Employing social construction theory helped the researcher to make sense of young people's sexual risk behaviour and adults' perspectives of young people's behaviour. It also directed the researcher to come up with recommendations for future HIV prevention interventions geared specifically for young people in Venda.

1.4 Aims of the study

The research question for this study is as follows:

How can HIV prevention interventions for young Vhavendas be improved by taking into account their constructions of sexuality and cultural beliefs and traditions?

The primary aim of the study was to investigate how young Vhavendas construct sexuality and the impact that such constructions have on these young people's sexual behaviour. Does young Vhavendas construct sexuality differently from other cultural groups?

A secondary aim of the study was to investigate whether sexuality construction amongst young people has a negative impact on the effectiveness of HIV and AIDS prevention programmes or places young Vhavendas at risk of HIV and AIDS. This was done by exploring Vhavenda youngsters' constructions regarding current HIV and AIDS prevention programmes and strategies.

A further aim of the study was to explore specific accepted cultural beliefs and traditions of the Vhavenda culture that could be used in culturally focused HIV prevention programmes to promote its effectiveness. This was carried out by exploring Vhavenda ideas and beliefs around sex as expressed by elders in Venda. The elders' sexuality construction was compared with young people's sexuality constructions to find out if there were differences or similarities and the influence those constructions have on young people's sexual behaviour. In short, the aim was to find information that might assist in the development of new HIV and AIDS prevention programmes.

The specific aims of the study were therefore:

- To identify the gaps/limitations in current HIV prevention interventions
- To explore how Vhavenda young people construct sexuality and whether it is different from other young people
- To explore if Vhavenda sexuality construction among young people is placing young people at risk of HIV and AIDS
- To explore Vhavenda cultural beliefs regarding sex and sexuality that could be incorporated into prevention programmes to enhance its effectiveness.

1.5 Outline of the study

1.5.1 Research Methodology

This study was conducted within a social construction theoretical framework and qualitative research methodology was utilised. Data was collected using focus group discussions with learners from four secondary schools in Venda; more specifically, two secondary schools in rural areas and two secondary schools in semi-rural areas. In addition, focus group discussions were held with community leaders and elders to understand aspects of the Venda culture that could be integrated into HIV prevention programmes. Text produced during focus group discussions was analysed using discourse analysis.

1.5.2 Overview of the Chapters

The background for the study was given in Chapter 1.

In Chapter 2, a review of literature on HIV and AIDS risk behaviours among young people, change in HIV and AIDS risk behaviours, HIV and AIDS prevention interventions.

Chapter 3 focuses on the impact of culture and sexuality on HIV and AIDS prevention interventions.

Chapter 4 focuses on the research methodology of the study. Social constructionism, as the theoretical framework within which the study is conducted, is debated. A description of qualitative research as an appropriate research methodology for this study follows. Thereafter, the participants and the sampling procedure are described. The technique of Focus group discussions as a method of data collection is discussed. Finally, discourse analysis as a method of analysis for the study is examined.

In Chapter 5 the analysis and discussion of the data and the discourses that were identified are presented.

Chapter 6 concludes the study by outlining a conclusion. A reflective account of the research process is presented. A consideration of the strengths and limitations of the study follows and the chapter is concluded by providing recommendations for HIV preventive interventions.

Chapter 2

Literature review

2.1 Introduction

Research on HIV and AIDS started with the discovery of the Human Immunodeficiency virus and the development of appropriate diagnostic assays. This was followed by the elucidation of the life cycle of HIV and the forming of an understanding of the pathogenesis of HIV infection and AIDS (Chan, 2012). Within approximately a decade from the emergence of HIV and AIDS, highly active antiretroviral therapy (HAART) was already developed (Padian, Isbell, Rusell, & Essex, 2012) and made available to those infected with HIV to prolong their lives. More recently, antiretroviral treatment (ART) has also become available as infection retardant for HIV serodiscordant couples and other high risk groups. Despite all these developments there is still no affordable and readily available vaccine for HIV and AIDS. There is also no cure as yet. HIV prevention by dissemination of information and promotion of behaviour change is therefore still the most important strategy to reduce the spread of HIV.

Since the beginning of the HIV and AIDS epidemic, HIV and AIDS prevention programmes have been developed to educate people on HIV transmission and to eradicate associated myths. This has been done with the aim of reducing HIV infections. Specific risk behaviours were identified (Campbell, 2003; Reddy et al., 2010) and prevention programmes were developed to reduce these risk behaviours. In recent years, HIV and AIDS prevention campaigns have moved from focusing on the individual to focusing more on social and structural efforts (Gupta et al., 2008; Rotheram-Borus, Swendeman & Chovnick, 2009) to reduce HIV infection. Preventive interventions are focusing on the use of medications or medical procedures including PMTCT, HAART, PEP, PrEP and circumcision (Cornell et al., 2010; UNAIDS, 2012).

In this chapter, existing literature on current HIV and AIDS risk behaviours which have been identified among young people is reviewed. This is followed by a discussion on the complexity of efforts to change risk behaviours. A critical review of HIV and AIDS

prevention interventions and the challenges these programmes face will follow. The role of culture in young people's constructions of sexuality, which seems to be a missing component in HIV and AIDS prevention interventions, is outlined.

2.2 HIV and AIDS and risk behaviours

HIV risk is defined as the probability that a person may acquire HIV infection (UNAIDS, 2014). Certain behaviours create or enhance and perpetuate risk of HIV infection. Some behaviours have been labelled as risky behaviours among young people for contracting HIV. Multiple concurrent partnerships, intergenerational sex and early sexual debut are risk behaviours that are associated with HIV among young people (Reddy et al., 2010; Shisana et al., 2009; Shisana et al., 2014). These are discussed below.

2.2.1 Multiple Concurrent Partnerships (MCP)

Multiple Concurrent Partnerships (MCP) was defined by Simbayi (2009) as relationships in which an individual has overlapping sexual relationships with more than one person. Zuma et al. (2016) reported a steady increase of multiple sexual partners from 11.5% in 2002 to 18.3% in 2012, with rates constantly higher for males. They also reported rates of MCP among people aged 15 to 24 years (22.4%) that were higher than among other age groups.

Mah and Halperin's (2008) review of studies on concurrent sexual partnerships and the HIV epidemic showed that MCP was higher in Sub-Saharan African countries than in Asian countries. MCP is considered to be one of the main reasons why HIV prevalence in Southern African is not decreasing (Halperin & Epstein, 2007; Mah, 2008; Rehle et al., 2008). Halperin and Epstein (2007) indicate that MCP leads to high HIV infection for two reasons: Firstly, HIV transmission is found to be much higher in concurrent partnerships of long duration. Secondly, the combined effects of sexual networking and acute infection spike in viral load means that as soon as one person in a sexual network is infected, everyone else in the network is at even higher risk (Halperin & Epstein, 2007).

According to Mah and Halperin (2008) there are many historical socio-economic, social, behavioural and potentially biological factors that may contribute to the high practice of MCP in South Africa. Some of these factors are as follows:

Firstly, polygamy in South Africa has traditional roots. Historically a man was allowed to marry many wives. This tradition currently still influences behaviour. Mah and Halperin (2008, p. 14) reported that: “concurrent partnerships are viewed as culturally rooted social structures that have existed and continue to persist despite social changes and changes in the health risks associated with such practices”. However, polygamy is also common in much of North and West Africa where HIV infection rates are lower than in sub-Saharan Africa. This is ascribed to a closer surveillance of women’s sexual behaviour in North and West Africa (Halperin & Epstein, 2007). Despite the absence of similar surveillance of male behaviour this nevertheless limits the extent of sexual networks. In South Africa both men and women are said to engage in MCP. Current involvement in MCP by young people in South Africa might be a result of historical and cultural constructions around sexuality in South African societies.

The second explanation for high levels of MCP in South Africa is related to the migrant labour system (Mah & Halperin, 2008). Many men move to the cities in search of work while their wives stay in rural areas. This results in spouses spending a long time apart. The implication is that many men developed relationships with a partner at home and another in the area where they work, while either or all of his partners are involved in other similar relationships as well.

The third explanation may be found in the democratisation of South Africa in 1994 that resulted in rapid globalisation (Mah & Halperin, 2008). Due to globalisation, young people are now aware of transactional sex as a way to acquire goods, not necessarily through blatant prostitution but often by having more than one supportive partner. Leclerc-Madlala (2003) noted that maintaining relationships with more than one partner concurrently is also viewed as a modern activity. This results in young people having many partners in order to acquire goods and improve their status among their peers.

A fourth explanation for MCP in South Africa is the discourses of masculinity. Male sexuality is associated with having many partners. A man acquires status by being able to

maintain many relationships. Women also recognise that a man's status, popularity and prestige in the community are boosted through having many girlfriends (Leclerc-Madlala, 2003). This community trend influences young males to have many partners and also makes young women tolerant of their male partners having many partners. Constructions of gender (which will be critically discussed later in this chapter) seem to influence engagement in MCP.

Sawers and Stillwaggon (2010) criticised the hypothesis that HIV infection rates are higher in sub-Saharan Africa because of concurrent sexual partnerships. They criticised the model that was used to calculate the rate of infection. The model calculated the frequency of sexual contact as if an individual have sex with every partner on a daily basis, which they reported does not reflect reality. Similarly, the model calculated sexual concurrency with the assumption that men and women's concurrency rates are equal. This also does not reflect reality as studies show that more males compared to females engage in MCP (Adimora et al., 2003; Mah, 2008; Shisana et al., 2014; Zuma et al., 2016). These assumptions lead to higher infection rate than it would be in reality. Finally, an assumption about transmission rates was also high at 0.05. The transmission rate is an estimation of the average risk of HIV transmission for a specific type of unprotected sex (Wilton, 2012). Sawyer and Stillwaggon (2010) reported that during acute infection, no one has found a heterosexual transmission rate as high as 0.05 in the absence of a cofactor. This assumption also exaggerates the effects of concurrency on HIV infection.

Studies (Lurie & Rosenthal, 2009; Sawers & Stillwaggon, 2010) also criticised the MCP hypothesis for the lack of a standard definition of concurrency in MCP research. This means that different research measures different types of relationships. Mah and Halperin's (2008) assumption that "*potentially biological factors*" among South Africans lead to MCP also indicate a stereotype of South African sexuality as rooted in biology. Sawyer and Stillwaggon (2010) criticised the concurrency hypothesis as another way of labelling Africans' sexuality as deviant and increasing the spread of HIV. This emphasises the notion that African sexuality is uncivilised and need to be controlled (McClintock, 1995; Tamale, 2011). Sawyer and Stillwaggon (2010) reported that the "spread of HIV involve a complex and contingent process that results from numerous and interacting factors" (p. 18).

It is my opinion that there are many and complex factors that contribute to the high incidence of HIV in South Africa. MCP can be one of those factors that fuel the transmission of HIV. Focusing on a single behaviour as the cause of high rates of HIV infection obscures the focus and leads to the failure of HIV prevention interventions. People engaging in MCP who do not use condoms during sexual intercourse contribute to the spread of HIV. Unsafe sex is therefore, a core issue. Partner reduction is one factor, but not the only factor in reducing HIV infection among young people. As there are many factors that influence infection rate, multiple, combination and cross disciplinary interventions that consider cultural factors are vital in HIV prevention. It is also valuable to focus on young people who do not engage in MCP to find out individual factors that are protective for them not to get involved in MCP. Such protective factors can be enhanced to protect those who are vulnerable to MCP.

2.2.2 Intergenerational relationships

Intergenerational relationships are defined as relationships between a young person (aged 15 to 19 years) and a partner at least 5 years older. Intergenerational relationships are considered risky as young women who engage in relationships with older men are more likely not to insist on or not to negotiate for condom use due to power imbalance in the relationship (Hallett, 2006; Hallett et al., 2007; Shisana et al., 2014). Analysis of the trend in data from 2005, 2008 and 2012 shows a steady increase in intergenerational relationships involving females aged 15 to 19 years (Shisana et al., 2014). Shisana et al. (2009) stated that the steady increase calls for concern because of its effect on HIV incidence among young women.

The term ‘sugar daddy’ is widely used in South Africa to refer to an older man who is in a relationship with a younger woman and provides financially for young women (Gobind & du Plessis, 2015). Recently, the term, ‘blesser’ has been coined in South Africa. It is a slang term for a rich man who offers support (typically financial and material) to a younger female companion in exchange for sex (eNCA, 13 May 2016). *Ban ten* is a term used to refer to a younger man who is in a relationship with an older woman. Of note is that men are the ones that are labelled or given names when they are involved in intergenerational relationships. The ‘sugar daddy’ relationship is the focus of most of the current research on the topic. This might be because of high HIV incidence among young women that is assumed to be fuelled by young women having relationships with older men.

There are several explanations for intergenerational relationships among young people. Firstly, people's preference in the choice of a partner is a result of constructions within the society regarding the characteristics of proper and acceptable partners. Traditionally, it is expected of young women to have sexual relationships with, or even marry, older men. Men are encouraged to marry younger women whose fertility is still high (Leclerc-Madlala, 2003). It is also believed that having sex with young women gives older men energy in life. Longfield, Glick, Waithaka and Berman (2004, p.129) stated: "By engaging in sex with younger partners, older men assure themselves that they are still desirable and can enjoy sex as they did when they were younger". Leclerc-Madlala (2008, p.S20) wrote:

"Many culturally inscribed assumptions and expectations that once legitimized these practices still prevail at present and continue to influence the meanings that people attach to contemporary sexual relations and expectations that people have in relationships".

A second explanation for intergenerational relationships is transactional sex. Research (Leclerc-Madlala, 2008; Longfield et al., 2004; Rehle & Shisana, 2003) have shown that young women prefer older men as they can provide gifts. Some young women enter into intergenerational relationships in order to support their families or for survival. Although some young women have legitimate financial needs and seek assistance from their older partners, others want to impress their peers by having luxuries like fancy clothes, cell phones and hairstyles. This becomes possible because of the financial benefits provided by their older partners. Transactional sex seems to be an important driving force for intergenerational relationships.

Probing questions related to intergenerational sex which appeared in the literature include:

- Why are young women's relationships with older men considered transactional?
- Why is it not considered as loving relationships?
- Is it only people of the same age that can love?
- What differentiates young people's gifts from those of older people in relationships?

Sawers and Stillwagon (2010) alluded to similar questions in their study questioning whether all adults who received gifts in their relationships (chocolates, flowers, etc.) on Valentine's Day are considered to be engaging in transactional sex. Such questions are important to

adjudicate the transactional sex hypothesis as an influence in HIV infections. The questions are important to ask to focus prevention interventions on risk behaviours. It is my opinion that the difference in such relationships lies in the main purpose of the relationship. If the main purpose is to give sex so that one can gain material things (big or small) and if there is limited freedom to refuse sex or unsafe sex because of the material gains, then that relationship involves transactional sex.

Thirdly, a possible explanation for intergenerational relationships is men's belief that young women are free from HIV infections. Longfield et al. (2004) reported that men sometimes argue that young women are a low risk group because they are innocent, sexually inexperienced, or have had few sexual partners. Young women are also said to believe that older married men are less risky compared to men their own age. Older men are (sometimes mistakenly) believed to be settled and not having many partners as they are married (Longfield et al., 2004). The notion of clustering people as 'risky' and 'not risky' seems to be influenced by biomedical and HIV and AIDS education programmes' discourses of labelling 'risky groups' (Nzioka, 1996; Zungu, 2013). This has led to lay constructions grouping people as less risky through perceived characteristics. This presents a risk in itself and further contributes to stereotypes.

Hallett, Gregson, Lopman and Garnet (2006) developed a mathematical model of heterosexual spread of HIV to predict the population impact of reducing cross-generational sex. Their model simulations indicated that intergenerational sex had little impact at the population's level of infection. They indicated that HIV can still reach a high endemic level even if 99% of sexual partnerships are formed between peers. It is just that more inter-peer sexual relations will increase HIV infections between partners from peer groups. This indicates that it is not only the *type* of relationship that people are engaged in that increase HIV infection but also the *risk* behaviours that people in those relationships engage in. In this case intergenerational relationships have an impact on HIV infections because of the power imbalance in the relationship and the implications on condom use (Hallett et al., 2006). Recent research (Evans et al., 2016) concluded that age-disparate sex is a risk factor for young women between 15 and 24 years in South Africa. They however, recommended further research as there are differing results from recent studies.

As intergenerational relationships have been associated with young people needing financial support from *sugar daddies*, the solution would be to enable young people to be financially independent rather than depending on older men (Gobind & du Plessis, 2015). This statement was tested in research by Cluver et al. (2014) where girls were empowered financially through receiving grants. The grants did make a difference in girls' risk behaviour. Even though such programmes are important in empowering young women, it is also important to develop behaviour change interventions that should focus on minimising unprotected sex. Young people should be empowered to negotiate safe sex rather than targeting the age difference between sexual partners (Hallett et al., 2006). Combination interventions are of significance to deal with intergenerational relationships which should include culturally deconstructing intergenerational relationships, giving young people grants and individual empowerment for young women.

2.2.3 Early Sexual Debut

Early sexual debut was identified as one of the risky sexual behaviours that result in young people infected with HIV and AIDS. Mathews et al. (2008) defined early coital (sexual) debut as having sex while 15 years or younger. Shisana et al. (2014) and Zuma et al. (2016) reported that the rate of early sexual debut was stable between the 2005 and 2008 survey, but increased slightly (from 10% to 11%) towards 2012. The Youth Risk Behaviour Survey (Reddy et al., 2010) reported that 37.7% of learners in grades 8 to 11 reported having had sex when they were 15 years or younger. Studies (Shisana et al., 2014; Zuma et al., 2016) indicated that more males than females report early sexual debut.

Early sexual debut is a risk factor for HIV because young people's period of potential exposure to HIV infection is longer. Younger girls' underdeveloped physiology and genital tract increase susceptibility to HIV. Young girls in intergenerational relationships are unlikely to be able to negotiate or insist on condom use (Hallett et al., 2006; Hallett, Lewis, Lopman, Nyamukapa, Mushati, Wambe, Garnett, & Gregson, 2007). Early sexual debut was also associated with other HIV risk behaviours. Studies by Hallett et al. (2006) and Harrison (2005) show that those who engage in early sexual debut are more likely to engage in MCP, engage more frequently in sexual activity and have more partners. All of these behaviours

increase the chances of being infected with HIV. For these reasons, HIV prevention usually encourages young people to delay sexual debut.

There are several explanations for young people to engage in early sexual debut. Constructions around masculinity were found to be one of the reasons. There seem to be constructions among young men that males should have sex as early as possible to prove their manhood and enhance their reputation among other young men (Marston & King, 2006; Wight et al., 2006). Wight et al. (2006) in their study among young people in rural Northern Tanzania, found that young virgin men are laughed at by those who have already initiated sex. This pressurises young men to initiate sex, to prove their masculinity.

Some young people believe that sex is natural and has health benefits (Izugbara, 2008; Wight et al., 2006). The belief that abstinence results in ill health, the blockage, death, malfunctioning or malformation of the penis, madness or homosexuality influences young people to initiate sex early. Wight et al. (2006, p. 992) reported that: “some young women said that having sex makes one beautiful and both sexes said that it leads to weight gain, considered to be desirable”. Constructions around sex and sexuality among young people seem to influence their engagement in early sexual debut.

Studies (Hargreaves et al., 2007; Mathews et al., 2008) also noted that socio-economic status influences young people to initiate sex early. Young people from low socio-economic status families sometimes initiate sex early in order to support themselves and their families. Early sexual debut is sometimes linked to transactional sex and intergenerational relationships.

It is important that HIV prevention interventions continue to focus on delaying sexual debut as it has proven difficult to change risk behaviours once they have been established (Harrison et al., 2005). HIV and AIDS prevention programmes have been campaigning for young people to delay having sex until they are older. These campaigns do not seem to be effective as young people’s early sexual debuts remained almost stable over the past decade (Shisana et al., 2014). Sexual experiences are part of the transition to adulthood and they are influenced by the environment, context and culture in which young people develop (Pettifor et al., 2009). HIV and AIDS prevention campaigns that do not consider the environmental and cultural influences, in which young people live, will continue not to be as effective as hoped for. HIV and AIDS prevention interventions may be more effective if based on a thorough

understanding of young people's constructions of sexuality, their actual sexual behaviour and the context in which those young people live rather than being based on current political and religious ideologies.

However, it was found that minimising early sexual debut on its own does not lead to reduction of HIV infection at population level (Hallett et al., 2006; 2007). This means that prevention of early sexual debut should be linked with other behaviour change programmes, such as increasing condom use, debunking constructions around masculinity and sex and constructions around early sexual debut, rather than focusing on one specific behaviour.

No one specific risk behaviour completely account for the spread of HIV unilaterally. There are many factors that influence HIV infection rates. Sexuality and HIV infection are impacted at multiple levels for example individual, behavioural, contextual and structural level. For this reason, campaigning for the reduction or eradication of one specific risk behaviour on its own will not lead to significant reduction in HIV infection. The appropriate response calls for combined interventions at multiple levels.

2.3 Behaviour change theories

To change risk behaviours indicated above (MCP, intergenerational relationships and early sexual debut) prevention interventions should be based on behaviour change theories and theories of people's interactions in communities. Appropriate theories may focus interventions on crucial factors or behaviours that should be addressed. The theories that guided HIV prevention interventions to date, (for example that correct information about HIV or practical skills to reduce sexual risk behaviour will result in the reduction of HIV infection) seemed not to be appropriate theories. Recent research indicates that multiple complex factors influence sexual risk behaviour, as sex happens in socio-cultural surroundings. Cultural norms and context therefore need to be considered in HIV prevention interventions. Other recent research indicates that structural factors increase some people's vulnerability to sexual risk behaviours and need to be addressed in HIV prevention interventions.

There are many theories that are used to understand change in health-related behaviour, namely, the Health Belief Model, AIDS Risk Reduction Model, the Stages of Change, the Theory of Planned Behaviour and many more. However, these theories do not seem to be effective in informing long-term change in risk behaviours amongst young people in an African context. The theories have been criticised for not capturing the elements necessary for behaviour change across cultures and for focusing only on individual-level factors (Airhihenbuwa & Obregon, 2000; Denison, 1996; Prado, Lightfoot, & Brown, 2013).

The section below critically discusses the Health Belief Model (HBM), Theory of Planned Behaviour (TBP), Social Ecological Model (SEM) and The PEN-3 Model, which are often used in prevention efforts in the context of HIV and AIDS to ensure more accuracy in predicting change in sexual risk behaviours among young people.

2.3.1 Health Belief Model

The Health Belief Model (HBM) was developed by Rosenstock (1966; 1974a; 1974b) to explain how individuals will take actions to avoid ill health. It was later extended by social psychologists to include people's response to symptoms, behaviour in response to diagnosis and to compliance with medical regimens (Fan, Conner, & Villarreal, 2004; Janz, Champion, & Stretcher, 2002). HBM proposes that people will be motivated to carry out preventive health behaviours in response to certain variables (see Figure 1 below).

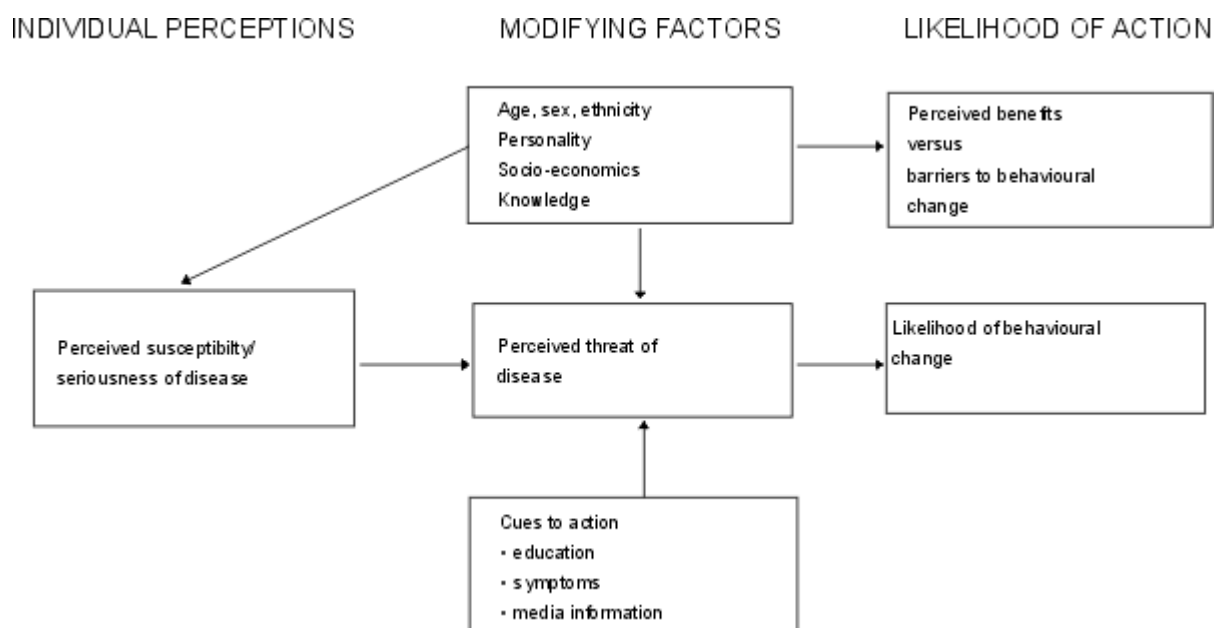


Figure 1 Health Belief Model Source: Glanz et al., 2002, p. 52

The premise of HBM in the HIV and AIDS context is that people will take action to avoid being infected with HIV if:

- they perceive themselves to be susceptible to HIV infection
- they believe that HIV is a serious health condition that is worth avoiding
- they believe that the course of action has more beneficial effects than barriers
- there are cues to action that influence engaging in the health behaviour
- they believe that they are capable of taking action that is required.

These variables are hypothesised to have a multiplicative relationship to one another (Levinton, 1989), which means that the likelihood of preventive action (condom use) is great when a person believes or experiences all five conditions. The fifth condition (self-efficacy) was added as there was a belief that if a person believe that he/she is capable of taking action, then he/she is more likely to take action. HBM has been effectively applied to a broad range of health behaviours and subject populations to predict healthy behaviour change (Conner & Norman, 1996).

HBM has been criticised for not offering suggestions for interventions except to provide information to people about the disease. It has been proven that information alone is not

adequate to motivate change in health related behaviours (Campbell, 2003; Orisakwe et al., 2012). HBM has also been criticised for its focus on individual behaviour and assumption that people are rational beings. The theory does not consider the impact of social and interactive contexts which influence people's perceptions of their susceptibility (Munro, Levin, Swart, & Volmink, 2007). HBM does not consider pressure from peers or partners that may encourage risky behaviours. The perceived severity variable led to interventions that reinforced the threat of HIV. This was counterproductive and led to the increase of stigma related to HIV and AIDS (Niehaus, 2007).

Several studies have been done to investigate the effectiveness of the HBM in predicting change in HIV risk behaviours. Albarracin, McNatt, Klein, Mitchell, Ho and Kumkale (2003) examined whether persuasive communication resulted in cognitive and behavioural changes. They found that communication intended to increase condom use had psychological influences. However, they found that HIV-preventive communication had no generalized impact on perceived susceptibility, severity, negotiation skills and condom use. Communication that increased self-efficacy though, increased the intention to engage in HIV-preventive behaviour. Orisakwe, Ross and Ocholla (2012) found that people in KwaZulu-Natal, did not go for HIV testing despite excellent knowledge of HIV. There was no correlation between knowledge, attitude, perception of risk and HIV-testing. Another study done among young people aged 15 to 24 years in Tanzania revealed that perception of severity of HIV and AIDS and perception of risk of HIV infection influenced young people's attitude in favour of HIV preventive behaviours. However, a study (Ndabarora & Mchunu, 2014) done in South Africa among university students found that most HBM variables were not predictors of the utilisation of HIV and AIDS prevention methods (that is, Voluntary Counselling and Testing (VCT) and condom use). Munro, Levin, Swart and Volmink (2007) also reported that the two reviews that examined HBM had inconclusive results. The above studies indicate that there is no conclusive evidence that HBM is effective in influencing people's health behaviours.

HBM focuses on the individual and internal beliefs that influence changes in risk behaviour. The literature reviewed in this study indicated that there are many factors outside of the individual that influences young people to engage in sexual risk behaviour. It is therefore the researcher's opinion that HBM on its own might not be effective in changing young people's sexual risk behaviour. It is important to educate young people about HIV and AIDS and its

dangers and ways to protect themselves. It is however, important to also consider context, structural factors and social interaction that influence young people to engage in sexual risk behaviour.

2.3.2 Theory of planned behaviour (TPB)

TPB (Ajzen & Fishbein, 1980) is an extension of the Theory of Reasoned Action (TRA) (Molla, Åstrøm, & Berhane, 2007; Munro et al., 2008). The goal of TPB is to predict and understand human behaviour. The assumptions of TPB are that most actions of social relevance are under volitional control and that human beings are rational in their use of information around them to inform their decisions (Ajzen & Fishbein, 1980).

TPB's premise is that intention to perform behaviour is the immediate determinant of the action. In the initial theory (TRA), it was claimed that behavioural intention is influenced by two factors (see Figure 2 below for a schematic outline of TPB). The first one is of a personal nature, which are behavioural beliefs. Behavioural beliefs are the individual's positive or negative evaluations of the behaviour and the individual's judgement that performing the behaviour will yield good or bad outcomes. The second one reflects social influence and it is called subjective norms. Subjective norms are the person's perception of the social pressures or beliefs about what significant others think of performing the behaviour. An individual will thus tend to perform the behaviour when they evaluate it positively and when they believe that significant others think they should perform the behaviour.

A third factor, perceived behavioural control, was added to the above two factors that comprised TRA. Perceived behavioural control was included because it was suggested that only behaviours under direct volitional control of the individual could be accurately predicted by intention (Munro et al., 2007). The variable perceived behavioural control therefore accounts for instances when this is not the case (Ajzen & Fishbein, 1980). Perceived behavioural control represents the perceived ease or difficulty of performing the behaviour. It is a function of control beliefs. Perceived behavioural control is said to be similar to self-efficacy in HBM discussed above (in Figure 1) (Munro et al., 2007).

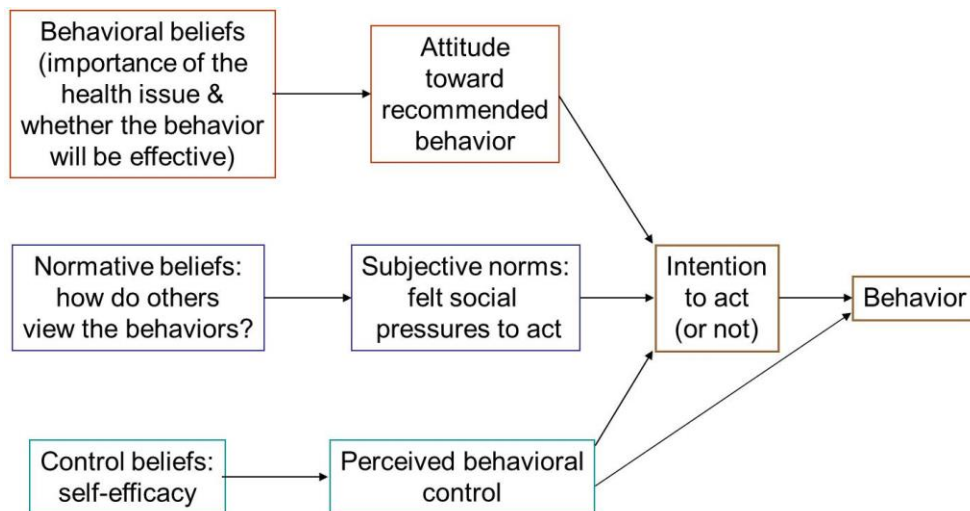


Figure 2 Theory of Planned Behaviour

Source: AFMC Primer on population health. www.phprimer.afmc.ca/part-theorythinkingabouthealth. (Retrieved August, 25 2016).

Research has been done to investigate TPB's effectiveness in influencing the adoption of safe sex behaviours. Most studies in HIV and AIDS prevention showed that TPB is effective in promoting condom use. The meta-analysis of Armitage and Conner (2001) supports the efficacy of TPB as a predictor of intentions and behaviour. However, the prediction was more accurate for self-reported behaviour than for observed behaviour. Munro et al. (2007) did a meta-analysis to determine the usefulness of TPB to promote long-term medication adherence for TB and HIV and AIDS. They reported that results were promising, although not conclusive.

A study done among students of the University of Cape Town (Muller & Robertshaw, 2003) found that TPB was a useful model for explaining condom use intentions. Specifically relevant in this study, is the research of Boer and Mashamba (2005) among young people of Venda. They reported that cognitive models (including TPB) are useful models for explaining condom use intentions. TPB can thus be useful in informing HIV prevention interventions that aim to increase condom use among young people. It should be considered though, that there are many other factors beyond behavioural intentions that influence condom use among young people.

It is the researcher's opinion that TPB is one part of the solution in increasing condom use. The social context of behaviour should also be considered.

2.3.3 Social ecological model

The Social Ecological Model (SEM) was developed by Uri Bronfenbrenner in the 1970s (DiClemente, Salazar, & Crosby, 2007; Prado, Lightfoot, & Brown, 2013). The basic premise of SEM is that behaviour is determined by multifaceted and interactive effects of personal and environmental factors. SEM proposes that there are five nested hierarchical levels that have an impact on individuals' behaviour. These levels are individual, interpersonal, community, organisational and a policy/enabling environment (see Figure 3 for a depiction of each of the SEM levels). SEM understands human behaviour as a function not only of the individual or his or her immediate social relationships but as depending on the community, organisation and the political and economic environment of the society as well.

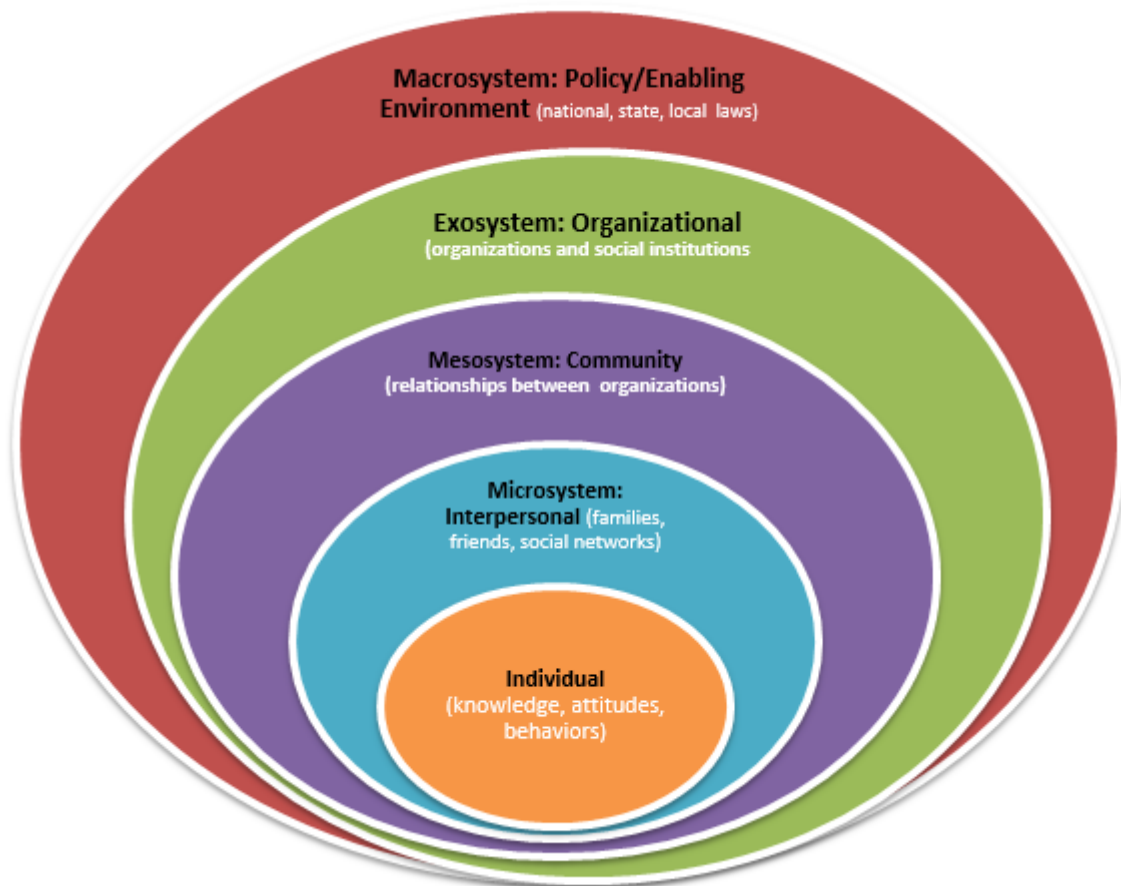


Figure 3. *The Social Ecological Model: A Framework for Prevention,*

Source: Adapted from the Centers for Disease Control and Prevention (CDC),

<http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html> (retrieved August, 4 2016).

In the HIV context, according to SEM, sexual risk behaviour is located within a dynamic interplay between SEM levels (Maticka-Tyndale, 2012). SEM provides a useful framework from which to examine factors associated with the HIV epidemic among young people (Prado et al., 2013). Understanding sexual risk behaviour as influenced from multiple levels also influences prevention interventions. According to SEM, to have an impact on sexual risk behaviour it is significant to design concurrent interventions aimed at multiple relevant modifiable levels of the social ecological model (DiClemente et al., 2007).

Recent interventions (Cluver et al., 2014; DiClemente et al., 2007; Prado et al., 2013) aimed at multiple (not necessarily all) levels of the social ecological model, have proven effective to bring about change in sexual risk behaviours among young people. DiClemente et al. (2007) reviewed individual focused HIV preventive interventions for adolescents and found that studies demonstrated significant reductions in sexual risk behaviours in the short-term. The criticism of those studies was the reliance on individual-level models. They reported that adolescents are exposed to diverse sources of influences transcending different levels of causation. They recommended that for prevention interventions to have long-term significant reduction of sexual risk behaviours, they should target myriad levels of causation.

Prado et al. (2013) studied the effects of macro-level prevention approaches among ethnic minority youth in the US and found that a combination of macro-level and individual-level interventions holds most promise for reducing HIV health disparities between ethnic minority youth and other segments of the US population. A recent study (Cluver et al., 2014) done in South Africa among young people in informal settlements aimed at individual behaviours, parental care and economic assistance showed effective results in reducing sexual risk behaviours among young people.

The literature review indicated that there are many factors at different levels of the SEM that have an impact on young people's sexual risk behaviour. This might be the reason why individual-level prevention interventions are not effective among young people. This calls for interventions that target sexual risk behaviours on multiple levels. It is the researcher's opinion that SEM offers the basis of such preventions interventions. SEM prevention interventions require intensified efforts and resources as it requires multiple and diverse prevention interventions to be implemented at the same time (DiClemente, 2007). Considering that individual-level and interventions offered individually have proved not to be

effective, more efforts and resources are warranted to be able to curb the HIV epidemic among young people.

2.3.4 The PEN-3 Model

The PEN-3 model was developed by Airhihenbuwa (1989, 1995), in response to the omission of culture in explaining health beliefs and behaviours in the existing health behaviour theories and models (Lwelumore, Newson, & Airhihenbuwa, 2013). The PEN-3 model's approach examines health beliefs, decisions and behaviours within a specific cultural context (Okoror, BeLue, Zungu, Adam, & Airhihenbuwa, 2014). The PEN-3 model focuses on both the risk and protective factors of a culture towards health beliefs and behaviours.

Rather than only focusing on factors surrounding the individual, the PEN-3 model expands and examines the role other factors play in influencing health risk behaviour and in supporting health behavioural changes (Lwelumor et al., 2013). According to the PEN-3 model, to explore the influence of culture on health is to recognise that the forest is more important than the individual tree (Airhihebuwa, 1999). The PEN-3 model recognises that health beliefs and behaviours are the responsibility of the collective. Culture and the community play an important role in influencing health beliefs and behaviours (Lwelunmore et al., 2013).

The PEN-3 model has 3 domains (cultural identity, relationship and expectations and cultural empowerment). Each domain has 3 interconnected dimensions that form the acronym PEN, 1) person, extended family and neighbourhood (Cultural identity); 2) perceptions, enablers and nurturers (relationship and expectations); 3) positive, existential and negative (cultural empowerment). This is illustrated in Figure 4.

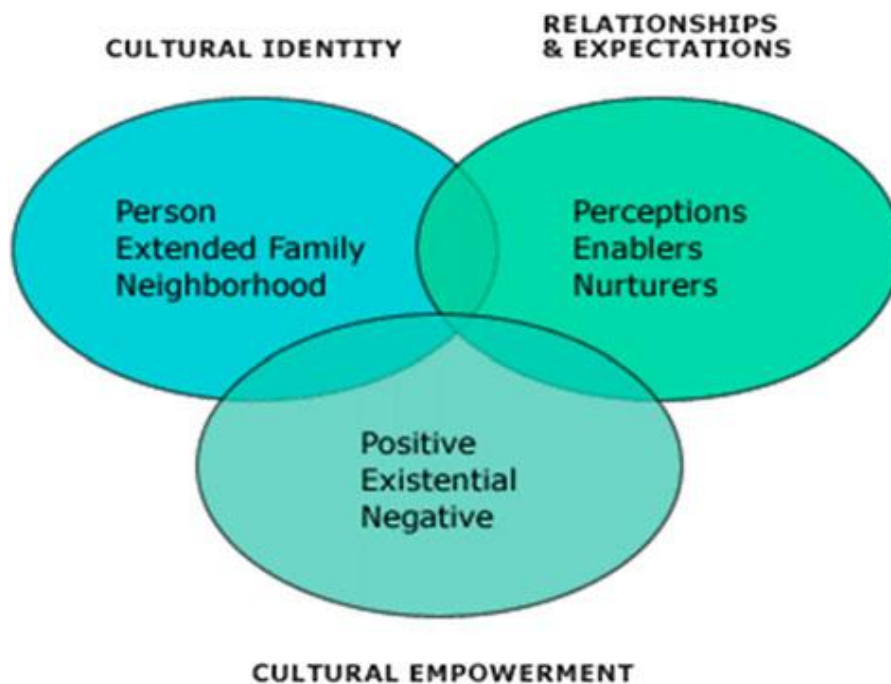


Figure 4. PEN-3 Model
 Source: Lwelumor et al., (2013)

PEN-3 encourages starting engagement with the community from a positive perspective (Airhihenbuwa, 1999). It is envisaged that identifying the positive within a community can lead to finding *ways of knowing* within the culture (Okoror et al., 2014). This can be invaluable in the development of prevention interventions. The existential factors are acknowledged while the negatives that serve as barriers are identified. The relationship and expectations domain focuses on the perceptions and attitudes that people have about health problems, the structural or societal responses that promote or discourage effective health behaviour and the influence of family and community on health decisions. The cultural identity domain indicates the interventions' points of entry (Lwelumor et al., 2013). Interventions may occur at individual level, family or community level.

Lwelumor et al. (2013) reviewed studies done on the PEN-3 model and its application on public health research and interventions. They found that the PEN-3 model helps focus research on the role of the collective/community in influencing health behaviours, which helps to guide prevention interventions on effective health behaviour change strategies.

2.3.5 Conclusion

Previously HIV and AIDS behavioural prevention interventions focused on making people aware of HIV and AIDS risk behaviours with the belief that people would change their behaviours if they knew the risks. History proved that this was not the case. Many researchers criticised the way in which behavioural prevention interventions used the knowledge that HIV and AIDS is a result of risk behaviours (Hein, 1992; Osbeck, 2004). Campbell (2003, p.7) wrote:

“Early in the HIV epidemic, it was assumed that sexual behaviour was shaped by the conscious decisions of rational individuals. Locating the cause of sexual behaviour at the individual level led to individual behaviour interventions. Optimistic sexual health promoters assumed that if only one could reach HIV-vulnerable people and tell them about the dangers of HIV and how to prevent it, they would quickly take care to safeguard their behaviour. It is as easy as A, B, C (Abstain, Be faithful or Condomise) became a familiar slogan in many African countries”.

In contrast, Marks (2002) described behaviour as subject to complex forces, internal psychologies and external pressures, all of which are not subject to immediate influences, yet can be more powerful than even the risk of disease and death. The forces shaping sexual behaviour and sexual health are far more complex than individual rational decisions based on simple factual knowledge about health risk and the availability of medical services (Campbell, 2003). These existing theories can be critiqued for their modernist representation of behaviour as determined by individual rational decision-making processes or by external structural forces, with inadequate recognition being given to the roles that human agency, subjective meaning and local context play in everyday actions (Evans & Lambert, 2008).

HIV and AIDS prevention interventions that campaign for behaviour change are attempting to control people’s behaviour, which is very difficult to do. These interventions focus on changing behaviours rather than focusing on the underlying reasons for risk behaviours. Interventions were instituted to try to delay the age of first intercourse and either to limit the number of partners or to encourage abstinence or monogamy (Campbell, 2003). By looking at the current prevalence of HIV and AIDS amongst young people and young people’s

engagement in HIV risk behaviours, it can be said that those programmes are not effective for all young people. There is a need for programmes to focus on those young people that are still engaging in risk behaviours.

The influence of contextual factors on risky sexual behaviours has not been studied sufficiently and has not been added into prevention interventions. This is important as people are mostly influenced by their context in their decisions to engage in risky sexual behaviours (Carey et al., 2011; Schultz, 2007). This underlines the need to use social ecological theory in HIV prevention interventions. Another aspect which has not been studied sufficiently is the cultural means of preventing HIV, AIDS and pregnancy and a cultural understanding of sexuality that has an impact on HIV risk behaviours. This is discussed under the section on culture and sexuality.

2.4 HIV and AIDS Prevention Interventions

Since the emergence of the HIV pandemic, interventions were developed to prevent HIV and AIDS and they can be classified into three categories: the biomedical, behavioural and structural interventions. The above interventions have usually been done in isolation. Recently the combination of biomedical, behavioural and structural interventions is promoted (Rotheram-Borus, Swendeman, & Chovnick, 2009, p.144). These interventions and their effectiveness are discussed to inform possible interventions.

2.4.1 HIV and AIDS Biomedical Prevention Interventions

Applicable biomedicine has advanced significantly since the advent of the HIV pandemic in the 1980s. It started with the discovery of the causative agent, development of diagnostic assays, elucidation of the life cycle of HIV and understanding of the pathogenesis of HIV infection and AIDS (Chan, 2012). Biomedicine has also developed HIV prevention interventions. The discussion that follows focuses on some biomedical prevention interventions which have shown evidence of effectiveness and which need to be integrated into combination preventive programmes.

2.4.1.1 Medical Male Circumcision (MMC)

Male circumcision (MC) has been a tradition in many African cultures. It is performed during late childhood or early teenage years as a rite of passage from boyhood to manhood. Westercamp and Bailey (2006, p. 345) recounted that: “as a rite of passage to becoming a man, the endurance of the pain from circumcision is often an integral aspect of the ceremony”.

MC is a traditional cultural practice in Venda and is called *Murundu*. Young boys are sent to the bush with highly respected community elders for circumcision as a rite of passage to manhood. *Murundu* usually lasts 3 months which is spent in the bush. The removal of the foreskin is a significant part of *Murundu*. It is also referred to as the *sharpening of the warrior spear* (Milubi, 2000, p. 58). The *spear* is the penis that is meant to strike an *elephant*, in this case a woman. Critics of *Murundu* have suggested that it influences men to perceive women as sexual objects because of the lyrics recited by men during the initiation process (Milubi, 2000). *Murundu* is associated with a certain status of masculinity. Malisha, Maharaj and Rogan (2008) in their study on the rite of passage to adulthood in Venda, reported that the majority of male adolescents defined traditional initiation schools as a place where young men are circumcised and trained to be *real men*. *Shuvhuru* was described as a derogatory term used to label men who have not attended initiation school and are consequently not seen as *real men*.

There have recently been many concerns regarding traditional male circumcision (TMC) in South Africa. Concerns ranged from safety and hygiene, unsterilized traditional surgical practices, physical abuse and underage circumcision without parental consent (Malala & Mulaudzi, 2015). There have been media reports of young men dying during TMC. City Press (27 Jan 2013) reported that one initiate lost his penis during TMC. Besides the many concerns raised, City Press (02 July 2015) reported that illegal TMC doubled between December 2013 and June 2014.

MMC is one of the biomedical interventions that are used to reduce the risk of HIV. Because of the many safety concerns with TMC, medical male circumcision (MMC) is recommended worldwide for HIV prevention. It was noticed that those African groups in which circumcision is routinely done on all boys have fewer cases of HIV *per capita* than groups where circumcision is not a tradition (Williams et al., 2006). Sawires et al. (2007) reported

that MMC is the most compelling evidence-based prevention strategy next to mother-to-child-transmission prevention. Auvert et al. (2006) reported that the three randomised control trials of adult male circumcision conducted in African countries with generalized HIV epidemics, showed strong risk reduction ranging from 48% to 61%. Evidence from these trials prompted the WHO and UNAIDS in 2007 to recommend MMC for a HIV prevention strategy in countries with high rates of HIV infection and low rates of male circumcision (UNAIDS, 2012). Since then MMC has been used as prevention strategy for HIV in Southern Africa.

The acceptance of MMC as one of the prevention interventions precipitates the employing of a culturally accepted practice in the fight against HIV and AIDS. This underlines the importance of the recognition of culture in HIV prevention. MMC functions as a multilevel HIV prevention intervention as it incorporates biomedicine (safe removal of the foreskin) and cultural practices (where men can still celebrate their masculinity).

Malala and Mulaudzi (2015) identified a problem with procedural MMC, however, when their study in a hospital in Venda found that MMC was done without any HIV, AIDS and sexual education. This is in contrast to TMC which is invariably accompanied by at least rudimentary education regarding sexuality, although a study about initiation schools in Venda found that the curricula of such education was not conducive to the reduction of HIV infection. The study found that initiation schools re-enforced traditional gender roles that fuels HIV infection due to gender inequality in heterosexual relationships (Malisha et al., 2008). Such challenges to TMC leads to voices campaigning for its replacement by MMC, but more South African men still undergo TMC (Shisana et al., 2014).

While MMC could indeed be a valuable asset in the reduction of HIV, it has hitherto surrendered a lot of potential benefit by not accepting the cue of TMC to incorporate concomitant sexual education into the regimen. The critics of TMC and MMC indicate the individualistic nature of these prevention interventions. In my view, while rectifying medical issues within TMC, sexuality education which was previously an integral part of TMC is now neglected. This further indicates the need for multidisciplinary interventions of biomedical, behavioural and structural interventions which should combine safe removal of the foreskin, education on sexuality and HIV and deconstructing of gender roles as part of cultural initiations.

The above discussion indicates that both TMC and MMC could contribute to HIV prevention interventions. Rather than blandly replacing TMC with MMC, it seems important to address the shortcomings of TMC. That would involve increasing the safety of TMC by having it done by skilled and qualified people, have policies and the law governing it and include HIV and gender equality education.

MC comes with the challenge that, if men believe that circumcision offers protection from HIV infection, they may increasingly engage in high sexual risk behaviours following circumcision. Westercamp and Bailey (2006) reported that, in focus groups done in Kenya, Malawi and Zambia, concerns about the possibility of behavioural disinhibition were expressed. “Concerns have been raised that nation-wide circumcision programs could breed complacency and undermine older prevention strategies based on abstinence, faithfulness and condom use” (Kagumire, 2008, p. 1120). Kibira, Nansubuga and Tumwesigye (2013) in their study in Uganda, found slightly increased sexual risk behaviour among men after circumcision. However, Westercamp, Agot, Jaoko and Bailey (2014) found no risk compensation in men after MMC in Kenya. A South African study found no difference in sexual risk behaviours between men who are circumcised and those who are not (Mashimbye, Johnson, Bello, Magni, Mangod, Mahlasela, & Delate, 2012). In contrast, it was found that there is no risk compensation among men who undergo MMC with respect to risk perception, sexual debut and condom use at last sex, but a higher risk of MCP and alcohol abuse following MMC (Zungu, Simbayi, Mabaso, Evans, Zuma, Ncetakalo, & Sifunda, 2016). The different findings in the studies above indicate that sexual risk behaviour is dependent on the wider context.

The different findings in studies mentioned above indicates that context, culture, cultural norms and beliefs around MC have an impact on whether men will engage in risky sexual behaviours after MC or not. Sawires et al. (2007, p. 709) stated: “the perception of risk is socially constructed and culturally embedded within groups and individual risk perception is perceived through this lens”. It is, therefore, important to consider context before, during and after introducing MC as a biological intervention for HIV transmission. Any intervention should be relevant locally and evidence-based.

MMC might be an appropriate intervention for young men in Venda because their culture already influences young people to undergo male circumcision. Findings from different countries regarding MMC and risk compensation indicate that it is important for MMC as a

biomedical intervention to be supported by behavioural interventions. The concept of risk reduction and the importance of avoiding other sexual risk behaviours, even if a man is circumcised, should be emphasised. Rotheram-Borus et al. (2009) reported that, like HIV vaccines, MC campaigns will require changes in behaviours at many levels. In Venda it is important to explore young people's constructions of initiation schools, their importance and benefits. Those constructions can be used to inform prevention interventions employing MC.

2.4.1.2 Anti-Retroviral therapy (ART)

Biomedical research led to the discovery and introduction of ART. ART decreases the viral replication, slows down immune suppression, increases CD4 count and improves prognosis in HIV-infected persons (Chan, 2012; Rotheram-Borus et al., 2009). HIV transmission predominantly occurs from persons with a high viral load and the reduction of viral load is therefore important in inhibiting transmission (WHO, 2012). The effective treating of people with HIV consequently not only improves the treated individual's health but can also reduce HIV transmission.

Because of its effectiveness, ART uptake has increased in the past decade. In 2011 the majority (54%) of people eligible for ART in low and middle income countries were receiving it (UNAIDS, 2012). Shisana et al. (2014) reported that, in South Africa, the number of people exposed to ART doubled between the 2008 and 2012 surveys. Large exposure to ART resulted in a decrease in mortality and an increase in life expectancy (Shisana et al., 2014; Zuma et al., 2016). The lowest exposure to ART amongst infected people was found with young people aged between 15 and 24 years (Shisana et al., 2014). This could be ascribed to many of them being recently infected and not eligible for free ART as yet. The following discussion will outline the progress made by biomedical prevention interventions through the use of ART. This will be followed by a critical discussion of ART in general.

ART works by slowing down clinical deterioration of HIV-infected persons, reducing opportunistic infections and curtailing other complications. Recently, in the treatment as prevention (TasP) intervention research, it was found that the use of ART for infected individuals can prevent transmission (Chan, 2012; Mascolini, Kort, & Gilden, 2009). ART is used to lower the viral load so that HIV transmission is less likely to occur.

ART is especially useful as prevention if administered to the HIV positive partners of discordant couples to prevent the infection of HIV negative partners. It is reported that ART can reduce HIV transmission to HIV negative partners by up to 96% (Cohen et al., 2011; WHO, 2012). The effectiveness of treatment as prevention (TasP) has led to the test and treat strategy which promotes urgent testing and treatment coverage in order to decrease the community viral load and to reduce the rate of new HIV infections. WHO (2013) recommend HIV treatment as early as possible because of the therapeutic and preventive benefits of therapy.

Post-exposure prophylaxes (PEP) are regimens of ART which are generally administered following accidental exposure to HIV in the workplace or following sexual assault. Chan (2012) indicated that the clinical effectiveness of non-occupational PEP for HIV is not conclusive due to limited evidence, however the review suggest that PEP may be cost-effective.

Pre-exposure prophylaxis (PrEP) has recently been introduced. PrEP is the use of ART by people who are HIV negative in order to prevent the acquisition of HIV (WHO, 2015). They are administered to a person at risk of sexually acquiring HIV. There are currently oral PrEP and vaginal gel or microbicide. PrEP has been found to be effective in a randomised controlled trial among homosexual men (Grant et al., 2010). However, mixed results among heterosexuals have been found, with two studies indicating PrEP to be effective (Adbool Karim et al., 2010; Thigpen et al., 2012) and two studies indicating PrEP not to be effective (Marrazzo et al., 2013; Van Damme et al., 2012).

PrEP is recommended for high risk key populations. In South Africa, high risk key populations include, sex workers, homosexual men, discordant couples and truck drivers. The positive factor about PrEP is that it is not a lifelong drug. People can stop taking it if they are no longer at high risk of HIV infection. PrEP is however only for HIV negative persons. If taken by an HIV positive person, it may lead to HIV resistant strains. This indicates the importance of regular testing and education on ARVs.

The discussion above indicates the development and progress of biomedical prevention interventions. Even though the above biomedical prevention interventions are not 100% effective, there is an indication of progress in attempts to prevent HIV infections. Although ART seems promising as a prevention strategy, it also bears many challenges, negative attitudes and suspicions. Some of them will now be discussed.

Earlier discourses about HIV and AIDS as a death sentence influenced attitudes toward ART and people taking them. ART has been named ‘life prolonging drugs’. The term has been used widely in the mass media and in health care settings. Foucault (1981) stated that discourse production is controlled, organised and distributed by a number of powerful forces. Government institutions, biomedicine and the media in this case are functioning as powerful forces that influence the discourse of ART as ‘life prolonging drugs’. This term is used with negative connotations: life prolonging is less useful than a cure (Ezekiel, Talle, Juma, & Klepp, 2008). In their study in Tanzania, Ezekiel et al. (2008) found that despite the discourse that ART could prolong lives; participants’ constructions still suggested that HIV is associated with death. This indicates that discourses are influenced by the historical situations and change slowly in a society.

The term, ‘fattening drugs’ has also been used to describe ART (Ezekiel, et al., 2008). This discourse relates to the bodily changes that are seen as a result of ART. The discourse of ART as ‘fattening drugs’ also has negative connotations. It describes people that came back from the dead. People receiving treatment are the subject of many rumours regarding their abrupt return to health (McNeil & Niehaus, 2009). This indicates the need to combine ART with behavioural and structural interventions to reduce stigma and attitudes towards ART and HIV.

Even though ART is bringing good results for people living with HIV, stigma around ART has the potential to negatively affect people’s uptake of and adherence to ART and disclosure of one’s status. The above discourses on ART indicate that information about ART should carry cultural appropriate messages (Ezekiel et al., 2008). McNeil and Niehaus (2009, p. 60) thus expressed the latter view: “Without the general understanding of the socio-cultural pressures and conventions that mould public discourse on these issues, we cannot begin to understand the ‘webs’ of meaning that have been spun around ART medication”.

The value of ART is diminished when there is a lack of adherence. Cornell et al. (2010) found that only 64% of people who were initiated on treatment between 2002 and 2007 were still in care 3 year later. It is widely agreed that once ART is initiated, it should not be interrupted as incomplete suppression causes resistant strains, which are hard to treat. Young people’s low HIV risk perception may also result in poor adherence to PrEP (Pettifor et al., 2013). Treatment adherence requires consistent counselling and monitoring. This shows the need for multi-disciplinary interventions with biomedicine and adherence counselling.

Convenient access to effective treatment may lower vigilance for protective behaviours (Hasse et al., 2010; Rotheram-Borus et al., 2009). Ezekiel et al. (2008, p. 962) reported that “sexual construction of the healthy body might explain concerns that restoration of good health, could potentially result into unprotected sexual activity among ARV users after restoring their health”. Research done in Switzerland showed increased access to ART can lead to the reduction in other prevention methods such as condom use (Hasse et al., 2010). WHO (2012), however, indicated that experience and research in Africa and other resource-constrained settings have not found that the availability of ART results in disinhibition or risk compensation. This indicates that Treatment as prevention (TasP) should be done together with behavioural and structural prevention interventions, with context sensitivity, as beliefs about a person’s risk is influenced by context.

On the other hand, lack of access to ART is a major stumbling block in the fight against HIV and AIDS. There are parts of South Africa where people struggle to access health care systems in general. With the importance of taking an effective amount of ART and adhering to medication, access to suitably equipped, stocked and managed health care facilities to procure ART poses a challenge. WHO (2012) warned that denying access to ARTs for people in resource-poor settings while providing it in the resource-rich settings could be detrimental to the whole population. MacQueen (2011) reported that the nature of the HIV epidemic is such that prevention research is situated within a context of poverty, exploitation, assaults on human dignity and human right abuses. The result is a complex web of research and intervention challenges that are socially biased along the lines of wealth and power. The provision of ART for TasP to protect professionals or assault victims at the expense of those with low CD4 count and in dire need of the very same therapy, poses one such ethical dilemma that is best avoided by providing sound structural prevention interventions. Such structural interventions should bridge the gap between members of society by providing suitable access to health care for all citizens in the HIV and AIDS context.

It is my opinion that poverty plays a significant role in the HIV epidemic. It influences sexual risk behaviours and access to treatment and care of HIV. This indicates that poverty is an important aspect to consider in HIV prevention interventions and regarding those already infected with HIV.

Mfecane (2010) in a study on masculinity and ART found that even though men in his study were willing to take ART, they were negative about some of the changes they had to make

while taking ART. For example, they objected to the fact that they should not use traditional medicines or alcohol while on ART. They felt that they needed traditional medicines for their spiritual wellbeing and to reduce *isinyama* (bad luck). They also need to use alcohol for a sense of belonging when they are with other men. Mfecane's (2010) study illustrated some conflict between biomedical intervention and cultural beliefs. The South African Department of Health acknowledges the use of traditional medicines. In my view, the gap between ART and traditional medicines requires traditional healers to be involved in HIV prevention interventions to contribute to the education about ART. Traditional healers can influence people's uptake of ART if they are included in counselling their clients regarding ART. This will also require an open mindedness within biomedical interventions as most African (black) people consult traditional healers for most of their ailments (Mfecane, 2010).

In relation to young people, ART comes with specific challenges, which might be the reason for a lack of ARVs specifically for young people. Drug trials among young people come with ethical challenges as there are requirements for consent from parents and guardians. This limits biomedical prevention research among young people and the development of biomedical prevention interventions for young people. Reproductive and sexual education clinics are generally not youth friendly, which limits young people's access to biomedical prevention interventions (Pettifor et al., 2013). There is a need for more research on biomedicine and young people.

Just like any single preventive method, ART is not 100% effective. Treatment alone will not end the global HIV epidemic. To be effective, treatment needs to be delivered as part of a comprehensive package of prevention methods including HIV, sexual health reproductive education, condom use and behaviour change (UNAIDS, 2011; Venkatesh et al., 2011; WHO, 2012). There is also a need for multi-purpose drugs that can prevent HIV, STIs and pregnancy at the same time (Pettifor et al., 2013).

2.4.1.3 Condoms

Condoms (especially male condoms) are a long standing biomedical preventative tool that has been the cornerstone of HIV prevention programmes since the emergence of the epidemic (Rotheram-Borus et al., 2009). Condoms are made of intact latex and polyurethane materials that are impenetrable to HIV, bacteria and sperm (Bekker, Beyrer, & Quinn, 2012; Collins,

Lyon, & Miller, 2007). Male condoms have been proven to be effective in reducing HIV transmission by at least 95% (Bekker et al., 2012; Rotheram-Borus et al., 2009).

Condom use is associated with challenges. The perception of condoms is associated with higher risk sexual partnerships. They bring about gender and power issues in the relationships with females not being able to negotiate condom use with their partners. Studies have shown that some communities have less uptake of condom use compared to others (Taylor, 2007).

Female condoms were also introduced in biomedical prevention interventions for HIV. Female condom use, just like male condoms, comes with various challenges. One of the challenges of female condoms is that they are expensive, sometimes unavailable and unfamiliar (Rotheram-Borus et al., 2009). Furthermore, female condoms have been criticised for not being concealable. It can thus not be used without the male partners being aware. A critical discussion about condoms and their challenges follows under behavioural prevention interventions in the present chapter (paragraph 2.4.3).

The above challenges indicate the need for condom use to be included as behavioural and structural prevention interventions that are context specific. Bekker et al. (2012, p. 1) reported that “combination prevention interventions should be based on scientifically derived evidence with input and engagement from local communities that fosters the successful integration of care and treatment”. The involvement of communities will assist in determining context specific issues that might affect the uptake of condoms.

2.4.1.4 Conclusion

Various strategies of biomedical prevention interventions (ART and MMC) seem to be promising and bring hope for future prevention of HIV transmission. The challenge is that some of the biomedical prevention interventions (like condoms) are not accepted in some contexts and that cultural practices are not always taken into account in preventive efforts. Another challenge is the negative effect that the success in some of the biomedical prevention interventions (MMC) has on risk behaviours. There is a need to combine interventions constructively to avoid the problem of the presence or absence of one intervention having a negative impact on other interventions. Condoms, ART and MMC are made available but

cultural, societal and peer norms influence the uptake of those biomedical preventions interventions. This indicates the importance of having culturally appropriate behavioural prevention interventions to influence the uptake of biomedical prevention interventions. Context and culture seem to be significant factors to consider when developing HIV prevention interventions.

2.4.2 Current Behavioural Prevention Interventions

After identification of HIV risk behaviours, behavioural prevention programmes were designed in an effort to reduce risk behaviours. Many educational programmes focused on the ABC model: Abstain, Be faithful, Condomise or other derivatives of the slogan originally proclaiming abstinence (postponement of becoming sexually active), long-term fidelity and condom use (as a way of having protected sex). Intervention programmes had some success in encouraging condom use among young people (Shisana et al., 2009, Zuma et al., 2016), but they had not been effective in discouraging young people from having sex or in reducing the number of partners (Shisana et al., 2009, Zuma et al., 2016). Critics (such as Taylor, 2007) have argued that some of the current HIV and AIDS prevention programmes are not applicable to the South African cultural context. The following section focuses on the critical discussion of the ABC model of HIV prevention, followed by behaviour prevention interventions geared specifically for young people in South Africa.

2.4.2.1 Abstinence

To curtail the spread of HIV, young people are encouraged to abstain from sex until they are much older. Research (Reddy et al., 2010; Shisana et al., 2009; Shisana et al., 2014; Zuma et al., 2016) has, however, found that the age of sexual debut remains the same despite decades of abstinence campaigns. Abstinence campaigns do not seem to be effective for some young people as a large percentage of young people are sexually active. Zuma et al. (2016) reported that in the national HIV prevalence, incidence and behaviour survey of 2012 early sexual debut was stable from 2002 until 2008 at 10% but increased slightly (to 11%) in 2012. The risk of early sexual debut and the reasons why young people have early sexual debut were given in paragraph 2.2.3.

Other studies (Gonzalez, 2004) have criticised the use of abstinence as prevention strategy for HIV and AIDS. Abstinence programmes are criticised as a way of controlling young people's sexuality (Gonzalez, 2004). Among black communities in South Africa, for example, among the Xhosa, Zulu and Sotho it was traditionally accepted that young people explore sexuality among themselves (Cassimjee, 1998; Delius & Glaser, 2002; Harrison, 2008). They were not discouraged to have sex although they had to adhere to the rules and norms set to govern young people's behaviour. Young people were taught to experiment with sex without penetration (Cassimjee, 1998). Girls were taught to keep their legs tightly together to prevent penetration as a way of preventing pregnancy. It is surprising that prevention programmes do not take this historical and cultural method of prevention into consideration in an effort to prevent the spread of HIV and AIDS in South Africa. This indicates that abstinence programmes are not culturally appropriate for some South African contexts.

Traditionally, elders within the community educated young people on sex and sexuality. In most African cultures, including those of the Vhavenda and AmaXhosa, young males and females used to go to the initiation for a rite of passage where they were educated on sexual matters. With urbanisation and globalisation, young people do not pay attention to sexual education provided by the elders in the community or society. Young people are getting educated about sex and sexuality mostly from their peers or the media (Baxen & Breidlid, 2009; Parker, 2007). Young people often initiate sex to experiment or in an effort to conform to peer pressure. Failure to conform to peer pressure diminishes one's status while conforming increases respect from peers (Parker, 2007; Visser, 2012). Social influences such as peer pressure has a much stronger influence on the behaviour of young people than abstinence messages.

2.4.2.2 Condom use

HIV prevention programmes also focus on condom use because unprotected sex was identified as risk behaviour. In the first part of this chapter (Chapter 2), unprotected sex was identified as the core of all risk behaviours. Most programmes focus on encouraging people to use condoms and teach people how to use condoms in an effort to protect people from

getting infected with HIV. Much progress has been made on condom use among young people in the past two decades (Shisana et al., 2009). Young people developed their sexual identity in the context of HIV. They grew up with messages of condom use. Many of them therefore see condom use as part of their definition of sexuality. Older people do not use condoms that often. They attach different messages to condoms as they grew up in a different context. However, Shisana et al. (2014) reported that condom use among young people decreased since 2008. It is thus important to explore young people's constructions of condom use to inform preventive interventions. These results also indicate the importance of updating prevention programmes to suit specific contexts, cultures and historical times.

Condoms have been met with suspicion by Africans since they were introduced. They are often associated with infidelity and mistrust and associated with HIV (Niehaus, 2007; Skinner & Mfecane, 2004). Many people who did not want to use condoms reported that sex with a condom is not pleasurable (Gausset, 2001; MacPhail & Campbell, 2001). This is indicated by slogans such as: *"Flesh to flesh"*, *"I cannot eat a banana with its skin"*, or *"one does not take a shower with a raincoat on"*.

Susser and Stein (2000) conducted a study among women in South Africa on the use of female condoms. They found that condoms were acceptable to some women. They concluded that "cultural acceptability for such methods (condoms) among women varies along different axes, both over time and among different populations. For this reason, local circumstances need to be taken into account" (Susser & Stein, 2000, p. 1042). Examining how different people construct their sexualities will help determine which strategies will be most effective for prevention.

Programmes that emphasise condom use for the prevention of HIV and AIDS have been highly criticised in Africa, mostly because they are perceived not to fit in with constructions of sexuality in Africa (Taylor, 2004). Taylor (2004) argued that African culture defines sexuality differently from Western cultures. In cultures where sex is meant for procreation condom use is not regarded as appropriate. For an African woman whose womanhood is defined by having children, it is more appealing to decide to have a child than to use a condom to prevent contracting HIV and AIDS. Taylor (2004, p. 7) stated: "The fear of not being married or having children is a form of social death which supersedes for most poor Shona women the risk of a biological death due from AIDS". Condom promotion is not

appropriate in these cultures and this indicates the need for different preventive strategies that are appropriate in these contexts and cultures.

Taylor's (2004) study was done among adults from the Shona culture. The results might be different from young people in Venda. Young people's purpose for having sex is not necessarily procreation. They are also not defined by their ability to have children yet. Condom use might be appropriate for young people. It is therefore important to explore constructions of condom use among young people in Venda to inform appropriate interventions to promote protected sex for young people.

2.4.2.3 Faithfulness

The third strategy propagated to change risk behaviours is the message of having one partner and being faithful. The assumption is that faithfulness will reduce the prevalence of HIV and counteract the practices of having multiple sexual partners. This strategy has been heavily criticised for not suiting African culture. It was (or still is) accepted in African culture that men could have more than one partner (Taylor, 2004). Traditionally, having many wives showed that a man had power and that he was rich. Women never had the power to disagree with their partners to have other partners. Nowadays most men do not *marry* many wives; however, some still have multiple sexual partners, while women have very little power to influence such behaviour. This has been discussed in the previous section under sexual risk behaviours.

Recent studies (Halperin & Epstein, 2007; Hunter, 2005; Mah, 2008; Parker et al., 2007; Rehle et al., 2008) have indicated that MCP is part of the problem that is resulting in higher rates of HIV infection in Africa than in Asian countries. Various studies (Adimora et al., 2003; Mah, 2008) have found that a higher number of males compared to females have multiple concurrent partners. Taylor (2004) found that the Shona construction for male sexuality was that,

“men believes that, as a man, one of his responsibilities in life is also to have sex with as many women as he can. Although the issue of procreation was not mentioned it could be argued that the acquisition of more children

is also highly valued for men, which then influence the non-use of condoms and sticking to one partner” (p. 8).

MCP in South Africa is described as fuelled by gender issues where men acquire their status by having sex with many women. The *Be faithful* campaign can be very significant for South African young people. However, because MCP is influenced by many socio-economic and structural factors (e.g. migration, masculinity, South Africa’s history of polygamy, democratisation of South Africa in 1994, subsequent rapid globalisation), the *Be faithful* campaign seems to be failing. It is important for those socio-economic and structural factors to be addressed before the reduction of partners’ campaign can show any effect.

In her study with women aged 15 to 25 from Umlazi in Durban, Leclerc-Madlala (2003) found that women accepted that men have many partners. They also accepted that they need to share men as there are very few good men. Leclerc-Madlala (2003) noted:

“Men’s inability to be loyal to one woman was spoken about in a very matter of fact manner. Although women did not claim to be happy about this, it was presented as something inevitable that required tolerance” (p. 221).

Recent research indicated that the *Be faithful* campaign is not effective in reducing the spread of HIV and AIDS in South Africa (Leclerc-Madlala, 2003; Mah, 2008; Shisana et al., 2014). This calls for a thorough and new look at what needs to be done to reduce the spread of HIV and AIDS in South Africa. It needs to be determined what the constructions around having many partners is amongst young people and how this construction results in making this risk behaviour prevalent. Traditionally, MCP was accepted but controlled by rules and norms to be adhered to. It therefore also needs to be determined how MCP was controlled traditionally and how this insight can be used to assist in the prevention of HIV and AIDS.

2.4.3 Behavioural prevention interventions for young people

High HIV incidence among young people resulted in the development of behavioural prevention programmes and policies specifically for young people. In 1995, the South African Department of Education developed a National Policy on HIV and AIDS Education (Visser, 2005). The policy resulted in the life skills curriculum for young people in schools. Besides the life skills curriculum in schools, peer education was implemented in schools for young people to educate each other about HIV, AIDS and sexuality. The mass media also has prevention campaigns that are geared specifically towards young people. The section below critically discusses HIV and AIDS Peer Educator Programmes in schools, Life Orientation and sexuality education and mass media HIV prevention programmes targeting young people.

2.4.3.1 Peer education

Peer education is a prevention intervention strategy whereby individuals from a target group provide information, training or resources to their peers (UNAIDS, 2010). Peer education in the HIV and AIDS context, involves peers disseminating HIV and AIDS information and discussing sexual risk behaviours and safe sex amongst each other (Campbell & MacPhail, 2002). In a school setting peer educators, usually selected by teachers, are given training and then educate their peers. Teachers are expected to guide and support peer educators, but to not be involved in the discussions *per se*.

Peers play a significant role in young people's lives (Selikow, Ahmed, Flisher, Mathews, & Mukoma, 2009). Peer education is described as the core pillar of HIV prevention (Cornish & Campbell, 2009), as young people learn about sexuality from peers and peer influence motivates sexual behaviour. Peer education interventions among young people are aimed at challenging negative social norms as young people's sexual risk behaviours are influenced socially through interacting with peers (Campbell & Macphail, 2002; Visser, 2007). Peer education is believed to be more effective than adult-led approaches in reaching vulnerable young people (Chandra-Mouli, Lane, & Wong, 2015).

Most research (Adeomi, Adeoye, Asekun-Olarinngbe, Abodurin, Obugbenga-Bello, & Sabageh, 2014; Al-Iryani, Basaleem, Al-Sakkaf, Kok, & Van den Borne, 2013; Swartz,

Bhana, Moolman, Arogundade, Solomon, Timol, & Vawda, 2014; UNAIDS, 2010; Visser, 2007) show that peer education is effective in improving HIV knowledge, attitude and some sexual risk behaviours among young people. However, some studies (Michielsen, Beauclair, Delva, Roelens, Van Rossem, & Temmerman, 2012; Swartz, Deutsch, Makoae, Michel, Harding, Garzouzie et al., 2012) report that peer education alone have limited effects in promoting healthy sexual behaviours and health outcomes among the target group. Peer educator programmes mostly benefit the peer educators as they are the ones that receive training and supervision (Chandra-Mouli, Lane, & Wong, 2015).

Besides the benefits that peer education has, there are many challenges involved. These challenges often result in peer education being ineffective. As peer education among young people is implemented in schools, previous research (Campbell & Macphail, 2002) indicated that rather than being guided and supported, peer educators, often work under strict supervision and authority of teachers and principals. This hampers peer educators and other young people from discussing issues openly, which then renders peer education ineffective.

Swartz et al. (2014) indicated that peer education is not standardised. The lack of standardisation makes peer education not to be effective as some key role players might not be aware of their roles. Another challenge is that young people move out of schools within a few years. Even though peer education is cost effective, the fact that peer educator programmes in schools continuously have to be in the process of selecting and training new peer educators makes it difficult, time consuming and not sustainable. The selection of peers by teachers is another challenge. That is because some selected peer educators might not be popular among young people and therefore not influence behaviour. Selected peer educators might also not be comfortable with their role as a result of, for example, not being socially confident especially in a group setting. This might influence the peer education programme negatively.

Even though peer education has many challenges, it is my opinion that, if the challenges are addressed, it can be one of the prevention methods that reduce risk behaviour among young people. Young people believe and act on information from their peers better than on information from adults. Young people are more open to discuss sexuality among their peers. If young people are given comprehensive sexuality education in the class and peer educators are also trained on sexuality, they are more likely to influence each other positively. However, for peer education to be effective, it is significant that peer education programmes

be standardised to enable all parties involved to be aware of their roles to function optimally. Rather than the traditional selection of peer educators, where teachers select the peer educators, it might be important to use popular members or informal leaders of the group through which positive social norms are disseminated (Selikow et al., 2009). Teachers should also not interfere with the programme other than just supporting the peer educators. Peer education programmes should be offered in conjunction with other prevention interventions, as they might not be effective on their own (Visser 2007).

2.4.3.2 Life Orientation

In response to young people's general life challenges and the challenge of HIV prevalence among young people, the department of Education (2002) launched a national programme for life skills, sexuality and HIV and AIDS education in schools. The programme was introduced as a module of Life Orientation (LO) among young people in Grade 8-12. Rather than leaving sexuality and reproductive education to clinics only, young people learn about those topics in schools. LO adds to a holistic approach in supporting and teaching young people about sexual matters and HIV and AIDS.

LO assist in the prevention of HIV and AIDS among young people. LO follows the ABC model in educating young people about sexual risk behaviours. Abstinence in the ABC campaign is ranked as the best, followed by being faithful and then decisions to use condoms when sexually active. Learners that choose to abstain are considered a privileged elite ranking higher than those who do not abstain (Francis, 2014). Abstinence as an HIV prevention strategy for young people has been implemented in the school environment as part of the LO curriculum in South African schools (Department of Education, 2002; Francis, 2011; Rooth, 2005). LO includes inter alia formal sexuality, risk and behaviour, HIV and AIDS, life skills education and health promotion (Francis, 2011; Rooth, 2005).

Life Orientation as a subject for young people has been criticised extensively. Research shows that the LO curriculum on sexuality is not standardized or formalised (Francis, 2010; 2011; Rooth, 2005; Shefer & MacLeod, 2015). Teachers can choose what they want to present and the format they want to use. Teachers often favour abstinence over comprehensive sexual education (Ahmed, Flisher, Mathews, Mukoma, & Jansen, 2009; Francis, 2011; Rooth, 2005; Shefer & MacLeod, 2015). Besides other challenges that were

identified (teachers' training, teacher's confidence, issues of culture, etc.) abstinence messages from schools are not effective.

Critics against abstinence as a prevention strategy for young people in the school setting indicated that it is not effective, as it focuses on discourses of disease rather than broader issues of sexuality (Shefer & Macleod, 2015). Young people are taught about the negatives of sex and sexuality, ignoring the positive aspects. Research shows that young people reported the need for comprehensive sexual education rather than just learning about abstinence as favoured by the teachers (Chandra-Mouli, Lane, & Wong, 2015; Francis, 2012, Shefer & Macleod, 2015). Despite such criticism from young people and despite the ineffectiveness of abstinence messages indicated by young people's early sexual debut, abstinence campaigns continue without modification. This shows that preventive programmes do not regard young people as having sexual agency. It also indicates that preventive programmes are not considering young people's context and culture. It is rather built around the context of adults.

It is challenging for teachers to teach young people about sexuality in schools, especially if they face opposition from parents, religious groups and the community due to cultural beliefs (Thaver & Leao, 2012). In most African traditions, it is inappropriate for adults to talk to young people about sex unless it is done during initiation schools. The cultural tradition and beliefs might make teachers uncomfortable in giving sexuality education to learners, especially if they have not been trained and have not done it before. The complexity of the context, culture and needs of both adults and young people renders the whole process complex and indicates a need for intervention for both adults (teachers) and young people to enhance the programme.

Besides the challenges and needs for both adults and young people regarding young people's sexuality, if abstinence alone is favoured as an elite preventive intervention, HIV preventive intervention will continue to fail young people. It is my opinion that there is a need to bridge the gap between young people and the views of adults. Young people should receive comprehensive sexuality education that will enable them to make informed decisions regarding sex. Such comprehensive sexuality education should view young people as sexual agents who have knowledge and opinions about sex. This means considering young people's culture, context and sexuality language so that young people can identify with such

campaigns. As it was a tradition for young people to learn about sexuality during initiation schools, respected adults within a community with extensive knowledge about comprehensive sexuality education, or who are willing to be trained and learn and feel comfortable to talk to young people about sexuality, should be selected for community sexual education.

2.4.3.3 Media

Young people also learn about HIV and AIDS prevention and sexuality in the media. UNAIDS (2004) reported that the media plays a critical role in HIV reduction. Modes of mass media prevention interventions are television, radio, newspapers and billboards. Research (Noar, Palmgreen, Chabot, Dobransky, & Zimmerman, 2009) shows that mass media campaign messages on HIV and AIDS changes with time. It started with raising awareness about HIV and AIDS and shifted to attempting to change sexual risk behaviours and to reduce stigma against HIV and AIDS. The media currently also educate and raise awareness of ART.

Media prevention messages stimulate discussions and encourage people to identify with certain characters, which then influence healthy behaviours. Messages built into drama become edutainment. UNAIDS (2011) reported that the mass media is a cost effective way of reducing HIV infections as it covers a large population. The mass media is an important driver of public opinion; it influences decision makers and social norms (Chalk, 2014). In South Africa, HIV prevention messages are incorporated into television drama, such as *Soul City* and *Shuga*. There are also television and radio advertisements on safe sexual behaviours (e.g. *HIVictory* and ART).

Research (McCombie, Hornik, & Anarfi 2002; Noar, Palmgreen, Chabot, Dobransky, & Zimmerman, 2009) indicates that when directed at a specific group and based on research, mass media prevention interventions can be effective. Bertrand and Anhang (2006) conducted a systematic review of studies done in developing countries that evaluated mass media interventions aimed at young people. They found that the mass media messages increase knowledge of HIV transmission, improve self-efficacy in condom use, influence social norms, increase interpersonal communication and increase condom use. On the other hand, the study indicates that mass media had insignificant effects on improving abstinence,

delaying age of sexual debut and decreasing the number of partners which are said to be current important drivers of HIV infection among young people in South Africa (Shisana et al., 2014; Zuma et al., 2015). This indicates that mass media strategies are not effective enough to change risk behaviour prominent among young people of South Africa.

Even though media prevention interventions can be effective in changing some behaviours, Chalk (2014) reported that it has not reached its full potential. Exposure to media coverage is higher in the urban areas than in the rural areas (McCombie, Hornik, & Anarfi 2002). This indicates the importance of scaling up media prevention interventions in the rural areas. It is also important to determine which modes of mass media and/or television channels are available to and preferred by people in rural areas prefer, as it might not be the same as in urban areas. This will assist developers to consider context and to use the media mode that will be the most effective in every geographical area.

Modes of media that are used change with time. There are currently online media coverage such as Facebook, sms, Twitter and Instagram which are popular among young people. *Mobile4Good* in Nigeria uses Facebook, Twitter, Instagram and sms to educate and answer young people's questions regarding sexuality and HIV and AIDS (Chalk, 2014). It is my opinion that, as media habits change, prevention initiatives should also change to keep up with young people's habits of communication.

Mass media prevention interventions present several challenges. This first challenge is that media prevention interventions are generally not participatory, which limits its effectiveness. Another challenge is that it is difficult to measure the effectiveness of media initiatives that is aimed at bringing about societal change (Chalk, 2014). Media initiatives do not always consider young people's culture and language (Romer et al., 2009), which makes it difficult for young people to identify with the message. This, in turn, limits the influence of the message on young people's risk behaviour.

Media prevention initiatives are not fully effective. Just like any other initiatives, they can be more effective if combined with other modes of prevention aimed at young people, such as discussion sessions, peer education and comprehensive sexuality education in schools. For media prevention initiatives to be effective, developers should consider young people's culture, language and the mode(s) of media which they currently use. Mass media prevention

interventions for young people should prioritise drama on television and/or radio as research shows that they are more effective, as they engage the audience at a deeper level than factual content (Chalk, 2014). It is also important for media prevention interventions for young people in South Africa to include online HIV prevention initiatives as most young people engage with Facebook, twitter, Instagram and sms on a daily basis.

2.4.3.4 Conclusion

HIV and AIDS behavioural prevention interventions seem to be effective for some people, age groups and cultural groups, but not for others. A combination of multi-disciplinary prevention interventions, with biomedical, behavioural and structural interventions working together and towards a common goal is needed for successful HIV and AIDS prevention interventions.

The combination of interventions needs to be

- context-specific,
- driven by young people and community members,
- in young people's language and
- viewing young people as sexual agents.

There is a further need for a thorough study of cultures and norms that govern behaviour in different communities. These factors might assist in designing combinatory HIV and AIDS prevention interventions that are more successful than existing ones. The following section focuses on HIV and AIDS structural prevention interventions.

2.4.4 HIV and AIDS Structural Prevention Intervention

Individual level behavioural and biomedical interventions have dominated the prevention intervention programmes until recently (Gupta, Parkhurst, Ogden, Aggleton, & Mahal, 2008). A few structural factors such as poverty, gender, policies, culture, national economic context and migration were identified as shaping or constraining individual behaviour. Structural

prevention interventions seek to change the context that contributes to the vulnerability and risk of HIV and AIDS (Coates, Richter, & Cacere, 2008; Gupta et al., 2008).

Structural factors are divided into two types. Firstly, macro structural factors are distal and determine risk through a longer series of causes and effects (Gupta et al., 2008). These factors may be far removed from individual control, but impact lives through economic inequalities, racism, sexism, stigmatisation and discrimination. Examples of macro structural factors are national economic context, culture and governance. The fact that some Venda young men are sent to initiation schools that foster gender inequality (Malisha et al., 2008) has an impact on how men and women in Venda relate to each other and whether they negotiate safe sex or not. This has implications for HIV transmission. Poverty is also a macro structural factor. It has an impact on HIV risk behaviours.

The second type of structural factors is micro structural factors. Micro structural factors are less distal and influence HIV risk more directly. Micro structural factors are closely linked to specific behaviours such as the availability of legal and accessible prevention services or products to reduce the likelihood of infection. The unavailability of clinics or condoms in some communities are examples. This does not afford some community members immediate access to condoms, ART and other services available for the treatment and prevention of HIV and AIDS. This has implications for HIV transmission and for care for people with HIV and AIDS.

2.4.4.1 Evidence linking structural factors to HIV

Gupta et al. (2008) argued that the fact that 90% of the world's HIV infections occur in developing countries is evidence that social, economic and political structures drive risk behaviours and shape vulnerability. Some structural factors related to HIV transmission are the following:

- More females than males are infected with HIV. Besides the physiology of females' bodies that make them vulnerable to HIV, there are also structural factors like gender inequality that contributes to vulnerability to HIV and proneness to engage in risky sexually behaviours.

- Migration has an influence on HIV risk. Mine workers migrating to a working place with no social support and separated from family members places some people in a position to engage in risky sexual behaviours or unprotected sex with prostitutes (Campbell, 2003; Gupta et al., 2008).
- Poverty seems to have an impact on risk behaviours among young girls. Intergenerational sex to provide for families, for example, does not give girls the power to negotiate safe sex (Leclerc- Madlala, 2008). In this case, poverty is placing young people in a position to readily engage in unsafe sexual practices.

Some structural factors act as barriers for individuals from accessing HIV prevention and treatment and care services (Gupta et al., 2008). Stigma and discrimination against people living with HIV discourages people from voluntary testing and counselling and from disclosing their HIV status which has an impact on HIV treatment and care. Stigma against ARVs also has an impact on people's uptake of ART.

2.4.4.2 Structural Interventions

Structural interventions address factors affecting individual behaviour rather than the behaviour itself. They seek to change the context that contributes to vulnerability and risk (Coates et al., 2008). They have been highlighted for their potential to address distal drivers of HIV epidemics and intersecting health and social problems (Rotheram-Borus et al., 2009). Gupta et al. (2008, p.766) wrote:

“Structural approaches include structural actions implemented as single policies or programmes that aim to change the conditions in which people live, multiple structural actions of this type implemented simultaneously or community processes that catalyse social and political change. These approaches can be applied in combination with behavioural or medical interventions targeted at individuals”.

There are several structural approaches that have been implemented with varying success, in an effort to reduce risk behaviours. Universal precautions for a safe blood supply, clean syringe availability for injecting drug users and funding support for HIV testing are some of

the examples of structural interventions that have been implemented to reduce the transmission of HIV (Rotheram-Borus et al., 2009).

One of the structural interventions that is mostly mentioned in literature is the 100% condom-use policies in sex-work which are established in Thailand and Asia (Gupta et al., 2008; Rotheram-Borus et al., 2009; Sumarjoto, 2000). Condom use in those areas apparently rose from 3% to 90% (Gupta et al., 2008). Other structural interventions include the intervention done with microfinance for AIDS and gender equality (IMAGE). This project aimed to enable local women to pursue microenterprises while also offering HIV education and discussing and mobilising action against gender-based violence. This intervention improved women's financial status which then resulted in women's power in relationships (Gupta et al., 2008).

Similarly, Cluver, Orkin, Boyes and Sherr (2014) found that providing young people with social protection in the form of cash (child grant) or food support and care in the form of positive parenting, was associated with the halved incidence of HIV-risk behaviours for both sexes. HIV-risk behaviours were reduced from 41 to 15% for girls and from 42 to 17% for boys. This research highlights how structural factors that drive the HIV epidemic can be addressed by relieving poverty and lack of family support. Of note in the Cluver et al. (2014) study is that a structural change of social protection was done in conjunction with care (positive parenting). This indicates the need for interventions to be done concurrently rather than in isolation as interventions offered piecemeal seem not to be effective. It is the researcher's opinion that interventions from different disciplines in conjunction with each other are more effective than single interventions.

Different communities and cultures have different factors that either have an impact on risk behaviours or function as barriers for individuals' access to HIV and AIDS prevention interventions or treatment and care. Because there are different structural factors in different communities and cultures, it is important to study each community's factors and develop local and relevant interventions. It might, for instance, be advantageous to have a structural intervention that addresses and governs curricula of initiation schools in Venda so as to include sex education in relation to HIV and AIDS, while the same arrangement might be contra productive in another community.

2.4.4.3 Conclusion

HIV prevention requires structural interventions in addition to individual-level interventions (Gupta et al., 2008). Structural interventions require a paradigm shift regarding changing behaviour by focusing on behaviour itself. The focus on behaviour as a target for interventions takes the focus away from the root causes of those behaviours. It is my opinion that prevention interventions should rather address the causes of risk behaviours through structural interventions. The important aspect is to focus on each context as different areas and cultures have different ways of doing as well as different laws and norms that may impact on risk behaviours differently. HIV prevention interventions do not function the same way or have the same effect in all groups and settings because people and their contexts differ. Structural interventions should be based on a thorough assessment of the contexts, policies and culture in those contexts and should also be informed by members of the local communities. Gupta et al. (2008, p.773) reported that “for structural approaches to be included in mainstream prevention, health agencies must recognise that context really does matter and that a combination of successful approaches in one place might not be transferable to another”. Besides being context-specific with structural interventions, there is also a need for all the disciplines in HIV prevention to work together. Although some individually oriented interventions have shown results in reducing risk behaviours, their success is substantially improved when HIV prevention addresses the broader structural factors that shape and constrain individual behaviour (Gupta et al., 2008). Further success will require a shift in perception about how to influence HIV risk behaviours. It will require the development and exercising of new interdisciplinary research methodologies as well.

2.4.5 Conclusion

Literature review indicates that HIV prevalence is high among young people. MCP, early sexual debut and intergenerational relationships were identified as risk behaviours influencing HIV prevalence among young people. It was argued that unprotected sex is the main cause of high HIV incidence among young people as mathematical models indicate that reduction of risk behaviours (including MCP, early sexual debut and intergenerational relationships) do not result in significant reduction of HIV infections at population level. This shows that HIV risk behaviours are not readily controlled by disseminating HIV and AIDS knowledge as

previously believed (Campbell, 2003). Norms, culture and economic status as structural factors influence people's engagement in HIV risk behaviours far more than individual knowledge. Peer and gender groups norms seem to have an even greater influence on young people's engagement in sexual risk behaviours (Visser, 2007). The review discussed current biomedical, behavioural and structural HIV prevention interventions. Current HIV and AIDS prevention interventions are not effective enough to reduce some risk behaviours among certain groups of young people because they are not cultural and context-specific. The review of current behavioural HIV prevention strategies focused on the ABC model and its shortcomings in the South African context and cultures. The next chapter will focus on culture and sexuality.

Chapter 3

Culture and sexuality

3.1 Introduction

The behavioural interventions to prevent HIV and AIDS transmission have not been effective enough to reduce the spread of HIV in Sub-Saharan Africa. These programs especially have neglected societal, cultural and normative factors that have an influence on sexuality (Gonzalez, 2004; MacPhail & Campbell, 2001; Mfecane, 2010; Mulaudzi, 2007; Parker, 2001; Taylor, 2004). Sexuality cannot be divorced from culture. How people have sex, with whom they have and the purpose of having sex is socially constructed from the society and culture that people live in (Gupta, 2000). Sexuality varies over time and in any given culture. What is considered sexually appropriate in one culture can be views as inappropriate in another culture and historical time. This Chapter is going to focus on culture and sexuality and their effects on sexual risk behaviour.

3.2 Culture

For the purpose of the present study, culture is defined as shared values, norms and codes that collectively shape a group's beliefs, attitudes and behaviour through their interaction in and with their environment (Lwelunmor, Newsome, & Airhihenbuwa, 2013). Culture is plural and relativistic (Taylor, 2007). This means that there are different cultures in different societies. Frankenberg (1995) reported that culture is not limited to time and place. Cultural ways of doing things change with time. Things considered appropriate in a particular culture at a particular time may differ in another time and in other societies. Young people and adults in a society will often have different cultural norms that influences their way of life, behaviour and thinking.

Culture is productive (Taylor, 2007). It influences people's behaviour and way of life. Culture determines how members of a society think and feel. It directs their actions and defines their outlook on life. Culture has an influence on how people have sex and for what

reasons. Foucault (1978) argued that sexuality is not a natural inner drive that remains the same across time and contexts. Sexuality is a social construct and its meaning is derived from cultural discourses. Sexuality includes people's identities in all their cultural and historical variety. Explicit and implicit rules imposed by society as defined by one's gender, age, economic status, ethnicity and other factors influence an individual's sexuality (Gupta, 2000). How people have sex, with whom and for what reasons differs from society to society and from time to time. Sexual activities condemned in one society are encouraged in another, for example sexual exploration was encouraged and allowed in some African cultures among young people whereas it was frowned upon in Western countries. Similarly, ideas about what is attractive or sexually satisfying may vary from society to society.

Some authors (Gausset, 2001; Taylor, 2007) believe that African cultures were considered to be a stumbling block towards the reduction of HIV or an influence in the proliferation of HIV. This might be the reason why culture was excluded in finding solutions to prevent HIV. Research that considered African cultures as an influence in the spreading of HIV were criticised for generalising sexual behaviour to all Africans in different cultures based on small-scale studies (Craddock, 2004; Mfecane, 2010). Such research was also criticised for viewing African sexuality as exotic, immoral and barbaric (Gausest, 2001; Mfecane, 2010, Taylor, 2007). In this sense culture was viewed as having a negative influence on HIV prevention. Gausset (2001) reported that a discourse on *othering* was used in earlier research on African sexuality which resulted in African cultures being excluded from HIV prevention interventions.

Gausset (2001, p. 511) related that "there is a double discourse: when a correlation is found between HIV and the use of modern facilities, the facilities have to be improved and made safer, but when some correlation between HIV and African cultural practices is found, the cultural practice is to be eradicated". This shows that cultural practices are not considered as one of the tools that can assist in the reduction of HIV infection.

I agree with the criticism above. A superficial understanding and negative view of African cultures lead to the exclusion of culture from HIV prevention interventions which results in a continued failure in the reduction of HIV infection. Recent research (Airhihenbuwa, Ford, & Lwelonmor, 2013; Mfecane, 2010; Taylor, 2007) indicates the need for a deeper understanding of culture and its potential inclusion in HIV prevention interventions.

Airhihenbuwa et al. (2013) indicated why culture is important in HIV prevention interventions. Airhihenbuwa (1989; 1995) developed the PEN-3 model to place culture at the centre of public health and health education. The model acknowledges that every culture has unique and positive contributions that can be used in prevention interventions. Researchers are encouraged to approach cultures from this positive perspective. The PEN-3 model also acknowledges that cultures might have negative aspects that contribute negatively to a health prevention intervention, which aspects should be addressed and reconsidered. One of the goals of this study is to identify Vhavenda cultural ways of doing things that can be used in HIV prevention.

There have been contributions of effective public health interventions that used cultural practices as strategies to convey the messages (Airhihenbuwa et al., 2013). There are however, a few HIV prevention interventions described in the literature that were based on specific cultural concepts (Gallant & Maticka-Tyndale, 2004; Marin, 2003; Soskolne & Shtarkshall, 2002). Gausset (2001) conducted a survey in Tonga (Zambia). He used drama groups with information which was adapted culturally (by differentiating AIDS and Kahungo, a disease which is acquired when a man has sex with a woman who had miscarried and has not been purified and which is generally thought to be AIDS) using the local vernacular. One play was about “a man who drinks and visits prostitutes, did not listen to warnings of friends about AIDS and STD and contracted HIV as a result. Information about AIDS, condom use, counselling and care of AIDS patients was given during the play” (Gausset, 2001, p. 515). The play managed to increase condom use by 15.3%. The study also opened the way for a change in the rules and norms of social behaviours and the negotiation of sexual relationships. This intervention was effective in increasing condom use in Tonga.

Another intervention developed for Hispanic men and women in STD clinics (Marin, 2003) started by identifying relevant gender roles and responsibilities regarding the introduction of condom use and norms, attitudes and values regarding condoms. Videos were made that reflected family closeness and concerns about family members' health typical among Hispanics. Family closeness and relations were important in this intervention as Hispanic culture emphasises family closeness. The videos used language and vocabulary of Hispanics who went to the clinic describing worries about using condoms and presented culturally appropriate ways to overcome specific barriers to condom use. In an evaluation of the Hispanic intervention, men and women receiving the intervention were found to be more

likely to redeem a coupon for a free condom than men and women who were not involved in the intervention.

The above two interventions were effective in their respective cultures and contexts. This shows the importance of considering cultural appropriate strategies in HIV prevention interventions. Of significance is not to view culture as the one and only tool to render prevention interventions effective, nor to view it as negative and exclude it in prevention interventions. Of significance is to have a balanced view that considers that culture can assist in HIV prevention interventions like the PEN-3 (Airhihenbuwa, 1989; 1995) model indicates. It is however, important that each culture is studied and specific interventions developed based on cultural definitions of sexuality and relationships in that particular context.

Some studies (Campbell & Mzaidume, 2002; Knox, 2010) have noted that there can be complications in interventions that are developed without the knowledge of culture and context, especially if it involves community members. Research done by Campbell and Mzaidume (2002) involving mine workers in Carletonville, west of Johannesburg in South Africa, was met with various challenges. The project was led by women. Men in the community rejected such programmes because of the patriarchal values in the community. Campbell and Mazaidume (2002, p. 231) reported that “such projects become the focus of personal and political conflict and controversies, unrelated to HIV issues”. The above study is a good example of the importance of studying a specific society, context, culture and its politics sufficiently before developing interventions. If the project respected the patriarchal values of the mine workers, the intervention may have been more effective.

Knox (2010) explored the potential for culturally relevant HIV prevention in Swaziland. Similarly, he was confronted with complexities associated with culture, politics and economic interests of some members in the community. Some local traditional healers rejected the intervention as they viewed it as competition to their healing businesses. The community viewed the intervention as a way of stealing traditional information and healing procedures while the researchers were not sharing their information. This led the programme to be aborted before it could be implemented in the community as there was a lack of trust. These examples of the complications involved in HIV interventions confirm the need for a thorough assessment of cultural norms and structural factors in the community, as well as collaboration with community members in implementing interventions.

The assessment of cultural norms before developing HIV prevention is significant as the way young people have sex is influenced by where they live, their age, their gender and what they observe and learn about sex in their culture. There is evidence that current HIV prevention programmes implemented among young people and especially in schools do not consider cultural practices (Rooth, 2005). The individualisation of behavioural and biomedical HIV prevention interventions have ignored the impact that culture has on young people's behaviour. This implies that interventions place the responsibility for prevention of HIV transmission on young people themselves. There is a need for HIV prevention interventions in schools to include cultural strategies that are effective in HIV prevention while countering cultural strategies that promotes HIV infection.

Venda culture embraces some positive practices that can aid HIV prevention interventions (Mulaudzi, 2007). Traditionally, young people (both girls and boys) in Venda were educated about sex and sexuality by the elders of the community through initiations or rites of passage. This education influenced how young people have sex and their negotiations around sex. The traditional way of educating young people about sexuality also assisted in having strict surveillance on young people's sexual behaviour which helped to delay sexual debut and to reduce pregnancy among young people (Delius & Glaser, 2002). Below are the rites of passage for young people in Venda as described in the literature:

3.2.1 Musevhetho

Musevhetho is a rite of passage for girls that initiate a girl from babyhood to the stage of puberty, before the girl starts menstruating (Milubi, 2000). This initiation involves the elongation of the girl's labia minora. This is done to increase sexual pleasure (Martínez Pérez, Bagnol, & Tomás Aznar, 2014).

"Musevhetho plays an important role in reducing early sexual debut amongst young girls as virginity status is checked by older women. Girls who are not virgins are ostracized at Musevhetho initiation school. The practice encourages girls to abstain from sex and discourages girls from losing their virginity before marriage. Musevhetho is believed to play an important role in preventing

unplanned teenage pregnancies” (Informal conversation with an elder in the community).

3.2.2 Vhusha/Vhukomba

Vhusha is the initiation for girls. This ceremony is attended by young girls as soon as possible after their first menstruation. Girls are expected to attend in order to learn good manners, cleanliness, house chores, respect and to regain their identity. They are also introduced to secret laws (*milayo*) meant to prepare them for their future roles as wives and mothers (Blacking, 1969c).

3.2.3 Murundu/Mula

Murundu is an initiation for boys. It involves the circumcision and teachings by older men of the society and older initiates. Young boys are taught about sexuality, to respect women, how to behave as men, taking care of family, to be responsible husbands and fathers and to lead by example. Recently, HIV and AIDS are supposed to be added to *Murundu* curricula. Detail about *Murundu* was given in Chapter 2.4.1.1.

3.2.4 Tshikanda

Tshikanda is an initiation for girls. It only takes one night, the day before *Domba* starts (Stayt, 1968). Young girls are taught songs and dances and rules of society to prepare them for *Domba* (a premarital initiation).

3.2.5 Domba

Domba is a pre-marital initiation that is done for young matured girls. This rite of passage was previously attended by both girls and boys after each individual had previously attended other separated initiations dedicated to one's gender; *Vhusha* and *Tshikanda* for girls and *Murundu* for boys.

“Since the missionaries decided that mixing males and females in the same ceremony was immoral, only girls attend the Domba”. (Informal conversation with an elder in the community)

Domba has two main functions namely teaching girls how to prepare themselves to become wives (birth planning, giving birth and child care, how to treat a husband and nowadays the avoidance of HIV and AIDS). They are also instructed in passing fertility to the new generation of the tribe. *Domba* allows young women to have full participation in society. They become respected and play leading roles in rituals, ceremonies and initiations.

Initiation schools are a cultural tool that can be used in aid of HIV prevention interventions for young people especially if they include comprehensive sexuality education.

People from the Venda culture practice a custom of premarital counselling or education sessions. Before marriage, adults attend counselling or educational sessions to educate a young couple individually, and to educate them on how they should behave as a married couple. This custom was criticised for perpetuating gender inequality as young women are told to obey their husbands’ wishes (especially sexually) and are thus disempowered from negotiating safe sex (Ramathuba, Tugli, & Mashau, 2014). This custom can however prove invaluable for HIV prevention interventions if the counselling and education is extended to both man and woman and if it is modified to promote gender equality and safe sex education like *Be faithful*.

There are also cultural idioms in Venda that can impact negatively on HIV prevention interventions. There are several idioms, e. g. *Munna ndi ndou ha li muri mithihi fhedzi*, (literally meaning: *a man should not have sex with only one women*), *munna ndi mbado* (literally meaning: *men are to be shared*) that promote multiple relationships. Such idioms should be highlighted and flagged as out-dated to show their contradictions with HIV prevention methods and the risk of contracting HIV. They also indicate the need to address gender inequality.

The researcher could not find any literature on published and implemented HIV prevention interventions that included specific cultural concepts of a specific traditional indigenous

culture in South Africa. As HIV infections are not decreasing as hoped for in South Africa, it is important to explore ways of adapting HIV prevention interventions to benefit various South African cultures. This can be done by exploring how sexuality is constructed by young people in different cultures in South Africa and by using those cultural concepts (as indicated above) to develop culture-specific prevention interventions or to re-negotiate several cultural practices that may be counter-productive.

Re-negotiating cultural practices, ideas and beliefs is possible because culture is developed by people as a way of conducting social interaction (Berger & Luckmann, 1966). Culture is historically and contextually determined – this means that culture is constantly evolving. Individuals within a society can and do change cultural ideas, beliefs and interests. Changes in the environment, for example, migration, globalisation and politics, sometimes facilitate changes in a culture. Cultural practices can be re-negotiated due to circumstances in a society. The HIV pandemic calls for the re-negotiation of some cultural practices, ideas and beliefs that does not promote the reduction of HIV infections.

Social constructions influences gender roles, beliefs and behaviours. Men and women interact with each other in relationships as determined by the society they live in. This can also influence behaviour that makes men and women vulnerable to HIV infection. The next section will focus on gender, how it influences risk behaviours and the development of HIV prevention.

3.3 Gender, risk behaviour and HIV prevention

In the last decade, researchers realised the importance of gender identities (especially gender inequality) as structural component influencing risk behaviour contributing to HIV and AIDS. Research indicates enormous gender disparities in rates of HIV infection between young men and women (Shisana et al., 2014; UNAIDS, 2015; Zuma et al., 2016). Research (Chong & Kvasny, 2007; UNAIDS, 2003) also indicates that current behavioural HIV prevention interventions (the ABC model) are not suitable to assist young women to make healthy choices as they often do not have the power to make healthy choices in relationships. Below

is a brief discussion about gender identity constructions, their impact on HIV risk behaviours and uptake of HIV prevention interventions among young people.

3.3.1 Gender

Gender has been studied and conceptualised by many disciplines. Essentialism, biological determinism as well as socialisation theory describe gender roles as deterministic. Connell's (1995) work emerged as critique of sex role theory (Demetriou, 2001; Donaldson, 1993; Morrell, 1998; Nye, 2005). Contemporary social scientists believe that gender is socially constructed rather than biologically or socially determined (Connell, 1995; Demetriou, 2001; Donaldson, 1993; Mfecane, 2010; Morrell, 1998; Nye, 2005). Social constructionists' assumption is that what we are as men and women is determined by the society we live in. Masculinity and femininity (gender identity) is constructed by interacting within a society. We construct roles, behaviours and expectations of how men and women should behave among ourselves. Gender is relational and it is achieved in interaction with others (Connell, 1995; Cooper, 1994).

Social constructionists' assumption is that gender identity is historically, contextually and culturally defined. Gender concerns expectations and norms of appropriate male and female behaviours and roles shared within a society at a particular historical time (Gupta, 2000). It concerns expectations of how men and women should behave, the roles they should have in a society and how men and women should relate to each other. Norms for masculinity and femininity, roles and sexual scripts allocated to men and women vary widely across communities and historical times (Strebel, Crawford, Shefer, Cloete, Dwaadwa-Henda, Kaufman, Simbayi, Magome, & Kalichman, 2006).

Social construction conceptualises that gender identity is taken for granted in society as a way of being. Gender identity is embedded in a way that it feels natural. People recognise it and organise their lives around it by accepting the expected gender roles. In this way, constructions of gender influence people's behaviour in ways that fit into their roles as men and women. Gender roles and relations have a significant impact on vulnerability to HIV and AIDS for both men and women. It also has an impact on the development and adherence to HIV prevention interventions.

In contrast, masculinity and femininity are constructions, which are dynamic, on-going, changing and changeable rather than static and fixed. The volatility of gender identity is important because it shows that gender identities can change. It also shows that not all men and women portray masculinity and femininity in similar respective ways (Morrell, 2001).

Connell (1995) indicated that gender is a concept of power. To theorise gender as a form of power, Connell (1987; 1995) draws from Gramsci's (1971) concept of hegemony. Connell (1995) indicated that firstly, power is exercised *between* genders (that is men having power over women). In this case "individual men each enjoyed the 'patriarchal dividend', the advantage men in general gain from overall subordination of women" (Connell 1995, p. 79). Secondly, power is exercised *within* gender groups, indicating that being a man conferred power even though not all men shared this power equally and not all men are individually exploitative.

3.3.2 Hegemonic Masculinity

In developing the concept of hegemonic masculinity, Connell (1995) developed the theme of different masculinities. While men are seen to oppress women, some men also dominate other men. Hegemonic masculinity is used to refer to the dominant constructions of what a man is or to stereotypes of men (for example, brave, strong, aggressive and resilient). Dworkin, Hatcher, Colvin and Peacock (2013) defined hegemonic masculinity as the most dominant form of masculinity in a given era and time. It is hierarchically defined in relation to marginalised and subordinated masculinities and in relation to women. While only a minority of men might enact the norms and practices of hegemonic masculinity, this idealised version of masculinity helps to shape configurations of practice beliefs and social action among hegemonic, marginalised and subordinated men (Connell, & Messerschmidt, 2005; Dworkin et al., 2013; Morrell, Jewkes, & Lindegger, 2012).

Reid and Walker (2005) indicated that in South Africa, masculinity has been shaped by colonialism and apartheid in the past. The transition to democracy in the 1990s also had an effect on the construction of masculinity as it was constructed in relation to patriarchy and violence to women. Current (post 1994) constructions of masculinity indicate that sexual behaviour is significant in constructing what manhood is (Lynch, Brouard, & Visser, 2010; Reid, & Walker, 2005).

In relation to this study, it is difficult to identify exactly which characteristics define hegemonic masculinity in Venda, for two reasons: Firstly, Vhavenda men have not been studied sufficiently in relation to social constructions of masculinity. Secondly, the influences of a shifting political and economic background make social constructions fluid and difficult to pinpoint. The definition of a *real man* is therefore dependant on place, time, opinion and mood. This study will explore how young Vhavendas define sexuality. This will assist in clarifying constructions of masculine and feminine sexual behaviour which place young people in Venda at risk of HIV infection.

In exploring topics such as HIV incidence among young women, violence and gender inequality, South African researchers has concluded that hegemonic masculinity fuels the spread of HIV and AIDS (Barker & Ricardo, 2005; Dworkin et al., 2013; Lerclec-Madlala, 2005; Mfecane, 2010; Morrell, Moletsane, Abdool Karim, Epstein, & Unterhalter, 2002; Shefer & Makhayi, 2007; Simpson, 2007).

Many cultural groups in Africa carry out initiation practices or rites of passage that include initiation as part of a ritual for boys to become men and to affirm their masculinity. Barker and Ricardo (2005, p. 9) reported that “rites of passage serve as a form of positive social control, they include information related to sexuality, with implications for HIV, violence against women and male and female intimate relations in general”. As discussed in sections 1.3.1 and **Error! Reference source not found.**, rites of passage are practiced for both boys and girls in Venda. It is used to initiate boys and girls into becoming men and women (Malisha, Maharaj, & Rogan, 2008; Milubi, 2000). For boys, initiation schools and rites of passage is indicated as something that is done to achieve masculinity (Milubi, 2000). (A discussion regarding girls will follow in Section 3.3.3), Even though many young people do not go to traditional initiation schools anymore, young boys who attend the traditional initiation schools and do not go to the hospital for circumcision are considered *real men* (Malisha et al., 2008; Milubi, 2000). Young men reported that older initiates at initiation schools advised them to confirm their initiation by *testing the spear* (having sex) as soon as they are healed (Milubi, 2000). This has an impact on HIV infection as no education regarding HIV and AIDS and safe sex is presented at initiation schools.

Contemporary hegemonic masculinity is constructed as heterosexual (and not homosexual) (Lynch, Brouard, & Visser, 2010; Shefer & Mankayi, 2007; Shefer & Ruiters, 1998). It is also through heterosexual sex that young men attain their hegemonic masculinity. First

vaginal penetration is perceived to be important in determining masculinity and marks the transition from boyhood to manhood (Marston & King, 2006; Shefer & Ruiter, 1998). Sexual experience is associated with an initiation into manhood and the achieving of socially recognised manhood. Sex is seen as an act of competence and achievement rather than acts of intimacy (Barker & Ricardo, 2005). The *male sexual drive discourse* (as coined by Hollway, 1984, 1989) refers to the portrayal of sex as masculine, a male-centered activity, a male preserve and an uncontrollable natural drive (Shefer & Foster, 2001). Such constructions and discourses of hegemonic masculinity and men's sexuality influences sexual risk behaviour, as young men initiate sex early in order to confirm their masculinity.

According to this discourse and research (Lynch, Brouard & Visser, 2010; Selikow, Zulu, & Cedra, 2002; Shefer & Mankayi, 2007) men also achieve their masculinity by having multiple partners. Multiple concurrent partnerships (MCP) have been identified as one of the factors that increase HIV infections. MCP is viewed as culturally rooted. These relationships have existed and continue to persist even in the plight of HIV and AIDS (Mah & Halperin, 2010). Young men experience pressure to have multiple partners in order to be seen as 'real men'. According to Marston and King (2006), young men's reputations can suffer if they are not seen to push for sexual access and numerous female partners. This is also supported by notions of culture, African history and peer pressure. Selikow (2004, p.104) reported that *male sexuality* in the township is defined by how many sexual partners men have and sexually assertive male behaviour is regarded as a prominent factor in being a *real man*. The notion of a *real man* is captured by the development of the term *ingagara*, referred to as the *top dog*. The construction that masculinity is achieved by having many partners influences young men to have multiple partners which place them at risk of HIV infection.

Additionally, it was found that men use violence against women to prove their masculinity (Selikow et al., 2002; Walsh & Mitchell, 2006). Physical violence by individuals are exacerbated by violence associated with gangsterism. Gender violence has been defined by Selikow et al. (2002, p.23) as "overt or covert acts that result in or could result in physical, sexual or psychological harm or suffering to either women or men". Walsh and Mitchell (2006) found that young men in their study who did not belong to gangs were nevertheless influenced by understandings of masculine identity perpetuated by gang culture. Such an understanding of masculine identity includes sexual violence against women.

Sexual violence is not only used to attain masculinity. It is sometimes used to maintain traditional gendered sexual roles in South Africa (Shefer et al, 2000; Strebel et al., 2006). In this case sexual violence is used as a form of punishment for women who step out of their sexual role, for example, lesbians (Conco, 1996; Shefer et al., 2000). The ability to live up to the normal prescripts of masculinity and femininity is significant for men in their experiences of being men. A challenge by women is approached either by violent punishment or derogatory naming in order for men to regain their male power (Shefer et al., 2000; Shefer & Ruiters, 1998).

Heterosexual sexuality is deeply implicated for the inequality between men and women and for sexual violence in heterosexual relationships (Shefer & Foster, 2001; Shefer, Strebel & Foster, 2000). In heterosexual relationships, men are the ones in control of how, when and where sex happens and women are expected to conform to what men want. Sexual violence is indicated as one of the reasons for young people to begin sexual activity and contributing to the challenge of HIV and AIDS. Many young women are coerced to have early sexual debut for love, to maintain relationships, due to peer pressure and sometimes as a result of rape. Sexual violence does not only refer to rape, but includes coercion and sexual pressure. Shefer et al. (2000) indicated that young women sometimes give in to male pressure for sex for fear of loss of a relationship or to display or receive love and commitment.

Traditional hegemonic masculinity has been problematized in the HIV context. It is constructed as bad, oppressing women and placing women and men at risk of HIV. It is also constructed in a way that sometimes blames men for engaging in behaviours that contribute to them achieving their masculinity and acceptance in the community. Masculinity develops in the context of gender relationships. Women thus contribute in creating the construction of masculinity and could benefit from such constructions. Research conducted by Leclerc-Madlala (2003) revealed that young women often accept such high risk behaviours of men, as men with many partners are viewed as more admirable. Shefer et al. (2000) found that some women reported that gender power inequality does not necessarily exclude a good experience.

Attaining the status of a *real man* is not always easy. It comes at a cost, as masculinity has to be achieved through certain actions. Some men inflict psychological and physical harm to themselves and others in their endeavours to strive for acceptance as *real men* (Herek, 1986; Wick & Mills, 2000). Hegemonic masculinity can be thus be costly and dysfunctional, not only for men but for society as a whole and, although it could have been an acceptable

requirement earlier, it has become an outmoded entity in need of transformation (Herek, 1986). Addressing of this necessary transformation through gender identity deconstruction is regarded as imperative to HIV prevention.

In light of the proliferation of HIV and AIDS, health care prevention strategies are persistently campaigning for change in men's behaviours. Being a man is a crucial component of personal identity for men in our society. Not being a man attracts many labels (such as *Isithipa* or *shuvhuru*) from other men and from society as a whole. If masculinity is so important in defining a sense of self for young men (even more important than the fear of HIV infection), it is important to explore the context in which masculinity labels develop and change. Men cannot change their behaviour without alternative constructions of ways of living and of achieving a sense of self (Herek, 1986). Formulating alternative constructions should be part of the agenda for HIV prevention interventions focusing on masculinity.

3.3.3 Femininity

It is not only masculine gender identity that has an influence on the spread of HIV. In a similar way feminine gender identity has an impact on the spread of HIV. Gender inequality places women in lower economic positions in the society which makes them vulnerable to sexual risk behaviours like intergenerational relationships and transactional sex, as indicated previously. Hunter (2002) reported that masculinity and the privileged position of men in society make women dependent on men and in some cases reliant on transactional sex.

Besides discourses of masculinity, there are also discourses and behaviours that are currently associated with womanhood among young people. Women are more emotional and will engage in risk behaviour to keep a partner. Leclerc-Madlala (2003) also indicated that discourses on current womanhood celebrate sex as a commodity and MCP as a signifier of modern life and sexual equality. These discourses influence young women to engage in sexual risk behaviour.

Discourse on female sexuality is viewed in relation to men's sexuality (Shefer & Foster, 2001). The *male sexual drive discourse* (Hollway, 1984, 1989) implies the construction of what female sexuality is supposed to be. In contrast with *the male sexual drive discourse* female sexuality is seen as bound up with love, emotions and commitment to a relationship.

This discourse indicates females as passive objects of heterosexual activity and males as active objects (Shefer & Foster, 2001). Such constructions of femininity or female sexuality in society influence women to be coerced into having sex to maintain relationships and to show love (Schepers & Zway, 2012). These constructions also silences women from negotiating safe sex for fear of knowing too much (which might lead to abuse) or in order to maintain their gender role by letting men control how sex should be in the relationship. This places women at risk of HIV infection.

As indicated above, both young boys and girls in the Venda culture attend initiation schools as a rite of passage into becoming men and women. Young girls' initiation education is mostly focused on educating young girls about gender roles and how to please men sexually (Manabe, 2010). Such education promotes gender inequality and the sense that sex is for men's enjoyment and not women's enjoyment. Such constructions put young women at risk of HIV infection as it encourages young women not to value their sexual needs or to negotiate safe sex.

While constructing men's behaviour as *bad* places blame on men, viewing feminine behaviour as invariable *good* may also place women at danger of HIV infection, as it suggests to woman that HIV and AIDS is not their concern (Chong & Kvasny, 2007). This construction gives young women a false sense of security and blamelessness about their chances of being infected.

The social construction of HIV prevention campaigns often leaves young women at risk of HIV. The patriarchal ideology behind campaigns for abstinence, monogamy and condom use may be disenfranchising to women as abstinence is not an option for young women who are forced into transactional sex for economic reasons, while being faithful does not provide adequate protection for women, when their partners are not faithful (Chong & Kvasny, 2007). Research has shown that married monogamous women are at greatest risk of HIV infection in Africa (UNAIDS, 2003). Condom use implies that women have to act assertively in sexual relations with men, which is not necessarily achievable (Chong & Kvasny, 2007). ABC prevention campaigns are presented as caring for the whole community, even though the socio-economic status and power of men over women invalidates this assumption.

According to social construction theory, discourse shapes society (Fairclough, 1995). The above discourse in the construction of masculinity and femininity shapes how women and men behave individually and in relation to each other. Various authors (Connell, 1995;

Morrell, 2001; Reid, & Walker, 2005) agree that gender identity is volatile and susceptible to change. Change is more likely to occur in critical times, times like the present where gender identity seems to hinder HIV infection prevention. To address the effect of current gender discourses on both men and women, it is important to encourage discourses that reconsider gender inequality and power imbalance in the HIV epidemic and to generate more empowering discourses.

3.4 Summary and conclusion

Current HIV prevention interventions do not consider cultural appropriate strategies and they focus on individualised behaviour. This renders them ineffective as HIV infection is influenced by multiple factors. The study reviewed prevention strategies geared specifically towards young people, but pointed out challenges and gaps that are disarming those strategies amongst young people. This chapter shows that HIV prevention interventions need to consider culture and context-specific constructions of sexuality. A thorough assessment of the cultural definitions of sexuality is a pre-requisite for developing HIV prevention interventions. The researcher's literature study indicated that there are currently no published implemented HIV interventions that include cultural concepts tailored for specific cultural groups in South Africa. This research will therefore explore constructions of sexuality and HIV risk among young people in Venda in order to come up with HIV prevention interventions suitable for young people of Venda.

Chapter 4 will focus on the research methodology of this study commissioning social construction as theoretical approach.

Chapter 4

Research Methodology

4.1 Introduction

The research methodology and theoretical framework which were employed in the study is discussed in this chapter. Social construction was chosen as a theoretical approach for the study as it is concerned with specific historical and cultural ways of understanding social interactions and creation of knowledge and reality in a particular context. This chapter also provides a description of qualitative research methodology and describes how it was used in this research. Data was collected using focus group discussions with Venda school learners from Grade ten to twelve and with community leaders in Venda. Text as data produced during focus group discussions was analysed using discourse analysis.

4.2 Theoretical framework

The philosophy of disciplines focuses on the construction of disciplines in relation to assumptions held in those disciplines. Three broad major philosophical systems have been used to explain knowledge generation in Psychology namely, pre-modernism, modernism and postmodernism (Bohan, 2002). Pre-modernism is a philosophical system that claims that knowledge is revealed from authoritative sources. The assumption of modernism is that knowledge is acquired through the accumulation of facts coupled with reason. Postmodernism's main assumption is that there are multiple ways of knowing. The ontological assumption that is the basis of the present study is grounded in postmodernism. The following section focuses on explaining postmodernism by contrasting it with modernism. The section will conclude by showing how postmodernism as a theoretical framework serves this study.

4.2.1 Postmodernism

Postmodernism as a philosophical movement developed in reaction to the limitations of assumptions and values of modernism. It is critical of the basic assumptions and universal

claims of modernism. Postmodernism emphasises the importance of power relationships, personalisation and discourse in the construction of truth and world views. In explaining postmodernism, many authors contrast it with modernist intellectual tradition that stems from *thought enlightenment* (Bohan, 2002). An inspection of related concepts and theories will now be presented.

4.2.1.1 Accumulation of knowledge

Modernism argues that it is possible to acquire the truth over time by getting factual information through careful observation and elaborating on the facts by reason. In other words, modernism observes the world for what it is and reports accordingly. Willig (2001) called it the *correspondence theory of truth*, as it proposes that it is possible to describe what is *out there* and to get it right. This modernist approach extends to an ontological level as reality is seen as completely knowable.

The modernist position is challenged by postmodern thinking. Postmodernism adheres to epistemological pluralism which embraced multiple ways of knowing. Postmodernism does not reject modernism, but instead it understands it as a partial way of knowing; that is one way among many ways of knowing. Postmodernism argues that we should doubt our capacity to know anything with certainty. Postmodernism questions the assumption that there is a methodology that guarantees access to correct knowledge. Postmodernism further argues that there are no facts to be accumulated, but only interpretations of which everybody will form their own.

Postmodernism states that we should always consider multiple ways of knowing to arrive at a deeper understanding of the issue and that some ways are more applicable or valid in some situations than in others (Gergen & College, 2001). We cannot only assume that by educating people on HIV, we will be able to change their sexual risk behaviours. There are various interpretations of HIV and various ways of understanding the content of HIV education. HIV education should also be viewed as one way of trying to change sexual risk behaviours. We also need to consider various other strategies of HIV prevention such as the biomedical and structural interventions that could assist in changing HIV risk. This will result in a deeper understanding of people's sexual risk behaviours and maybe an effective way of changing

those behaviours. There is a need to understand the different influences on people's sexual behaviour from different perspectives and to consider how these can be used in HIV prevention strategies.

4.2.1.2 Nature of Truth

Modernism assumes that we are able to obtain the ultimate truth by collecting facts and elaborating on them by reason or logic. Postmodernism, on the other hand, postulates that there is no ultimate truth that we can fully know. Alvesson and Skoldberg (2000, p.152) stated:

“Theoretical truth is not a fixed entity discovered according to a meta-theoretical blueprint of linearity or hierarchy but is invented within an on-going self-reflective community in which the ‘theorist’ or ‘social scientist’, ‘target’ and ‘critic’ become relatively interchangeable”.

What we take as *truth* is created and warranted not through evidence or facts, but through social exchange that sustains a collective agreement about truth and validity (Bohan, 2002). Accordingly, we do not know that accepted *facts* are true, but we simply agree that we believe that they are true. Instead of accepting facts as true separate from social interaction, postmodern thinkers attempt to analyse the conditions that give rise to the construction of meaning through interaction between people (West, 1996). The original belief that HIV is a *death sentence* is not the ultimate truth. It is a result of how HIV was introduced into our communities as an incurable disease coupled with communal constructions that followed such an introduction. This belief also changed to HIV being interpreted as a chronic disease with the introduction of different evidence.

4.2.1.3 Research

In research, modernism uses a singular method of research that is regarded as superior to obtain knowledge (Gergen & College, 2001). Postmodernism, on the other hand, encourages the use of multiple methodologies in conjunction to approach knowledge of the *truth*. In

conducting research from a modern perspective, the implication is that the research will produce objective knowledge based on an outsider view without personal involvement of the researcher (Willig, 2001). The researcher objectively reports what he or she discovers. From a postmodern perspective there is no means of declaring that the world is either *out there* or reflected objectively by an *in here* (Gergen & College, 2001 p. 807). Postmodernism views the researcher as having an impact on the research results. The researcher's interpretations affect the results as he or she interprets the results according to how he or she sees texts produced. That is why recent research emphasises the need for epistemological reflexivity where the researcher engages in a continual process of reflecting upon his or her assumptions of knowledge and the world and how those assumptions might have an impact on research findings (Willig, 2004).

4.2.1.4 Language

Modernism assumes that our words (in both science and culture) are reflections of internal conceptions. In other words, we mirror the world and communicate it to others through language as truth. According to Gergen and College (2001), "If the individual mind acquires knowledge of the world and language is our means of conveying the content of mind to others, then language becomes the bearer of truth" (p. 804). According to modernism, language objectively describes truth. In contrast, postmodernism states that language is not a child of the mind, but of cultural process (Gergen & College, 2001). To speak of the world requires language. Therefore, words are not mirrors of the world, but constituents of language systems.

Potter and Whetherell (1987, p.7) stated, "Discourse is a combination of both spoken and written texts"; this indicates that discourse is language. Discourses are practices of talking and writing which bring objects into being through the production and dissemination of texts. It is through discourse that we form relations with one another and reinforce or challenge our beliefs. It is through language or discourse that we constitute our experiences. Habituating the same meaning over time provides the background of common experience within a community which gives context for the same behaviour.

4.2.1.5 Social Construction

All language or discourse is socially constructed. We understand the world solely in terms of our linguistic or social constructs. What we believe to be true about human functioning is a by-product of communal constructions. Discourse supports particular social patterns by creating and sustaining forms of argumentation, categories for understanding, labels and metaphors and accounts of legitimate action (Barret, Thomas, & Hocevar, 1995).

There are, for example, constructions within African communities that *real men* have many partners. The by-product of this communal construction is men having many partners to fit into the descriptions of what *real men* are, which then gets reflected as the truth regarding African men. This created a discourse about the sexuality of African men which formed perceptions about African sexuality.

4.2.1.6 Power

Postmodernism also acknowledges power and its influence on society. According to postmodernism, power is not isolated and cannot be studied on its own. Power is viewed as something that exists in relationships and it is expressed in action (Alvesson & Skoldberg, 2000). Power is said to be exercised rather than possessed. Its effect is manifested and sometimes extended by the position of those who are dominated (Alvesson & Skoldberg, 2000).

Postmodernism is an appropriate ontological approach in researching notions of sexuality and HIV and AIDS prevention interventions because there is no absolute truth in how people define sexuality, in how, when and with whom they choose to have sex and in how they practice sexual behaviour. Matters of sexuality are social constructs (Foucault, 1978); they are influenced by social interaction and, on the other hand, they influence social interaction. Society classifies certain sexual acts and desires as normal, respectable and moral and others as not normal or respectable. This influences how people behave sexually. It may be socially acceptable in certain societies for a man to have multiple sexual partners which influences more men to engage in MCP than women. Dunphy (2000, p. 65) postulated that:

“modern heterosexuality is every bit as much a social construction as modern homosexuality and lesbianism and can only be understood in terms of meanings, discourses, power relations, power within relationships and institutionalisation of norms which produces privileges as well as disadvantages for groups according to how they are labelled”.

People react differently to HIV depending on the constructions that are available in their culture. When HIV first emerged, people constructed it as an illness that was acquired through immoral behaviour and also as a *death sentence*. This resulted in people having a fear of HIV and consequently in stigmatisation of people diagnosed with HIV. Research and prevention interventions also contributed to such constructions by educating people on HIV as a dreadful disease and showing AIDS sufferers as thin and not being able to do anything for themselves. These constructions then determine the behaviour of people towards those living with HIV.

Adherence to HIV and AIDS prevention strategies also seems to be influenced by social constructions. That is because some people and society adhere to some HIV and AIDS prevention interventions and others do not. Such behaviour seems to be influenced by social interactions and constructions that show some prevention interventions as appropriate for certain communities and age groups. Berger and Luckmann (1966, p. 3) in explaining social construction reported that:

“what is more interesting is to study how some knowledge or reality is taken for granted in one society and not another, how it is maintained in one society and not another and how such reality or knowledge may be lost to an individual or to a collective.”

This observation is still relevant. ART was introduced by biomedicine in order to improve the prognosis of people living with HIV. ART was originally labelled as *fattening drugs* (Ezekiel et al., 2008), which gave it a negative connotation and accordingly influenced people's uptake of ART. There are also different constructions around condoms depending on culture and age groups. Taylor (2007) indicated that condoms were constructed as un-African in the

Shona community which affected people's use of condoms. Adherence to HIV and AIDS prevention strategies is influenced by one's culture, norms, gender norms and period in time. It is important to explore social constructions that make some societies adhere to some HIV and AIDS prevention strategies whereas others do not.

In researching constructions of sexuality and HIV and AIDS prevention interventions, it is necessary to use an approach that acknowledges that there is no single truth which applies to everyone. Such an approach should acknowledge that knowledge and reality is socially relative and should attempt to analyse the conditions that results in certain meanings and actions.

4.2.2 Social Constructionism

Social constructionism emerged in the 1960s with Berger and Luckmann as major influences in the development (Burr, 1995). Berger and Luckmann (1991) acknowledge that their thinking in an attempt to come to terms with the nature of reality and knowledge were influenced by theorists such as Mead, Max, Schultz and Durkheim. Social construction is formulated from multidisciplinary sources, including sociology, literature and postmodern approaches (Young & Collin, 2004).

Berger and Luckmann (1991) view knowledge as created by interaction of individuals within a society. They also view society as existing both as objective and subjective reality (Andrews, 2012; Eberle, 1992; Gergen, 2015). This means that reality is created through the interaction of people with the social world. They emphasise the importance of language in social constructions. Burr (1995) maintains that it is language that makes thoughts and concepts possible. Berger and Luckmann (1991) maintain that conversation is the most important means of maintaining, modifying and reconstructing subjective reality. Language constructs reality rather than mirroring it (Georgaca & Avdi, 2012).

Social constructionism reflects a postmodern epistemology. It emphasises the notion of multiple realities that all are meaningful, that is based on the effort to move away from the limitations of modernism. This relativist position is the source of most criticisms labelled against social construction (Andrews, 2012) which will be discussed in detail later in the chapter.

Social constructionists believe that a self is constructed in relationships. People are embedded in a specific cultural and historical situation, with a focus on the self in a network of relations and on the interrelationship of a local context in a linguistic and social construction of reality. The self in postmodern theory is thus regarded in terms of on-going processes as being continually constructed and reconstructed in particular relationships over time. Social constructionism postulates that the content of our consciousness and our mode of relating to others is taught by our culture and society. All the metaphysical quantities we take for granted are learned from others around us (Owen, 1992).

Social constructionist thought is mainly concerned with the idea that every society constructs its way of being. It focuses on the interaction between society and the individual and how such interaction produces certain actions in individuals (Gergen, 2015). It shifts from a search for mental processes inside each individual toward a socially mediated and historically situated study of action and experience. Social construction assumes that meaning is created in coordination with other human beings, not separately within the individual (Andrews, 2012; Gergen, 2015). Social construction's view is that knowledge in any area is a product of our social practices and institutions or of the interactions and negotiations between relevant social groups (Gasper, 1999). People interact through language and it is an important aspect of constructing knowledge (Willig, 2001). According to Gergen (1985), a social constructionist approach has one or more of the following assumptions.

4.2.2.1 A critical stance towards knowledge

Social constructionism is critical of ways of understanding the world which are taken for granted elsewhere. It challenges the view that conventional knowledge is based upon objective, unbiased observation. It cautions us to be suspicious of our assumptions about how the world appears to be. Our knowledge is constructed through the lens of our interpretation and understanding, which is based on our internalisation of our culture's constructed knowledge (Stainton Rogers & Stainton Rogers, 2001). Our knowledge is thus limited to this specific perspective while for any state of affairs there can be potentially unlimited descriptions and explanations (Gergen, 2005).

The concept *gender* may be used as an example of a meaning that is taken for granted. Gender has meaning for us, because humankind gave it meaning through social construction.

Some communities has created a meaning that women should be shy when it comes to issues of sexuality. Women are expected to be directed by men in how sex should be. This makes women vulnerable to HIV and AIDS as they are not supposed to negotiate sex and condom use with men.

In relation to the present study, instead of campaigning for certain HIV and AIDS prevention strategies in all communities, we should attempt to first validate and improve our knowledge by finding suitable answers to questions such as: *Who proposed this knowledge?* and: *For which purpose?* (Stainton Rogers & Stainton Rogers, 2001) before designing context specific combined interventions and introducing them concurrently.

A train of relevant questions to precede an intervention design for a given community may, for instance, include:

- Who proposed the ABC HIV prevention intervention?
- Where was the research done to propose the ABC campaign as suitable for HIV prevention?
- For which purpose was the ABC campaign launched?
- How would the given community react to the ABC campaign?

Condoms were originally developed as a form of contraceptive. In the fight against HIV and AIDS, condom use was first introduced to homosexual communities. Considering where it was developed and the purpose for which it was developed, it cannot be taken for granted that condom use will be suitable for, and accepted by, every culture and community. It is important that we determine under which conditions some people will use condoms and under which conditions some people will not. We also need to find out which meanings are attached to condoms in different contexts. Local truths are important in sustaining people's ways of doing things. Presuming local truths to be universal is, however, not only arrogant, but introduces conflict and the undue suppressing of other local truths (Gergen & College, 2001).

4.2.2.2 Knowledge is historically and culturally specific

The second assumption is that the ways in which we understand the world are historically and culturally specific. Stainton Rogers and Stainton Rogers (2001 p. 163) said that “given that knowledge is a human product, it follows that knowledge is meaningful and useful only in the historical time and culture in which it was/is created and maintained”. Gergen and College (1985, p. 267) phrased it differently by stating that “*the terms in which the world is understood are social artefacts, products of historically situated interchanges among people*”. The way in which we commonly understand the world, the categories and concepts we use, are thus historically and culturally specific. It depends on where and when in the world one lives. This means that people’s understanding of HIV and AIDS and HIV and AIDS prevention campaigns is affected by where and when they are in the world and on how they construct their realities. As HIV and AIDS prevalence is not decreasing as wished for in Africa, it is a possibility that people in Africa construct HIV and AIDS-related issues differently from elsewhere where HIV and AIDS infection is decreasing. This calls for a thorough investigation of the construction of HIV and AIDS, HIV and AIDS prevention campaigns and sexuality and the culture influencing these constructions.

4.2.2.3 Knowledge is created and sustained by social processes

The third assumption of social construction is that knowledge is created and sustained by social processes. This means that people construct knowledge of the world between themselves through interactions. Burr (1995 p. 4) wrote:

“It is through the daily interactions between people in the course of social life that our versions of knowledge become fabricated. Therefore, social interaction of all kinds and particularly language is of great interest to social construction. Therefore what we regard as truth is the product not of objective observation of the world but of social processes and interactions in which people are constantly engaged with each other”.

The way society interacts in relation to HIV and AIDS and sexuality leads to constructions of knowledge on how people should behave in relationships. This also leads to knowledge,

beliefs and norms on how people should interact sexually. Research has shown that knowledge about HIV and AIDS has limited influence on sexual risk behaviours. Societal, gender and peer norms seem to play more roles in decision-making around sexual risk behaviours than rational decision-making influenced by fear of HIV. Constructions around sexuality seem to have more influence on people's sexual behaviour than their knowledge about HIV.

4.2.2.4 Knowledge embraces social action

The fourth and final assumption of social construction is that knowledge and social action go together. According to Burr (1995), each different construction brings with it or invites a different kind of action from human beings. Stainton Rogers and Stainton Rogers (2001, p. 166) stated that “knowledge often carries with it a mandate or warrant of action”. In South African townships male sexuality among some young men is defined by having sex with many partners (Mah & Halperin, 2008). Not having sex with many partners leads to exclusion from peer groups and not having high status among peers. Stainton Rogers and Stainton Rogers (2001) noted that knowledge is not just created. The form in which it is made carries implications for people's lives, livelihoods and opportunities. In the constructions of African masculinity mentioned above, knowledge of social norms places young men at risk of HIV and AIDS as they engage in risky behaviours in order to belong. In relation to the study, it means that how we construct sexuality leads to certain actions that may or may not support adherence to the HIV and AIDS prevention strategies.

Research done through the South African Demographic Health Survey (2006) indicated that South African youth reported the lowest knowledge about ways to prevent HIV transmission. Shisana et al. (2014) also reported a decrease in knowledge about HIV transmission between the 2008 and 2014 surveys.

Because of the complexity of knowledge construction, the notion that knowledge embraces social action cannot lead to the conclusion that imparted knowledge will forthwith precipitate desired social action, as the recipient of such knowledge modifies the knowledge to conform to his or her previous knowledge before enacting the resultant construct. It can consequently not be deduced that young people's propensity for high risk sexual behaviour will be

inversely proportional to their learning about ways to prevent HIV transmission. Besides young people's limited knowledge about ways to prevent HIV, young people are teaching each other high risk sexual behaviours. For example, they are teaching each other that condoms prevents sex from being enjoyable and having multiple sexual partners improves one's status. Such influences contribute to young people acting in accordance to an own construct of what they are taught. It can be considered why peer group sexual notions are leading to social action among young people while HIV prevention knowledge is not enacted. It is my opinion that the source of information might play a role in determining which knowledge leads to social action. Knowledge from dominant sources lead to social action and for young people, dominant sources might be the peer group.

Most criticism against social construction is summarised by its perceived conceptualisation of realism and relativism (Andrews, 2012). In denying that knowledge is a direct perception of reality, social construction is criticised for being anti-realist. This criticism relates to ontological and epistemological claims (Andrews, 2012; Stam, 2001). In response to the anti-realist criticisms, social construction by Berger and Luckmann (1991) makes no ontological claims but only epistemological claims. Gergen (2015, p. 8) explains this by saying "the ways in which we describe and explain the world are not required by what there is".

Linking the criticism regarding realism to this study, social construction would not deny that HIV and AIDS is real. It would however claim that the way we view, explain and react to HIV and AIDS is socially constructed. This has been most evident in the history of HIV and AIDS where it was initially constructed as a moral and deadly illness, which resulted in stigma against people living with HIV. The reasons for using the term HIV and AIDS as opposed to HIV/AIDS are socially constructed notions independent of the virus and deficiency itself. Social construction does not deny that reality exists, it emphasises that the meaning and experience of illness is shaped by cultural and social systems (Conrad & Barker, 2010).

Another criticism of social constructionism is its relativism. Relativism leads to the conclusion that there are multiple realities and none is having precedence over the other (Andrews, 2012). This leads to another critique that research done from a social construction perspective does not lead to any significant benefit, because it just highlights one of many discourses. This benchmarks it as one of the least developed areas of constructionism (Burr,

1995). However, it is my opinion that such criticism is not valid as social construction can generate real debate leading to change. In relation to this study, relativism seems to be an appropriate position as it gives permission for people in different contexts to define their own reality and way of understanding HIV and sexual risk behaviour. This may result in context specific HIV prevention interventions as current generalised HIV preventions seems not to be effective in all contexts. According to Gergen (2015) multiple realities in social construction is an advantage as it give us freedom to challenge that which we hitherto took for granted, change it and create new realities.

Young people's construction of sexuality is the main focus of this research. This explains why social construction and not African theory or framework was used in this study. The social construction theoretical framework is suitable for the study because it is concerned with historically and culturally specific ways of explaining social interactions. HIV and AIDS is not just a medical problem as the social effects of the pandemic are severe. The social aspects affecting people differ between different cultural contexts where concepts such as sexuality are perceived and constructed differently. For a woman whose womanhood is defined by how many children she has, the perception towards mainstream prevention programmes will be different from a young man whose manhood is defined by how many partners he has and whether he is a virgin or not.

The study was concerned with how Vhavenda young people (specific group and culture) currently construct sexuality and whether this construction has an effect on Vhavenda young people's sexual risk behaviour and adherence to current HIV and AIDS prevention campaigns. Another focus was on how cultural beliefs and practices could be used to improve prevention interventions. In the next section, the research methodology used to study young people's constructions within the social constructionism paradigm will be outlined. Qualitative research methodology, sampling and focus group discussions as a data collection method are discussed.

4.3 Research Methodology

4.3.1 Qualitative research methodology

4.3.1.1 Introduction

This study was conducted using qualitative research methodology. Qualitative research is a process of inquiry that is aimed at discovering how human beings understand, experience, interpret and produce the social world (Sandelowski, 2000). Qualitative research data is used to develop concepts and theories that help us to understand the social world rather than test an existing theory. Qualitative research aims to gain insight and explore the depth, richness and complexity inherent to the phenomenon. Qualitative research usually takes place in a natural setting and attempts to make sense of or interpret phenomena in terms of the meaning people bring to them (Abawi, 2008; Denzin & Lincoln, 2003; Kvale, 2007). The goal of qualitative research is to develop an understanding of a social or human problem from multiple perspectives (Abawi, 2008). This method of doing research thus fits well with using social construction as a research paradigm.

4.3.1.2 Doing qualitative research

Qualitative research is concerned with finding the answers to questions which begin with *Why...*, *How...* and *In what way...* (Abawi, 2008). It is concerned with opinions, experiences and feelings of individuals producing subjective data. Qualitative research is a systematic, subjective approach used to describe life experiences and to give them meaning (McRoy, 2000; Denzin, & Lincoln, 2011).

Through qualitative research methods a researcher collects data from a small sample size (Abawi, 2008). The benefit of using a small sample size includes richness of data and deeper understanding or insight into the phenomena being studied. The aim is not to generalise the results, but to understand the individuals or group that is being studied. Qualitative research is also referred to as naturalistic research (McRoy, 2000; Denzin, & Lincoln, 2011). Direct observations are made of human behaviour or interactions. Qualitative researchers believe that gaining knowledge from sources that have *intimate familiarity* with an issue is far better

than the objective distancing approach that characterises quantitative methods (Rich & Ginsburg, 1999).

Qualitative data analysis involves coding and classifying data. The main goal is to identify extracts of data that are informative and to search for important messages hidden in the data. The goal of qualitative data analysis is to determine and explain a pattern of relationships that may best be analysed by grouping the data (Abawi, 2008; Rich & Ginsburg, 1999).

In conclusion, qualitative research methods seek to develop a deeper understanding of a social phenomenon from multiple perspectives by studying participants in their natural setting. As the main aim is to understand a phenomenon, it utilises a small sample. Qualitative research methods often collect data face to face with an individual or in a group context. Data analysis is done through coding of the resultant data and subsequently extracting meaning based on the coded data.

4.3.1.3 Criticisms of qualitative research

No research approach is complete or flawless. Both qualitative and quantitative research has different strengths and limitations. The value of criticism depends on the source it comes from, not only in terms of the critical party, but more importantly of the context and purpose of the criticism. Disadvantages identified by critics of qualitative research in certain settings may prove to be distinct advantages in other settings.

One common criticism of qualitative research is that the results of a study may not be generalised to a larger population (Malterud, 2001), because the sample is usually small and the subjects are not chosen randomly. Qualitative research usually studies a specific group that is the focus of research. In these studies, generalisability of findings to a wider population is usually not the aim. The present study focused on young people in Venda. The aim was not to generalise the results to young people in other areas, but to have a deeper understating of sexuality constructions among young people in Venda and of the impact of those constructions on their sexual risk behaviours.

A second criticism is the researcher's bias (Malterud, 2001). Even though bias is at work in all research approaches, the naturalistic method of collecting data in qualitative approaches increases the probability that collected data may be biased by the researcher's perspective. Qualitative researchers minimise the potential for bias in their research by acknowledging the

effect of a researcher's position and perspectives and disputing the belief of a natural observer. This has resulted in a commitment to reflexivity. During all the steps of the research process, the effect of the researcher should be assessed and later shared (Malterud, 2001). In the present study, the researcher acknowledges that she was not a neutral observer. The fact that she was born and bred in Venda and is now staying and working in Pretoria has an effect on how she observed the participants' responses and selected the text produced. It is accepted that the researcher and the participants co-construct a reality during the interview process. The participants share their point of view and the researcher interprets what they say through her own perspective (Wilkinson, 1998a). To be aware of and reflect on her own biases, the researcher kept a diary of her reflections and feelings and how they might have affected her observation of interactions and text produced. More information about the researcher's reflexivity and how she tried to ensure trustworthiness of the data is discussed later in this chapter.

A lack of validity or trustworthiness of data, i.e. inaccuracy of research findings, is also mentioned as one of the criticisms of qualitative research. Malterud (2001) suggested that to improve trustworthiness, researchers must use triangulation, respondent validation, clear detailing of methods of data collection and analysis reflexivity as well as attention to conflicting cases. The researcher's engagement in the process of reflexivity and data collection is also explained in detail later in this chapter.

4.3.1.4 Qualitative research implemented in the current research

Social constructionism is the theoretical framework that was employed in the study. Qualitative research methodology was used for the study because of its constructivistic approach that links with the social construction theory (Bear-Lehman, 2002). In qualitative research, the researcher must be prepared to use strategies for questioning findings and interpretations instead of taking them for granted (Malterud, 2001; Denzin & Lincoln, 2011). This is related to a social constructionism assumption of taking a critical stance towards knowledge. As indicated in the literature review, current HIV prevention interventions are not effective for everyone. Instead of just taking it for granted that HIV campaigns will be effective for all young people, the current study adopted a critical stance. It questions why these campaigns are not proving to be effective. The study aimed at a deeper understanding of influences that play a role in the sexual behaviour of young people in Venda.

The researcher in qualitative research is also expected to assess the trustworthiness and applicability of research results instead of assuming them as obvious or universal. This expectation for a qualitative researcher is linked to a social construction assumption that knowledge is historically and culturally specific. Sexuality is perceived differently in different cultures and times. Similarly, HIV prevention interventions are perceived differently in different cultures, depending on how sexuality is perceived in that culture and time. The researcher also acknowledges that phenomena are not universal, but are historically and culturally specific.

Research from a social construction point of departure results in co-construction of reality and knowledge through the interaction of the researcher and the participants (Wilkinson, 1998a) as knowledge is created by social processes. By studying young people in groups, the researcher aimed to explore how interaction among young people influence their sexual behaviour. There were co-constructions of reality within the group between the participants and the researcher.

Qualitative researchers interact with the participants and actively work to minimize the distance between the researcher and participants (Abawi, 2008; Denzin, & Lincoln, 2011). The researcher and the participants co-construct reality in their interaction within the group. Qualitative research allows for an unstructured and semi-structured method of inquiry. It allows open and flexible responses that permit new and anticipated responses to be explored (Willig, 2001).

The qualitative researcher's qualities and social construction assumptions as discussed above indicate that qualitative research methodology fits in with the assumptions of social construction. This is why the qualitative research method was chosen for this study. Besides qualitative research's link to social construction, the theoretical framework of the study, qualitative research was an appropriate research methodology for the study because it is used when present knowledge and theories to explain a phenomenon are inadequate (Kneale & Santy, 1999).

As current HIV and AIDS prevention interventions have proved not to be effective in some communities and age groups. It was, therefore, important to explore other ways of reducing sexual risk behaviours among young people through qualitative research. Many of the life experiences, understandings and beliefs that place young people's health at risk are difficult to quantify. Qualitative research offers tools to examine these powerful forces at work in

young people's lives. It looks beyond diagnostic outcomes to explore context and motivation; the how and the why of young people's sexual risk behaviours. It is for this reason that qualitative research methodology was used for this study: to explore how Vhavenda young people currently construct sexuality and whether this has an effect on Vhavenda young people's adherence to current HIV and AIDS prevention interventions.

4.3.2 Participants and sampling

The study was aimed at young people in the urban and rural areas of Venda. The definition of young people varies depending on the context in which it is used. Young people are defined as people in the period between childhood and adulthood. For the purpose of the study, young people were defined as people between the ages of 15 to 19; making use of the definition of the United Nations (2007). Participants of the study were recruited from secondary/high schools. The fact that they were school-going young people also played a role in the definition of young people in the study.

A sample of participants was obtained from the schools in Venda using a two-pronged selection process. Firstly, the schools were selected and thereafter, participants were selected from the schools.

Schools were chosen for this study because they provide easy access to young people aged 15 to 19 years. A list of all secondary schools (152 secondary schools) in Venda was obtained from Vhembe Department of Education. The 63 secondary schools from urban areas in Venda were placed in one hat and 89 secondary schools from rural areas in Venda were placed in another hat. For this study, urban area was defined as a settled area inside or near towns and cities. The inhabitants generally lived in suburbs. There was access to infrastructure such as shopping malls, banks and hospitals. Rural area, on the other hand, was defined as a settled area outside towns and cities. The inhabitants generally lived in villages or farms. They had poor access to infrastructural facilities such as shopping malls, banks and hospitals.

Four secondary schools were selected to participate in this study. Two secondary schools from rural areas and two from urban areas of Venda were randomly selected by drawing names from a hat. The following is the description of the schools that were selected:

- Gondeni Secondary School has at least 950 students. The School bears the name of the area it is in. Gondeni is a rural area in Venda that is occupied by small villages. People in Gondeni use subsistence farming as a source of survival. The nearest hospital to Gondeni is Donald Fraser Hospital which is at least 15 kilometres from Gondeni. The nearest town is Sibasa which is about 50 kilometres from Gondeni.
- David Mutshinyalo Secondary School has at least 1005 learners. It is situated in an area called Matangari. Matangari is mostly populated by farmers who are involved in both commercial and subsistence farming. The nearest hospital to Matangari is Donald Fraser Hospital which is at least 45 kilometres from Matangari. The nearest town is Sibasa, which is about 60 kilometres from Matangari.
- Thohoyandou Maniini Secondary School has at least 2000 learners. Thohoyandou Maniini Secondary School is named after the area it is situated in. Thohoyandou is one of the major cities in Venda. Thohoyandou has the biggest mall in Venda. The mall attracts shoppers from other areas around Venda like Giyani and Malamulele. Thohoyandou is occupied by people who are considered to be wealthy by the Vhavenda. Citizens of Thohoyandou usually own businesses or work in government. Thohoyandou presents easy access to malls and infrastructures like hospitals, clinics and private doctors. Maniini is a semi-rural suburb of Thohoyandou.
- Finally, Marude Secondary school has at least 1 500 learners. Marude Secondary school is named after the area it is situated in. Marude is an area near Thohoyandou. Marude is an area mostly occupied by rich people who depend on infrastructure like hospitals, clinics and private doctors, in Thohoyandou.

4.3.2.1 Selection of learners from each school

The researcher explained the research to the learners in Grade ten to twelve in each school. The teachers were not present at the time to make sure that learners did not feel coerced to participate in the study. To motivate learners to participate in the study, the researcher explained the research and informed them about the current HIV and AIDS statistics and sexual risk behaviours among young people. Learners were also encouraged to participate as it was an opportunity to change those situations among young people.

A total of 843 learners in Grade ten to twelve were present in these four schools when the research was explained. Initially, a total of 120 learners showed willingness to participate. In a smaller class setting the research was again explained to the learners who volunteered initially. Learners were then asked to confirm that they volunteer by conveying consent forms to their parents or guardians and, if the adults agreed, to personally complete assent form themselves. From the original 120 volunteers, 54 learners had withdrawn from the study before consent forms were collected. Some parents were unwilling to complete consent forms, some students neglected to present the forms to their parents, some realised that participation will clash with other commitments, while some were uncomfortable with the subject or simply lost interest. The remaining 66 learners (41 girls and 25 boys) participated in the study.

The focus groups comprised a mix of male-only, female-only and mixed gender focus groups made up of learners. The names of the groups (mixed and same gender) were written on small pieces of paper and put in one hat. Learners were asked to draw a name from the hat to determine the group to which they were assigned. This was done in schools that had more than one focus group discussion. The decision to have both mixed and same gender focus groups was for the study to have comprehensive information from the focus groups. The mixed gender focus groups were included in order to observe how discourse would vary depending on the presence of peers of the opposite gender and to generate debates on gender issues.

Six focus group discussions of at least two hours each were conducted at the respective schools.

- Two focus group discussions were held in Gondeni with 19 learners. One group comprised eleven girls and another group comprised eight boys.
- One focus group discussion was held at Matangari with ten learners. The group comprised six girls and four boys.
- Two focus group discussions were held at Thohoyandou Maniini with 25 learners. One group comprised nine girls and five boys and the other group comprised eleven girls.
- Finally, one focus group discussion was held with twelve learners from Marude. The group comprised eight girls and four boys.

4.3.2.2 Selection of community leaders from each area

The study also included community leaders from the area surrounding each school as participants. They were parents, healthcare workers, priests, chiefs, elders and teachers. These areas were chosen as they are areas where the participating schools are situated. The chiefs in Gondeni, Thohoyandou Maniini, Matangari and Marude were asked to recruit volunteers to participate in the study. The chiefs asked for volunteers from the community during community meetings attended by elders of the community. The researcher met with the 45 community leaders from the different areas who were interested in the study and explained the research to them. After the explanation, community leaders were asked to volunteer to participate in the study. A total of 31 community leaders volunteered to participate in the study: 13 of these community leaders were from urban areas and 18 were from rural areas. A total of four groups of at least two hours each were conducted with community leaders who volunteered to participate in the study.

Two focus groups were done in urban areas (Thohoyandou Maniini and Marude) and two focus groups were done in rural areas (Gondeni and Matangari). Groups of community leaders were all mixed gender groups. Teachers, parents, healthcare workers, priests, chiefs, elders and teachers were mixed in each focus group. Mixing community leaders in focus groups was done in order to encourage critical discussions as different community leaders might have different opinions related to sex, sexuality and HIV and AIDS prevention programmes.

The adult participants were selected because the researcher is of the opinion that there is a need to look at the adult and young people's constructions of sexuality as both have an effect on how young people behave sexually. Adults observe young people's sexual behaviour and might have an understanding of what is affecting young people's sexuality. The inclusion of adult participants would contribute to multiple data sources to explore different levels of constructions in the community. The adult participants were also selected because it is the researcher's view that it is important to explore cultural constructions of sexuality although this might differ with the definitions of young people. This is important as adults' constructions have an effect on young people's construction of sexuality. It is also

important to include adults as they can give insight into the cultural practices that can aid in the prevention of HIV and AIDS.

4.3.3 Data collection

Focus group discussions were used to collect qualitative data for the study. Focus group discussions are group discussions organised to explore a specific set of issues. They are group interviews that use the interaction among participants as a source of data (Willig, 2001). They usually consist of six to ten participants led by a moderator. They are characterised by a non-directive style of interviewing where the prime concern is to encourage a variety of viewpoints on the topic from the group (Kvale & Brinkman, 2009). Focus group discussions as a method of data collection was chosen for this study as previous research (Harrison, Xaba, Kunene, & Ntuli, 2001) indicated that it is difficult to interview young people about a sensitive topic such as their early sexual experiences. One-to-one interviews can be intimidating for young people. Group interactions provide peer support when discussing sexual issues and group processes also assist to uncover group norms.

The focus group was chosen as a data collection strategy for this study as it allows for interactions among group members which, in turn, allow statements to be challenged, extended, developed, undermined or qualified in ways that generate rich data for the researcher (Willig, 2001). Focus group discussions give the researcher insight into the interactions and constructions among participants.

Focus groups are suited for exploratory studies since the lively collective interaction may lead to more spontaneous expressive and emotional views than individual interviews (Kvale & Brinkman, 2009). Focus group discussions also complement social construction theory as a theoretical approach as they allow participants to construct the reality of their world in the process of social interaction in the group just, as they do on a daily basis. Focus groups also afford the participants and the researcher the opportunity to co-construct reality as the researcher learns from the participants. The focus of the research is on the social constructions of sexuality. The group is thus an ideal situation to observe constructions of sexuality and allow the researcher to join the process of co-construction of their views (Kvale & Brinkman, 2009; Wilkinson, 1998a).

When using focus group discussions, the researcher had to attempt to address the impact of the researcher's identity as an adult female on the interaction that might take place in the research interview around sex and sexuality with young people. As an adult person researching young people, the researcher could have been assumed to be conducting the study from the position of an outsider. The same can also be said about the researcher's position as a person who no longer stayed in Venda. This also led the researcher to assume the position of an outsider. However, other factors about the researcher, for example, the ability to speak Tshivenda, being from Venda originally and understanding Venda culture allowed her to assume the position of an insider. Recent discussions of insider/outsider status have shown that there is complexity in both statuses. The boundaries between the positions are not clearly defined (Merriam et al., 2001). According to Merriam et al. (2001, p.405), "In the real world of data collection there is a good bit of slippage and fluidity between the two states". Assuming both an insider and outsider position affords the researcher the opportunity to elicit responses and to get rich and fuller information from the group.

To complement the position of the researcher in the focus group discussions, a co-facilitator who was a black male aged 35 years from Venda was used. The co-facilitator was not well-known to the participants, but he could nevertheless assume the position of an insider, because he was born and bred in Venda. The co-facilitator also assumed a position of an insider in male only groups. This was important in discussions around male issues and masculinity. As an outsider, the researcher could assist by posing more probing questions in instances where some things were assumed to be known. The co-facilitator also assumed a role of an outsider in female only groups. His position might have had a negative impact on the discussions as it is not accepted for females to discuss sexual matters in the presence of an adult male figure. His position in those groups might also have assisted as he was able to pose more probing questions in situations where information was assumed to be well-known among females. This resulted in more and deeper discussions around issues and topics that were taken for granted. Focus group discussions with learners were held at the schools where learners attended classes. The focus group discussions were done after formal school hours. Learners were not compensated for participating in the study but refreshments were served after focus group discussions.

The focus group discussions were done using a semi-structured discussion guide on how young people construct sexuality. The semi-structured discussion guide was chosen for this study as it is well suited to studying people's understanding of the meanings in their lived world (Kvale & Brinkman, 2009). The guide also seeks to obtain descriptions of the life world of the participants with respect to interpreting the meaning of the described phenomenon. The guide had some suggested questions, yet at the same time there was an openness to change the sequence and forms of questions in order to follow up the specific answers given and the stories told by the participants (Kvale & Brinkman, 2009). This is important as it gives the researcher an opportunity to explore participants' differences and tease out a diverse range of meanings on the topic by encouraging interaction with the group.

The focus group discussions with learners were guided by semi-structured questions, as displayed below, around sex, sexuality construction, sexual risk behaviours and HIV and AIDS prevention programmes. The questions are based upon previous studies and the literature reviewed.

Semi-Structured discussion guide for learners.

Questions:

1. How do you as young people protect yourselves from HIV and AIDS?
2. Why do young people engage in HIV and AIDS risk behaviours?
3. What does sexuality mean to you as young people?
4. How do gender roles and expectations influence your sexual behaviour?
5. What do you think of current HIV and AIDS prevention programmes?
6. How have current HIV and AIDS prevention programmes influenced your sexual behaviour?
7. What are the possible alternative ways to prevent HIV among young people?
8. Are there any other comments you would like to add?

Focus group discussions with community leaders were held at the chief's home in the different areas. Neutral locations for focus group discussions are helpful for avoiding negative or positive associations with a particular place. The chief's home was chosen as it was a convenient and neutral place for the community leaders as they meet at the chief's home regularly for community meetings. As the home of the chief is the place where the community addresses social issues and resolves community problems, the place might have influenced the results positively by portraying the discussions as a serious matter that participants needed to resolve regarding young people's sexual risk behaviours and propose solutions for. Community leaders might have also used the group discussions as a place to voice their concerns regarding young people and government, as the chief's home is the place where their concerns are raised and resolved. The disadvantage of using the chief's house is that it might have influenced the discussions to be more traditionally focused as the chief's house focuses more on traditional matters.

Both the researcher and the co-facilitator was present in community leaders' focus group discussions. The community leaders' focus group discussions were mixed gender groups. The researcher, who can be seen as an outsider, and the co-facilitator, who functioned as an insider in these groups, collaborated well. It might have been assumed that the co-facilitator was more familiar and accustomed to Venda culture and tradition. The co-facilitator and the researcher's ages were similar. This made them assume the position of outsiders as they had focus group discussions with older people. Having two facilitators from different perspectives helped in probing further to deepen discussions on issues that were taken for granted.

The focus group discussions with community leaders were guided by semi-structured questions, as displayed below, around sex and sexuality, young people's sexuality and traditional cultural ways of the prevention of HIV and AIDS. The questions were also developed based on previous studies and literature reviewed.

Semi-structured discussion guide for community leaders

Questions:

1. What is the Venda cultural definition of sexuality?
2. What cultural practices exist around sexuality?
3. How do you understand young people's sexual behaviour?
4. What are culturally defined ways to protect one from pregnancy and HIV and AIDS?
5. Are there any other comments?

All focus group discussions were conducted in Tshivenda. The focus group discussions were tape recorded with the permission of the participants and then transcribed by the researcher. All utterances by the participants and the facilitators were noted, including pauses and/or interruptions. The transcribed utterances were then translated into English. The co-facilitator then translated the utterances back to Tshivenda to make sure that all information was captured with the same meaning.

4.3.4 Method of Analysis

Discourse analysis was used as a method of data analysis for this study. Discourse analysis is the study of social life understood through analysing language (Shaw & Bailey, 2009). Discourse analysis was developed in the 1990s by Jonathan Potter and Derek Edwards out of the *turn to language* social construction of social reality (Georgaca & Avdi, 2012; Talja, 1999). Discourse analysis is referred to as one of the dominant research approaches in sociology, social psychology and psychology (Talja, 1999). Burr (1995, p. 48) defined discourse as “a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events”. Willig (2004, p. 164) described discourse analysis as “a way of reading a text. This reading is informed by a conceptualisation of language as performative. It requires us to adopt an orientation to talk and text as social action”.

4.3.4.1 Assumptions of discourse analysis

Discourse analysis is underpinned by social constructionist ontology (Holt, 2011). It assumes that it is through language or discourse that people construct reality (Georgaca & Advi, 2012; Whetherell and Potter, 1988). Language is a means of constructing rather than mirroring reality (Georgaca & Advi, 2012). In analysing discourse the social construction assumption is appropriate for the following reasons (Whetherell & Potter, 1988).

- Social construction reminds us that active selection is taking place when people use language. Out of the many available linguistic resources some will be used and some not. This is why we need to analyse the use of language to get an understanding of participants' constructions.
- Social construction assumption emphasize that discourses have an action orientation with practical consequences (Whetherell & Potter, 1988). Shaw and Bailey (2009) reported that discourse is considered a form of social action. Language has a function.
- Discourse has particular repercussions of its own. People use language to achieve certain interpersonal goals. This is why language and interaction are best understood in context.
- Discourse is context specific. In explaining this Whetherell and Potter (1988) reported that language is not a straight forward matter of external reference but depends on the local and broader discursive systems in which language is embedded. For this reason, it is important for discourse analysts to examine variability in people's accounts and functions of talk in specific context.

Language is an important aspect of constructing knowledge (Willig, 2001). Language also contains elements which we use to understand ourselves and which affect the way we act (Burman & Parker, 1993). The other defining feature of discourse analysis is that it questions the *truths* which are *taken for granted* (Holt, 2011). Young people's attitudes towards current HIV and AIDS preventive programmes and HIV and AIDS risk behaviours are influenced by language used around HIV and AIDS. The goal of discourse analysis is to deconstruct the text and in that way challenge the *taken for granted* way of understanding. This is done by looking thoroughly at a text produced by participants. It then results in the creation of new

knowledge and new ways of understanding the world. It also gives insight into the meaning that participants attach to constructs.

Discourse coagulates with power (Georgaca & Avdi, 2012). The ways we think and talk about a subject influence and reflect the ways we act in relation to that subject (Karlburg, 2005). By understanding how society is constructed through language, discourse analysis also reflects existing power relationships (Arribas-Ayllon & Walkerdine, 2008). It constructs certain versions of reality whilst marginalising alternative knowledge and associated practices. Language organised into discourses has power to shape people's experiences and how they behave. Through language, meanings are negotiated and realities produced.

Georgaca and Avdi (2012) reported that discourses entail subject positions and that speakers take up certain positions and position others when they use language. Discourse analyses examine how people's roles are constructed resulting in people's positioning in society and within organisations. Willig (2004, p.171) noted that: "discourses offer subject positions which when taken up have implications for subjectivity and experience". Discourse analysis also attempts to understand how individuals view the world. It studies interaction in personal and institutional relationships (Arribas-Ayllon & Walkerdine, 2008).

Discourse analysis for the present study regarding HIV and AIDS prevention programmes and sexuality focused on text produced by young people in Venda. The researcher explored the implications which young people's constructions around sexuality, HIV and AIDS and preventive programmes have on their sexual behaviour.

Text produced by community leaders regarding young people's sexuality and Vhavenda cultural ways of preventing HIV and AIDS were perused likewise. The researcher explored the implications that those constructions have on young people's sexual behaviour.

4.3.5 The process of discourse analysis

Despite attempts to prescribe ways to do discourse analysis (Fairclough, 1989; Parker, 1992; Potter & Whetterell, 1987), thankfully no prescribed method exists. Foucauldian Discourse Analysis (FDA) and Discursive Psychology (DP) are approaches to discourse analysis which

are usually used in Psychology. The two approaches have been explained and differentiated in many research articles (Burr, 1995; Holt, 2011; Willig, 2004). FDA and DP are not incompatible; they simply reflect the different concerns of people working under the social constructionist umbrella (Burr, 1995). Most writers (Burr, 1995; Potter & Wetherell, 1995) recommended that the distinction between the two approaches should not be emphasised. On the contrary, they advocated synthesis of the two approaches (Willig, 2004). Discourse analysis for this study followed the Discursive Psychology approach to discourse analysis. Discursive Psychology (DP) was chosen for this study as this method construes discourse as productive. Discourse is seen to construct versions of reality that achieve social objectives. DP also frames discourse as situated and context-specific (Willig, 2004). It also has the ability to be constructive and be constructed (Burr, 1995). The way DP frames discourse is related to social construction, which is the theoretical framework chosen for the study; thus DP is suited for the study.

Discourse analysis for the study followed the ten steps of analysis suggested by Potter and Whetherell (1987). Potter and Whetherell's (1987) method of discourse analysis was chosen for this study because it focuses more on the immediate interactional setting that produces data. Holt (2004) stated: "Discursive Psychology is particularly concerned with the action orientation of discourse in its recognition that language is a social practice that has a performative function" (p.71). In relation to this study, it means that the language we use on matters of sexuality leads to certain actions that may or may not support adherence to the HIV and AIDS prevention interventions. The first four steps of discourse analysis suggested by Potter and Whetherell (1995) are part of the research planning:

4.3.5.1.1 Step 1: Formulation of research question

Research questions in discourse analysis vary even though their main focus is on analysing the discourse construction. Discourse analysts' questions are broadly related to construction, its function and advantages (Potter & Whetherell, 1987). The double barrelled research question of this study is:

How do young people construct sexuality and what is the influence of such (a) construction(s) on young people's sexual risk behaviour?

This links to discourse analysis's assumption of action orientation. The research question for this study concomitantly links to the relativists' epistemology of discourse analysis. The research question implies that Vhavenda young people's constructions of sexuality may be quite different from other young people's constructions in a different context and culture.

4.3.5.1.2 Step 2: Sample selection

Sample selection depends on the research objective and the researcher's strategy to ensure that the objective will be manifested through the use of language. Sample size does not determine the success of a discourse analysis study as discourse analysis focuses on language used rather than on the number of people generating it (Potter & Whetherell, 1987).

4.3.5.1.3 Step 3: Collection of records

Discourse Analysis needs accurate records and relying on memory to replicate what has been said will not suffice. The researcher must be committed to thorough record keeping by means of transcripts, diaries, videotapes, audiotapes or many other forms of collecting records. In this study the researcher used audiotape to record the focus group discussions for this study. She also kept a diary to record the activity in the groups as well as her personal reflections on the progress of the research process and group interactions.

4.3.5.1.4 Step 4: Interviews

Discourse analysts frequently utilises participant interviews. When participant interviews are used as sources of data, discourse analysts are able to gain a better understanding of how language is constructed (Potter & Whetherell, 1987). This study used focus group discussions to collect data. Focus group discussion enables the researcher to collect research generated text. Focus group discussions also enable the researcher to collect naturally flowing data through interactions and discussions among participants. Discourse analysts analyse interviews to find out how discourse is constructed and what it conveys and not to determine if such discourse presents an accurate description. Consistency and differences in

participants' accounts are also analysed (Potter & Whetherell, 1987). Discourse analysts do not view the researcher's questions as neutral, but as active and constructive.

Data analysis is specifically described in the next few steps:

4.3.5.1.5 Step 5: Transcribe

According to Potter and Whetherell (1987), working with records of interaction or interviews necessitates producing transcriptions direct from audiotapes. A good transcription is important and it requires intensive involvement of the researcher(s). The audio tape used in this study recorded the focus group interviews. The information recorded was transcribed fully, translated and back-translated to assure the accuracy of meaning of the text.

4.3.5.1.6 Step 6: Coding

Coding is a process that enables the researcher to identify meaningful text and set the stage for interpreting and drawing conclusions (Coffey & Atkinson, 1996). Coding is not analysis in itself; it is the selection of material for analysis (Willig, 2004). Potter & Whetherell (1987) quipped: "The goal of coding is to squeeze a body of discourse into manageable chunks."

Coding was done by reading and re-reading produced text and then selecting extracts which were considered relevant to the research questions. Different codes were used for the young people and adult participants of the study, even though the coding processes were identical. With regard to the young people, all produced texts which related to young people's sexuality, HIV risk and culture in relation to young people's sexuality and HIV, were coded. Concerning the adult participants, all texts produced that related to young people's sexuality, HIV risk, Venda cultural ideas of young people's sexuality and HIV prevention among young people were coded. All relevant texts were included even if they only vaguely related to the specified codes as identified. This was done so that coding could be as inclusive as possible. An example of discourse in the study was that *men are elephants, so they cannot be expected to graze on a single tree*. The latter related to discourse of masculinity and was used as a disclaimer to justify multiple relationships for males.

4.3.5.1.7 Step 7. Analysis

There is no mechanical procedure for analysing discourse. Potter and Whetherell (1987, p. 168) stated that: “*analysis involves a lot of careful reading and re-reading*”. According to Potter and Whetherell (1987) analysis commences with a search for pattern in the data. The pattern is in the form of variability and consistency. This is done by paying attention to the interpretative repertoires used within the discourse; namely, the terminology, stylistic and grammatical features, preferred metaphors and figures of speech that are used within the constructions (Willig, 2004).

Discourse in this study was analysed by identifying information that was variable and consistent in most of the focus groups that were conducted. Discourse was also analysed by comparing the adults’ discourse with the young people’s discourse. Both the adult and young people’s discourses were analysed by finding out the variability and consistency between the young people and adult participants’ discourse. The interpretative repertoires were also identified. Most of the interpretative repertoires emphasised that masculinity is proved by engaging in sexual risk behaviours and that it is culturally acceptable for men to have multiple relationships.

Potter and Whetherell (1987) suggest that the next phase of analysis is concerned with forming hypotheses by searching for linguistic evidence. There is concern for the function and consequence of discourse because discourse analysts’ main argument is that discourse fulfils many functions and has varying effects. To identify action orientation of accounts, the analyst needs to pay attention to the discursive contexts within which such discourses are produced and to trace their consequences for the participants in a conversation (Willig, 2004).

Discourse analysis in this situation requires that language be analysed in context. In this study, the young people’s discourses were analysed by checking for influences which such discourses have on young people’s sexual risk behaviours. For young people, constructions of sexuality as natural and hegemonic masculinity were found to influence young people’s sexual risk behaviours. The adult participants’ discourses were also analysed by checking the influences adults’ discourses have on young people’s sexual risk behaviours. Adult’s discourse of young people’s sexuality showed that young people are viewed, positioned and

expected to be blank slates in sexual matters and not to have sexual needs. Adult's constructions of young people's sexuality influenced young people's sexual risk behaviours as it invalidated young people's sexual needs which make young people to rely on peer influence in their sexual decisions. Adult's discourse about young people's sexuality also influences adults and parents not to communicate with young people about sexual matters.

4.3.5.1.8 Step 8: Validation

Qualitative research data analysis raises questions regarding the validity and reliability of results. Reliability and validity are concepts that are mostly used in quantitative research. In qualitative research, validity and reliability have been replaced with concepts such as credibility, trustworthiness and rigour (Davies & Dodd, 2002; Golafshani, 2003; Lincoln, Lynham, & Guba, 2011). The quality of data interpretation depends on the trustworthiness of the study and research findings. A researcher's constructions, perspective and views can have an effect on the results. Any research process is always filtered through the lenses of the language, gender, social class, race and ethnicity of the researcher. There are no objective observations, only observations socially situated in the worlds of the observer and the observed. The fact that the researcher was born and bred in Venda created a bond and certain expectations from young people. Her age difference from the people that were interviewed, her social class and the fact that she no longer resided in Venda might have had an influence on her interpretation of the data. The personal experiences of the research process and how it might have impacted on the research findings is discussed in Chapter 6.

There are many techniques that can be used to validate discourse analysis research. Potter and Whetherell (1987) identified four main techniques that are explained below. In the following section the researcher describes how the techniques for validation were implemented to validate the research.

- *Coherence* – Analysis should show how discourse interlaces and how discourse produces effects and functions. If discourse does not fit together and there is no explanation of how discourse produces effects and functions, analysis is less likely to be regarded as complete and trustworthy. Stiles (1993) reported that coherence includes internal consistency, comprehensiveness of the elements to be interpreted and the relations between elements and usefulness in encompassing new elements as they

come into view. This study used coherence by showing how discourse of this study fit in with discourses from previous studies. The male sexual drive discourse is one of the discourses produces in this study and it coincides with the discourse framed by Hollway (1984, 1989). Discourse produced in this study also has an effect and functions in influencing young people's sexual risk behaviour.

- *Participants' orientation* – Discourse analysis focuses on the orientation of the participants. What the **analysts** view as consistent or different is not of importance; what is important is what the **participants** view as consistent and different as it has implications on how the participants interact (Potter & Whetherell, 1987). For this to be met, the participants must have access to the results and interpretation of the results and comment on what the researcher analysed. In this research the researcher reflected on what she understood after each focus group discussion. During reflection, the participants verified that the researcher heard and understood what the participants said. The researcher plans to present the results to the participants for comments before using it in future planning.
- *New problems* – New problems may emerge during discourse analysis. Potter and Whetherell (1987, p. 171) noted that “one of the primary goals of discourse analysis is to clarify the linguistic resources used to make certain things happen. However, these resources will not only solve problems, but will also create new problems of their own”. New problems can be used to validate analytic suggestions. New problems for this study are indicated as suggested future research in Chapter 6.
- *Fruitfulness* – Fruitfulness “refers to the scope of an analytic scheme to make sense of new kinds of discourse and to generate novel explanations” (Potter, & Whetherell, 1987, p. 171). Analytic claims are considered valid if they can be used to generate new solutions to the problems. The fruitfulness of this study is indicated in Chapter 6 under recommendations for reducing young people's sexual risk behaviour.

In addition to validation, reflexivity is also suggested to improve the credibility of qualitative research. Cooper and Endacott (2007) described reflexivity as sensitivity to the ways the researcher and the research process have shaped the collection of data, including the influence prior assumptions and experiences have on constructions and co-constructions of reality. Such prior assumptions can stem from the researcher's background, perceptions and interests. In qualitative research and social constructionism, the researcher is part of the research. He

or she is also a participant in the construction process and not merely an observer. It is important for the researcher to analyse and interpret his or her own constructions within the context of the research.

Reason and Rowan (1981) said that valid research rests on high quality awareness of the researcher (reflexivity). High quality awareness is maintained if the researcher engages in systematic methods of personal and interpersonal development. The researcher kept a journal where awareness and personal feelings arising from the study were noted to encourage the process of self-awareness. The researcher was aware of the effect that the researcher's culture, age, socio-economic background and personal feelings can have on the research findings. A reflection of the researcher's background, culture, age and personal feelings and how it potentially impacted on the research findings are discussed in Chapter 6.

Triangulation is also reported as a powerful strategy to enhance the quality of research, particularly the credibility of the research (Knafl & Breitmayer, 1989). Triangulation means seeking information from multiple perspectives for the mutual confirmation of data to ensure that all aspects of a phenomenon have been investigated. The study employed triangulation of data sources as described by Knafl and Breitmayer (1989) in order to investigate young people's sexual risk behaviours from different perspectives. Participants from different schools and different areas of Venda were interviewed. Young people and adult participants of different professions and religious beliefs were interviewed. Results from these different groupings of people were converged in order to enhance the quality of research.

4.3.5.1.9 Step 9: The report

The final report constitutes the confirmation and validation of the research itself. The final report is written in detail and the analysis is written in a way that is accessible to the reader. This affords the reader the opportunity to evaluate the different stages of analysis of the research and either agreeing with the conclusions or finding grounds for disagreement (Potter & Whetherell, 1987).

4.3.5.1.10 Step 10: Application

Potter and Whetherell (1987) emphasised the importance of the application of the research findings. They suggested two models for the application of discourse analysis. Firstly, popularisation disseminates the knowledge as freely as possible and secondly, it opens up a dialogue with people who have been participants in the study. This study will be made available to the public, especially organisations involved in HIV and AIDS prevention programmes. The aim is to assist those organisations in developing future prevention programmes that are culture, area and age specific. The research findings will also be made available to the people in Venda. The main aim is to involve them in finding ways to reduce young people's HIV and AIDS risk behaviours.

4.3.6 Conclusion

This chapter provided an overview of the theoretical framework and research methodology that informed the study. Postmodernism and social construction as the theoretical framework grounding the study were discussed. The chapter was concluded by showing how social construction assumptions have influenced the use of focus groups as a method of data collection and discourse analysis as a method of analysing text produced for the study. Willig (2000, p. 97) stated:

“For purposes of presenting discourse analytic research, it makes sense to merge analysis and discussion as in most qualitative research; findings cannot be presented first and then discussed. Instead, a meaningful presentation of the analysis of data can only really take place within the context of a discussion of the insights generated by analysis.”

The following chapter presents the analysis of discourses produced for the study while combining it with suitable discussions.

Chapter 5

Analysis and Discussion

5.1 Introduction

This chapter focuses on the analysis of the discourses produced from the focus group discussions with participants. The discourses were analysed in relation to how shared meanings and understandings produced knowledge that forms the basis of young people's social action. The analysis examines participants' use of knowledge that is *taken for granted* to make sense of their actions. It investigates how participants make sense of their sexuality, sexual risk behaviours among young people and HIV and AIDS.

Analysis of discourses and discussion are merged into one chapter, as it is difficult to separate the two sections in discourse analytic research. In motivating for the amalgamation of analysis and discussion in discourse analytic research, Willig (2001, p. 97) noted that "a meaningful presentation of the analysis of data can only really take place within the context of a discussion of the insights generated by the analysis".

Discourse analysis in this study, as indicated in Chapter 4, was done using Discursive Psychology (DP) and followed the 10 steps suggested by Potter and Whetherell (1987). DP was used to analyse the immediate interactional setting and the action orientation discourse.

In conducting discourse analysis, several and diverse discourses emerged from both the young and adult participants' texts. Discourses identified by young people and adults are presented separately, although similarities and differences between the two groups' ideas are highlighted. Discourses that influence young people's sexual behaviour that emerged among the young people's texts will be explored first.

5.2 Constructions of sexuality

5.2.1 The male sexual drive discourse

The male sexual drive discourse framed by Hollway (1984; 1989) is a central discourse for males' sexuality that emerged from text produced in the focus group discussion. The main constructions about this discourse are that men need sex and that it is an uncontrollable

biological drive. The male sexual drive discourse also explains females' sexuality. According to this discourse female sexuality is constructed as enmeshed with emotion, love and relationships. The male sexual drive discourse has been identified, researched, and is well documented in South African literature (Shefer & Foster, 2001, Shefer & Mankayi, 2007, Strebel, 1993; Wood & Foster, 1995). Young men in this study constructed sexuality as something that is biologically uncontrollable, natural and that cannot be avoided or abstained from. They viewed themselves as victims of the impulses to have sex that cannot be held back. This discourse also implied that abstinence is not an option for young men. One participant declared:

Sex is natural, people. Er, – everyone can feel when the time arrives to have sex. You cannot even control yourself. Sometimes I do not even know what to do to forget about it and er, er, (laugh) not lust for it. The mind is always there, you think about it and dream about it all the time. (Boy from rural area)

There were also constructions within the focus group discussions which revealed that young people find it difficult to abstain especially if they are not virgins. Two participants voiced their opinions:

Sometime we know the dangers of sex after we have started having sex and it is not easy to stop after you have started. The feeling of wanting to have sex calls you all the time. The first time calls for the second time, it is like the old saying, ntsa ya la munawa a i humi [if you taste something good, you are tempted to go back for more]. It is better that we get taught how to have sex safely than to say we should abstain because it is not possible. (Girl from urban area)

It is one and the same thing; we have already started to do it [have sex]. It is better to teach us better ways of doing it [having sex] instead of telling us to abstain because we have already started. It is not easy to stop.

(Boy from rural area)

The male sexual drive discourse also constructs how female sexuality is supposed to be (Shefer & Foster, 2001). Young people in this study regards sex for females as bound up by emotions, love and commitment to the relationship. Young females reported constructions of sex as a means of maintaining relationships and to avoid a break-up.

Young females reported that the fear of losing their partners influenced them to engage in sex at times. One declared:

Sometimes if you love someone and he tells you that, if you don't have sex, he will break-up with you, you end up getting into it [having sex] because you don't want the relationship to end. (Girl from rural area)

Sex was also constructed by young females as a means of pleasing one's partner. Young people reported that young males sometimes ask in a pleading way and they end up agreeing to have sex so as to take care of their lovers. Two of them thus voiced this view:

We feel sorry for them sometimes because they ask so nicely, even kneeling down at times (laughter). When that happens, you will want to please him by giving him what he is asking [sex]. (Girl from urban area)

Sometimes men ask for sex in a way that we cannot refuse as they plead and sometimes even cry for sex. When that happens and you really love the guy, you are more likely to give in. (Girl from rural area)

Undie, Crichton and Zulu (2007) in their study among young people in Malawi also reported that the speech used suggests that young people approach sex as a utility and conceive it as a natural, routine activity. If young people construct sex as natural and constructions lead to actions, young people will continue to have sex even though HIV interventions campaign may promote abstinence.

Sex as a natural activity was also emphasized by constructions indicating that sex is health-giving. Participants from this study also constructed sex as health-giving and this influenced their engagement in sex. This view was captured by the following statements:

*If you do not have sex as young men, you can become insane.
(Boy from rural area)*

*For us, young women, we are always told that it is better to break your virginity when you are still young because if you delay it, it will be very painful as an adult.
(Girl from rural area)*

The discourse of sex as health-giving was mostly among participants in the rural areas. Sex as health-giving never came up within the focus groups with urban participants.

Wight et al. (2006) in their study among young people in rural Northern Tanzania found that there was a widely held belief and discourse regarding sex as natural and health-giving. Izugbara (2008) indicated that young men believe that abstinence from sex results in ill health, the blockage, death, malfunctioning of the penis and madness. Sex is viewed as food for the penis and it may die or lose power if not fed for extended periods of time.

As sex is constructed as an uncontrollable natural drive, young people discussed alternative ways to have sex or to get sexual satisfaction such as masturbation. The young people reported that it is sometimes better if they just masturbate to release the tension and need for sex. However, young females reported frustrations about not knowing how females can masturbate and what to use. They reported that it will be better for them to know so that they can also help themselves. One expressed it as follows:

But, how do females masturbate? (Laughter) Maybe government should provide young females with tools to help themselves because we would also like to help ourselves. We have to be educated so that we can do it ourselves without depending on men. (Girl from rural area)

This discourse confirms that abstinence programmes will not easily be accepted by young people. This indicates that those interventions were developed without an understanding of what will appeal and help young people to reduce the spread of HIV. It is vital for HIV prevention interventions to rather educate young people on other forms of sexual pleasure while protecting themselves (e.g. masturbation).

5.2.2 Discourse of sex as a Commodity

Among young people in Venda, there were several discourses related to transactional sex, which is seen as sexual exchange for material gain. Some participants focused on material gains used for survival purposes and some would engage in transactional sex in their pursuit of modernity (Leclerc-Madlala, 2003). Transactional sex was mostly reported by females within the focus groups. Males were against transactional sex as they felt that they are unable to have some girlfriends because of lack of money.

From the focus group discussions, females expressed that parents sometimes expect young girls to have boyfriends with money who can provide for the family. A participant reported the following:

Some parents tell you to bring muroho [food] knowing that you do not have money as you are not working. They send us to have boyfriends who have money so that the family can have money to survive. If they keep on saying the same thing, you end up thinking that it is not wrong and you start doing it.

(Girl from rural area)

The young people in the study expressed a discourse of transactional sex for survival. Regarding such discourses, it can be mentioned that Leclerc-Madlala (2003, p. 215) reported: “Where the exchange is not necessarily a straight forward cash transaction and where sex is not pursued on a professional basis, the term ‘survival sex’ has gained currency and has generally been interpreted as a consequence of women’s poverty and economic dependence on men”.

Besides the issue of having transactional sex, the participants also indicated that young girls’ discourse of sex for survival is strengthened by adults. Because of the expectations from parents, young girls end up having sex, even unprotected sex. In their study on transactional sex in Tanzania, Wamoyi et al. (2010) reported constructions of transactional sex that was caused by poverty. Wamoyi et al. (2010) found that parents and grandmothers expected young women to have sex with men for gifts.

The above description indicates a situation where some adults condone transactional sex among young girls. Adults turn a blind eye to such actions, as gifts from these relationships contribute towards the household. Such expectations lead young girls to engage in transactional sex.

Young girls reported that they sometimes engage in transactional sex in pursuit of modernity and status. A participant reported:

The other thing is to show that you have status. That’s why you will find a lot of young people having sugar daddies. A sugar daddy can supply you with everything so that you can be seen to have status. And because he gives me everything, I will submit to everything he says even not using a condom.

(Girl from urban area)

For some girls sex is therefore constructed as a means to get luxury goods. Rather than seeking and maintaining relationships for subsistence purposes, many young women also seek and maintain relationships primarily for consumption purposes (Lerlec-Madlala, 2003).

There are several reasons for transactional sex in South Africa which have been described in the literature. Hunter (2002) reported that the status associated with masculinity and the privileged position of men in society make some women dependent on men and reliant on transactional sex.

The young people's constructions indicated that transactional sex in pursuit of modernity influences intergenerational relationships and MCP. There were more constructions of intergenerational relationships by females than males. Females indicated that being in a relationship with an older male is preferable as older males have experience in relationships and can teach them about matters of relationships. They also reported that older males support them financially and that helps in improving their status. One participant reported:

There is no excitement in a relationship with someone your own age. Our thinking is the same. You always talk about school work, er – physics, ... er maths and it is boring. I want someone older who will stimulate my mind and talk about things that will make me happy. Ya, ... That makes me to always want to be with him. The other thing is that an older partner supplies me with everything so that I can be seen to have things and have status. (Girl from urban area)

Intergenerational relationships are seen to be linked to transactional sex. Younger women prefer to be in relationships with older men as they are working and are able to provide for them (Leclerc-Madlala, 2008). This links to the recent constructions of *blessers* and *sugar daddies* that were discussed in Chapter 2 (Gobind & du Plessis, 2015).

The young males, on the other hand, reported that intergenerational relationships are responsible for the rapid spreading of HIV. They also had a feeling that older men were taking their girlfriends. This view was thus reported by some boys:

If you check here around our school, most people have relationships with people who are at university and those at university also have relationships with others at university. That means that, that is where AIDS is spreading.

(Boy from urban area)

Older men are taking women from us because they have money. Women want someone who can take them out and we are at school, we cannot afford to take women out every time they want to be taken out. They will always win with girls our age. (Boy from rural area)

The construction of transactional sex for modernity was also related to multiple sexual partners. Young people reported that the need for benefits from intergenerational relationships encourages them to have multiple relationships. Having multiple partners provides them with material resources and being able to be taken out often. One participant said:

We have many partners because if this one cannot take me out today, I will go out with the other one. If this one cannot buy me airtime, the other one can buy it for me. (Girl from urban area)

Young females reported that they have relationships with males their own age as well. However, usually they are additional partners, as older males might be married or have other partners. Males their own age are always available and will be there when their older partners are not available.

Two participants expressed their sentiments thus:

The other thing is that you think that you will be bored when the older partner cannot see you. So you also go out with boys your own age. (Girl from rural area)

There is this thing that you need to be ready for when you get dumped. You need to have a "spare wheel" or "something to lean on" if something happens. That's why you need to have many partners. (Girl from urban area)

5.2.3 Discourse of traditional hegemonic masculinity

Several studies (Connell, 1995; Morrell, 1998) have been conducted on the construction and implications of the construction of masculinity. It has been described as a set of role behaviours that most men are encouraged to perform (Brown, Sorrel, & Raffaelli, 2006). It is not an entity embedded in the body or personality traits of individuals (Connell & Messerschmidt, 2005). Hegemonic masculinity is something achieved by behaving and acting in specific ways as observed by a social group (Barker & Richard, 2005). Achieving masculinity is judged by other men and women to see if men live up to the expectation of being a *real man*.

There were dominant discourses of hegemonic masculinity in the text produced by the young people in the study. They presented constructions of what defines a *real man*. These constructions were drawn from culture, tradition and peer group norms. Those masculinity discourses have an effect on young people's sexual behaviour. The text produced included discourses on initiation schools as an influence for young people to prove their manhood, multiple concurrent relationships as normative among men, having sex (especially sex without a condom) and sexual violence as indicative of being a *real man*. These constructions will be discussed in succession.

5.2.3.1 What does it mean to be a man in Venda

5.2.3.1.1 Culture and rite of passage

The social requirement of achieving masculinity in Africa is achieving some level of financial independence, employment or income and subsequently, starting a family (Barker & Ricardo, 2005). Many cultural groups in Africa carry out initiation practices or a rite of passage that include initiation as part of a ritual for boys to become men and achieve their masculinity status. Barker and Ricardo (2005, p. 9) reported that “rites of passage serve as a form of positive social control, they include information related to sexuality, with implications for HIV, violence against women and male and female intimate relations in general”.

In Venda, rites of passage are practiced for both boys and girls (as described in Chapter 2). It is used to initiate boys and girls into becoming men and women (Malisha, Maharaj, & Rogan, 2008; Milubi, 2000). The young males' discourse around initiation schools and rites of passage indicated that it is something that is done to achieve masculinity. Besides initiation, young men reported that sex after initiation is encouraged to further prove masculinity. Even though many young people do not go to traditional initiation schools anymore, young boys who attend the traditional initiation schools and get circumcised in the bush are considered *real men*. One participant shared the following:

We tease each other regarding the way we had our circumcision. If you did not go to the bush for it, you are not man enough. It means you just did it to prevent diseases and you are still not a man. (Boy from rural area)

Besides achieving manhood through initiation, the young people's text indicated a discourse of initiation schools as influencing young people to have sex after initiation school to further proof their masculinity. One participant reported:

The language we use at hogoni (initiation school) is vulgar language that includes sex. There is a song that says "when will whoever ever come back so that we can do things like those [have sex]". Even the time when the girls bring food, the language we use is related to each other's private parts and sex. Such things makes us to think of sex all the time even while we are still at hogoni [initiation school] and when we come back that is the first thing we want to do. (Boy from rural area)

Malisha et al. (2008) indicated that participants in their study reported that, if they had not attended initiation schools, they would not have become sexually active at an early age. This means that young people perceive the initiation school as contributing to early sexual activity.

The young women reported that, during their female initiation period, female older initiates are allowed to come and join the initiates at night and spend the night with them. They reported that a lot of sexual matters are discussed there. Even though education is provided by the elders, young people also influence each other during their evening gatherings. One of the females who went to the female initiation school reported:

When I was going through initiation, there were young people who used to come and tell us about their boyfriends and what they do. Some of them used to use the opportunity to meet with their boyfriends, pretending to be coming to the initiation school. So if you did not know anything about boys that is where you start learning. (Girl from rural area)

Young females within the focus groups spoke about initiation as a cut-off point to have sex. They reported that they know that after the initiation there will not be virginity checks any more. One of the participants reported:

Most young people are virgins when they go for initiations. They are also promised [by parents] that if you go for the initiation and found to be a virgin, we will do this and this for you. When you hear this, you can control yourself until the initiation. Even if you have a boyfriend, you can ask him to wait until then. Then after the initiation you know that you are free to have sex because you will not be checked again. (Girl from rural area)

Other participants reported that females are taught how to take care of a man sexually during the initiation. This is said to influence young people to try and be caring toward men even before they are married. One participant reported this as follows:

During initiation, they teach you how to have sex with a man and when. When you sleep with him this is what you should do. When you finish the initiation, you know everything and you start practicing what you have been taught. (Girl from rural area)

Similar constructions of initiation schools were found in other research. Young men reported that when they go to the initiation school, they are told by older initiates that when they come out of the initiation school, it will be time to test their *spear* by having sex (Milubi, 2000). According to the participants in the groups, HIV and AIDS and safe sex is not part of the education at initiation schools.

Despite the sexual education that young people receive from adults during initiation, young people seem to influence each other negatively. Peer social networks strongly influence risk behaviours (Bajos, 2010; Latkin & Knowlton, 2005). Visser (2012, p.234) reported that “peer

pressure among young people unmistakably undermines healthy social norms and HIV prevention messages”. Young people’s constructions also indicate peer pressure and peer norms influencing their engagement in sex and sexual risk behaviour. Peers advocate hegemonic masculinity which leaves young men feeling influenced and pressured to have sex and even unsafe sex in order to achieve their masculinity. Young people reported that peer pressure during initiation school influences them to engage in sexual risk behaviour. A participant reported:

There is a lot of peer pressure among young people... eh... but mostly with us males. When a friend is having sex and tells you, you end up wanting to do it. And we mostly influence each other in negative things not positive or good things.
(Boy from urban area)

Females who do not attend traditional initiation schools often receive initiation from their churches. Initiation at church (usually done by traditional rather than modern churches) is faith based. It is considered to be superior, as biblical principles are applied in advising young people regarding sexual matters. Young females, however, indicated that even at church, young people influence each other negatively in their evening gatherings when older people are not around.

Young people blame their culture, specifically initiation schools, as encouraging them to have sex. On the other hand, the adult participants reported that, when they were young, culture and initiation schools *helped* them to control their sexual urges. The adult participants also reported that young people do not attend cultural initiation schools as before because young males mostly get circumcised in hospitals.

There appeared to be a difference in discourse regarding initiation schools between the young people and adult participants. The adult participants spoke highly of the initiation schools. They reported that the initiation schools helped in maintaining order within the community. They also reported that it helped young men to be *real men*, to control their sexual urges and to respect women. One participant shared the following:

Things that used to help us are the traditional initiations that we have here at the chief’s house. We used to have vhusa, vhutambo and hogo. There were traditional lessons we used to teach these young people. Those things helped

men to be real men and not just have sex. Young people nowadays are spoiled. We used to spend time with girls and not touch them because we respected the elders and the lessons we were taught. We also respected those girls because it was important to marry her when she is a virgin.

(Adult male participant from rural area)

This discourse implies that a moral base that were underpinning sexual education at initiation schools have been eroded over the last generation or two in favour of young people having to teach each other. Because parents have traditionally relied on initiation schools to impart this knowledge, they now feel disenfranchised, as reported as follows by another parent:

As parents we cannot educate our own children about the education from the initiation, it is not possible. Leaving it is also not right, but what can we do if they do not want [to attend initiation schools]? That is why HIV is increasing.

(Adult female participant from rural area)

The contrasting constructions between young people and adult participants regarding their cultural ways of doing things are puzzling. In any event, the value of initiation schools in delaying sexual debut is belied by research results indicating that initiation schools encourage early sexual debut (Malisha, et al., 2008; Munthali & Zulu, 2007). These results predominantly identified the construction of initiation school as a rite of passage from boyhood to manhood which delivers instruction on sexual matters promoting sexual debut shortly after initiation school (e.g. *Kusasa fumbi* meaning *removing dust* in Malawi and *testing the spear* in Venda). Vincent (2008) argues that:

“the sexual socialization role of the institution of circumcision among the Xhosa has been replaced by the emergence of a norm in which circumcision is regarded as a gateway to sex rather than as marking the point at which responsible sexual behaviour begins” (p. 433).

This affirms the construction of young women in this study who reported that they wait for initiation school because they know that they will not be checked for virginity after that.

Young men also reiterate this as indicated in the passages above. This poses a challenge in the context of HIV and AIDS for HIV prevention interventions.

There is vast evidence of initiation schools traditionally assisting in educating young people about sexual reserve and control, respect, hygiene and societal rules and regulations (Niang & Boiro, 2007) as confirmed by adult participants in this study. The recent construction of initiation schools as promoting early sexual debut needs to be addressed in order for some prevention interventions to be effective. In this light, it should be considered if initiation schools still serve the purpose that the community intended them to. It needs to be investigated whether initiation schools can be re-enfranchised to deliver comprehensive sexual education which can aid in changing young people's sexual risk behaviour and in reducing HIV infections among young people. The medical intervention of removing the foreskin should likewise be performed using health-promoting techniques.

5.2.3.1.2 Discourse of having sex to prove masculinity

Another discourse of traditional hegemonic masculinity is that sexual activity is a central marker of being a *real man*. There is a certain age in which a *real man* is expected not to be a virgin anymore. Such discourses are related to peer norms. Associating abstinence with the risk of ridicule and peer disrespect demonstrates the importance of norms of gender in the text produced. It clearly resonates with the male sexual potency construction which emphasizes sexual activity as a central marker of masculinity. This also relates to the male sexual drive discourse discussed above. Marston and King (2006) found that vaginal penetration is perceived to be important in determining masculinity and marks the transition from boyhood to manhood. Two of the participants expressed their opinions as follows:

It is not allowed for a young man to be virgin. He must have sex no matter what. It does not even matter how the woman he is having sex with looks like, he must just have sex. (Boy from urban area)

You know, if you are virgin and we are sitting like this and someone says this one is a virgin, the others will mock you until you are embarrassed and your status is low. They even read your mind to check if you have been with a girl because of how you talk. If you have not been with a girl, you are not even allowed to sit with other men. (Boy from rural area)

Shefer, Kruger and Schepers (2015) also found that young people in their study were teased for being virgins. Such discourses and expectations among young people encourage young men to have unsafe sex as being a *real man* is defined by having sex. A recent addition is that the status of a *real man* grows whenever he has sex without a condom and with multiple partners. One participant said:

Having sex without a condom increases status among us, as boys. And also if you have many girlfriends at the same time you are cool, you have a lot of status. Other guys respect you and ask advice about women from you.
(Boy from urban area)

Sexual experience is associated with an initiation into manhood with concomitant social recognition. Sexual intercourse is seen as a display of sexual competence or achievement rather than as an act of intimacy (Barker & Ricardo, 2005).

Text above indicates that young people know about condoms. They have knowledge about HIV and preventing HIV by using condoms. Constructions of masculinity make them not to use condoms as they have to take risks and have sex without a condom to prove their masculinity. Even though young people indicated that having sex without a condom improves status among peers, there were instances where young people acknowledged trying to use condoms and disclosed the complications relating to their manhood which they encountered in doing so. One young man said:

Condoms need to be negotiated with your person [girlfriend] and you cannot do that before being aroused and it takes the arousal away... laughter. But also condoms sometimes take the arousal away because you become nervous or you start fumbling around when putting on a condom. Those things are embarrassing to us as males and make us to sometimes just avoid it and have sex without a condom. (Boy from urban area)

It is important that young people voice the complexities of using condoms to find better strategies of using it. This could be included in developing condom promotion interventions. HIV and AIDS preventive interventions should address complications raised in the text

above. Educating young people about condoms and how to use them is important, but it is also crucial to address issues of anxiety while putting on a condom or when negotiating condom use. This accentuates the importance of comprehensive sexual education.

5.2.3.1.3 Munna ndi ndou, ha li muri muthihi (A man is an elephant, he does not graze on one tree)

The focus group discussions revealed a discourse of men being expected to have multiple partners. Being a real man was constructed as constituted by having many partners. Young men experience pressure to have multiple partners in order to be seen as *real men*. A male participant reported:

“If you have many partners as a man you have a high status. And women also like such men who have high status.” (Boy from urban area)

Multiple concurrent partnerships (MCP) have been identified as one of the factors which increase HIV infections. MCP is viewed as culturally rooted. MCP existed historically and continue to persist even in the light of HIV and AIDS (Mah & Halperin, 2010). Research (Selikow, Zulu, & Cedra, 2002) has indicated that men acquire the status of being *real men* by having multiple partners.

Mah and Halperin (2008, p.15) found that male sexuality was defined by how many sexual partners men have. This is reflected in terms such as *ingagara* and *isithipa* (an unfashionable man without many girlfriends). According to Marston and King (2006), young men’s reputations can suffer if they are not seen to push for sexual access and numerous female partners. This is also supported by notions of culture, African history and peer pressure.

This discourse gives permission to men to have many partners. It also encourages women to be tolerant of their men having many partners; the latter view was thus expressed:

This thing of men having multiple partners, we as women cannot do anything about it. It comes from our history, men used to marry many wives. It is as the saying goes munna ndi ndou ha li muri muthihi [a man is an elephant; he does not graze on one tree]. (Girl from urban area)

Some females expressed opinions of discomfort with young men having MCP. There were constructions of abuse and unfairness in males' behaviour, as males prefer to marry virgins. The following discussion indicates such arguments:

When you guys have sex with many women, do you end up marrying one of those many women you slept with or do you marry a virgin? (Girl from rural area)

I would not go for a girl who is already destroyed when there is a nicer girl. I would marry a virgin. (Boy from rural area)

*Why do you guys want to destroy us by playing with our emotions?
(Girl from rural area)*

*What you men do is unfair, you want to sleep with many women when you are young but prefer to marry a virgin? It means when you finish with us we are not worthy to be married. Why do you play with our emotions and future?
(Girl from rural area)*

The discussion above indicates females' resistance to male-centred sexuality. It also acknowledges females' sexuality as entwined with love and emotions which is why females feel used when males indicate that they want virgins as wives. The above discussion also indicates constructions of heterosexuality and heterosexual practices arguing that men *do sex* and *sex is being done to* women (Holland, 1996; Shefer & Foster, 2001).

The adult participants also spoke about MCP in relation to culture and history in Venda. There were talks about multiple partners being traditionally acceptable in Venda, but with control measures which curtailed illnesses like *Thusula* (STIs). One adult participant within the focus group reported:

Polygamy was acceptable in our culture, but there were ways of controlling it. Men did not sleep with every woman they met like these young people nowadays. Men slept with multiple women but they were married to those women. Before you sleep with that woman, there were ceremonies of mixing blood between a

man and a woman. This was done to control the illnesses [STIs] because the bloods were now related, but it was also to control those relationships because a man would not sleep with a woman if they are not mixed, so you only sleep with your wives. (Adult male participant from rural area)

Mixing of blood was done to introduce the wife to the ancestors and it was believed that, it is then that the ancestors will protect the couple from illnesses (*key informant interview with a community elder*). However, the participants indicated that besides the original intention of the mixing of blood, the ritual also indirectly controlled MCP as men would only have sex with their wives to avoid curses from the ancestors.

The adult participants associated having many partners with showing masculinity and the fact that a man is rich enough to support a big family. This discourse still persists as young people nowadays show their masculinity by having many partners (Selikow et al., 2002). This confirms Mah and Halperin's (2008) argument that culture has an influence on MCP in South Africa as discussed in Chapter 2.

With the erosion of tradition and culture, practices of marrying many wives and mixing blood are not done anymore. Tradition has now become more informally interpreted as a man's right to have as many sexual partners as he wishes. While the tradition has been dismantled by various social and economic factors and limited by the law, the normative discourse that a man needs more than one partner continues (Barker & Ricardo, 2005).

5.2.3.1.4 Discourse of sexual violence to prove masculinity

The young people in the focus group discussions revealed a discourse of masculinity through sexual violence. They reported that they sometimes acquire manhood status by having sex with *difficult* women. Difficult women were constructed as women who do not agree to men's proposals for relationships or to have sex easily. The young men reported that having a relationship and ultimately having sex with such a person improves their status among their peers. The status was also graded in terms of how (with or without a condom) one had sex with a *difficult* woman. Even more status is gained if the *difficult* woman falls pregnant. Two participants described this as follows:

There are some girls that are well known for being difficult to get as your girlfriend. If I succeed in having her as my girlfriend and also sleep with her, I am a champion among the boys. Ya, I am a winner. (Boy from rural area)

I have sex with some women just to teach them a lesson especially if they are difficult and they think they are better than everyone. So, if you get a woman who thinks she is high and mighty, you have sex with her to make sure she gets pregnant and drop her status. She will no longer think she is better than everyone with a big stomach. And as a man you are praised for succeeding with a difficult woman. You get more respect from other young men. (Boy from urban area)

The constructions above indicate the discourse of heterosexuality as male power (Shefer et al., 2000). The discourse of heterosexuality as male power holds that sexuality between men and women is inevitably a situation of power inequality with male domination. Men exert power over women to protect and fight for their masculinity and to maintain traditional gender roles (Shefer, et al, 2000; Strebel, et al., 2006). Females who challenge male power and masculinity are brought back to line. A challenge by women is approached either by violent punishment or derogatory naming in order for men to regain their male power (Shefer, et al., 2000; Shefer, Kruger & Schepers, 2015; Shefer & Ruiters, 1998). The construction of a *difficult* woman seems to relate to the discourse of heterosexuality as male power.

There were some differences between rural and urban area participants' methods of attaining masculinity. The discourse of initiation as a way of attaining masculinity was mostly from the participants from the rural area. The urban area participants mostly attained their masculinity through having sex, MCP and some forms of sexual violence.

The findings above indicate that constructions of sexuality among young people in Venda are similar to constructions of sexuality found in previous research in other regions in South Africa and Africa in general (Holland, 1996; Shefer & Ruiters, 1998; Shefer, et al., 2000; Shefer & Foster, 2001; Shefer, Kruger & Schepers, 2015; Strebel, et al., 2006) The same sexuality constructions place young people of Venda as risk of HIV infection.

The constructions of sexuality by young people are summarized in table 1.

Table 1 Summary of constructions of sexuality

Constructions of Sexuality by young people
• Sex as natural and unavoidable
• Sex as a commodity
• Traditional hegemonic masculinity
○ Culture/rite of passage
○ Sex to prove masculinity
○ Munna ndi ndou ha li muri muthihi fhedzi (MCP to prove masculinity)
○ Sex violence to prove masculinity

5.3 Community Leaders’ Discourses

5.3.1 Constructions of young people’s sexuality

Community leaders, namely parents, healthcare workers, priests, chiefs, elders and teachers were included as participants of this study. Adult participants were included in order to explore their discourses in relation to young people’s sexual behaviour. Other reasons for including them is to understand the cultural means of reducing sexual risk behaviours among young people and the role that community leaders, parents and culture used to play to reduce sexual risk among young people in the past. Four discourses about young people’s sexual behaviour were identified in the adult participants’ focus group discussions: Discourses of lack of morals among young people, young people’s sense of freedom and human rights, breakdown of traditional authority and the discourse of disempowerment among parents. Constructions from the adult participants are discussed below.

5.3.1.1 Moral discourse

The discourse of lack of morals among young people were strongly presented during focus group discussions with community leaders.

The adult participants in this study viewed young people's lack of moral values as the main driver of sexual risk behaviours. This discourse was expressed from the vantage points of both traditional culture and Christianity.

According to the traditionalists, young people are not following cultural guidelines and do not respect cultural taboos. Consequently, they end up engaging in sexual risk behaviours. Adults are of the opinion that young people interact differently than they did when they were young. Adults believe that young people have lost respect for authority and culture. Three participants voiced their concerns as follows:

In the past young boys and girls used to spend time together at night. Eh, eh, ceremonies like Mahundwane.... Mm, young people used to spend time together as a family for a week out there. It was a play, where one will play being a husband and another, a wife and others will be kids. They will do that for a week, sleeping out there, but you will never hear that one person had sex with the other. There was nothing special, except knowing that you will get into a lot of trouble with the chief if you do that. That made young people to have morals.

(Adult female participant from rural area)

Parents' and the chiefs' strong hand and discipline enforced morals among young people. (Adult Male from rural area)

The education they received from the initiation was just to educate that you are now a matured young person, you should not play around with guys because you will get pregnant. Such education came with a lot of rules and regulation of keeping secrecy that made young people to have morals and to accept and respect what they have been told. (Female from urban area)

The adults reported that the fact that young people do not attend traditional initiation schools as they previously did, was the main reason why young people engage in sexual risk behaviours. One participant stated:

Young people do not attend initiation schools. They view attending initiation as cultural and backwards. They just don't know the education they are missing out on and how it might protect them from many risks like pregnancy and HIV.
(Adult female from rural area)

According to Christian teaching young people's unbiblical attitudes stands to be blamed for them engaging in sexual risk behaviours. Christian participants reported that young people should attend church and follow what the Bible says. In obeying the Bible they should not have sex before marriage. Two participants said:

The Bible says that sex before marriage is a sin. Young people are not only having sex before they are married; they are having sex with a lot of people. No wonder we have HIV and AIDS. (Adult male from urban area)

If young people follow what the Bible says, we would not have sexual risk behaviour. We would not be concerned about HIV among young people.
(Adult female from rural area)

The Christian way of preventing HIV is similar to the Abstain (ABC model) from the medical HIV intervention. Such interventions have appeared to be ineffective during the past 30 years as young people continue to have sex despite the messages of abstinence.

The moral discourse is frequently judgmental and it involves blaming others. The moral discourse is linked to the medical discourse of HIV and AIDS as a disease of certain groups of people such as prostitutes and homosexuals who are considered by most communities as lacking morals (Atilola, Akpa, & Komolafe, 2010; Nzioka, 1996).

5.3.1.2 Young people's sense of freedom and human rights

South Africa entered into a new dispensation based on democracy, equality, fundamental rights, the promotion of national unity and reconciliation in 1994. Human rights policies were developed immediately after entering the new dispensation. The Children's Rights

Policy was part of the Human Rights Policy (Children's Bill of Rights, 2003). The Children's Rights Policy was developed as children need special protection as they are among the most vulnerable members of society. They are dependent on others for care and protection. The *best interest of the child* is the overriding concern of the Children's Rights Policy. Among various other children's rights, children have the right to access medical treatment, which includes the right to have an abortion and contraceptives, even without parental consent.

The adult participants in the focus group discussions expressed the opinion that the beginning of the era of democracy was the beginning of the change in behaviour among young people. They perceived that the Children's Rights Policy gave young people the right not to attend initiation schools and not to be tested for virginity. It also gave them rights to use contraception and have an abortion without parental consent. According to the participants, this led young people to start with early sexual risk behaviours. Two of the participants expressed this concern as follows:

...before, we had tshitambo [a transition ritual and ceremony] to educate young boys and girls about the rules and laws around sex and respect in the community. This thing ended with Mandela and his democracy. (Adult female from rural area)

This democracy came with rights and some of the things the parents and the community cannot do because they are afraid of children's rights. If the child does not want to go to the initiation with the chief, you cannot force her; you just pay a fine to the chief and let her do as she pleases. (Adult female from rural area)

The enactment of children's rights therefore had implications for the children's behaviour and the status of authority in the community.

Traditional and conservative communities criticized the Children's Rights movement as it affected many cultural ways of doing in those communities (South African Human Rights Commission, 2007). One of the traditional practices it affected was virginity testing. Virginity testing is a traditional practice in many African cultures. Virginity testing is done as many African cultures place a high premium on virginity for girls when they get married. It has an effect on the *lobola* (bride-price) and status of the marriage (South African Human

Rights Commission, 2003). According to the Children's Rights Policy, virginity testing is perceived as a violation of privacy for girls.

5.3.1.3 Breakdown of traditional authority

The focus group discussions with community leaders revealed that adult participants believe that the fact that the traditional leaders do not have power over the community is a factor that influences young people to engage in sexual risk behaviours. One chief declared:

Democracy came with a lot of changes. We, as chiefs are not consulted when such changes takes place. They do not ask us, how we want things to be done in our community, they just implement and as chiefs, we do not have power any more. Eh, eh... the issue of the, the taverns, we were not consulted when the tavern owners were given licenses that they can close their taverns at 02:00. As a chief I cannot tell him/her to close the tavern because they have letters these people and we know that that is where our young people contract HIV after they are drunk and coming back at 03:00 in the morning. (Chief from rural area)

Traditional leaders are expected to maintain order, resolve conflict, provide spiritual guidance and promote the well-being of the community (Williams, 2004). The chieftaincy represents security, order and stability. The community depends on their chief to resolve disputes and to make sure that the community is peaceful. The introduction of a democratic country reduced the power of the chiefs. They now depend on the state courts to resolve matters. The traditional leaders also have limited authority over the community members. Participants reported that this has contributed to young people engaging in sexual risk behaviours as chiefs do not have authority over the community and young people. With changes in the democratic era, young people's behaviour is considered out of control because of the disintegration of community structures (traditional leadership) that previously regulated behaviour. Two of the participants expressed their concerns as follows:

The children's rights that were brought about by the democracy also introduced abortion as an option for young people if they fall pregnant. Before, if you made someone pregnant, it used to be reported to the chief and the chief used to have a court and deliberate. The person who impregnated someone used to be fined

cows. It made young people to be careful because they were afraid of fines and the embarrassment. Ya, hey, nowadays if a child falls pregnant, it is my own responsibility as a parent alone. Who will reprimand now?

(Adult female from rural area)

In our traditional way of doing things, when a child gets a hiding from the mother, he/she runs to report to the father, if it is the father, he/she will report it to the mother. But nowadays, a child runs to report it to the police station and as a parent you get arrested. We have no control over our children anymore.

(Chief from rural area)

Historically, the homelands were governed by the Black Self-Government Act of 1959 (Khunou, 2009). The black population was arranged and categorized into national units based on language and culture. Each nation had to develop according to its own culture and under its own government. The communities in those nations were guided and led by the traditional leaders. The traditional leaders could pass their own legislation. They also had their own courts and made decisions regarding the running of their communities (Khunou, 2009). Venda was one of the homelands that were led by traditional leaders.

When South Africa entered into a democratic era the homelands were abolished and became part of South Africa. The institution, status and role of traditional leadership according to indigenous law were recognised. However, the roles and functions of traditional leaders were not enshrined (Khunou, 2009). The recognition of customary law and traditional leadership was subject to the supremacy of the constitution and chapter on the Bill of Rights. This means traditional leaders have to comply with the core constitutional values of human dignity, equality, non-sexism, human rights and freedom. According to Williams (2004), traditional leaders criticized the supremacy of the constitution over their authority. They felt that it takes away their decision-making powers and consigns them to the role of mere custodians of law.

Research done by the Traditional Authorities Research Group (1999) in North West, KwaZulu Natal and Northern Province (now known as Limpopo) found that participants indicated that traditional authorities were important in their communities and that if

abolished, it would lead to chaos in the community. Community leaders also believe lack of traditional authority also influences young people's sexual risk behaviour.

5.3.1.4 Childhood discourse in the democratic era disempowers parents

Childhood is a social construct that differs from one historical period, culture, class and ethnicity to another. Parenting is as much a social construct as childhood is (Gergen, 1973). Parenting is constantly being constructed according to the ideologies and paradigms of the sciences and professions that dominate at any point in time by dictating what is good for children (Ambert, 1994).

The development of the Children's Rights Policy has led parents to feel disempowered in their authority to parent their children in a traditional way as indicated by the following participants' statements:

We know that young people are having sex. We see them walking together in the streets hugging each other. Even now when we leave here, we will meet them in the way hugging each other, but what can we do? (Adult male from urban area)

As a parent if you tell your child that this is a curfew to come home and he/she does not come at that time, you cannot do anything. You cannot give him/her a hiding because it is abuse. How do you emphasize such good behaviour without punishing a child? Hai... they are our children but we no longer have control over their behaviour. The system is making it difficult for us.

(Adult male from rural area)

The conflict between children's rights and parenting was also revealed in the focus group discussions with young people regarding condoms. Young people reported that they sometimes do not have condoms when they want to have sex, because they cannot keep them in the house as they are afraid that parents will find them. Other young people within the focus groups spoke about their rights to privacy. One participant stated:

Parents like to snoop around in our rooms (bedrooms) but we do not get into their rooms. Everyone is entitled to his or her own privacy, it is our right. So I say, put them where they can find them so that they can learn a lesson not to snoop around our rooms. (Boy from urban area)

According to the adult participants in the study, current constructions of children as having the right to be free and being independent in making certain health decisions is disempowering parents in their role. When such changes are made and the policies are developed, parents are not trained in new ways of parenting that consider new policies. This makes parents feel helpless as they do not know any way of parenting that is in line with the new policies.

Current youth subcultures and policies are often in opposition to parents' values and beliefs. Such subcultures and policies render parents more helpless and disempowered. There is, therefore, a need for support of parents. However, most parenting programmes have focused on the nutrition, health and development of young children, while failing to consider parenting training and assistance in raising adolescents (Datta, 2007). It is also surprising that there is little research on the effects of young people's policies on parental power. One participant shared:

*The community cannot teach young people about sex and sexuality because of democracy and the rights that children have, we have given up because we are not protected and we do not know any other way to teach our kids about such things. The traditional way (through initiation schools) is the only way we knew how and it was also a time of special activities for the community.
(Adult female from urban area)*

Text produced in this study indicates that adults do not regard themselves as being able to educate young people about sexuality. Because of the traditional ways of doing things parents do not use the opportunities they have to influence young people's sexual behaviour. If young people do not want to attend initiation schools, they are learning about sexuality and sexual behaviour from peers. Behaviour that is given status by the peer group, such as transactional sex, MCP and ways to prove masculinity, is encouraged among young people.

Research by Cluver and colleagues revealed that adolescents who are detached from their families, especially parents, are more at risk of engaging in sexual risk behaviours than adolescents who are close to their parents (Cluver, Orkin, Boyes, & Sherr, 2014). As adults are experiencing difficulties in parenting children, it might have an impact on the bond between parents or adults and young people and increase the risk of engaging in sexual risk behaviours.

When the Children's Rights Policy was introduced into communities like Venda (who had traditional ways of raising children), it was not explained to parents and the leaders of the community. The adults expressed that parents feel confused and disempowered in their parenting role because they could not raise and discipline their children in the ways they were used to. One of the participants said:

As parents we cannot educate our own children about the education from the initiation, it is not possible. Leaving it is also not right, but what can we do if they do not want? That is why HIV is increasing. (Adult female from rural area)

National policies replaced local principles of parenting and this was not done in consultation with communities. Even though it is important to have national policies, it is crucial to consider whether such policies will be beneficial in all local contexts before enacting them. As it stands parents and adults in Venda are reporting that legislation regarding children's rights are disempowering them in educating young people about sexuality.

In summary, the democratic era brought some structural changes (including a rights approach) that are having an impact on parental control, traditional authority and community structures shaping the behaviour of young people. Even though such structural factors have advantages in some areas of young people's lives, such as child abuse, they also have disadvantages on young people's sexual risk behaviours. Parental disempowerment and the disintegration in community structures that governed behaviour, are an indication of the importance of context-specific policies and HIV interventions.

As traditional authority is considered important in rural areas, it is important to have specific roles defined for them in the democratic era. It is also important that people in Venda find ways of parenting children in the democratic era without contravening legislation.

Young people and adults have different constructions about young people’s sexual risk behaviour. The fading away of traditional ways of doing (like initiation schools) and cultural norms might be contributing to the different constructions between young people and adults. Contemporary sexual openness might be contributing to the differences in constructions as young people are exposed to information through globalization. The different constructions might have a negative impact on young people’s sexual risk behaviour as young people’s behaviour seems to be influenced more by social interaction amongst peers than by informed interaction with adults in the community. In developing HIV prevention interventions it is important to consider young people’s contemporary social constructions in conjunction with traditions and current scientific knowledge. Community leaders’ discourses regarding young people’s sexuality are listed in Table 2.

Table 2 Summary of Community leaders’ constructions

Constructions of young people’s sexuality
Moral discourse
Young people’s sense of freedom and human rights
Breakdown of traditional authority
Childhood discourse in the democratic era

5.4 Young people’s discourses about HIV and AIDS

5.4.1 Normalisation of HIV: *AIDS is like flu*

The current study showed that young people currently do not construct HIV and AIDS as scary, but as just another disease. This social construction influences the behaviour of young people. They consequently have unsafe sex despite being aware of the risk of contracting HIV. Participants reported:

Ah, hey – nowadays they say being thin does not mean you have AIDS, those who have AIDS can also be fat, I mean fatty boom boom. So, whether you have it or not, AIDS is like flu. You get it, you get the treatment just like with any other illness. (Boy from rural area)

We are told sometimes that so and so has HIV and he/she has been having it since you were born. When you look you see that he/she is healthy and just taking tablets. Arg, it is the same thing because she is still alive. You find those without AIDS dying before her. (Girl from rural area)

This is related to the finding that young people knew people who were HIV positive and they accepted them as part of the community. Young people accepted people living with HIV because they viewed HIV as any other illness (LoveLife, 2012). Two participants reported:

Actually, young people nowadays do not take AIDS as scary. Other illnesses are stronger than AIDS. Illnesses like, sugar diabetes and high blood pressure. These illnesses make you not to enjoy some foods but with HIV, you just take medication. (Girl from rural area)

I have lived with someone with HIV but it does not scare me. We are all living to die. I take it like any other illness. Everyone has his or her time to die whether you have it or not. (Boy from urban area)

The current discourse of ART as life prolonging drugs for people with HIV and AIDS influences young people's constructions of HIV and AIDS and the need to practice safe sex among young people. A participant confirmed this:

The problem is the campaigns that tell us that if you have HIV and AIDS, you can find yourself living for more than 20 years. When I hear that, I take it that there is no problem in having it [sex] without a condom, I will just have to follow instructions from the doctors and I will live just like any other person. (Girl from urban area)

Niehaus (2007), in reporting an ethnographic study in Bushbuckridge, reported that people likened AIDS to death, similar to the health discourses at that time that defined AIDS as a terminal illness (Niehaus, 2007, p. 848). Media and educational campaigns were seen as politically driven and were responsible for shaping people's attitudes and for constructing the face of HIV and AIDS (Graffigna & Olson, 2009). The construction of HIV and AIDS as being similar to death contributed to the development of stigma of HIV and those infected. Because of the fear of stigmatization, family members resorted to keeping HIV infection a

secret and were hiding family members when they were terminally ill (McNeil & Niehaus, 2009; Niehaus, 2007). The introduction of ART in 2004 and of stigma reduction programmes led to a shift in discourse regarding HIV and ART. HIV and AIDS was then constructed as an illness just like any other illness to try and reduce the stigma against those infected.

Linked to the idea that HIV and AIDS is like any other illness, young people believe that pregnancy is more of a threat than HIV. They constructed pregnancy as scary because it is visible to everyone, but not AIDS; medication can be used for HIV, but a child does not go away. These opinions were voiced by a few participants:

You think more about getting pregnant during sex than HIV even though pregnancy has many solutions. (Girl from urban area)

If we talk about sex, I think of a child, not HIV. To have a child is scarier than AIDS. It is difficult to support a child while you are at school. A child makes you suffer. (Girl from rural area)

If you have a HIV, you can drink pills and be better. But you cannot take away a child. (Boy from rural area)

The normalization of AIDS happens because youth are not exposed to the serious consequences of HIV and AIDS. They see HIV-infected people when they are taking medication and are well; they are seldom confronted with people with advanced AIDS. Two of the participants expressed the following:

People speak about HIV positive people when they are still healthy. When they are at an AIDS stage and near death they are hidden so that we do not see them. We will only hear that they passed on but we will not know how painful it was and what happened in their last days. (Girl from urban area)

Even the TV dramas on HIV and AIDS prevention just inform us that a person has HIV and then goes and takes medication. They do not go on to show us what happened to that person when they were in their last stages. It will be better to know the pain and the suffering that those people go through. It might help a little bit for us to fear the pain and then play it safe. (Girl from urban area)

Niehaus (2007) confirmed that AIDS patients in Bushbuckridge were usually shielded from public view when they were terminally ill. This was linked to a discourse by young people that *there is no AIDS until I see it*. In the present study, young people indicated that they do not know anyone who has publicly declared that they have HIV. They reported that they know people with HIV from rumours around the community. This might have an influence in their belief and conviction of HIV and its effects on people. This means HIV is invisible to young people. Young people want to see the evidence of HIV in people's lives to believe in the disease.

5.4.2 Discourse of invulnerability

From the focus group discussions, there were social constructions of healthy (clean) people or situations that are safe for having unsafe sex. Young people expressed that they are expected to have unprotected sex with a partner, especially if they have been dating for a long time. This was expressed without looking at whether the partner has been faithful or not. The fact that the relationship is a long one makes it safe to have unsafe sex. One participant stated:

I mean you cannot have sex with a condom with your partner for more than one year. If he is with you for such a long time, it means he is trustworthy and safe to have unprotected sex with. (Girl from urban area)

Young people also expressed their ability to identify a partner that is HIV negative. There were constructions of partners that are not thin, look innocent, without many boyfriends/girlfriends as the ones that are clean and safe to have unprotected sex with. A participant shared:

I can see if a girl is clean or not clean. There are girls that you can see that they are innocent, which indicate that they are virgins. There are others that you see that they have no illness because they have not been with many boyfriends. Er— but you also check how they look to confirm your suspicions. Then you are free to have sex with them without a condom. (Boy from rural area)

The biomedical constructions of the risk groups and the *clean* and *unclean* people seem to still have an influence on young people's risk behaviours. The fact that HIV and AIDS is also constructed as a moral disease makes young people diagnose people's status by looking at their behaviours and morals. Because of the information they receive from the biomedical field, young people feel that they have the ability to diagnose those who are infected. This makes young people feel invulnerable as they are having unsafe sex with people they consider to be *clean*.

The young people's constructions of *safe* and *unsafe* people and situations show the need for HIV prevention interventions to consider young people's social constructions of describing safe sex and HIV negative people. It also points to the importance of considering young people's context and their language as they are using biomedical descriptions of HIV and AIDS, risk behaviours and safe sex and integrating them with their own understanding and language to come up with their own constructions of what they consider to be safe.

Descriptions of HIV and AIDS have often taken the form of metaphors about signs and symptoms in people living with HIV. Being skinny, dirty and physically weak are considered to be signs of being HIV positive. Such "constructions derive from clinical associations of HIV and AIDS with physical emaciation or a weak body" (Nzioka, 1996, p. 576). Some constructions describe people considered as risky groups of HIV and AIDS. There are some occupational, economic, social and physical attributes that are considered risky for HIV and AIDS. Sex workers, truck drivers, physically weak or the dirty are constructed as risky groups for HIV and AIDS. This is influenced by moral and biomedical discourses related to HIV and AIDS (Nzioka, 1996).

Some of these constructions of classifying people as safe are reiterated by biomedical and HIV and AIDS education programs' discourses of people that are considered as risk groups. People's HIV status is socially diagnosed not through HIV antibody test results, but through the known or perceived behaviour and character of the concerned individuals or their overt physical appearance (Mfecane, 2010; Nzioka, 1996; Zungu, 2013). The constructions of HIV and AIDS can result in risk behaviours as certain people are considered safe to have unsafe sex with.

5.4.3 Discourse of male circumcision protecting one from STIs

Young people participating in the focus group discussions reported constructions of male circumcision as a way of comprehensively protecting one (and not just reducing the chances) from contracting STIs including HIV. This discourse was linked to other means of protection, for example, taking a bath immediately after having sex and releasing one's penis immediately after ejaculating. Two participants shared:

*They also mention it in the radio that if you cannot take your son to the bush for initiation, you must take him to the hospital so that he can be safe from HIV.
(Boy from rural area)*

*As a man, when you have been circumcised you do not get STIs. It happens that I can release my thing [penis] before she releases her liquid and I do not get sick, especially because I no longer have a foreskin, it helps not to get any illnesses.
(Boy from rural area)*

Feelings of invulnerability are socially constructed from the conceptions and misconceptions of incomplete acquired wisdom supplemented by peer opinion, own deductions and interpretation of discordant media clips (Nzioka, 1996). These constructions permit young people to engage in unsafe sexual behaviours. MC alone does not eradicate HIV. Because of misconceptions of HIV and HIV prevention efforts, young people continue with risk behaviours. It is imperative for MMC and TMC to include comprehensive sexual education. Such education should also educate young people that MC does not prevent HIV but simply reduce the chances of getting infected.

5.5 Community leaders' discourse about HIV and AIDS

In this section the findings regarding community leaders' views on HIV and AIDS and young people's sexual behaviour are presented. HIV and AIDS and young people's sexual behaviour were clustered together because the participants' constructions around them were related. Community leaders were also asked which suggestions they have on how HIV and AIDS should be controlled in their communities. The following discourses were produced.

5.5.1 Traditional ethno-medical discourses

Ideas of disease causation, dynamics and treatment are said to be determined by one's culture (Nzioka, 1996). Community leaders in the focus group discussions constructed HIV and AIDS in diverse ways. They see it as a disease that has been around for a long time. They explained it as one of the STIs known as *Thusula* in Venda. One of the participants explained:

*When we say Thusula, Thusula is the one which is AIDS. Thusula does not come out. It is a lot of pimples that are inside. Once they close the womb, you die.
(Adult female from rural area)*

HIV and AIDS was also constructed by community leaders as a mixture of diseases (*Vhulwadze ho tangananaho*). In trying to explain how she understands HIV and AIDS, one participant reported:

*Even the doctors cannot tell you which symptom is a symptom of HIV. They only explain it by looking at your blood. You can have different symptoms even though you both have HIV. That is because HIV has different diseases. In Venda we call it *vhulwadze ho tangananaho* [a mixture of diseases].
(Adult female from rural area)*

Community leaders constructed HIV and AIDS from the traditional cultural and biomedical perspectives. This seems to influence their perspectives on the treatment of HIV and AIDS. Participants agreed that there is no traditional medicine to cure HIV. They reported that it can only be controlled in the biomedical field. Two participants reported:

There is no cure for HIV. Even at the clinic when we go, just like with high blood and diabetes, they tell us that the pills are just to control the illness not to remove it. In Venda, as HIV is a mixture of diseases, you control it by boiling tips of leaves of different trees and drink the liquid after it is boiled. There is no tree that cannot be eaten. When you drink that liquid, it cleanses your pimples inside and you get better. (Adult female from rural area)

All the diseases used to be curable even if you have sex with someone who had a miscarriage without being cleansed, but HIV...; there is no one who cures it. You just have to follow what the hospital is saying, if you do not follow their instructions, you will end up dead. (Adult male from urban area)

5.5.2 Disease caused by cultural erosion

HIV and AIDS was also constructed as a disease that is influenced by the erosion of culture. The adult participants viewed young people's sexual risk behaviours as immoral and opposing the Venda culture. These behaviours contribute to the risk of HIV-infection. Participants compared cultural ways of doing with current practices. One of the chiefs in the focus groups responded:

Things that helped in the past were the rules, laws and taboos that young people used to learn here at the chief's house during different traditional ceremonies like Vhusha and Tshitambo. There were rules and laws that they used to be taught that if you do this, this will happen. It is things like saying if you sit on Tshiukhuvha (Stoep), something bad will happen. No one knows what happens but we never used to sit to test what will happen. But young people today do not believe it and that is the problem. (Chief from rural area)

A participant from another group also indicated that young people's lack of moral behaviour and their disregard of culture contribute to HIV-risk. Young people do not want to listen to the elders, they do not believe in taboos and they behave immorally. He reported:

... As a young person, we never used to argue with adults. It was not possible. If they say this should not be done, you will never do it and you will never ask why it should not be done. But nowadays, hey... they ask you why, what will happen and can you prove it. (Adult male from urban area)

The young people, on the other hand, reported that they know about taboos in their culture, but they do not believe them as they know that things have to be proven scientifically. One participant reported:

We young people nowadays do not just believe things. Even if they tell us that to sit on a tswia [tripod for cooking] is a taboo, we will sit on it just to prove if it is true. We use science nowadays to prove things. We know that that taboo is just to make sure that you don't sit on a tswia when it is hot. So... it is the same with HIV and AIDS, we will continue to have sex until we see that it is really around and it makes people suffer. (Boy from rural area)

The social construction of HIV and AIDS of the young people is influenced by the community hiding HIV infected people during their AIDS stage. When HIV and AIDS prevention interventions were started, they started by scaring people with the construction of HIV and AIDS as a deadly disease (Niehaus, 2007). That was changed because fear is not an effective prevention strategy and these messages contributed to HIV-related stigma (Niehaus, 2007). The current generation believes through seeing and having hard evidence. They reported that they want to see people suffering and have evidence that HIV and AIDS makes people suffer. Such a message might reinforce the reality of HIV which might contribute to change in their behaviour. It is important that such information is considered while developing HIV and AIDS prevention interventions. It might be helpful to campaign for ART and that they prolong the lives of those living with HIV but also indicate that eventually, AIDS related death is painful and makes people suffer.

As HIV and AIDS is socially constructed as a disease that is influenced by the erosion of culture, the adult participants believe that the only way to reduce HIV infections, is for young people to follow culturally approved behaviour. They should attend the initiation schools with no right to object. They should also believe the cultural taboos that will make them afraid to engage in certain sexual behaviours. By attending all cultural rituals and initiation schools, adult participants believe that young people will behave morally. This is an authoritarian way of raising children with which adult participants are familiar, but it may not be effective with the younger generation.

5.6 HIV and AIDS messages aimed at young people

There are different communication strategies that have been used to educate people on HIV and AIDS. Radio, television, peer educators, billboards and NGOs have been involved in HIV prevention. Specific interventions have been targeting young people (as discussed in Chapter 2). These include peer education programmes in schools (Visser, 2007), Life Orientation as a subject (Mukoma et al., 2009) and information disseminated by way of mass media (television and radio). The young people had specific views regarding such interventions and the effects they have on their sexual risk behaviours. Their constructions of HIV prevention interventions are discussed next.

5.6.1 Advertisements too complicated and not interesting

The young people debated that HIV and AIDS prevention advertisements in the media are not interesting and do not relate to their lives. They, therefore, do not have an effect on their lives. They discussed how other advertisements, such as those advertising alcohol, are interesting to them, are relevant in their lives and motivate their behaviour. One participant reported:

HIV adverts are not interesting. There are other adverts that you even know the lyrics of the sound and you can hear the sound from far and you feel that you do not want to miss, yo... you have to see it. But eish, when it comes to HIV adverts, I mean it is not everyone who can understand them. You have to know where it started and what people in the adverts are supposed to experience. There are also no beautiful pictures and those adverts are not attractive. I find them very complicated to understand what is going on. (Boy from urban area)

Another participant from another group reported the same thing regarding HIV and AIDS advertisements. She spoke specifically of the LoveLife advertisement called, HIVictory. She reported:

Young people's HIV and AIDS adverts are very complicated. There is that one of HIVictory. I see it but I do not understand what it is saying. (Girl from urban area)

Texts above indicate that even though young people have access to HIV and AIDS advertisement, they do not understand the messages. It is possible that the current HIV and AIDS media interventions do not cater for young people. They are not appealing to young people and are difficult to understand. They metaphorically do not speak in the language of young people. A study conducted by Graffigna and Olson (2009) among young people in Canada found similar results. Young people thought that HIV and AIDS campaigns were too authoritarian and moralistic and did not speak the language of young people. If young people were involved in the development of the advertisements, they would have been constructed in young people's language and they would have been more appealing to young people. This confirms the importance of considering context when developing HIV and AIDS interventions.

5.6.2 Not available in vernacular

Another opinion of the young people in the study was that there are not many HIV and AIDS prevention programmes that are presented in their home language, Tshivenda. This concern was voiced by a number of participants:

There are no TV series or dramas that are done in Tshivenda that talk about HIV and AIDS and it shows that we are not important in those things. I even ask myself, 'Is there no one from Venda who can produce those things to be placed on TV?' (Girl from urban area)

Ya, when we see drama in other languages, we always say to ourselves that we are being oppressed by these things. (Boy in urban area)

Even the AIDS ribbon that we are given sometimes, you will find that they have Zulu writing on them and we do not even know what it says. (Girl from urban area)

We become interested if there are things on TV that are spoken about in our own language. When they come on TV, we call each other to come and watch. It will be better if we are taught about HIV on TV in our own language.

(Girl from rural area)

As indicated in the description of the context of the study, Tshivenda as a language is different from the Nguni languages. The fact that Tshivenda is not utilized on television regularly brings with it feelings of oppression and not being cared for. It also has an impact on young people’s understanding of HIV prevention advertisements, which has an impact on sexual risk behaviour.

Table 3 summarises constructions of HIV and AIDS and HIV messages.

<u>Discourses of HIV and AIDS</u>
Normalisation of HIV
Discourse of invulnerability
Discourse of MC protecting one from STIs
<u>HIV Messages</u>
Adverts too complicated and not interesting
Not available in vernacular

Table 3 Summary of constructions of HIV and AIDS and HIV messages

5.6.3 No formal school HIV intervention

Young people in the focus group discussions reported that they never have time to discuss sexual matters in school. Some participants expressed the importance of the focus group discussions as part of the research as they had learned a lot from others during the discussions. Participants also reported that Life Orientation was not implemented properly in their schools. The opinions of two participants were:

... for example, in this school it is the first time that we get the chance to discuss this topic. I mean sitting face-to-face and discussing about sex and HIV. I think it should also be introduced into our school. (Girl from rural area)

This discussion was good. It educated us. We never have such groups in our school. We are only taught about HIV in Life Orientation and sometimes the teacher skips some things if they are too embarrassing. (Boy from urban area)

Peer educator programmes and Life Orientation were introduced in South African schools by government as compulsory components of the syllabus. It is surprising that none of the schools that were involved in the study have peer educator programmes. Life Orientation is not taught effectively in order to cement course material as knowledge and values. Research (Ahmed, Flisher, Mathews, Mukoma, & Jansen, 2009; Chandra-Mouli, Lane, & Wong, 2015; Francis, 2012; Rooth, 2005; Shefer & Macleod, 2015) indicated that Life Orientation currently does not meet the needs of young people and it makes teachers uncomfortable to teach certain topics. The lack of HIV prevention programmes in schools in Venda reflects the disabling impact that insufficient or dysfunctional structural factors can have on society. Social determinant factors like access to educational programmes play a role in determining with whom, how often and on which terms people interact with others, both publicly and privately (Robinson & Moodle-Mills, 2012). A lack of HIV prevention programmes might be having an impact on the information that young people are passing to each other as they do not have access to information from reliable sources in a controlled environment. This means that there is no intervention to contrast the strong discourses that encourages unsafe sex.

Even though there is vast evidence that some HIV and AIDS information is not reaching young people, there is also evidence from the text produced by young people and community leaders which indicate some effectiveness in HIV prevention interventions. For example, young people spoke about condoms and issues they have with condom use. The complications raised by young people ranged from lack of a safe place where young people can keep condoms without parents finding them, experiencing a lack of pleasure and forgetting to use condoms when one is overwhelmed by feelings to have sex. These were expressed in the texts below:

To tell the truth, there is a difference in pleasure when you have sex without a condom. It is nicer...(laughter). Ag, let's tell the truth. This saying about eating a sweet with a cover on is true. (Boy from urban area)

Sometimes you prepare yourself and take your condom with you. But when she agrees to have sex, you get too excited...(laughter)... and you forget. But sometimes you meet your person [girlfriend] without planning it and it leads to sex without you being prepared and you have sex without a condom ...mmm (agreement from group members). (Boy from rural area)

We cannot stay with a box of condoms at home. Our parents clean thoroughly looking for things. They like to go through our things in our rooms. If they find condoms, you are in trouble. They can even throw you out of their house. (Boy from urban area)

Texts above indicate that the promotion of condoms has an effect on young people's awareness and use of condoms. Young people think about using condoms and seem to have some experience of using it. They expressed the gaps and challenges when they want to use condoms. Finding condoms in a young person's room can be an opportunity for parents to start educating their child on sexual matters. This however, could be integrated into parents' programmes on how to communicate with their children about sexual matters.

There is evidence of some knowledge about HIV transmission and ART from the text produced. This is reassuring as this indicates that HIV and AIDS prevention interventions do have an effect. Texts below indicate such knowledge:

If you check here around our school, most people have relationships with people who are at university and those at university also have relationships with others at university. That means that, that is where AIDS is spreading. (Boy from urban area)

AIDS is not scary nowadays. There are people that we are told have HIV and they have been having it before we were born. Those people are still alive because they are taking medication. It makes them not to be sick and live long. (Girl from rural area)

HIV prevention interventions do have an effect in these communities to raise awareness and knowledge about HIV and ART and to promote condom use. However, young people are not positive about prevention messages and would like them to be improved. Prevention interventions in schools are also not presented in way that has an effect on behaviour. It is given in an authoritarian way and young people nowadays prefer to make their own decisions based on facts presented to them. The complex part is for prevention interventions to translate knowledge into action.

5.7 Cultural strategies that were used in the past to reduce STI's and pregnancy

Community leaders were asked about strategies that were traditionally used to prevent sexually transmitted diseases and pregnancy. The participants discussed several strategies to prevent and to reduce STIs. The strategies below are not advocated by the researcher as safe methods in the prevention of pregnancy and HIV. The value of these strategies is considered and the positives and negatives are highlighted. Suggestions on how to improve them in the context of HIV and AIDS are also mentioned. This is in line with the PEN-3 model's suggestion that the researcher should approach culture from a positive perspective. The strategies that were used in the past are discussed below.

5.7.1 Virginty Testing

The text produced by community leaders in Venda revealed that virginty testing was one of the customs that was used to prevent sexually transmitted diseases and pregnancy among young women. It is still viewed as an important customary practice in reducing HIV infections and pregnancy. The views of some of the participants are as follows:

Young girls used to be checked for virginty. Knowing that they will be checked and be an embarrassment for the family, young girls were then careful not to sleep around before marriage. (Adult male from rural area)

Virginty testing should still be done. You see, it can help to prevent HIV. But also, someone who has to be married to the chief and give birth to a future chief

cannot be a person who has been sleeping around. That is why it is important that they should be checked for virginity. (Adult female from rural area)

Virginity testing helps a lot when it comes to sexual problems. But nowadays it is about rights for young people. (Adult male from rural area)

The young people also spoke about virginity testing. They reported that they only get checked until they go to initiation schools, but after that they are not checked. They reported that they sometimes have an agreement with their boyfriends to wait until they attend initiation school and then have sex after that. Two participants shared:

When you know you will be checked at the initiation school, you control yourself and even tell your boyfriend that we should wait until the inspection. After that then you can start doing it (having sex). (Girl from rural area)

Parents also create a cut-off point with the initiation. They tell you that you should not embarrass the family by having sex before the inspection at the initiation school. They also promise a lot of gifts if you are found to be a virgin. This makes us to sometimes wait until after the initiation. (Girl from rural area)

Virginity testing has been practiced in many African communities to control chastity before marriage. Virginity testing is a highly contested issue in South Africa: it clearly illustrates conflict between customary and statutory law (Martin & Mbambo, 2011). Virginity testing has been marked by controversy since the mid-1990s when the Bill of Rights was introduced in South Africa (Leclerc-Madlala, 2001). It was viewed as an invasion of privacy for young girls and promoting gender inequality as young boys were not subjected to such violation. It was also interpreted as indicating that women are the ones who spread HIV and should be controlled through virginity testing to make sure that they do not have sex. However, traditionalists and proponents of virginity view virginity testing as an African solution to the African AIDS problem (Leclerc-Madlala, 2001).

Virginity testing can be beneficial in delaying sexual debut if done in privacy not to expose those who are not virgins to public shame and ridicule and only if done with the girls' consent. Virginity testing should be done in conjunction with comprehensive sexual education so that young people have sexual knowledge when they decide to engage in sex. Considering the violation of young women's privacy, it should not be propagated as a general HIV prevention strategy.

5.7.2 Mixing of blood

The community leaders reported that there was a ritual that used to be performed for a man and woman when they get married. The ritual involved the mixing of the blood of the man and the woman. Such rituals were done by a traditional healer. If a man married many wives, his blood was mixed with the blood of each of his wives. This ritual is said to make ancestors to protect the couple from illnesses. It was reported that the mixing of blood also indirectly controlled with whom people have sex. Men would not sleep with women if their blood was not mixed, because this relationship would not be protected by the ancestors. Two participants reported:

Yes, historically, there was a ritual of mixing of blood. Before you meet together at all [have sex] as a man and a woman you used to go and have a ritual of mixing blood. If you do that, there will not be any illnesses between you because your bloods were in line with each other. (Male from urban area)

When your blood is mixed, you go to a traditional healer who takes the woman's and the man's blood and mix with some traditional medicines. But most importantly it also helped to control that you do not just sleep with everyone. The person you sleep with is your wife, with whom the blood has been mixed. (Male from rural area)

It seemed that it is one of those rituals or taboos that is done and no-one asks the reasons for or effects of it. One participant stated:

No-one knows what happens if you sleep with a person whose blood is not mixed with but we as adults never ask those things. This goes with what we were saying about young people. They will never just believe and do as they are told. But like you... (laughter) they will ask why and what happens. (Male from rural area)

Mixing of blood has potential negative effects in HIV and AIDS depending on how blood is drawn and how it is mixed. If one believes in the value of the ritual it can be a control measure for MCP that could be beneficial in the HIV and AIDS context.

5.7.3 Tying to prevent pregnancy (*U vhofha*)

The community leaders' text revealed that there were strategies that were used to prevent girls from falling pregnant. *U vhofha* was done with the help of a traditional healer. It was done by mixing menstrual blood and traditional medicine and thereafter placing the mixture in a hidden place only known by the traditional healer. It was believed that girls then would not get pregnant if they had sex. *U vhofha* was done by families privately. Community leaders reported that such a practice was not favoured traditionally because it promoted promiscuity among young women. It was also reported that *U vhofha* had long term consequences as it sometimes becomes difficult to reverse the process. When the child gets married she can no longer have children and it can embarrass the family. Participants voiced their concerns:

Young women are sometimes tied (u vhofha) so that even though they sleep with a man, they do not fall pregnant. But it influences young women to run around (have sex) with many men. (Adult female from urban area)

To tie (u vhofha) a child increases sexually transmitted diseases and HIV because she knows that I cannot fall pregnant. (Adult female from rural area)

But it just shows that parents are more afraid of pregnancy than HIV. That is why they tie their daughters. (Adult male from urban area)

But this thing, sometimes it happens that you forget where you placed the things that were used to tie her or the house gets burned with those things inside. Then you are doomed because she will never have a child even when she is married. And who gets embarrassed? Me as a parent. (Female from rural area)

Some participants highlighted that *U vhofha* can influence sexual risk behaviour as young people would believe that even if they have unsafe sex, they will not fall pregnant. However, *U vhofha* can be compared to contraceptives that are made available to young people. Both are meant to prevent pregnancy.

Tying to prevent pregnancy can be beneficial especially if it combined with PrEP to prevent HIV. There is a need for prevention intervention that prevents both HIV and pregnancy at the same time. More research is needed to find out how tying was done, whether young people can fall pregnant again later on in life when they want to and if it is something that can be used to assist young people.

The community leaders' constructions of HIV and AIDS and cultural strategies to prevent HIV and pregnancy are summarised in Table 4.

Table 4 Community leaders' constructions of HIV and AIDS and Cultural strategies to prevent HIV and pregnancy

Discourse of HIV and AIDS
Traditional ethno-medical discourse
Cultural erosion disease
Cultural strategies to reduce STIs and Pregnancy
Virginity testing
Mixing of blood
Trying to prevent pregnancy (U vhofha)

5.7.4 Summary

In summary, the young people and adult participants' constructions of sex and sexual risk behaviours was radically different. The young people socially constructed sex as natural and unavoidable whereas the adult participants interpreted this behaviour as immoral. They believe that young people should be able to control themselves.

The adult participants believe that if young people follow the rules and taboos of their culture and also attend initiations, they should be able to control themselves and not engage in sex or sexual risk behaviours. The young people, on the other hand, construct culture and initiation schools as encouraging early sexual debut and sexual risk behaviours because of peer group influence. The different constructions regarding sex, sexual risk behaviours, culture and parental disempowerment have led to a serious communication gap between young people and adults.

There is also no formal comprehensive sexual education at schools. This results in more peer influence than parental or adult influence in sexual matters. The results confirm the role of young people's interpersonal interaction in determining HIV and AIDS sexual risk behaviour. The results also show the importance of social discourses about HIV and AIDS in influencing the effects of HIV and AIDS preventive interventions on young people's attitudes, behaviour and beliefs.

Chapter 6

Conclusion and Recommendations

6.1 Introduction

This chapter presents an overview of the current study. The results are interpreted in relation to the theoretical framework and previous research. The study is also evaluated in terms of its strengths and limitations. The chapter is concluded by suggesting recommendations for future prevention strategies and further research.

The study identified a lack of focus on culturally accepted practices and understanding of young people's construction of sexuality as gaps in current HIV prevention. The study then explored how Vhavenda young people construct sexuality and how these constructions influence risk behaviours and the effectiveness of HIV and AIDS preventive programmes in this context. Cultural practices that could promote HIV prevention were explored among community leaders. The research was conducted to inform more successful HIV prevention interventions using accepted Venda cultural beliefs.

The literature review on HIV sexual risk behaviours among young people indicated that engagement in early sexual debut, multiple concurrent relationships (MCP) and intergenerational relationships placed them at risk of HIV (Reddy et al., 2010; Shisana et al., 2009; Shisana et al., 2014). The literature revealed that, despite great progress in biomedical prevention interventions (Hosek, Celum, Wilson, Kapogiannis, Delany-Moretlwe, & Bekker, 2016), there is currently no single intervention which can adequately prevent the spread of HIV (Rotheram-Borus et al., 2009). The focus of the study was to explore young people's constructions of sexuality and cultural perspectives in an effort to contribute to the development of interventions aimed at HIV prevention.

Focus group discussions were conducted with young people in Grade ten to twelve (aged 15 to 19 year old) in rural and urban areas of Venda. Additionally, community leaders in rural and urban areas also participated in focus group discussions. Text produced in focus group discussions was analysed using discourse analysis (Potter & Whetherell, 1987). The study revealed that there are many discourses and social constructions that developed from social interaction among people that have an effect on young people's sexual risk behaviours.

The male sexual drive discourse (Hollway, 1984, 1989) featured prominently in this research, especially in describing male sexual behaviour. This confirms previous South African research that also identified this discourse as linked to HIV risk (Schepers & Zway, 2012; Shefer & Foster, 2001; Shefer & Mankayi, 2007; Strebel, 1993; Wood & Foster, 1995). The sexual drive discourse has been contested by voices contradicting constructions of female sexuality as passive but showing greater acknowledgement of female sexual desire and sexual initiation (Hunter, 2002, Shefer & Foster, 2001). Some components of female sexuality can be related to the male sexual drive discourse, as girls associated sex with emotions and relationships. Additionally, there are evidence that girls are more empowered and do not accept the male sexual drive discourse. Some girls are active in seeking sexual pleasure and make their own decisions related to sexual relationships.

Current HIV prevention interventions educate young people on heterosexual and coital sex. Non penetrative sex is not communicated about as safe sex. There is a need for a more balanced view of sex which focuses on pleasure, power and safer sex. There are some cultures that teach young people about their bodies and non-penetrative sex during initiation schools (e.g. *ukusoma* in Zulu) (Cassimjee, 1998; Delius & Glaser, 2002; Harrison, 2008). It is vital for prevention interventions to educate young people on how to protect themselves and also on other forms of sexual pleasure (e.g. masturbation and touching). This might lead to safe sex among young people, especially for young girls who do not conform to the male sexual drive discourse.

What stood out in this research was that constructions of sexuality among Venda young people were similar to those identified among other young people in African countries from different cultural groups (Holland, 1996; Shefer & Ruiters, 1998; Shefer, et al., 2000; Shefer & Foster, 2001; Shefer, Kruger & Schepers, 2015; Strebel, et al., 2006). The construction of sexuality among these young people was also similar to constructions found through the years (Holland, 1996; Shefer & Ruiters, 1998; Shefer, et al., 2000; Shefer & Foster, 2001; Shefer, Kruger & Schepers, 2015; Strebel, et al., 2006). This indicates that decades of HIV prevention did not have a drastic effect on the constructions of sexuality on young people.

Sex as a commodity was identified among young women in this study. Young women expressed transactional sex for survival and also in pursuit of modernity. Young women indicated that sex as a commodity is sometimes endorsed by parents or adults. Transactional sex was related to intergenerational sex. Young women reported having relationships with

older males as they can provide for them financially. The discourse of sex as a commodity has been researched extensively in South Africa and linked to sexual risk behaviour especially among young women (Leclerc-Madlala, 2003; Leclerc-Madlala, 2008; Longfiled et al., 2004; Rehle & Shisana, 2003). The construction of sex as a commodity is usually linked to women's economic status in the society and thus depicts women as victims in this situation. Studies (Hunter, 2002; Leclerc-Madlala, 2003; MacPhail, Pettifor & Rees, 2007) have shown that sex as a commodity can also be viewed as women asserting themselves in order to exploit sexual relationships and have access to resources and financial security. In this situation women have the power through transactional sex to change their lives.

The hegemonic masculinity discourse strongly emerged from young people's constructions of sexuality. Reid and Walker (2005) indicated that in South Africa, masculinity has been influenced by colonialism and apartheid in the past. The transition to democracy in the 1990s had a further effect on the construction of masculinity as it was constructed in relation to patriarchy and violence to women. Current (post 1994) constructions of masculinity indicate that sexual behaviour is significant in constructing what manhood is (Reid & Walker, 2005). The same constructions were found in this study. The construction of boys attaining manhood through sexual risk behaviours support findings of previous research (Barker & Ricardo, 2005; Marston & King, 2006; Selikow et al., 2002). The discourse of hegemonic masculinity (Connell, 1995; Morrell, 1998) has implications for young people's sexual risk behaviours and HIV/AIDS prevention interventions.

Shefer, Kruger and Schepers (2015) indicate that most research on masculinity in South Africa since 1994 tend to focus on boys and masculinity as dangerous and a problem in the HIV and AIDS context and having a negative impact on girls and women. There are also South African scholars (Ratele et al., 2010) who have indicated that masculinity presents risk for boys and men. Scholars have indicated that the focus on hegemonic masculinity created a problematic portrayal of young black males as having dangerous and uncontrolled sexual urges. Recent research (Shefer, Kruger & Schepers, 2015) indicate the importance of focusing on boys' and men's vulnerabilities and also acknowledging the complexities of being a boy or men. The results of this study are in line with most research that indicates masculinity as influencing sexual risk among young men which also affects young women negatively. The researcher is aware that there are complexities and vulnerabilities in being a young black man. The complexities and vulnerabilities of being a young black man should

be considered when developing HIV prevention interventions focusing on deconstructing gender roles.

As discussed previously, masculinity is not just about men, it is about gender relations (Chong & Kvasny, 2007; Connell, 1995; Cooper, 1994). Masculinity is socially constructed in relation to femininity. Besides discourses of masculinity, there are also discourses and behaviours that are currently associated with womanhood and femininity among young people. Leclerc-Madlala (2003) indicated that discourses on current womanhood among young people celebrate sex as a commodity and MCP as a signifier of modern life and sexual equality. The same discourses were revealed in the current study. As discussed above, young women reported sex as a commodity for survival and a means to acquire social status. The young people in the study also indicated that such behaviour is condoned by adult family members as they expect young women to support their families through relationships with older men. This is an indication that constructions of gender roles are not about men or women alone, but about communal constructions in the society as a whole. Current constructions of womanhood have implications for HIV and AIDS and young women's adherence to HIV prevention interventions

The prominence of the hegemonic masculinity and femininity constructions is confirmed by the extent to which young people experience peer pressure to conform to these constructions of sexuality. This study identified that young men engage in sexual risk behaviours because of peer influence and the need to satisfy peer expectations. Similar results have been found in South African research previously (Parker, 2007; Visser, 2007; Visser, 2012). A sense of acceptance and belonging to a group is constructed as more important than the fear of HIV (Campbell, 2010). This influences young people to adhere to the dominant discourses constructed by young people, rather than the constructions promoted by their parents or HIV prevention interventions. These discourses influence young people not to adhere to HIV/AIDS prevention interventions.

Young people's discourses of sexuality (indicated above and in Chapter 5) have been researched, reported and linked to HIV risk since the beginning of the HIV epidemic (Preston-Whyte, 1999). This research indicates that constructions of sexuality among young people of Venda are similar to those found in other provinces in South Africa and Africa in general. This means that current HIV prevention strategies have not resulted in changes in the above discourses and behaviours related to them. It is important that HIV prevention

interventions take young people's discourses into account. As current prevention interventions have not changed the discourses identified above and the behaviours related to them, it is important for decisions to be made on how these discourses will be incorporated into prevention interventions as they continue to put young people at risk of HIV.

The study also identified community leaders' (adults') discourse of young people's sexuality. Community leaders were of the opinion that young people engage in risk behaviours because they lack moral values. The moral discourse is linked to the medical discourse of HIV/AIDS (Seidel, 1993). The medico-moral discourse is frequently judgemental and puts blame on the *other* (Seidel, 1993). In relation to HIV/AIDS, medico-moral discourse locates the blame for disease on the immorality or sin of the *other*. Seidel (1993) expressed the opinion that these constructions of sexuality are part of the older, religious tradition of using sexual taboos and prescribed behaviours to reinforce existing sexual orders. The social order is then structured in the interest of the well and powerful. This results in the constructions of the powerful being accepted and the suppression of the minorities' agency.

The community leaders' constructions are similar to the constructions of sexuality that form the foundation of the current prevention interventions. Current prevention strategies judge young people's sexual behaviour as *risky*. They call for young people to change their behaviour and follow ways prescribed by the ABC model. Morality and abstinence has been emphasised in most behavioural prevention interventions in line with the discourse of adult participants. This indicates that prevention interventions are developed to suit what adults perceive to be right and not according to young people's constructions. This might be the reason why current prevention interventions are not effective among young people.

Parents in this study feel disempowered in their parenting role and do not educate young people about sexuality as it is not in line with their tradition. The text produced by the adult participants revealed a sense of disempowerment of both parents and traditional leaders in raising young people. Parents blame democracy and the new constitution developed in the 1990s as the root of children's disregard for authority and rules. The Bill of Rights (2003) currently constructs children as vulnerable and needing protection, hence, the Children's Bill of Rights Policy (2003) was developed. Childhood construction also gives children power and some form of autonomy and rights. Children's rights which allow young people a sense of freedom was accepted as part of the new constitution. This resulted in parents constructing themselves as disempowered in their parental role.

In addition, the community leaders mentioned that new government structures such as police stations in each area and the local government and policies, introduced as part of post-apartheid re-organisation, had resulted in the disintegration of traditional structures that controlled the behaviour of people in communities. The power of traditional leaders to lead their communities has decreased. A bill, namely, the Termination of Pregnancy Bill of 1996 which stipulates that girls as young as twelve years old may have abortions without parental consent, is seen as undermining the authority of parents in their child's life. The adults mentioned that these changes contributed to parents' constructions of disempowerment in their parental role and to young people engaging in sexual risk behaviours.

The adult participants reported that they do not know how to teach young people about sexuality because according to their culture, parents should not talk directly to their children about sexual matters (Bastien, Kajula, & Muhwezi, 2011; Goodnight, Salama, Grim, Anthony, Armistead, et al., 2014; Mchunu, 2005). Sexual education was traditionally done through initiation schools (Malisha, Maharaj, & Rogan, 2008; Milubi, 2000). Young people presently have a choice whether they want to attend initiation schools or not. This results in a lack of sexual education for young people. The dominant construction of sexuality in the peer group among young people is thus not counteracted by constructive sexual education.

Adult's constructions of their parenting roles and young people's sexual behaviours have an impact on young people's sexual risk behaviours. Societal change (in the form of the bill of rights and globalisation) has an influence on parental guidance in relation to morals and sexuality. Young people grow up in an era that focuses on sexual openness, media exposure and children's rights. They do not accept authority and questions everything if it is not proved. Societal change increased the gap between young people and parents and resulted in different constructions of sexuality and lack of communication. Young people view sex as perfectly natural while parents view it as immoral for young people to have sex. The different constructions between young people and parents decreased the balance between the influence of parents and their cultural ways on the one hand and the peer group on the other. The result is an increase in sexual risk behaviours among young people. Previous research indicates that parental influence stemming from sound relations could have a positive effect on sexual risk behaviour (Cluver et al., 2014).

There is a need to close the gap between young people and parents. This can be done by educating adults regarding young people's constructions of sexuality and regarding forces

that impact on their sexual risk behaviours. There is also a need for parental skills training that is in line with the new way of raising children based on the Children's Rights approach. There is also a need to improve initiation schools by including comprehensive sexual education, exclude factors that influence sexual risk behaviours and to also make it appealing for young people. It is important for community leaders to work with young people to restore parental authority and to recreate community structures which regulate behaviour. The participation of young people in these matters is important for it to be acceptable and appealing to young people.

Access to health care information through television advertisements, peer educator programme and Life Orientation are contextual factors that could influence young people's behaviour. These multi-faceted factors influencing behaviour indicate the need for multi-level and multi-dimensional prevention interventions in order to reduce young people's vulnerability to HIV infection.

A unique contribution of this study is the identification of Vhavenda ways of doing things and cultural initiations that can be included into the HIV prevention interventions to increase their effectiveness. The study identified resources that can assist in improving HIV prevention interventions aimed at young people of Venda. The young people's focus group discussions indicated that some young people attend initiation schools at churches. The church is one of the resources that can be used to educate young people about sexual risk behaviours and HIV. Traditional initiation schools can also be used to educate young people on sexual risk behaviours and HIV.

Young people in this study indicated that they prefer to be educated about sexual matters earlier before they start having sex. This study identified that Vhavenda initiations starts educating young girls when they transition from babyhood to puberty (*Musevhetho*). Comprehensive sexuality education can be started at *Musevhetho* and be graded up with different stages of initiations when young people grow older. In this way HIV prevention interventions can implement comprehensive sexuality education according to the Venda cultural way of educating young people about matters of sexuality. Young people in this study also indicated that they use condoms, even though there are some challenges they experience when they use condoms. Condom use can be improved in HIV prevention interventions by attending to the challenges young people experience when they use condoms. HIV prevention interventions should, for example, attend to the perception that sex

with a condom is not as pleasurable as skin to skin. They should also attend to issues of anxiety related to fitting a condom and negotiating condom use while sexually aroused.

The fact that community leaders are concerned about young people's sexual risk behaviour is a positive factor and can be used to improve HIV prevention interventions by including parents in the development of HIV prevention interventions and by educating parents on how to educate young people about sexuality. Text produced also indicated agency amongst young people. For example, young girls being against young men who use young women sexually but prefer to marry virgins. The fact that participants mentioned *difficult* women indicates that not all young women are willing to be sexually active or to be involved in concurrent partnerships. This resistance against young men's behaviour can be used to empower young women to protect themselves by not allowing young men to use them sexually. It can also be used to make young women aware of how current gender role constructions can sometimes put them at risk.

6.2 Evaluation of the study

In this section, aspects of the present study that could have influenced the results of the study are evaluated. Epistemological and personal reflexivity and some limitations of the present study are discussed.

6.2.1 Reflexivity

Reflexivity is the process of examining oneself as a researcher considering the research relationship that could influence the quality of the research. Willig (2001) reported that when conducting research, the researcher cannot assume the position of an impartial observer. A researcher's background and position affect what the researcher chooses to investigate, the way he or she chooses to investigate, the methods used, the findings considered most appropriate and the ways of communicating the findings (Malterud, 2001). Examining oneself involves examining one's assumptions and preconceptions and the affect these have on decisions made in the research. It involves examining one's relationship with the participants and the effect of the dynamics of the relationship on the participants' responses to questions.

6.2.1.1 Epistemological and Ontological Reflexivity

The context in which the researcher is rooted plays a role in shaping decisions regarding ontological and epistemological positioning and methodological and theoretical perspective (Mauther & Doucet, 2003). While reviewing literature, the researcher took cognisance of a movement in South African research towards finding an African way of reducing HIV infections (Harrison, Cleland & Frohlich, 2008; Leclerc-Madlala, 2008). In the literature study, the researcher also found that qualitative research is currently more relevant in the HIV and AIDS context because of the complexity of sexual risk behaviours and HIV prevention. The literature review also indicated the need for context-specific prevention interventions as there is no universal *one-size-fits-all* method of preventing HIV infections. This might have influenced the researcher's decision to do qualitative research that is context-specific. The literature thus influenced the choice of methodology and the theoretical perspective that the researcher chose.

Even though there might have been influences from the literature review in choosing the research design for the study, it was coherent and appropriate for the study. An epistemological framework of social construction theory, accompanied by qualitative research methodology and discourse analysis was appropriate for the study as it made it possible to achieve the aims of the study. The research design enabled the researcher to generate new knowledge such as an awareness of the relationship between young people and parents and the impact the relationship has on young people's sexual risk behaviours. As social construction acknowledges multiple realities, it allowed the researcher to explore the realities of different role players (young people, adults and community leaders) into young people's sexual risk behaviours. The study gave a voice to young people to express their constructions. Their constructions are accepted as their reality that influences sexual risk behaviours.

Social construction as a theoretical framework assisted the research process, but also presented unique challenges. The social construction's position is that there is no one way of knowing, but multiple realities; none of which is better than others (Gergen & College, 2001). As there are multiple realities and multiple ways of knowing, the researcher could not discredit opposing arguments or findings by comparing them with current research findings,

as the current findings are also not *truths* or objective reality. The current findings are social constructions between the researcher and participants.

The social construction position discussed above presented a conundrum in considering and formulating recommendations for future HIV prevention interventions in Venda. As there are multiple realities, the researcher's reality and way of knowing is not better than the participants' reality and thus, should also not be suggested as a better way of living or preventing HIV for the participants. It was a challenge for the researcher to divorce herself from being a professional who is supposed to know better and make recommendations to the participants and step down from her position of power. A consideration of the social construction position assisted the researcher as she realised that what she considers effective might not be effective when taking the participants' way of knowing into account in preventing HIV. This forced the researcher to base her recommendations on the participants' constructions as they represent how participants would like prevention interventions to be done and to be implemented in their context. The researcher also relied on the social construction position that change is brought about by human activity and interaction (Berger & Luckmann, 1991). Individuals and groups construct their own reality. The researcher initiated arguments that can generate real debate about HIV risk behaviours among young people, their constructions of sexuality and HIV prevention interventions that might lead to change. Considering these arguments could precipitate a reduction in young people's vulnerability to HIV.

6.2.1.2 Personal Reflexivity

As indicated in Chapter 1, the researcher's interest in young people's sexual risk behaviour started when she was working as a clinical psychologist in a clinic in Soshanguve. The researcher linked the presenting problems of young people in Soshanguve to adult concerns about young people's behaviours in Venda. This influenced the researcher to be curious and to make enquiries into Vhavenda young people's sexual risk behaviour and HIV. The researcher was puzzled by the complex nature of factors that influenced young people's sexual risk behaviour. The researcher focused on Venda as she was born and bred in Venda. (A detailed discussion about personal reflexivity is in Chapter 1 under motivation of the study). Being a clinical psychologist, working with young people and being born and bred in

Venda had an influence on the researcher's choice of research topic and on the focus area of the study.

The researcher's profession and the birth of her twin sons during her PhD study might have affected data analysis. As a psychologist and a new mother with beliefs on raising children in a non-authoritarian manner, my beliefs might have affected the understanding and analysis of data produced by the community leaders. The theoretical background of social construction might have helped in keeping a check on my beliefs and the impact they may have on data analysis. The knowledge that there is no one truth and one way of doing things and the knowledge that one's way of doing things is not necessarily better than other people's way of doing things (Gergen & College, 2001), helped me to put my beliefs aside and focus on the community leaders' constructions.

Social construction theory implies that social interaction is important in shaping people's lives and behaviour (Burr, 1995). Social construction might have provided the researcher with the basis for relational thinking while analysing data. It enabled the researcher to theorise about young people's sexual risk behaviours as a result of interaction with their peers. She could contrast this theory with the youth's disconnection with culture and the views of parents and adults. It helped the researcher to formulate a frame of reference to interpret data without resorting to personal points of view.

In discussing results and recommending more successful prevention interventions, the researcher had a double role. I had to explore and understand the participants' social discourses and at the same time had a role to suggest improved prevention interventions for young people. During this phase the researcher had to acknowledge and introduce the evident health discourses of HIV. The researcher could then bridge the gap between HIV prevention strategies and discourses about sexuality amongst young people.

The researcher took utmost care to remain reflective during the different stages of the research. Regular meetings with the co-facilitator and breaks from analysis enhanced reflexivity when the research process traversed its unavoidable intense and confusing stages. Nevertheless, according to Mauther and Doucet (2003, p. 425) "no matter how aware and reflexive, we try to be, the author's intentions, emotions, psyche and interiority are not only inaccessible to the readers, they are likely to be inaccessible to the author herself". Like other researchers, this one is human and intends to remain so.

6.2.2 Credibility of the study

There are many techniques that can be used to validate discourse analysis research. Potter and Whetherell (1987) identified four main techniques: coherence, participants' orientation, new problems and fruitfulness (discussed in Chapter 4). The research is evaluated according to these constructs.

6.2.2.1 Coherence

Analytic claims are considered to be coherent if they show how discourses fit together and how discourse produces effects and functions (Potter & Whetherell, 1987). The discourse analysis showed how young people's sexuality discourse has an impact on their sexual risk behaviours. The discourse in the study also showed how the lack of sexual education from parents has an influence on young people's sexual risk behaviours as they turn to their peers for information related to sex. The discourse indicated that peer influence on sexual matters has an influence on young people's sexual risk behaviours. The combined discourses confirmed the importance of context-specific prevention interventions for young people of Venda.

6.2.2.2 Participants' orientation

Discourse analysis focuses on the orientation of the participants. What the researcher views as consistent or not, is of no importance; what is important is the participants' view (Potter & Whetherell, 1987). For this to be met, the participants must have access to the results and interpretation of the results and be invited to comment on the findings. The researcher reflected on what she understood after each focus group discussion. During reflection, the participants verified that the researcher heard and understood what the participants said. The researcher plans to provide the results to the participants for comments before using it in future planning.

6.2.2.3 New problems

Discourse analysis in a study may create new problems. This technique of validating a study relates to the researcher using new problems to validate analytic suggestions (Potter & Whetherell, 1987). The criteria on new problems was met in the study. In constructing young people's sexual risk behaviours, community leaders came up with primary discourses around sexual risks in their community. Those discourses include parents' constructions of young people as lacking morals, not accepting authority of parents and not respecting the Venda tradition. The primary discourse from community leaders created new problems that indicated a secondary discourse of the policies in the democratic era impacting on their parenting role.

6.2.2.4 Fruitfulness

Analytic claims are considered to be valid if they can be used to generate new solutions to problems concerned (Potter & Whetherell, 1987). The study met the fruitfulness criterion as it resulted in potential new strategies to address young people's sexual risk behaviours and the dilemma of parents who are confused about their parenting roles.

6.2.3 Limitations of the study

The aim of the study was to understand adolescents' constructions of sexuality and HIV and Vhavenda cultural ways of preventing HIV and AIDS. To achieve this, community leaders were included as participants. The community leaders were recruited at the chief's kraal during a community meeting. The focus group discussions were also held at the chief's kraal. Most people who attend community meetings at the chief's kraal are traditionalists and focus on cultural ways of doing things. The information obtained from the adult participants may, therefore, be limited as it is from a traditional perspective only. There may be many other perspectives on sexuality and parenting that were not discussed in the groups.

Data collection was done using focus group discussions. Focus group discussions are valuable especially in a social constructionist study where the researcher would like to get interactive data and where meaning is constructed in a social setting (Kvale & Brinkman,

2009). In discussing sensitive issues such as sexuality, it may sometimes be difficult for people to openly voice their opinions or to be open about their own behaviour. Issues of privacy, confidentiality or assertiveness could have limited the participation of some participants. The use of focus group discussions might have resulted in some discourses being highlighted or even over-exposed because of dynamics in the groups. In such a group discussion the dominant discourse is often highlighted because participants may strive for acceptance during the discussion. The group setting could also result in some alternative discourses being silenced because they conveyed no dominant arguments. Alternative or individual discourses might not be prominent in the discussion leading to lack of information of alternative or protective behaviour. It might have been beneficial for the study to use both focus group discussions and individual interviews. The joint use of focus group discussions and individual interviews might have resulted in richer constructions about young people's sexuality, representing more alternative constructions.

The focus group discussions with young people did not focus on the impact of parenting or the relationship with adults in the community on their sexual risk behaviours. It is vital for future research to focus on how changes in the Vhavenda community have influenced young people's sexual risk behaviours. It is also important to determine whether young people perceive such changes to have an impact on their behaviour.

The young people discussed the fact that pregnancy has many solutions and that it makes them have unsafe sex, as they know that they can have an abortion. The young people's discussion could have focused in detail on the young people's perception of children's rights and the impact they have on HIV and AIDS and sexual risk behaviours among young people. This could have assisted in exploring the structural factors that are affecting young people's sexual risk behaviours.

6.2.4 Implications of the study

The study aimed to explore young people's constructions of sexuality and the effect those constructions have on young people's sexual behaviour. The study also aimed to inform more successful HIV prevention interventions for young people in Venda in future.

The theory of social construction acknowledges that social discourses influence behaviour (Burr, 1995). The study revealed that sexuality discourses among young people influence them to engage in some unsafe sex practices such as early sexual debut, sex as a commodity, intergenerational sex and MCP. The study indicated constructions of gender roles having implications on young people's sexual risk behaviours as young men engage in sexual risk behaviours in order to attain masculinity and young women behave in a way complementary way that confirm their femininity and strengthen discourses of masculinity. The value of the study is to confirm that these dominant discourses have not been changed by decades of HIV prevention efforts. The research emphasized the importance of acknowledging young people's constructions and the necessity to incorporate their views into HIV prevention efforts.

The study's main contribution is that parents' discourse of young people's statutory rights disempowers parents from their parental role, which creates a gap between parents and young people. This further influences young people to engage in sexual risk behaviour as they do not have a constructive way of learning about sexuality other than through their peers. Media messages of sexual risk behaviours are not influential in young people's lives as they are not in their vernacular and are considered complex to understand. This also indicates that societal change lead to different sexuality constructions between young people and parents, which invites young people to engage in sexual risk behaviours as they live in an era that accepts sexual openness. The study also showed discourses of HIV and AIDS as a manageable chronic illness having little influence on young people's sexual behaviour, as they believe that they can cope and live with an HIV positive status.

Overall, the study found that there are many role players with different discourses that interact to influence young people's sexual behaviour. As there are many factors and discourses influencing young people's sexual behaviour, it also requires multi-level and multi-disciplinary HIV prevention interventions. This knowledge can be applied to HIV and AIDS prevention strategies so as to develop multi-level prevention interventions that can target all role players at the same time in order to have a better chance of success in reducing young people's vulnerability to HIV infections.

Discourse analysis unmask and delineates understandings that are taken for granted. This helps to focus on such understandings and on the implications they have for behaviour. This study identified the male sexual drive discourse (Hollway, 1985, 1989) among young people.

This may contribute significantly to earlier constructions of young people's sexuality as expressed by parents and the designers of HIV prevention strategies. Adults and prevention programmes do generally not view sex as part of young people's lives and view it as something that young people can abstain from or avoid. The study presented young people's discourses being different from dominant discourses of adults and the medical model and prevention interventions directed towards them. The study serves to highlight young people's sexuality and to give voice to descriptions of sexuality by young people. This insight can be applied in HIV prevention interventions by involving young people in developing prevention interventions that are more suitable and effective for them.

The study also presented discourses of sexuality that influence young people to engage in sexual risk behaviours such as MCP. Such discourses were shown to be maintained as important in achieving masculinity, social status and a sense of self by young people. Social construction acknowledges that discourses are constructed and they can be deconstructed and/or reconstructed (Herek, 1986). Critical awareness of discourses and their implications can open discussion of the discourses and their influences which could contribute to change. Freire (2005) emphasised that when people reflect about themselves and their world, it increases the scope of their perceptions, redirecting their observations and attention. Thus "knowledge emerges only through invention and reinvention, through ... inquiry human beings pursue in the world, with the world and with each other (Freire, 2005, p.72). Opening up the dialogue about different discourses that influence behaviour can, therefore, contribute to HIV and AIDS prevention in Venda.

Social construction acknowledges that knowledge implies action (Burr, 1995). This is shown in findings that indicate that young people's constructions of sexuality among peers lead to young people engaging in sexual risk behaviours. The study indicated that young people are mostly educated about sexuality by their peers. Adult sexuality education is not reaching young people effectively, as most young people choose not to attend cultural initiation schools. It seems that peer influence at the initiation school overshadows the influence of traditional leaders. According to young people, peer education and Life Orientation at schools do not have a lasting impression on young people's behaviour. Young people are thus not receiving effective sex and HIV education from formal structures. Young people's sexual risk behaviour is the action resulting from knowledge that young people get from their peers as there is currently no sufficient alternative education. These findings can be applied to improve current prevention interventions by addressing peer influence on sexual risk

behaviours. This can be done by having discussions on peer influence and its impact on sexual risk behaviours among young people. These discussions can raise awareness and lead to different actions among young people.

The medical discourse of HIV as a chronic illness influences young people to engage in sexual risk behaviours. This insight can be used to indicate the need for multi-level prevention interventions that could address multiple factors that influence sexual risk behaviours at the same time. This will assist so as to have a better chance of reducing young people's vulnerability to HIV infection.

6.3 Recommendations

This section outlines the recommendations based on the constructions from participants and on suggestions made by the participants for more successful prevention strategies. These recommendations are augmented by recommendations regarding the process for developing such prevention interventions.

The lack of a medical cure for HIV and AIDS put the spotlight on preventive efforts for the reduction of HIV infections (Melkote, Moore, & Velu, 2014). As discussed in Chapter 2, there is a need for context-specific prevention strategies as current prevention interventions are not effective for certain cultures, age groups and societies (Marin, 2003). Furthermore, research such as that of Chandra-Mouli, Lane and Wong (2015) has shown that there are certain factors that render preventive strategies ineffective among young people. Those factors and constructions from participants highlighted in the study are discussed so as to suggest more effective prevention strategies. In order for the recommended preventive interventions to be successful, they should be offered concurrently and efficiently (Chandra-Mouli et al., 2015) and not haphazardly. The discussion of prevention strategies that are recommended for young people of Venda follows.

6.3.1 The male sexual drive discourse

As indicated in **Error! Reference source not found. 5**, young people construct sex as natural and unavoidable. This discourse showed that sex is important for young people and serves

many functions for them. Young people also indicated that the current prevention intervention of *abstinence* is introduced to them when they have already started having sex. They indicated that it is difficult to abstain when they are no longer virgins. Consequently, abstinence as a prevention intervention should be introduced at a much younger age.

6.3.2 Abstinence

Abstinence is traditionally and culturally appropriate behaviour and should be encouraged from a young age and specifically for primary school children. According to constructions of sexuality by young people, this can be effective if carefully designed targeting the age group just before adolescence. In relation to the PEN 3 model (Airhihenbuwa, 1999) the Venda rites of passage aimed at different age groups, can be used in the development of HIV prevention programmes. The abstinence programme can be done at school or it can be linked to the first initiation school (*Musevhetho*) that is done when young girls move from baby stage to puberty before they start menstruating. This cultural practice for young girls can be used to promote abstinence as HIV prevention. As there is no rite of passage aimed at boys at this stage, boys can have access to this programme at school.

6.3.3 Safer sex Programme

The Safer Sex Programme is recommended for young people at secondary school age. At this stage, young people should still be informed about abstinence as a preventive strategy. Because young people indicated that they would like to be taught safer ways to have sex, the programme should educate young people on ways of having sex without the risk of contracting HIV; for example, masturbation and condom use. As constructions of sex and HIV infection are influenced by many factors in relationships, this programme should inform young people about sex, love, sexual competence, HIV risk, positive sexual health and gender roles. This programme should be aimed at arming young people with knowledge so that they are empowered with skills and knowledge when they have their first sexual encounter.

This can be done at school or at initiation school (*Vhusha* for girls immediately after their first menstrual period and *Murundu* for boys). Running the programme both at school and at

the initiation school will benefit even those who choose not to attend initiation schools and reinforce the message for others.

It is recommended that the Safer Sex Programme is implemented by specifically trained Life Orientation teachers. The young people indicated the need for such discussions and education in their classes. The effectiveness of the presentation of such a programme, is crucial to have an effect on the behaviour of young people (Chandra-Mouli et al., 2014). The young people indicated that teachers often avoid topics which cause them discomfort. This was also identified by Chandra-Mouli et al. (2014), who found that teachers who were supposed to present sex education topics were often unprepared and not willing to deal with sensitive topics. Teachers that are open-minded about sexuality education for young people should be selected to present these topics. They should be empowered with skills and knowledge about the subject matter so that they will be able to run the programme effectively.

The Safe Sex Programme should be developed with the input of young people and considering their context. The topics included should take into account their constructions of sexuality, factors that impact on their sexuality and their vulnerability to HIV infection. The programme should also be monitored for effectiveness on a regular basis.

6.3.4 HIV prevention targeting pregnancy

Young people are more afraid of falling pregnant than of contracting HIV. It is recommended that HIV prevention messages be added to messages of prevention of pregnancy so that young people will attend to them. Young people might value and practise such messages because of the fear of falling pregnant, thereby preventing HIV. There is also a need for biomedical prevention intervention that could simultaneously prevent HIV, STI and pregnancy.

Culturally, *u vhofoha* can be used as a prevention strategy. However, the consequences (discussed in **Error! Reference source not found. 5**) need to be researched and addressed to make sure that young women are not put in a position where they might not have children when they are older and decide to have children.

6.3.5 Constructions of sexuality

As revealed previously, construction of hegemonic masculinity is problematized in an HIV context. It is indicated as bad and needing to be reconstructed. However, young women's constructions have shown that they accept the current constructions of masculinity and somewhat benefit from them (Leclerc-Madlala, 2003). Discussions about sexuality and gender roles (masculinity and femininity) and their impact on individuals, relationships and HIV infections among young people can bring about change in discourse and thereby influence change in sexual behaviour. Detailed recommendations to address traditional hegemonic masculinity follow:

6.3.6 Governmental Financial support

Sex as commodity is usually influenced by young people's socio-economic conditions. To curtail transactional sex it can be considered to employ state cash transfers (financial grants) to assist young people from poor economic background and who are most vulnerable to HIV infection. State cash transfer might bridge daily needs thereby alleviating the need for transactional sex and intergenerational sex, as the two are linked.

6.3.7 Participative HIV prevention interventions

Risk and risk behaviours, as discussed previously, are socially constructed. The selection of current risk behaviours among young people seems to be problematized and in favour of adult's constructions of sexuality for young people. This might be the reason why prevention interventions selected and constructed by adults for young people are not effective enough to reduce young people's vulnerability to HIV infection.

Preventive interventions that are participative may be more effective. It is recommended that young people of Venda contribute to the development of their own prevention interventions that will be suitable for them. These prevention interventions might be more effective as they will focus on the constructions of risk and sexuality of the specific age group and will consider young people's cultural practices. This is in line with social construction's position that constructions of sexuality are context-specific and influence behaviour. Young people

can formulate and suggest prevention strategies in a focus group context where they can have discussions about prevention strategies and where they can support each other to implement these strategies.

6.3.8 Traditional Male Circumcision

Vhavenda practises a rite of passage for boys to become men through traditional initiation that also includes MC. TMC is, according to the PEN 3 model (Airhihenbuwa, 1999) a positive factor in the Vhavenda culture that can assist in HIV prevention. TMC is recommended as a prevention intervention that reduces young men's vulnerability to HIV. Young men constructed the attainment of masculinity through TMC as important for them. When done traditionally, MC might assist young men to attain their masculinity as it is important for their sense of self and belonging. All challenges that face TMC currently (hygiene, age of initiates, parental consent, training of TMC practitioners) (Malala & Mulaudzi, 2015) should be addressed. Policies should also be developed to formulate standard operation procedures for TMC. TMC should be accompanied by comprehensive education on sexuality and condom use. A detailed discussion on TMC in the section on combination interventions follows.

6.3.9 Combination Interventions

HIV intervention strategies to date have focused mainly on individual-level behavioural interventions (such as HIV education and condom use), which was not found to be generally effective. The Social Ecological Model identifies that sexual risk behaviour is influenced by many factors at different levels in the society (Maticka-Tyndale, 2012). Therefore, the effectiveness of HIV behavioural interventions can be substantially improved when combined with strategies which address structural factors (Gupta et al., 2008).

It is recommended that MC (as the most compelling evidence based prevention strategy (Sawires et al., 2007)), reconstruction of gender roles and condom use be combined as one intervention for young people. This intervention can be done at initiation schools as Shisana et al. (2014) revealed that most of the men receive TMC. Appropriate gender roles and condom use can also be emphasised when young people attend initiation schools. Community elders that are involved in the initiation schools can be the custodians of such a

programme. This research showed that traditional leaders are concerned about young people's risk behaviour and may collaborate with health authorities to address their concerns.

It is recommended that young people and community leaders come up with regulations or policies that govern behaviour, norms and education provided to initiates. Young people and community leaders can identify improved ways that can reduce risk behaviours and can address the reconstruction of gender roles in those regulations and policies. Prevention programmes that have addressed the reconstruction of gender roles and rights are said to improve reproductive health outcomes and are more likely to delay sexual debut (Chandra-Mouli et al., 2015).

As stated previously, biological prevention interventions have an authoritative voice and are accepted more because they have a scientific base and are supported by the health care system (Seidel, 1993). Those factors allow biological interventions to influence constructions. For combination interventions to be effective, behavioural and structural interventions should also be supported by the health care system. The effectiveness of such interventions should be researched and communicated to communities.

6.3.10 HIV prevention messages

Young people reported that HIV messages do not reach them in an effective way, as media advertisements on HIV prevention are not done in their vernacular or in way that grab young people's attention. They also reported that peer educator programmes were not implemented in their schools. Such concerns from young people indicate unequal access to health care resources compared to youth in other provinces. Shisana et al. (2014) recently reported that, from all South-African provinces, respondents from Limpopo had the least knowledge of HIV transmission and prevention interventions.

For Venda young people to have equal access to HIV and AIDS resources, the lack of resources need to be reported to the three kings of Venda namely, King Tshivhase, King Mphephu and King Sinthumule and the local government. The community should also inform the kings and local government of the implications that such unequal access has on young people's sexual behaviours and HIV infections. The community should indicate the resources needed to combat such unequal access. The kings and local government have the authority to address the situation by reporting it to the national government.

6.3.11 Change in parents' authority

The study found that parents and guardians feel disempowered and they do not know how to discuss sexual matters with their children. The community leaders also reported that culturally, it is inappropriate to talk to your own children about sexual matters. It is for this reason that such education is done at initiation schools. The problem, presently, is that attending initiation schools is optional for young people, which leave some young people without the education they need and parents feeling disempowered in their parenting role.

Parental disempowerment does not only affect sexual education, but general guidance for young people. The following are recommended:

6.3.12 Parental skill programme

Parental support is indicated as one of the factors that reduces vulnerability to HIV (Cluver et al., 2014). It is, therefore, imperative to have parental skills training. There should be specific training for parenting different age groups of children. Such training should aim at building good and close relationships between parents and their children. During appropriate or special community meetings it can be debated whether taboos on parents discussing sexual issues with their children should be supported or changed. This might open the door for change as some parents might be willing to discuss sex with their children. Even though some parents might not discuss sex with their children, they might be in a position to give their children guidance about other important matters like alcohol, careers or education. A close bond between parents and children might give young people some stability and a sense of direction in life, which might in turn have an influence on sexual risk behaviours.

6.3.13 Alternative to parental sex education

As young people sometimes do not want to attend initiation schools, the community leaders need to introduce alternative ways to educate young people who are not in favour of attending initiation schools. For example, older relatives, health care clinics and/or the church could be suggested as alternatives to educate those young people. Such alternative suggestions should be discussed and agreed upon within the community, taking the Venda culture into

consideration. This will assist young people to have the sexual education they need without parents having to discuss sensitive sexual matters with their own children, which is against their cultural practices. This prevention intervention might be successful as it would be developed by the community itself and considered as Venda culture.

6.3.14 Parent-child Programme

There is a gap in the constructions of sexuality between young people and parents. The gap is contributing to young people's sexual risks as they turn to peers for sex information. It is recommended that young people and parents have dialogues on young people's sexuality and what it means to them. This will help parents develop insight into young people's sexuality and be in a position to understand and influence young people's sexual behaviours. This might help to reduce peer sexual influence. Such dialogues might result in different constructions of young people's sexuality among adults and young people alike, which might reduce the communication gap between young people and adults. The different constructions and understanding from adults might have a positive influence on young people's sexual risk behaviours.

6.3.15 Process for development of prevention interventions for young people of Venda

Focus group discussions identified shortcomings which render current prevention interventions ineffective in meeting the needs and expectations of young people. These shortcomings include, amongst others, the lack of involvement of community leaders and parents in the development of policies, lack of standardized curriculum for Life Orientation and discomfort of teachers in teaching some sections of Life Orientation. It is important to address such shortcomings in developing future prevention. This section conveys the process that should be followed in the development of prevention interventions for young people in Venda. It is aimed at the elimination of shortcomings, considering young Vhavendas' culture and context.

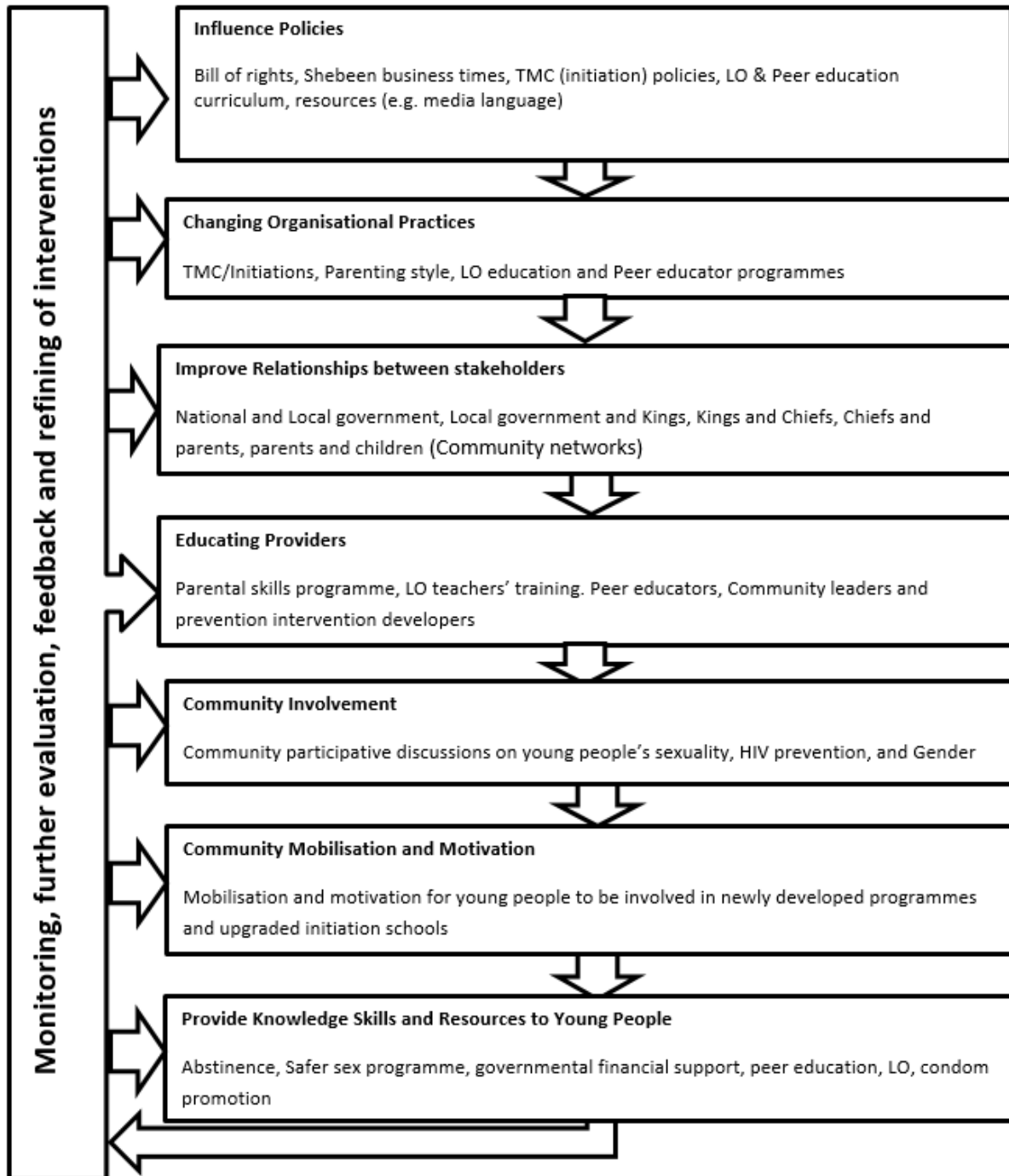


Figure 5 Process for the development of multiple concurrent interventions for young people in Venda

A lack of consultation between national government and chiefs in Venda in the development of policies makes it difficult for chiefs to have authority over their communities. For effective prevention interventions, kings and chiefs in Venda should be empowered to develop culture and context specific local policies subject to national oversight. Such local policies, should direct practices in initiation schools as well as Life Orientation and peer

educator programmes in local schools. The changes should be in line with young people's constructions indicating what will work for them.

To promote change in organisational practices there should be meaningful networking between national and local government, local government and kings, kings and chiefs, chiefs and parents and parents and children. This will assure that information is passed on from one stakeholder of the community to the other. Parents, LO teachers, peer educators and community leaders can then have suitable communication structures to convey reliable and current information to young people.

Community leaders can be trained to lead the community in participative discussions on young people's sexuality, HIV prevention for young people and deconstructing gender roles. Young people should be included in such community participative discussions so that their needs are reflected. After community participative discussions, interventions will be developed in line with what was discussed and found suitable for young people in Venda. Community leaders and prevention intervention developers will develop the interventions. After completion, community leaders and older role models will mobilise and motivate young people to take part in the implementation of newly developed interventions. Such interventions will then be available to all young people.

Developed programmes should not be limited to verbal orders directed at young people *ad nauseam*. Education programmes should be presented in ways which are likely to invite adolescents to identify with the information – such as dramas, role plays and discussion forums. Young people should feel welcome to participate in the development of knowledge and attitudes and discussions on social media. Such interventions should be available in the local vernacular. They may then be effective as they will consider what is appropriate for the community. As young people would have been involved, young people will also hear young voices regarding behaviour and actions which are appropriate, effective and healthy.

6.4 Conclusion

This study aimed to explore constructions of sexuality among young people of Venda and their impact on young people's sexual behaviours. This study aimed to inform more successful HIV future prevention interventions for young people. The literature study showed that young people are engaging in sexual risk behaviours despite current prevention strategies. This implies that current prevention strategies are not effective enough for young people. This shows the need for context-specific prevention interventions specifically for young people. The findings of the study indicate that young people's constructions of sexuality, masculinity and HIV have an influence on young people's sexual risk behaviours. The study also found a lack of parental sexual education for young people; thus, encouraging peer influence that encourages sexual risk behaviours.

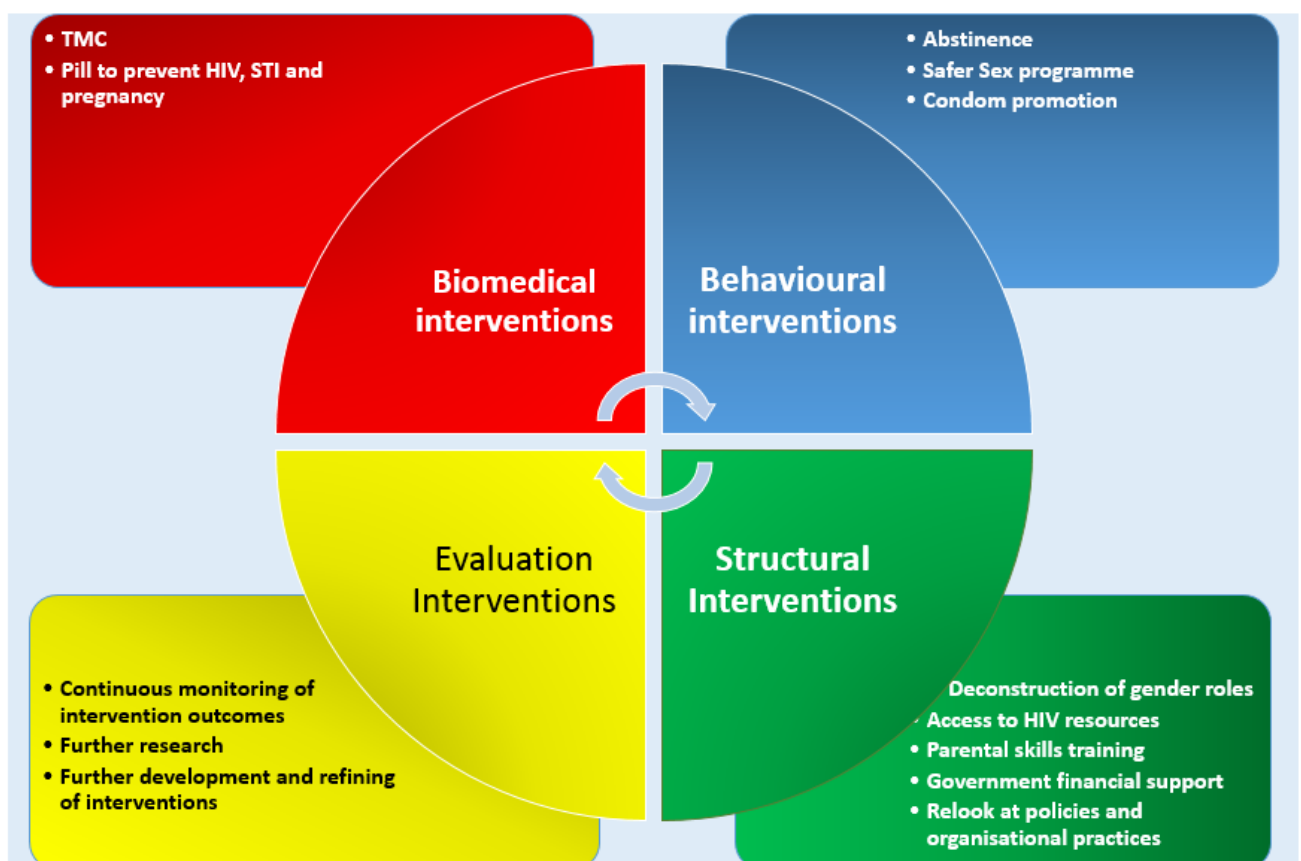


Figure 6 Recommended concurrent interventions at a glance

Future prevention interventions should be developed by young people for young people. They should consider young people's constructions of sexuality and their context as those constructions have an impact on how, with whom and when to have sex (Gupta, 2000). Sexuality is influenced by many factors and discourses. Prevention interventions should consider combination interventions as they are more likely to have an effect on many people and impact different angles of HIV vulnerability concurrently. Combination interventions could also have an effect on different constructions which influence sexual behaviour at the same time. For more successful prevention interventions, the study recommends the combination of interventions illustrated by Figure 6 and listed below:

- abstinence, safer sex education and condom use (behavioural interventions) delivered through various channels, such as schools, initiation schools and various contemporary media;
- improvement of access to HIV resources through the involvement of local government and kings, discussions to promote the re-construction of gender roles and parental skills training (structural interventions) and
- TMC as biological intervention.

These interventions should be developed and owned by Vhavenda young people and the community with consideration of young people's constructions of sexuality and Vhavenda culture.

The foregoing opens avenues for the researcher and other stakeholders and interested parties to continue the work. The thesis is released with the prayer that it will contribute to the wellbeing of the youth and people of Venda and ideally also further afield.

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Appendix 1

Definition of key terms

Uncertainty exists regarding certain terms used in relation to HIV and AIDS. Definitions suggested by the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2009) follows. These terms are important in understanding the epidemic and are used in the study above.

Behaviour change

Behaviour change is usually defined as the adoption and maintenance of healthy behaviours (with respect to particular practices) that reduce the chances of acquiring HIV.

Behavioural prevention intervention

Behavioural prevention interventions refers interventions to motivate behavioural change in individuals and social units by use of a range of educational, motivational, peer-led, skill-building approaches as well as community normative approaches.

Combination HIV prevention

Combination HIV prevention refers to a combination of behavioural, biomedical and structural approaches to HIV prevention to achieve maximum impact on reducing HIV transmission and acquisition.

Concurrent sexual partnerships

Concurrent sexual partnerships refer to persons who report at least two partners for which the most recent sex is reported as less than or equal to six months ago.

Epidemic

An epidemic is an unusual increase in the number of new cases of a disease in a human population.

HIV incidence

HIV incidence is the number of new HIV infections that occur in a given population over a given period of time. Incidence is usually expressed as a number or percentage of infections that occur in a given population over a given period of time. Knowing the current incidence of HIV in a population provides information on how fast the virus is spreading.

HIV prevalence

HIV prevalence is a measure of the proportion of people who are living with HIV in a given population at a particular point in time. Prevalence is typically measured in cross-sectional surveys. It is a useful measure for understanding the total burden of disease and for planning care and treatment needs.

HIV risk

Risk is defined as the risk of exposure to HIV or the likelihood that a person may become infected with HIV.

HIV risk behaviour

HIV risk behaviours refer to behaviours that increase the risk of exposure to HIV.

Structural interventions

Structural interventions are those that seek to alter the physical and social environment in which individual behaviour takes place.

Appendix 2 Permission



LIMPOPO

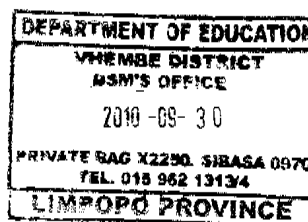
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

Ref: 14/7/R
Enq: M.S. Matibe
Tel: 0159621029

DEPARTMENT OF
EDUCATION

VHEMBE DISTRICT

M.S. Veronica Sivhabu
2 Hansie Oord
Van Der Hoff Road
Booyens
0082



APPLICATION FOR PERMISSION TO CONDUCT RESEARCH IN SECONDARY SCHOOLS.

1. The above matter bears reference.
2. Your application for permission to conduct a research project on "The influence of sexuality construction and culture on Hiv/Aids risk behavior amongst youth in Venda" has been granted.
3. Kindly inform Circuit Managers and Principals of affected schools prior to your visits which should be done after school as indicated in your application letter.
4. Wishing you the best in your endeavours for scholastic achievements.

DISTRICT SENIOR MANAGER

DATE

Thohoyandou Government Building, Old Parliament, Block D, Private Bag X2250, SIBASA, 0970
Tel: (015) 962 1313 or (015) 962 1331, Fax: (015) 962 6039 or (015) 962 2288

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Appendix 3

Informed consent form for adult participants



**Department of Psychology
Humanities**

Declaration of informed consent: Adult participants

Hereby I acknowledge that I have been informed about the research. I agree that I am willing to participate in the research. I acknowledge that I have read the research information sheet, attached to this form. I know that I don't have to participate in the group discussions if I feel uncomfortable. I am also aware that I may withdraw from the research study at any stage.

Participant's permission:

Name and Surname: _____

Signed at: _____

Date: _____

Signed: _____

Participant:

I hereby consent that the research group discussions can be audio- recorded and that the discussions may be published.

Date: _____

Signed: _____

Witness:

Name and Surname: _____

Date: _____

Signed: _____

Researcher:

Name and Surname: _____

Date: _____

Signed: _____

Should you have any question, please feel free to contact me.

Veronica Sivhabu
083 403 4061

Appendix 4
Informed consent form for parents of juvenile participants



Department of Psychology
Humanities

Declaration of informed consent: Proxy Consent

Parent/ guardian or caregiver permission:

I acknowledge that I read and understood the research information sheet attached to this form. I agree that my child can participate in this research. I acknowledge that the group discussions will be published and that no names will be disclosed.

Name and Surname: _____

Signed at: _____

Date: _____

Signed: _____

Contact number: _____

Postal Address: _____

Parent/ guardian or caregiver:

I hereby consent that the research group discussions with my child can be audio- recorded and that the discussions may be published.

Date: _____

Signed: _____

Witness:

Name and Surname: _____

Date: _____

Signed: _____

Researcher:

Name and Surname: _____

Date: _____

Signed: _____

Should you have any question, please feel free to contact me.

Veronica Sivhabu
083 403 4061

Appendix 5 Assent form for learners



**Department of Psychology
Humanities**

Learner's assent

I hereby acknowledge that I have been informed about the research. I agree that I am willing to participate in the research. I acknowledge that I have read the research information sheet, attached to this form. I know that I don't have to participate in the group discussions if I feel uncomfortable. I am also aware that I may withdraw from the research study at any stage.

Learner's permission:

Name and Surname: _____

Signed at: _____

Date: _____

Signed: _____

Learner:

I hereby agree that the research group discussion can be audio- recorded and that the discussions may be published.

Date: _____

Signed: _____

Witness:

Name and Surname: _____

Date: _____

Signed: _____

Researcher:

Name and Surname: _____

Date: _____

Signed: _____

Should you have any question, please feel free to contact me.

Veronica Sivhabu

083 403 4061