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

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Abstract

The study explored constructions of sexuality among young people of Venda (in Limpopo, South Africa) and cultural practices that can be used to develop context-specific HIV prevention programmes. HIV prevention can be promoted by including some cultural practices in prevention programmes and changing some aspects of culture that may contribute negatively to health. Six focus group discussions were held with school-going young people (grades 10 to 12) in urban and rural areas in Venda to explore their constructions of sexuality and HIV risk. Four focus group discussions were held with community leaders in the same areas to explore their constructions of young people's sexuality and cultural practices relevant to HIV prevention. Through discourse analysis, the following dominant discourses, which influence young people's sexual risk behaviour, were identified: *rite of passage, the male sexual drive discourse* (sex is natural and unavoidable); *discourse of hegemonic masculinity* (sex to prove masculinity); *sex as a commodity*; *non-adherence to cultural practices*; and *HIV is normalised ("AIDS is like flu*"). Though, some trends of alternative constructions and shifts in gender norms were notices, especially among female participants. The constructions of young people were not culture-specific, but similar to those identified in other South African cultures. Community leaders identified a few cultural practices that could be considered in HIV prevention, for example, reinstating the rite of passage to provide age-appropriate sex and HIV education (behavioural intervention) and promoting traditional male circumcision (biological intervention). Cultural practices that contribute negatively to health should be challenged such as current constructions of gender roles (masculinity and femininity) and the practice that parents do not talk to young people about sex (both structural interventions).

Key terms: *Constructions of sexuality, cultural practices, discourse analysis, HIV prevention, sexual risk behaviours, social construction.*

Introduction

The prevailing high HIV incidence in South Africa, particularly among young women (UNAIDS, 2014; Human Sciences Research Council [HSRC], 2018), suggests that the current behavioural prevention strategies are ineffective. Risk behaviour such as lack of condom use, early sexual debut and intergenerational sex remain high (HSRC, 2018). HIV knowledge differs between age groups and geographical areas, and has decreased among young people over the past few years (Shisana et al., 2014). HIV prevalence varies geographically across the country with the highest numbers in KwaZulu-Natal (27%), Eastern Cape (25%) and Free State (25%) and the lowest in the Western Cape (12.6%) (HSRC, 2018). The spread of HIV is thus complex and related to various context-specific factors.

Because of this complexity, generic HIV prevention programmes are seldom effective, as different geographical areas and cultural and age groups may have different norms, beliefs and constructions of sexuality, which contribute to different behaviour patterns (Taylor, 2004; Latkin & Knowlton, 2005; Gupta, Parkhurst, Ogden, Aggleton, & Mahal, 2008; Rotherham-Borus, Swendeman, & Chovnick, 2009; Manyaapelo et al., 2019). Foucault (2007) argued that sexuality is not a natural inner drive that remains the same across time and contexts. Sexuality is socially constructed and its meaning is derived from cultural discourses. Culture can be defined as shared values, norms and codes that collectively shape a group's beliefs, attitudes and behaviour through interaction in and with the environment (Lwelunmor, Newsome, & Airhihenbuwa, 2013). Furthermore, culture is not simplistic but can have different meanings for different generations in different times and contexts. 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). Culture thus influences how people have sex, with whom, under what circumstances and for what reasons, and these aspects may change over time. It also influences how we talk about sex and with whom.

Sexual risk behaviours are therefore also socially constructed and can be influenced by factors such as gender inequality, societal norms, poverty, culture, peer pressure and personal choice (Campbell, 2003; Latkin & Knowlton, 2005). To date HIV education programmes for young people focused largely on HIV awareness and education, skills building and condom use based on the Abstinence, Be faithful, 'Use a Condom' (ABC) model (Rooth,

2005; Wood & Wilmot, 2012). Interventions focused mainly on the individual and were not constructed by young people or with an understanding of young people's constructions of sexuality. Prevention programmes neglected societal, cultural, gender and normative factors that influence sexuality (Mulaudzi, 2007; Mfecane, 2010; Francis, 2011; Chandra-Mouli, Lane, & Wong, 2015; Shefer & Macleod, 2015; Mpondo, Ruiter, Schaafsma, van den Borne, & Reddy, 2018).

Recent research (Taylor, 2007; Mfecane, 2010; Airhihenbuwa, Ford, & Lwelunmor, 2013) indicates the need for a deeper understanding of culture and its potential inclusion in HIV prevention interventions. According to the PEN-3 model (Airhihenbuwa, 1989, 1995; 2007) culture should be at the centre of public health interventions, since every culture has unique and positive contributions to health promotion. The PEN-3 model offers a cultural framework to understand health behaviour in terms of three interrelated dimensions: cultural identity (socio-ecological relationships influencing individuals), cultural empowerment (aspects contributing positively and negatively to health and uniqueness of culture) and relationships and expectations (perceptions, enablers of behaviour and nurturing relationships). To assist HIV prevention efforts, a balanced view is needed that some cultural practices can promote health, while others may affect health negatively and need to be changed (Airhihenbuwa, 2007). HIV prevention programmes should not be generic but specific, taking constructions of sexuality and risk behaviours prevalent in an area, age group and/or context into account. This can result in structural changes to address the underlying causes of sexual risk behaviour - an approach that seems to be most effective in preventing HIV (Gupta et al., 2008; Cluver, Orkin, Boyes, & Sherr, 2014).

The study focused on Vhavenda young people because limited research has been done among this population group. The Vhavenda group constitute the second smallest ethnic group in South Africa. They are approximately 1.2 million people – 2.4% of the South African population. Vhavendas live mostly in the northern part of Limpopo, near the South African-Zimbabwean border. The current HIV prevalence rate for adults (15-49 years) in Limpopo is 17.2% - this is among the lower infection rates for provinces. This may be explained by the area being largely rural and high rates of male circumcision (64%) (Johnson, Dorrington, & Moolla, 2017). On the other hand, respondents from Limpopo have been reported to have the least knowledge about HIV transmission and prevention (Shisana et al., 2014). Only 59% school going young people in Limpopo reported that they participated in HIV prevention

programmes at school (Reddy et al., 2013). This lack of knowledge about HIV may be the result of Tshivenda seldom been used in the media for HIV education. Tshivenda originated from languages in Zimbabwe and Zambia and it differs from languages of Nguni and Sotho origin mostly used in South Africa (McNeill & Niehaus, 2009). The lack of HIV prevention in Tshivenda might have an impact on young people's knowledge of HIV and their risk behaviours.

In an effort to contribute to HIV prevention, the researchers interacted with Vhavenda young people and community leaders to explore their constructions of sexuality, the impact these had on their sexual risk behaviour and the effectiveness of HIV-prevention programmes. A further aim was to explore Vhavenda cultural beliefs and practices that could be used in culturally focused HIV prevention programmes to promote their effectiveness.

Methodology

Research design

A qualitative research design (Denzin & Lincoln, 2011) was used within a social constructionist theoretical framework (Gergen, 1985) to explore young people's constructions of sexuality. According to social construction there are multiple realities, constructed through social interaction and language. These constructions can be accepted by communities as dominant truths or discourses that influence people's behaviour. Because constructions are human interpretations, they can be changed to more productive ones if needed (Stainton Rogers & Stainton Rogers, 2001; Burr, 2003).

Participants

The study targeted young people aged 15 to 19 years (United Nations, 2007) in the urban and rural areas of Venda. Out of 152 secondary schools, two from rural areas and two from urban areas were randomly selected by drawing names from a hat. Learners from grades 10 to 12 were asked to volunteer to participate in the study. A total of 66 learners (41 females and 25 males) volunteered and took part in six focus group discussions.

To explore cultural beliefs and practices, chiefs in the same areas as the selected schools were asked to recruit prominent community leaders, such as elders, teachers, health care workers and priests, to participate in focus group discussions. A total of 31 community

leaders—13 from urban areas and 18 from rural areas—participated in four focus group discussions.

Data collection

Focus group discussions (Willig, 2013; Kvale & Brinkmann, 2015) lasting at least two hours each were conducted with volunteer learners and community leaders. Focus group discussions complement social construction theory in that they allow participants to construct the reality of their world during social interaction in a group. Such discussions may highlight dominant discourses due to group dynamics and downplay individual and alternative discourses that also influence the behaviour of individuals.

The focus group discussions with young people were conducted in a classroom after school hours. A semi-structured interview guide was used (Kvale & Brinkmann, 2015). Examples of questions were: "What does sexuality mean to you as young people?" and "Why do young people engage in sexual risk behaviour?"

Group discussions with community leaders were conducted in the chief's home where the local Tshivenda tribal council take place regularly. Examples of questions in the semi-structured interview guide were: "How do you understand young people's sexual behaviour?" and "What are culturally defined ways to protect one from pregnancy and HIV?"

To put participants at ease to talk about sex and sexuality, focus group discussions were conducted in Tshivenda by a male and a female researcher familiar with the Venda culture. Discussions were tape-recorded with the permission of the participants, transcribed and translated into English and translated back into Tshivenda to make sure all information and the correct meanings were captured.

Data analysis

Discourse analysis (Potter & Whetherell, 1987; Potter, 2012) was used to analyse the data. Analysis included identifying meaningful text, searching for patterns, comparing data from different sources and forming hypotheses (Willig, 2013). As discourse analysis requires language to be analysed in context, the young people's discourses were checked for influences that such discourses had on young people's sexual risk behaviours. Moreover, constructions of young people and community leaders were compared.

The trustworthiness of interpretations was enhanced through reflections on how the researchers' own constructions could influence their interpretations. Two researchers interpreted the data separately and reached consensus about the dominant discourses. Data of different areas, schools and groups were compared and converged to enhance data quality (Willig, 2013).

Ethics

The Ethics Committee of the Faculty of Humanities, University of Pretoria gave ethical approval for the research. All participants volunteered to participate and gave their informed consent/assent. The young people's parents also agreed to their children's participation.

Findings

Young people's constructions of sexuality

Dominant discourses expressed by young people are outlined below. These discourses, sanctioned by the peer group, may reflect mainly dominant discourses and not all discourses influencing their sexual behaviour. Young people constructed sexuality as related to the cultural rite of passage, the male sexual drive and hegemonic discourses and sex as a commodity.

The cultural rite of passage

Similar to other cultural groups in South Africa (Mfecane, 2016), the practice of *Murundu* or rite of passage for boys to become men, is still important in achieving masculinity. *Murundu* involves a period of three months spent in the bush and being taught and circumcised by older respected men. Traditionally, the rite of passage is seen as a form of positive social control as it educates boys about sexual relationships, sexual control, respect and societal rules (Barker & Ricardo, 2005; Niang & Boiro, 2007; Malisha, Maharaj, & Rogan, 2008). Community leaders spoke highly of initiation that helped men to be real men, control sexual urges, respect women and maintain order in society (see cultural practices).

Young men regarded boys who had attended traditional initiation (*Murundu)* and had been circumcised in the bush (*u rubiswa*) as "real men", giving them status in the community:

> *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)

Young men reported that peers and older initiates at initiation ceremonies encourage them "*to test their spear"* by having sex after attending initiation. This was in contrast with the opinion of community leaders. It seems that peer social networks strongly influence young people's risk behaviours during and after initiation. According to the participants, HIV prevention and safer sex practices are not taught as part of initiation, confirming the research of Malisha et al. (2008). One participant reported:

> *The language we use at* hogoni *[initiation] is vulgar language that includes sex. There is a song that says "when will [she] ever come back so that we can do things like those [have sex]". Such things make us to think of sex all the time even while we are still at* hogoni *and when we come back that is the first thing we want to do.* (Boy from rural area)

Research by Munthali and Zulu (2007), Malisha et al. (2008) and Vincent (2008) confirms that initiation is regarded as a gateway to have sex. Young men blame culture for encouraging them to have sex.

Vhavenda girls can choose to attend *Vhukomba* (girls' rite of passage) where they learn to respect and nurture their future husband. Virginity testing is done there, and if found not to be a virgin, the girl is seen as embarrassing her family. Therefore, many girls make sure to remain virgins until initiation, after which they can be sexually active as they know they will not be tested again. One of the girls reported:

> *Most young people are virgins when they go for initiations. They tell you that you should not embarrass the family by having sex before the inspection at the initiation. They also promise a lot of gifts if you are found to be a virgin. Even if you have a boyfriend, you can control yourself and ask him to wait until initiation. Then after the initiation you know that you are free to have sex because you will not be checked again.* (Girl from rural area)

Initiation is thus still a valued practice in Vhavenda culture. Community leaders expressed their concern that some young people choose not to attend initiation anymore and miss out on valuable education:

> *Some young people do not attend initiation. They view it 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)

The male sexual drive discourse

Young people in this study constructed sexuality as a natural part of their development. Especially young men viewed sex as biologically uncontrollable, it could not be avoided or abstained from. They saw themselves as victims of sexual impulses they could not control. One participant declared:

> *Sex is natural, people. 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 (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)

Young people find it especially difficult to abstain if they are not virgins:

> *We know the dangers of sex. After we have started having sex it is not easy to stop. 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)

Some young people in the rural area believed that sex is necessary to be healthy:

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

The male sexual drive discourse as framed by Hollway (1989) emerged as a central discourse in the focus group discussions. According to this discourse, men are controlled by biological and social determined sexual drives that determine their sexual behaviour

(Shefer, Kruger, & Schepers, 2015). This discourse is well documented in the South African literature (Shefer & Mankayi, 2007; Leclerc-Madlala, 2009; Stern, Clarfelt, & Buikema, 2015). The male sexual drive discourse also promotes norms for women to understand and tolerate men's sexuality. Women are then driven by emotion and a need for love and relationships (Shefer & Foster, 2009). The responses of some girls confirmed that they sometimes agree to sex to take care of their partners:

> *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)*

This discourse implies that abstinence is not an option for HIV prevention among young people. Young people should rather be educated how to protect themselves from HIV or about forms of sexual pleasure other than intercourse.

Discourse of traditional hegemonic masculinity — Sex to prove masculinity

A dominant discourse of young men was that having sex meant being a "real man." To prove his masculinity and achieve status among his peers and the girls, a young man has to have unsafe sex (without a condom), have sex with multiple partners and show his sexual competence through force and violence. These constructions, which are drawn from culture, tradition and peer group norms, relate to the discourse of hegemonic masculinity that describes masculinity as a set of role behaviours that the social group encourages men to perform (Connell, 1995; Morrell, 1998; Barker & Ricardo, 2005; Brown, Sorrell, & Raffaelli, 2005; Shefer et al., 2007; Morrell, Jewkes, Lindegger & Hamlall, 2013; Shefer et al., 2015; Stern et al., 2015).

For young men sexual activity is seen as a central marker of being a real man. His status among his peers grows when he has risky sex, which is sex without a condom and with multiple partners:

> *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)

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)

The peer group advocates hegemonic masculinity and pressurizes young men to have unsafe sex. It is expected of a real man not to be a virgin anymore by a certain age. Young men mostly conform to avoid the risk of being ridiculed by peers:

It is not allowed for a young man to be virgin. He must have sex no matter what. If you are a virgin, the others will mock you until you are embarrassed and your status is low. If you have not been with a girl, you are not even allowed to sit with other men. (Boy from urban area)

Young men experience serious peer pressure to prove their manhood (Shefer et al., 2015; Manyaapelo et al., 2019). It is not necessarily their own choice of behaviour. In the focus groups young men discussed that they are aware of the value of condoms, how they hide condoms and have difficulty when using condoms. This indicates that young men are accepting but subverting the importance of using condoms to prove their masculinity.

Having multiple partners is seen to be culturally rooted and part of African history (Mah & Halperin, 2010; Leclerc-Madlala, 2009). This discourse gives men permission to have many partners, and encourages girls to be tolerant if their boyfriends have many partners:

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)

However, some girls expressed discomfort about young men having many partners. They see it as unfair practice and misuse of females:

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)

This shows girls' resistance to male-centred sexuality. Girls who are supposed to be passive in sexual relationships, show agency amidst inequality in gender relationships.

A small number of young men reported that they gain status among their peers by practicing sexual force and violence:

> *I have sex with some women just to teach them a lesson. 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. As a man you are praised for succeeding with a difficult woman. You get more respect from other young men.* (Boy from urban area)

In some contexts the practice of force and violence is seen as part of hegemonic masculinity, demonstrating male power (Morrell et al., 2013). Men exert power over women to protect and fight for their masculinity. Females who challenge male power is often approached either by punishment or derogatory naming ("difficult woman") in order for men to regain their power (Strebel et al., 2006; Shefer et al., 2015).

Sex as a commodity

The construction of sex as a commodity (Leclerc-Madlala, 2003; 2008) was mostly discussed by females in the focus groups. High levels of poverty and unemployment have an effect on the material nature of relationships (Hunter, 2010). Girls focused on sex for survival and the pursuit of modernity and status. Males were mostly negative about transactional sex as they felt that they were unable to have certain girlfriends because of a lack of money.

A few young girls felt pressurized by their parents to have boyfriends who had money to provide for the family:

> *Some parents 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)

Some of the other girls reported that they engaged in sex with multiple older partners who could give them luxury goods and status:

> *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)

> *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)

Some girls also reported that they had relationships with males their own age as additional partners, because older males might be unavailable sometimes, if they were married or had other partners, whereas young men were more available. The construction of sex as commodity shows that girls are not accepting a passive role in relationships. Some of them are taking control in sexual decision-making (Bhana & Pattman, 2011; Mfecane, 2013).

Young people's construction of HIV as normalised—"AIDS is like flu"

Young people indicated that they did not view HIV or AIDS as a threat but as a chronic disease that could be treated with antiretroviral therapy to prolong life. Based on such constructions they have unsafe sex despite being aware of the risk of HIV. Participants reported:

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

> *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)

Young people demonstrated in the focus group discussions that their knowledge about HIV was relatively accurate. Although they had access to prevention messages in the media, these were not in their vernacular and did not appeal to them. The anti-stigma messages influenced their constructions of HIV and sexual risk behaviour:

> *The problem is the campaigns that tell us that if you have HIV/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 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)

The young people even feared pregnancy more than HIV (also found by Manyaapelo et al., 2019) because it was visible to everyone and could not be reversed, whereas HIV could be treated:

> *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)

These constructions show that young people's behaviour is more influenced by gender norms than their exposure to HIV prevention strategies.

Community leaders' constructions of young people's sexuality

Community leaders did not approve of young people's sexual risk behaviour. They regard young people's behaviour as out of control because of lack of moral values and non-adherence to cultural traditions. Adults believe that political changes and globalisation contribute to young people's loss of respect for authority and culture and to the disintegration of community structures that previously regulated behaviour:

> *In the past, young boys and girls used to spend time together but you will not hear that one person had sex with the other. You knew 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)
>
> *Before, if you made someone pregnant, it used to be reported to the chief. 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. Nowadays if a child falls pregnant, it is my own responsibility as a parent alone.* (Adult female from rural area)

Cultural practices used in the past to reduce sexual risk behaviour

Community leaders discussed several cultural practices used in the past to control sexual risk behaviours among young people.

Rite of passage/Initiation: It was not regarded as culturally appropriate for parents to talk to their children about sex. Instead, young people were educated about the rules related

to sexuality and relationships, morals, responsible behaviour, respect and maintaining order in the community through initiation for boys and girls. Initiation for girls are tailor-made to prepare girls for the next life stages: *Musevhetho* (before menstruation), *Vhusha/Vhukomba* (after first menstruation) and *Domba* (when matured and ready to get married). These initiations promote abstinence through virginity testing and they teach girls relationship skills. Initiation for boys (called *murundu* or *mula*) includes circumcision, education about sexuality and how to behave as men, respect for women, to take care of family, be responsible husbands and fathers and lead by example. Adult participants described the value of initiation as follows:

> *Things that used to help us are the traditional initiations that we have here at the chief's house. There were traditional lessons that helped men to be real men and not just have sex. 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)

> *Initiation taught us 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)

Community leaders are concerned that some young people do not attend initiation:

> *"As parents we cannot educate our own children like initiation, it is not possible. Leaving it is also not right, but what can we do if they do not want to attend? That is why HIV is increasing"* (Adult female, rural area).

Traditional circumcision: Traditional circumcision (cutting the foreskin) is part of boys' initiation. Culturally it is highly regarded as necessary if one is to be a real man. Circumcision, which can reduce the chances of HIV infection, was traditionally seen as a sign of responsible sexual behaviour, but it has come to be seen as a gateway to sex (Vincent, 2008).

Mixing of blood: Mixing of blood takes place to introduce the wife to the ancestors. It was believed that the ancestors will protect the couple from illnesses. This ritual indirectly regulates relationships, as men will only have sex with their wives to avoid being cursed by the ancestors. Having multiple partners was thus an accepted practice but it was controlled by such rituals to curtail sexually transmitted infections:

> *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 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, rural area)

Virginity testing: Virginity testing is a traditional practice in many African cultures as a high premium is placed on girls being virgins when they get married. A virgin bride fetches a high *lobola* (bride-price) and increases the status of the marriage.

> *Young girls used to be checked for virginity. 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, rural area)

In describing the above practices of the past, the researchers do not advocate that they are safe methods for preventing pregnancy and HIV. The value they hold for HIV prevention should be considered carefully.

Discussion

This study of Vhavenda young people's constructions of sexuality confirms the dominant constructions of gender inequality with men being powerful and aspiring towards hegemonic masculinity (Connell, 1995; Morell, 1998; Morell et al., 2013) by taking sexual risks such as having unprotected sex and multiple sexual partners (Barker & Ricardo, 2005; Strebel et al., 2006; Shefer et al., 2007; Mah & Halperin, 2010; Shefer et al., 2015; Stern et al., 2015) and women expected to be more submissive and passive (Shefer & Foster, 2009; Stern, Buikema, & Cooper, 2016). The power dynamics in the focus group discussions probably contributed to

the prominent focus on the dominant constructions. It is acknowledged that young people's constructions of sexuality are fluid and complex and depends on the context (Langa, 2010). In the young people's responses there are some indications of emerging alternative constructions and shifts in gender norms (girls showing agency), also observed in other current research (Ampolo & Boatery, 2007; Shefer & Foster, 2009; Langa, 2010; Stern et al., 2015). Young men are aware that they are vulnerable to peer pressure to conform to the dominant mode of masculinity (Shefer et al., 2007; Langa, 2010; Shefer et al., 2015; Manyaapelo et al., 2019). Their expressed constructions and behaviour may not reflect their own constructions. They acknowledge the importance of condom use, but conform to prove their masculinity. While some women participated in the maintenance of hegemonic male constructions by being submissive and available to their boyfriends' needs (Shefer & Foster, 2009), this research shows developing trends of young females becoming more empowered by challenging male behaviour and making their own decisions about sexual relationships (Bhana & Pattman, 2011; Mfecane, 2013). Through transactional sex (sex as a commodity), young women assert themselves and exploit sexual relationships to get access to resources and achieve financial security. They thus support the concept of provider masculinity (Hunter, 2010). In this situation, transactional sex gives women the power to change their lives (Hunter, 2002; Leclerc-Madlala, 2003; 2008; MacPhail, Pettifor, & Rees, 2007; Bhana & Pattman, 2011).

These discourses identified by Vhavenda young people creates a problematic portrayal of young people engaging in risky sexual behaviour that can place them at risk of HIV. Recent national studies confirm that risk behaviour remains prominent among young people in the country (Reddy et al., 2013; Shisana et al., 2014; Visser, 2017; HSRC, 2018). Reddy et al. (2013) report that 60% of Grade 11 boys were sexually active and two thirds of them had multiple partners. The risk behaviour of learners in Limpopo showed similar patterns than the overall statistics for this age group (Reddy et al., 2013). The conclusion was made that HIV prevention has not made notable progress with behavioural change (Kahn, 2018).

The study reveals that Vhavenda young people who are geographically and culturally removed from other young people in South Africa and speak a unique language, share similar constructions of sexuality with other groups. These dominant constructions are not unique to their culture and feature prominently in other research involving different cultural groups in South Africa and sub-Saharan Africa (Barker & Ricardo, 2005; Strebel et al., 2006; Ampofo &

Boateng, 2007; Ratele, Shefer, Strebel, & Fouten, 2010; Shefer et al., 2015; Stern et al., 2015; Mfecane, 2016; Manyaapelo et al., 2019).

The transition to democracy in the 1990s, the disintegration of traditional community structures, change in the perception of authority and the movement towards globalisation (Reid & Walker, 2005) have had an effect on the construction of sexuality of young people. In revealing the contrast in the constructions of sexuality between young people and adults/community leaders, this study illustrates the changing climate in which young people grow up. Community leaders ascribe sexual risk behaviour of young people to a lack of morals and a lack of adherence to cultural traditions. Adults generally do not view sex as part of young people's lives but as something that can be abstained from or avoided. In contrast, young people experience high levels of peer pressure to conform to dominant constructions of sexuality (Selikow, Ahmed, Flisher, Mathews, & Mukoma, 2009; Visser 2017; Manyaapelo et al., 2019). They attach more importance to acceptance by and belonging to a group than they do to the constructions promoted by their parents/adults/community leaders, cultural practices and HIV prevention messages. If cultural influences are less, the dominant construction of sexuality in the peer group is much stronger and not counteracted by constructive sexual education.

A significant contribution of this study lies in obtaining the views of community leaders and identifying Vhavenda traditions that can be considered to improve HIV prevention. Rite of passage and traditional circumcision are widely accepted practices (Greely, Maharaj, Letsoalo, & Miti, 2013). These practices can be promoted to provide comprehensive sexuality education and HIV prevention. Mixing of blood may promote partner faithfulness, but can be risk behaviour in itself. Some traditionalists view virginity testing as an African solution to the AIDS problem since it may delay sexual debut among girls (Leclerc-Madlala, 2001). Nevertheless, virginity testing is widely criticised as violating the privacy of girls (Leclerc-Madlala, 2001; South African Human Rights Commission, 2003; Martin & Mbambo, 2011) and cannot be promoted in HIV prevention.

Implications for HIV prevention

The research results alert researchers that the dominant constructions of sexuality among young people have not changed enough to effect large-scale behaviour change since the HIV epidemic started (Holland, Ramazanoglu, & Thomson, 1996; Preston-Whyte, 1999). There is

a shift noticed though in men's recognition of risk and the need to prevent HIV (Kaufman, Shefer, Crawford, Simbayi, & Kalichman, 2008). To bring about change in sexual risk behaviour, HIV prevention programmes should focus on the deconstruction of some of the sexuality discourses and their cultural underpinnings, as change in structural factors that maintain risk behaviour (Gupta et al., 2008). Below are recommendations regarding cultural practices that could be strengthened.

Culturally accepted initiation practices of various cultural groups are still important in educating young people about sexuality (Malisha et al., 2008; Vincent, 2008; Mfecane, 2016). Currently, there is a lack of HIV information (Malisha et al., 2008) and it seems that the moral underpinnings of initiation may have been eroded somewhat. The rite of passage/initiation can be reinstated in collaboration between health authorities, cultural leaders and young people to provide age-appropriate education on sexuality and HIV. This could include HIV risk, positive sexual health, condom use, non-penetrative sex, relationship skills and gender roles. Running similar programmes from various community structures (e.g. schools, initiation, faith-based organisations, the media) could reinforce messages.

Considering that male medical circumcision is an important HIV prevention strategy (Sawires, Dworkin, Peacock, Szekeres, & Coates, 2007; Halperin et al., 2008) and that there is widespread support for traditional male circumcision (Greely et al., 2013; Mfecane, 2016), medical and traditional circumcision could be promoted as a biological intervention. All challenges relating to traditional circumcision (hygiene, age of initiates, parental consent, training of practitioners) (Malala & Mulaudzi, 2015) should be addressed, and circumcised young men should receive comprehensive education on sexuality and condom use. Dionisio and Viviani (2013) report that an integration of medical and traditional circumcision is practiced in Venda. Some circumcisions are done in the day clinic and where it is done in the bush by traditional operators, a health care worker often supervises the process. This practice could be promoted.

Cultural practices that should be challenged and addressed because these practices contribute negatively to young people's health (Airhihenbuwa, 1995, 2007) include current constructions of gender roles (masculinity and femininity) and the practice that parents do not talk to young people about sex.

Young people need the opportunity for dialogue to reconstruct and renegotiate gender roles and to construct more positive masculinities and femininities, as the current

constructions place them at risk of HIV. Most research on masculinity in South Africa describes masculinity constructions as problematic because of the risk of HIV and their negative impact on girls and women (Ratele, 2014; Shefer et al., 2015). The complexities and vulnerabilities of being a young black man and societal processes involved (Ratele et al., 2010; Ratele, 2014) as well as the implications of multiplicity of masculinities (Hunter, 2010) should be discussed when deconstructing and re-negotiating gender roles. Conversation need to start in the peer group context and move to the inter-gender context (Stern et al., 2015). Prevention programmes addressing the reconstruction of gender roles and rights have been found to improve reproductive health outcomes and to be more likely to delay sexual debut (Chandra-Mouli et al., 2015).

Parents/caregivers should be empowered to communicate with young people about sex, not only to share and understand perspectives but also to empower young people to choose healthy sexual practices. This could decrease the gap between different generations' constructions of sexuality. Previous research indicates that parental support can reduce young people's vulnerability to HIV (Cluver et al., 2014; Setswe et al., 2014; Visser, 2017).

Limitations

Although focus group discussions are valuable in a social constructionist study where the researcher wishes to obtain interactive data based on meaning constructed in a social setting (Kvale & Brinkmann, 2015), group discussions of sensitive issues such as sexuality might highlight dominant constructions. It may downplay or silence alternative or individual or nuanced constructions because of group dynamics. All constructions of sexuality may therefore not be presented in the data. It might have been beneficial for the study to use both focus group discussions and individual interviews to explore more alternative constructions to understand the vulnerabilities and complexities of negotiating sexualities and the gap between subjective narratives and idealised masculinity in the cultural context (Shefer et al., 2015).

The same applies to the discourses of community leaders. Community leaders were recruited at the chief's kraal during a meeting of the local Tshivenda tribal council and the focus group discussions were held at the chief's kraal. It is possible that the community leaders who participated in the discussions were traditionally oriented, because people who

attend community meetings often adhere strongly to cultural norms. The existence of other perspectives about young people's sexuality cannot therefore be discounted.

The focus group discussions were conducted in the Tshivenda language so that participants could express their views freely. Although translations were done with care, it is possible that some meanings got lost in translation.

Conclusion

This study aimed to explore constructions of sexuality among Vhavenda young people and the use of cultural practices to develop more successful context-specific HIV prevention programmes for young people. The results show that the dominant discourses promote sexual risk behaviour and that similar constructions existed in other South African cultural groups. Peer pressure emphasised the dominant discourses, while adults/parents and community leaders felt disempowered to influence young people's risk behaviour. These results paint a predominantly dim picture of behavioural change interventions to prevent HIV and AIDS. Though, it re-directs HIV prevention strategies to promote culturally appropriate strategies and to address constructions of sexuality and empower parents to provide sex education.

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