Reappraising men's sexual behaviors and gendered attitudes from the sexual-history narratives of South African men and women in a time of HIV/AIDS

by Erin Andrea Stern (MSc, B.A [Hons])

Thesis Presented for the Degree of

DOCTOR OF PHILOSOPHY

in the Women's Health Research Unit, School of Public Health and Family Medicine

UNIVERSITY OF CAPE TOWN

November 2013

DECLARATION

I, *Erin Stern*, hereby declare that the work on which this dissertation is based is my original work (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

I empower the university to reproduce for the purpose of research either the whole or any portion of the contents in any manner whatsoever.

Signature: ……

Date: ……

ABSTRACT

While the frequent positioning of men's sexual behaviours as driving the HIV epidemic in South Africa has generated much interest in men's sexuality, much research to date has presented men as a homogenous group, or treats male sexuality as a set of isolated, individually driven behaviours. As a result, the current body of knowledge provides only a partial basis for meeting men's sexual and reproductive health (SRH) needs and addressing HIV-prevention among men. A narrative approach, which foregrounds the diversity and meaning in participant's lived experiences, was used in this study to examine the subjective and social impact of dominant norms of masculinity on South African men's sexual behaviours and gendered attitudes. This was expected to yield more nuanced, and contextualised understandings of men's SRH, with practical consideration for what means of men's sexual health can be enhanced.

Fifty sexual-history interviews and ten focus group discussions with men, and twenty-five sexual-history interviews with women, were conducted with participants purposely sampled from three age categories (aged 18–24, 25–54, and 55+ years), a range of language and racial backgrounds, and urban and rural sites across five provinces in South Africa. The interviews were structured to elicit accounts of early knowledge of sex and sexual experimentation and to explore the range of sexual relationships and experiences among men and women throughout their adulthood. Participants' engagement with the risk of sexually transmitted infections, including HIV, and their reproductive health management were also explored. The data were analysed using the principles of thematic and narrative analysis, with NVivo software used for data management.

The data appreciates the diversity and fluidity in men and women's lived experiences while recognising the social and cultural norms that structure sexuality. The narratives reveal a number of footholds for understanding how individual men both conform to and resist gender norms that can be damaging to their SRH. Such findings provide insights to inform how programmes and services could better engage men in HIV prevention and care. Especially, the study points to the value of a narrative approach to more deeply understand men's sexual risk and agency and the social structures, meanings and experiences that underlie it.

ACKNOWLEDGMENTS

I would like to thank the following persons and organisations to whom I owe completion of this doctoral research:

- The participants who were willing to share their personal and intimate stories;
- Dr. Diane Cooper, my supervisor, and Dr. Rosemarie Buikema, my co-supervisor, for their ongoing support and guidance;
- The Centre for AIDS Development, Research and Evaluation (CADRE) for their assistance with the initial phase of the research and permitting me to use the data towards an academic degree;
- Dr Kevin Kelly, the Director of CADRE, for encouraging me to undertake a doctorate on this topic;
- USAID through Johns Hopkins Health Education South Africa (JHESSA) for funding CADRE's facilitation of the initial phase of the research;
- University of Cape Town Research Associateship for providing financial support in 2011
- Deutsche Gesellschaft fuer Internationale Zusammenarbeit (GIZ) GmbH for funding the costs of the research in the rural Eastern Cape and Mpumalanga sites;
- Tshepo Phalane, Gcobani Qambela, Luphumlo Sam, and Gary Parker for their assistance with recruiting participants, conducting interviews, and translating the data;
- Dr Asta Rau, Senior Researcher at the Centre of Health Systems Research and Development, University of the Free State, and Alice Clarfelt, an advisor to Eastern Cape AIDS Council for Deutsche Gesellschaft fuer Internationale Zusammenarbeit (GIZ) GmbH, for offering valuable insights for analyzing and conceptualizing the data;
- My supportive colleagues in the Women's Health Research Unit at UCT;
- Cindy Kulongowski for careful editing of an earlier draft; and,
- My family for their constant and unwavering support.

CODES USED FOR INTERVIEWEE REFERENCING

M = Male

F = Female

JNB = Johannesburg

GTOWN = Grahamstown, Eastern Cape Province

CBAY = Coffee Bay, Eastern Cape Province

NELS = Nelspruit, Mpumalanga Province

JNB = Johannesburg, Gauteng Province

CPT = Cape Town, Western Cape Province

PTZB = Pietermaritzburg, KwaZulu-Natal Province

FG = Focus Group

R = Rural

I = Interviewer

P = Participant

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral treatment
BFL	Brothers for life
CADRE	Centre for AIDS Development, Research and Evaluation
FGD	Focus group discussion
GBV	Gender-based violence
HCT	HIV counselling and testing
HIV	Human immunodeficiency virus
HSRC	Human Sciences Research Council
IPC	Injectable progesterone contraceptive
IPV	Intimate partner violence
JHHESA	Johns Hopkins Health and Education South Africa
LO	Life Orientation
MCP	Multiple concurrent partner
MFC	Men for change
MRC	Medical Research Council
NGO	Non-governmental organisation
OMC	One man can campaign
PIA	Prevention in action
SBCC	Social and behavioural-change communication
SOA	Sexual Offences Act
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
WHO	World Health Organisation

TABLE OF CONTENTS

CHAPTER 1: GENERAL INTRODUCTION

> "I wanted to cry like a bereaved woman. But I am a man. A man never cries. He bows his head and listens to the pain deep inside him. The making of a man is the ability to contain tears even when they try to force their way out." Siphiwo Mahala, *When a Man Cries* (2007: University of KwaZulu-Natal Press)

Aim of the study

This research examined the subjective and social impact of dominant norms of masculinity on South African men's sexual health behaviours, with practical consideration for what means or determinants of men's sexual health can be enhanced. Sexual-history narratives were conducted to give voice to the personal experiences of South African men and women, investigating how their accounts support or contradict the ideologies promulgated by dominant masculinities, and, in doing so, illuminate how some men resist rigid gender norms to the benefit of their own and their partner's sexual health. The narratives were used to document the changes in expressions of male sexuality and which social norms around sexuality, at which life stage, are particularly influential to men's sexual and reproductive health (SRH). By seeking to understand the social and cultural norms which structure the sexual identity of men and women, implications for how to promote HIV-risk reduction can be gained through the narratives. In accounting for the variations of masculinities, this study sought to avoid a unitary and generally negative characterization that often marks HIV/AIDS-related studies of men. In addition, these insights can contribute to an understanding of the key barriers to men's uptake of SRH services, assist the formulation of programs and services that most adequately meet the SRH needs of men and women, and better engage men in HIV prevention and care.

Background

Gender and HIV risk

HIV disproportionately affects more women than men in South Africa, with black females ages 20–34 years the most at-risk population group, with an HIV prevalence exceeding 32% in 2012

(Shisana 2013). Women are physiologically more vulnerable to contracting HIV from unprotected sexual intercourse than men (Quinn and Overbach 2005). Social factors contributing to the HIV prevalence among women include the high rate of sexual violence in South Africa, women's often disadvantaged economic position, relative acceptability of intergenerational sex between young women and older men, and the related difficulty for many women to insist on condom use (Jewkes *et al*. 2002; Reddy and Dune 2007; Seedat *et al*. 2009). As a result, many HIV-prevention efforts in South Africa have targeted women — which is appropriate and necessary. However, this focus could also place the burden of HIV prevention and response on women, or exacerbate the stigmatisation of women as responsible for the disease (Chant and Gutmann 2000). Encouraging women to negotiate safer sex assumes a level of autonomy that is denied to many South African women (Sathiparsad 2007; Ratele and Shefer 2002). Moreover, various studies have demonstrated how dominant constructions of masculinity in South Africa contribute to men's risky sexual practices and poor health-seeking behaviours. These include norms that promote men's sexual entitlement to women, a demand for toughness and strength, aversion to expressions of emotion and weakness, and engagement in multiple concurrent partnerships (Hunter 2005; Dunkle *et al*. 2006; Lindegger and Quayle 2009; Hunter 2010; Jewkes and Morrell 2010). Society's often routine depiction of men as invulnerable, and a general perception of SRH clinics as being a woman's domain, are believed to play a role in hindering men from acknowledging health risks and seeking SRH care, including testing for HIV (Peacock *et al*. 2009; Dwadwa-Henda *et al*. 2010). Men are more likely than women to access anti-retroviral treatment (ART) late and die of AIDS as a result (Mills, Ford and Mugyeni 2009). Such understandings have generated a recent growth of interest and attempts to better engage South African men in HIV prevention and care.

However, the majority of research to date has tended to "conceive of men as one category and to impute one (fixed) idea of what it means 'to be a man' to South Africans" (Morrell, Jewkes and Lindegger 2012, p. 24). Men who feel disempowered by or who challenge gender norms are often neglected in HIV-prevention and research efforts. Homogenising men's experience of their gender role and sexual relationships fails to appreciate that not all men hold unbridled power, since factors including socioeconomic class, race and sexuality can oppress men and impact on the feasibility of attaining a masculine ideal (Morrell 2001; Hearn 2004; Peacock *et al*. 2009). In the African context in particular, male hegemony has come to be linked with a common portrayal

of 'bad men' (Morrell, Lindegger and Jewkes 2012), which can contribute to one-dimensional views of 'African' masculinity and sexuality. In the process, men, rather than particular versions of masculinities, are positioned as a fixed problem rather than an integral part of the solution to HIV/AIDS (Seidler 2006; Clowes 2013). Limited consideration of the range of men's sexual behaviour results in studies that treat sexuality in terms of isolated, individually driven and quantifiable behaviours, such as measuring the percentage of men who 'condomized' at last sex, or rely on self-reports of knowledge, attitudes and practices in relation to HIV risk. Such an approach does not account for the complex social, cultural and gender norms influencing men's sexual behaviour (Campbell 1997). As a result, our current stock of knowledge in the area of men's SRH and behaviour provides a limited basis for meeting men's SRH needs and for comprehensively addressing the gendered aspects of HIV prevention.

Theoretical framework of the research: hegemonic masculinity

Connell's (1995) framework of hegemonic masculinity provides an avenue to deconstruct homogenous and individually driven understandings of men's sexuality. Hegemonic masculinity refers to an "ideal type of masculinity that imposes, on all other forms of masculinity (and femininity), meanings about their own position and identity" (Connell 1995, p.47). The concept identifies a set of social norms males are encouraged to subscribe to, such as being unemotional and aggressive, in order to be legitimised as men (Connell 1995; Flood 2003a; Shefer *et al*. 2008). These standards not only maintain men's power over women, but also produce hierarchies between men, since men who do not adhere to dominant norms of masculinity are often marginalised by both genders (Jewkes and Morrell 2010). The concept recognizes thus recognizes that not all men have equivalent privileges and power (Morrell 2007), and also appreciates that the most valued forms of masculinity differ depending on the social, historical and cultural environment. This contextual nature of masculine norms means that they can and do change (Hearn 2004; Simpson 2005; Coles 2009).

The concept of hegemonic masculinity is therefore an appropriate framework for studies assessing the fluidity of gender norms, how men are socialised within their contexts, and how hegemonic norms of masculinity are lived out differently among individual men. The concept has been widely drawn upon in HIV-related research to support the recognition that HIV-

prevention efforts must promote a shift in gendered behavioural norms linked to HIV risk rather than focus primarily on individual behaviour change.

Limitations of the theory of hegemonic masculinity

While the theory of hegemonic masculinity has generated better understanding around how men are susceptible and respond to HIV risk, the concept has been criticised for inadequately addressing the *process* through which men conform to dominant gender norms in their relational interactions and social practices (Wetherhell and Edley 1999; Whitehead 1999). Hegemonic masculinity often describes male power at a structural level, with inadequate attention given to how this power may be organised in terms of conformity and resistance at the individual level (Coles 2009). Moreover, the concept has been criticised for its tendency to portray men as either conceding to dominant gender norms or being marginalised by them. This common portrayal of men conforming to a typology of hegemony is limited, as various studies suggest that men can hold multiple and even conflicting social identities simultaneously (Lindegger and Maxwell 2006), in a particular social context (Cornwall 2007), or among a certain group (Frosh, Phoenix and Pattman 2002). Despite the recognition of multiple masculinities, hegemonic male behaviour has arguably been overemphasized to the neglect of alternative and resistant masculinities. Understanding the latter is necessary in order to oppose, rather than reproduce, male hegemony:

> Though it is important to understand how a system of oppression is reproduced by 'studying up' those in the dominant group, there is little hope of ever undermining the current gender order without also understanding its contradictions and weaknesses (Wedgewood 2009, p. 335).

The concept of hegemonic masculinity has also been problematized for giving insufficient attention to the production and maintenance of hegemonic masculine norms *by women*. Hegemony involves the consent of both men and women to maintain the patriarchal relations of power (Hearn 2004). Nonetheless, Connell and Messerschmidt (2005, p. 837) note that "there is a tendency in men's studies to presume separate spheres as if women were not a relevant part of the analysis and to analyse masculinities by looking only at men and relations among men." Research on the topic of masculinity rarely involves women, and if it does, their voices are often neglected in the analysis. For instance, Talbot and Quayle (2012) reviewed 140 evidence-based studies published between 1999 and 2007 in the journal *Men and Masculinities*. Of the studies that relied on archival data, about 77% had analysed articles that were predominantly about men.

Of 84 published studies that used interview data, 69% had interviewed only men. While other articles had included female participants, the insights of women were regularly underrepresented in the published study. By frequently positioning women as passive receivers of masculine norms, the concept of hegemonic masculinity is prone to reinforcing divisions between men and women and thereby 're-excluding' women (Hearn 2004). Through asserting men's investment in various forms of masculinity rather than deconstructing masculinity, power inequalities between men and women can be reinforced (Macleod 2007). It has also been argued that masculinity studies tend to construct women as a single category with little regards to differences such as race, class and sexual orientation (Macleod 2007). Yet in rebuttal to this, Morrell (2007) argued that the concept of hegemonic masculinities seeks to challenge inequalities between men and women by indicating the limitations imposed by dominant forms of masculinity. Moreover, rather than neglecting women, men's relations with women are a key determinant of constructions of masculinity (Morrell 2007). The concept appreciates that women can agree with practices that subordinate them and that men can be disadvantaged which "allows us to get beyond the oppositional binary in analysis and politics" (Morrell 2007, 22).

In response to such concerns about how the concept has been deployed, Connell and Messerschmidt (2005) argued that applications of the theory need to recognise men's internal contradictions, as men can both conform to and resist hegemonic norms, when convenient and in multiple ways. These authors also suggest that both hegemonic and alternative gender norms should be recognised in order to "explicitly acknowledge the possibility of democratising gender relations, of abolishing power differentials, not just of reproducing hierarchy" (Connell and Messerschmidt 2005, p. 853). To better account for the diversity among men, the authors recommended prioritising how factors such as class, region, culture and race connect with dominant masculinities, and likewise evaluate changes in hegemonic masculinities. The authors also urged expansion of the concept to emphasise women's participation in the construction and legitimation of hegemonic male norms.

Performative gender

The research presented here also situates itself with Butler's (1999) concept of performative gender, which recognises gender as a set of social and cultural practices, *performed* by men and women, intended to produce a certain effect. According to Butler (1999), gender categories

create the illusion of coming about biologically, yet they largely exist as reiterations of the practices that men and women are expected to adhere to. Asserting one's gender through socially legitimated practices emphasises how performance of masculinity is an ideal that has to be lived up to, which is often made possible through definitions of being different and opposite to dominant expressions of femininity. The concept of performative gender as a set of ideals appreciates how gender norms and roles are never fully fixed. To some extent, gender norms always fail in producing conformity and as a result, gender roles and identities are constantly being created and redefined. Appreciating the performative aspect of gender is critical in order to recognize the social practices of gender, and the multiplicity of gender norms; both useful to promote transformation at the level of gender identity.

Sexual-history narratives

A way to detect and have access to the diversity, complexities and performativity of men's sexuality is to prioritize individual's related meanings, expectations, desires and sexual practices. A narrative approach to sexuality, by foregrounding personal experiences and meaning, appreciates that sexuality is about not only sexual practices, but also what people believe about sex and how they enact their gender identity in multiple and sometimes conflicting ways. Listening to stories can lend to a rich understanding of cultural and social norms, and thus recognize the normative masculine repertories that shape men's sexual behaviors. Narratives allow individuals to discuss their subjective understandings of gender norms in relation to their social, political and economic environment (Ojermark 2007). According to Atkinson (1998) a life history refers to narration of one's life experience whereby one highlights the most important aspects in relation to the domain of inquiry. A sexual history approach can thus probe how men's notions of manhood and their sexual practices are moulded by their life experiences, and how men's engagement with and expressions of masculinity change over time.

Connell and Messerschmidt (2005, p. 852) argue that "the careful analysis of life histories may reflect different hegemonic masculinity and also hold seeds of change." Although the life-history method is central to Connell's (1995) insight into the complexity of masculinity construction, only a small portion of the research on masculinities over the past two decades has rested on a narrative approach (Wedgewood 2009). Through the use of sexual-history narratives with men

and women across various racial and cultural groups, the research attempts to expand the concept of hegemonic masculinity, as recommended by Connell and Messerschmidt (2005), in the following ways: 1) document the costs and consequences of hegemony in relation to the HIV epidemic; 2) uncover personal mechanisms of male hegemony; 3) show greater diversity in masculinities; 4) trace change in men's gender roles and identities; and, 5) recognise how hegemonic male norms are constructed by both men and women.

Involving men in HIV prevention through a gender-transformative approach

Connell (2006) argued that a main obstacle to behaviour change among men is the belief that some male behaviours cannot be changed, and that men are predisposed to certain behaviours because of genetics, self-interest, socialisation and so forth. Research has shown that promoting a shift in dominant gender norms, as well as more gender-equitable relationships (although it is often a slow and complex process) can be as dramatic and effective in HIV prevention as a vaccine would be (Barker 2005). Indeed, a World Health Organization (WHO) (2007) review of 57 interventions with men (in areas of SRH, maternal and child health, gender-based violence, fatherhood and HIV/AIDS) suggested that programmes that are gender-transformative[1] within the education sessions, training with staff, and communication were likely to change men's attitudes and behaviors than programs that were gender sensitive or gender neutral (Peacock and Barker 2012). Gender transformation approaches attempt to change gender "biased and discriminatory policies, practices, ideas and beliefs" (Betron *et al.* 2012, p.5). Engaging men in gender transformative HIV prevention efforts provides a space to consider the possibility that gender inequalities can be harmful to men, and that accordingly, gender equity can be beneficial to men (Clowes 2013). As Flood (2007, p. 11) suggests: "male inclusion [in a gender transformative way] increases men's responsibility for change and the belief that they too will gain from gender equality."

Some concerns of targeting men with HIV prevention and care efforts are that this may threaten funding and initiatives for HIV prevention programmes catered to women (Flood 2007).

[1] 'Gender–transformative' programmatic efforts represent a continuum at the opposite spectrum of gender exploitative. 'Gender–exploitative' efforts refer to projects that exploit gender inequalities and stereotypes in pursuit of health outcomes. 'Gender–neutral' refers to projects that do not attempt to address gender per se. 'Gender–sensitive' refers to projects that accommodate gender differences in pursuit of health and demographic outcomes. 'Gender–transformative' refers to projects that seek to transform gender relations and roles to promote equity as a means to reach health outcomes (Promundo, UNFPA, Men Engage, Engaging men and boys in gender equality and health: A global toolkit for action, 2010).

Moreover, emphasising men's vulnerability may communicate a false sense of symmetry between men and women's social positions, and neglect what men to do maintain power (Sideris 2004b). As Peacock (2013, p. 129) asserted, 'men, even marginalized men or, for that matter, men who oppose patriarchy, continue to derive benefits because of the status bestowed by society on men as dominant and women as subordinate.' In light of such concerns, this study prioritized how forms of hegemonic masculinity can negatively affect the SRH of both men and women. To do so, it was important to include both men and women's perspectives in this study. Moreover, the study situates itself with a gender transformative perspective, whereby the overall goal is for how HIV-prevention efforts can advance gender equality efforts to the benefit of both men and women.

Research questions

To investigate participant's sexual history narratives, the research process was guided by the following questions which were structured around three themes as a sequence of events: early sexual awareness and sexual debut experiences, engagement in sexual relationships, and management of SRH including HIV risk:

1) What is the value of a sexual history narrative approach for understanding how, and to what extent, men and women's understanding and perceptions of hegemonic masculinity (particularly in relation to sexual behaviours) affect their sexual attitudes and practices?
2) How do men and women's early awareness and evaluation of sex and sexual risk and their sexual debut experiences differ; and, how might participant's early sexual awareness and experiences influence their subsequent sexual attitudes and practices? (Chapters 4 and 5)
3) How do men and women's endorsements of normative male sexuality affect their SRH practices and expectations in their heterosexual relationships? (Chapters 6 and 7)
4) What are the gaps in men and women's knowledge and engagement in managing their sexual health, and what psychological, cultural and contextual factors act as obstacles to participant's engagement in safer sexual practices including uptake of SRH services? (Chapter 8)

5) What key findings regarding male sexuality can contribute to men's engagement in HIV prevention and sexual behaviour change using a gender-transformative approach? (Chapter 9)

Overview and structure of the thesis

Chapter 1 provides the overall aims of the research and the background to the study including the benefits and drawbacks of the application of the conceptual framework used to guide the research. The chapter also introduces the study method of sexual-history narratives, and details the five key questions that guided the research process.

Chapter 2 describes the study setting and presents a review of the pertinent literature.

Chapter 3 describes the research design and methods and, especially, explores the value of narrative inquiry, which is a notably underutilised method of enquiry in the field of men's studies of sexual health or behaviour. The research design, context of the research, participant recruitment, data collection process, and the narrative and thematic data analyses are also described. Finally, the ethical considerations and limitations of the research are discussed, noting the importance of reflexivity as a researcher.

Chapters 4 through 8 present the main findings according to the domains of enquiry guiding the research questions.

Chapter 4 highlights the participants' sources of early knowledge or awareness of sex and HIV and how the quality of this information differs depending on where it is learnt. Gendered differences in access to and evaluation of sources of SRH information are also highlighted.

Chapter 5 presents the participants' experiences of sexual debut, the variable meaning that men and women attribute to this experience, and how this could affect an individual's subsequent sexual attitudes and behaviours. Gendered differences in this domain are discussed.

Chapter 6 investigates the relational nature of gender in terms of the ways men and women conform to or resist hegemonic gender norms in and through their sexual relationships, and how this influences their SRH needs and practices. The findings are presented according to three major types of heterosexual relationships: established sexual relationships, casual sexual relationships, and multiple concurrent partnerships.

Chapter 7 discusses men and women's reported experiences of sexual coercion as revealed in the participants' narratives. Gender differences in terms of experiences, conceptualization and the impact of sexually coercive experiences on sexual attitudes and practices are discussed. The chapter also addresses how performing to and condoning dominant forms of masculinity influence men's use of sexual coercion in their relationships with women.

Chapter 8 discusses men's and women's sexual health behaviour — including HIV testing, contraception use, and STI prevention. The gaps in men's and women's knowledge of and engagement with SRH, and the psychological, cultural and contextual factors that act as obstacles to accessing appropriate SRH services are identified.

Chapter 9 provides conclusions drawn from the sexual-history narratives. Insights from the inquiry are used to frame suggestions on how to improve men's engagement in HIV prevention using a gender-transformative approach. Lastly, areas of inquiry that should be explored in the future and the value of a sexual history approach to investigating men and women's sexual health are discussed.

CHAPTER 2: STUDY SETTING AND LITERATURE REVIEW

> "Our single most important challenge is therefore to help establish a social order in which the freedom of the individual will truly mean the freedom of the individual. We must construct that people-centered society of freedom in such a manner that it guarantees the political liberties and the human rights of all our citizens." Nelson Mandela (speech at the opening of the South African parliament, Cape Town 25 May 1994).

This chapter introduces the setting in which the research took place and gives a review of the literature pertinent to the inquiry made among the participants: specifically the topics of men and women's 1) early awareness of sex and their sexual debut experience; 2) mediation of sexual relationships; and 3) understandings and behaviours relating to sexual and reproductive health (SRH), including HIV risk.

The South African context

Given that hegemonic masculinity is culturally and historically located, it is important to contextualise this study within the socio-political landscape of South Africa. The population of more than 50 million is roughly 79% black, 9% white, 9% coloured[2], and 3% Asian/Indian (Statistics South Africa [Stats SA] 2012). These racial categories were formalised under apartheid[3] (1948-1994) and remain in use largely for demographic purposes and to monitor changes in inequity based on race. Under apartheid, coloureds, Indians and Asians were moderately disadvantaged relative to whites in terms of access to education, public services, employment opportunities, and fair remuneration, while blacks were severely disadvantaged. Millions of black Africans were confined to 'homeland' regions characterised by extremely low levels of employment and a poorer quality of education[4]. Until 1986, pass laws[5] restricted black

[2] In the South African context, the term 'coloured' was created to refer to a diverse group of people who had ancestry of a previous generation classified as white and another classified as black. Coloured also refers to descents of the Khoi-San peoples or slaves brought from countries such as Indonesia, Malaysia, and Madagascar.
[3] Apartheid was a system of racial segregation enforced through legislation by the National Party governments.
[4] Homelands were created by colonialism and the apartheid regime to relegate the majority of black African people to rural enclaves.
[5] Pass laws originated in 1760 in the Cape when slaves moving between urban and rural areas were required to carry passes authorizing their travel. From 1916 to 1986, the Black African population was required to carry pass books with them when outside their homelands or designated areas. Failure to produce a pass often resulted in the person being arrested and during the period of 1916 to 1984, 17,745,000 Africans were arrested or prosecuted under violation of the pass laws (Savage 1986).

people from leaving these designated areas (Savage 1986). Although apartheid formally ended in the early 1990s, racial inequality and segregation continue in South Africa (Burgard and Treiman 2006). The wealth distribution is extremely unequal, and in 2008 an estimated 1.4% of the population lived on less than US$1 per day (South African Institute of Race Relations [SAIRR] 2010). According to the National Treasury (2011), more than 4 million people (24% of the population) are unemployed. This disproportionally affects those under age 25 who account for approximately 30% of the total unemployment rate. Black South Africans account for the majority of unemployed; as of 2008, the unemployment rate was 27% among black people, 17.4% among coloured, 10.3% among white people, and 6.6% among Indian people (NIDS 2008). In the context of severe unemployment, poverty, and mass levels of migration, women have increasingly taken on financial provider roles (Sideris *et al.* 2004b). As a result, many men have lost their role as the primary breadwinner, affecting their ability to marry, which has historically been one of the key anchors of masculinity (Hunter 2010). This is particularly the case among some African men where marriage typically requires payment of a bride price, known as *lobola*, from a prospective husband to a bride's family (Jewkes *et al*. 2012b). Only approximately one third of couples in South Africa are married (SA Census 2011), and upwards of 40% of households are female-headed (Barbarin and Richter 2001; Morrell, Jewkes and Lindegger 2012). Having children out of wedlock is common. The average age of marriage for women is 28 years, and typically the majority of women have their first child before age 21 (Jewkes, Morrell and Christofides 2009). Fathers often have a minimal role in the upbringing of their children due to a variety of factors including the expansion of migrant labour, the relatively late age of marriage, and increasing female autonomy (Richter *et al.* 2012). For instance, in 2002, approximately 46% of children had absent living fathers (Morrell, Jewkes and Lindegger 2012).

South Africa has extremely high levels of crime and violence; the murder rate of 38.6 per 100 000 population was more than four times the global average (South African Police Service 2008). Men are more likely than women to be perpetrators of crime, and between 1995 and 2009, the total prison population increased by 33%, where 98% of incarcerated people were males (SAIRR 2010). The national homicide rate of men is approximately seven to eight times that of

women, and predominantly affects young black and coloured men (Ratele 2013). The country also has an alarmingly high level of sexual violence. For the period April 2011 to March 2012, the South African Police Service (SAPS) recorded 64,514 sexual offences (SAPS 2012). Despite such high figures, the actual rate of rape is expected to be significantly higher because of the documented under-reporting of rape. For instance, one study in Gauteng Province found that only one in 25 women reported an incident of rape to the police (Machisa and Jewkes 2011). Furthermore, less than 10% of reported rape are said to lead to convictions, which provides little incentive for women to report rape (Moffett 2006; Peacock *et al*. 2008). South Africa also has the world's largest HIV epidemic, with UNAIDS estimating that at the end of 2009, around approximately 5.6 million people were living with HIV (UNAIDS 2010).

In 1996, South Africa adopted a constitution that promoted equality for all people, including a strong mandate for women's rights (Morrell, Jewkes and Lindegger 2012). The government passed liberal abortion laws, provided free contraception and antenatal services, and rights to maternity leave (Morrell, Jewkes and Lindegger 2012). The government also implemented the 2007 Sexual Offences Act (2007) to expand the legal definition of sexual violence to include forced sex through means other than physical force, such as persuasion and manipulation, and provided more protection for women in court, such as making it illegal for a prosecutor to use a victim's sexual history against her. Women are widely represented in government as a result of government legislation. The general elections in 2009 resulted in 43% women representatives in parliament, which marked a 9% increase from the 2004 general elections and the fourth highest percentage of female parliamentarians worldwide (Van Klaveren *et al*. 2009). Women are required by law to be paid the same as men for equal work and there has been a dramatic increase of women in the formal labour sector since the mid-1990s (Geisler 2004). However, formal wage employment in South Africa remains dominated by men, and more women than men continue to live in abject poverty (UNAIDS 2010).

Despite such achievements for women's rights, there has been a large gap between policy formalization and implementation creating "an almost schizophrenic environment" (Bennett 2009, p. 4). Cultural constructions of manhood in South Africa tend to legitimize male authority, and such norms continue to have influence in social and institutional settings (Sideris 2004b).

Various studies have explored how the development of women's rights have been perceived as a disadvantage to men's rights, or undermining traditional norms of masculinity (Sideris 2004b; Hunter 2005; Walker 2005; Shefer *et al*. 2008; Dworkin *et al*. 2012). For some men, feelings of disempowerment have fuelled a backlash against women, including a reassertion of patriarchal values, and the use of violence or control against women (Wood and Jewkes 1998; Richter and Morrell 2005; Dworkin *et al*. 2012; Peacock 2013). Nonetheless, other men have embraced and supported the advancement of women's rights (Robins 2008), and a men's movement that advances the goals of gender equality and participates in anti-violence and HIV prevention mobilization has developed (Peacock, Khumalo and McNab 2006; Colvin, Robins and Leavens 2012). Public acknowledgment of the crises of HIV/AIDS and sexual violence has led to the contestation of gendered norms that condone male authority and control (Posel 2003; Sideris 2004b), opened spaces for men to reflect on and criticize certain forms of manhood (Hunter 2003; Walker 2003). Overall, men's reactions to the progression of women's rights are diverse and ambivalent, all of which are necessary to understand in order to effectively engage men in gender-transformative efforts.

Literature review

This literature review provides a summary of the literature relevant to the areas of inquiry, namely: early awareness of sex and sexual debut experiences; sexual relationships and practices, especially in relation to masculinity and HIV risk; and the management of one's SRH, including HIV-risk behaviour, HIV testing, and contraception use. The research for this thesis specifically explores forms of hegemonic masculinity among heterosexual men and women. Hence this literature review draws on studies on heterosexual men and women's identities, sexualities and practices in relation to hegemonic masculinity. This does not detract from the importance of literature and studies examining gay and lesbian sexual debut, relationships and SRH practices. However, the latter topics fall outside the scope of enquiry of this thesis.

Early sexual experience and awareness

Awareness of sex and HIV risk

Various studies have noted that peers provide the primary source of information about sex and HIV for South African youth, which is problematic since peer-led knowledge is often misguided

and uninformed (MacPhail and Campbell 2001; Gevers *et al*. 2012; McLaughlin *et al.* 2012). Although the subject 'Life Orientation' was introduced to all South African schools in the 1990s to provide schoolchildren with SRH information, evaluations of the curriculum have found it is often not sufficiently implemented (Visser 2005). Factors such as large and overcrowded school classes, AIDS 'fatigue', and inadequate teacher training have hindered the curriculum's effectiveness (Gallant and Matick-Tyndale 2004; Visser 2005). There is still much stigma around young people's sexuality, and consequently many teachers do not feel comfortable or equipped to address the topic in a classroom setting (Wood and Jewkes 2006; McLaughlin *et al.* 2012). In the context of SRH education, teachers may be required to act as caregivers and counsellors, which can undermine their teaching and lead to burn out in the absence of proper support (Holderness 2012).

Outside of schools, mass media campaigns, NGOs, and faith-based organisations have, in various ways, provided HIV-prevention information to youth as well as the general population. However, the results of such communication efforts are mixed. The third South African National HIV Communication Survey in 2012 found that South African youth have a generally good understanding of how HIV is spread, the consequences of HIV infection, and how individuals can protect themselves against infection (JHHESA 2012). Yet, HIV prevalence among young people (ages 15-24) in South Africa remains one of the world's highest, and young people remain highly vulnerable to new HIV infections (Shisana *et al*. 2009). This suggests that acquisition of knowledge is not in itself a guarantee of behaviour change (Campbell 2003). Young people often have less economic power, and are at heightened risk of sexual exploitation (Aggleton and Rivers 1999). Various research has demonstrated that young people perceive their risk of HIV to be low due to a general feeling of invulnerability (Moore and Rosenthal 2006). This has been found to be the case even if young people live in an area with high HIV prevalence, are informed about HIV transmission, and engage in risky sexual behaviours themselves (MacPhail and Campbell 2001; Pettifor *et al*. 2004).

Gendered differences in sexual-health awareness and HIV-risk perceptions

There are significant gender disparities among young people's sexual awareness and risk. In South Africa, young females (15-24) have an HIV prevalence that is three to four times higher

than their male peers and infection rates peak at an earlier age than in males (Shisana *et al.* 2005). Factors influencing this include the practice of young women having sex with older men (Katz and Low-Beer 2008), and the vulnerability of young women to sexual abuse (Jewkes *et al.* 2002). Differences in sexual-health awareness and HIV-risk perceptions among young men and women have also been noted (MacIntyre *et al*. 2004; Anderson, Beutel and Maughan-Brown 2007). For instance, one study in the township[6] of Khayelitsha, Cape Town, found that engaging in sexual intercourse was a significant predictor of perceived HIV risk for women but not for men (Anderson, Beutel and Maughan-Brown 2007). Gender-based social pressure and gender roles may contribute to differential perceptions. Girls may receive more support from family members to maintain their sexual behaviours according to their own perceptions of HIV risk (MacIntyre *et al*. 2004). They may also be subject to harsher controls around retaining their virginity than boys (Pettifor *et al*. 2009). Yet, while sexually active women may be more aware of their HIV risk, they are likely to have less control in negotiating protected sex than men (Campbell and MacPhail 2002). Moreover, taboos associated with young women's discussion of sexuality in formal settings may result in women being less knowledgeable about sexual health than men (Burgoyne and Drummond 2008). Alternatively, the social expectation that men should be more knowledgeable about sex than women may make them more reluctant to admit ignorance, which can promote their engagement in higher-risk sexual behaviours (Aggelton and Rivers 1999). While there is often strong societal pressure for young men to engage in sex, this is often not accompanied by promoting awareness of sexual risks (Anderson, Beutel and Maughan-Brown 2007).

Experiences and impact of sexual debut

Given the vulnerability of young people to the acquisition of HIV, age and circumstance of sexual debut has emerged as an important focal point of HIV prevention (Shisana *et al.* 2009). The circumstances of sexual debut (first sex) and early sexual experiences can have a significant impact on young people's development and subsequent sexual relationships in adulthood (Gevers *et al*. 2012). Furthermore, one of the best predictors of condom use at last sexual intercourse is condom use at first sex (Hendriksen *et al.* 2007). For instance, the Third South African National HIV Communication Survey, 2012 found that condom use with one's most

[6] In the South African context, a township generally refers to urban living areas which are typically underdeveloped, and were reserved for non-whites from the late 19th century to the end of apartheid.

recent partner is greater (68%) if one used a condom for the first time he/she had sex than if not (43%). Self-reported HIV positive status was significantly lower among those who used a first time they had sex (3.5% for males, 6.2% for females) compared to those that did not use a condom at first sex (13.6% for men, and 18.5% for females).

Many young women report being convinced, manipulated, or coerced into their first sexual experience by their first partners (Wood *et al*. 1998; Jewkes *et al*. 2001; Manzini 2001; Pettifor *et al.* 2009). An association between younger age for women and the likelihood of first sex being coerced has been documented. For instance, Dunkle *et.al's* (2004) study of 1,395 women attending antenatal clinics in Soweto, Gauteng Province found that among 45.2% of the women who reported sexual debut before 16 years of years, 97% reported non-consensual first sex before age 13, 26.7% reported this at ages 13 or 14, and 8.9% at age 15. An association between early age of sexual debut and lack of contraception has also been documented (Manning, Longmore and Giordano 2000; Cooper *et al*. 2007; Pettifor *et al*. 2009). However, it appears that much of the HIV risk attributable to early sexual debut can be explained by other factors that enhance HIV infection risk among women who have sex at an early age. For instance, Zuma *et al*. (2011) found that women with earlier sexual debut also had a significantly higher general risk profile, including multiple lifetime partners, not completing high school, and engaging in sex work. In addition to the length of a female's sexual activity (years since sexual debut), such factors also increase the probability of acquiring HIV (Pettifor *et al*. 2004). Girls who report their first sexual intercourse during their early teen years have also been found to have higher rates of teenage pregnancy and childbearing than girls who have later sexual debut (Shisana *et al.* 2009). Teenage pregnancy has been found to be a strong predictor of HIV infection among 15-24 year olds given the similar risk factors, including unprotected sex (Pettifor *et al.* 2004). Several studies have also documented that young women are more likely to experience non-consensual sexual debut in age-disparate sexual relationships, where their male partner is at least five years older (Leclerc-Madlala *et al*. 2002; Luke and Kurz 2002; Pettifor *et al*. 2009).

Little attention has been given to the dynamics and experiences of South African men's sexual debut including the implications of these experiences on men's subsequent sexual behaviours, attitudes, and constructions of their gender identity (Ott *et al.* 2012). Boys often hold greater

decision-making power at sexual debut as they are expected to initiate and be in control of first sex (Harrison 2002; O'Sullivan 2005; Jewkes *et al*. 2010). Men's sexual debut experiences are significantly less likely to be coerced than women's (Petttifor *et al*. 2009). Nonetheless, there is strong societal pressure for young men to engage in sex for the first time (MacPhail and Campbell 2001; Barker 2005). Young men often view sexual initiation as a way to gain status among their male peers, and they may compete with each other to gain the earliest sexual experience, which can contribute to experimentation with sex in 'unsafe' ways (Holland *et al*. 1994b; Pantos 1999; Lindegger and Maxwell 2006). Viewing sex as a vehicle for asserting manhood may continue into adulthood, with men affirming social status through their sexual relationships with women (Kelly and Ntlabati 2002). Some studies have found that the frequency of multiple sexual partners was greater among men who had an earlier sexual debut than those who sexual debuted in later teen and young adult years (Harrison 2005; Zuma *et al.* 2011). There is a need to more adequately consider diverse forms of masculinity in relation to men's sexual debut experiences and conceptualizations. For instance, in focus group discussions with young men, MacPhail (2003) found that many dominant norms related to sexual debut, such as negative attitudes towards condom use and being in control of the sexual encounter, regularly conflicted with young men's preferences. In this study, many men were against the use of pressure or force in sexual encounters, and were committed to have protected sex.

Overall, there is a need for more contextualised understandings of young people's early sexual awareness and experiences to provide a stronger foundation for HIV-prevention efforts among youth (Kelly and Ntlabati 2002). Bhana and Pattman (2009, p. 69) argue that:

> "Currently, we know very little about the world inhabited by young adults, how they see themselves, what they wish for, their desires and passions, their fears and the ways in which the performance of masculinities and femininities are constructed, how it is advantageous and how it can inhibit other potential experiences and how it is vulnerable to disease."

Narrative approaches could generate a richer understanding of how young people experience and conceptualize sexual debut, and how this impacts on young people's subsequent sexual attitudes and behaviours.

Management of sexual relationships

Various studies have assessed how the uptake of normative masculinities impact on men and women's SRH practices in sexual relationships (Cusick and Rhodes 2000; Leclerc-Madlala 2009a; Campo-Engelstein 2013). Perceptions about manhood can be tied to notions of sexual prowess (Jewkes and Morrell 2010), misogynist attitudes (Pattman 2005), and the pursuit of multiple and/or concurrent partners (Varga 2001; Leclerc-Madlala 2009b). In heterosexual encounters, relationship norms expect men to initiate sex, while women are encouraged to be relatively passive and inexperienced sexually (Holland *et al*. 1994a; O'Sullivan *et al*. 2006). Even so, the responsibility of contraception is commonly relegated to women, and such paradoxes often negatively influence safer-sex practices in relationships. As pointed out previously, women play a role in the production and maintenance of hegemonic male norms in relationships. Various types of relationships have been found to exacerbate HIV transmission according to the diversity of gender norms promulgated in sexual relationships (e.g. age-disparate sexual relationships, multiple-concurrent partnerships, and transactional sexual relationships). Sexual violence in relationships also exacerbates the risk of HIV transmission both directly and indirectly (Jewkes *et al.* 2011).

Age-disparate sexual relationships

Age-disparate sex refers to relationships where the gap between partners is five years or more. The HSRC's report on HIV Prevalence, Incidence, Behaviour and Communication Survey 2008 found that the percentage of women with sexual partners who were more than five years older increased from 18.5% in 2005 to 27.6% in 2008 (Shisana *et al.* 2009). This trend is an area of concern because an age gap between young women and older men has been found to increase a woman's risk of acquiring HIV (Gregson *et al*. 2002; Luke and Kurz 2002). Women in age-disparate relationships are less likely to discuss HIV risk and suggest condom use. Risk perception in age-disparate relationships is often low (Leclerc-Madlala 2008). Men regularly perceive young female partners as more likely to be free of STIs, and some young women view older men as less risk-taking, more stable, and thus 'safer' partners than young men (Jones 2006; Nkosana and Rosenthal 2007). For young women, relationships with much older men commonly co-exist with relationships with their male peer(s), and with an older man's wife or main partner. Thus, age-disparate relationships typically feed into sexual networks of concurrency, which enhances the likelihood of the spread of HIV (Jewkes 2005; Epstein 2007).

Adolescent girls have been found to desire relationships with older men for being seen as sexually and romantically advanced, respectable, mature, and more likely to provide economic security (Luke 2003; Jewkes and Morrell 2012). Yet some young women are also aware of the risks of having older sexually partners including being more violent and controlling, and contracting STIs or becoming pregnant as a result of unprotected sex (Leclerc-Madlala 2008; Jewkes and Morrell 2012). Leclerc-Madlala (2008) noted that many young women deemed age-disparate relationships as inappropriate and wished their relied upon financial benefits could be as easily accessed through other means. This reflects a diversity of young women's opinions towards age-disparate sex. Few studies have explored men's motivations for engaging in age-disparate relationships. Although there is concern that HIV-positive men aspire to have sex with younger women because they believe sex with a virgin can cure HIV, this motivation appears to be uncommon and ill-founded in reality (Jewkes, Martin and Penn-Kekana 2002; Leclerc-Madlala 2008). Leclerc-Madlala (2008) found that men's primary motivation for seeking younger partners was entertainment, relief from workplace and family stress, and desire for 'clean' partners. Attracting a younger female partner can also raise a man's social status (Leclerc-Madlala 2008; Hunter 2010).

Multiple concurrent partnerships (MCPs)

Several studies have reported that multiple concurrent partnerships (MCPs) are common in South Africa, particularly among men (Hunter 2005; Parker *et al*. 2007; Shisana *et al*. 2009; Leclerc-Madlala 2009a; Mah and Maughan-Brown 2009). It is argued that as opposed to multiple serial partnerships (sexual partnerships that occur in succession, one at a time), multiple concurrent partnerships (where having more than one sexual partners overlaps in time) leads to a far greater risk of HIV transmission (Jewkes *et al*. 2008; Leclerc-Madlala 2008; Kelly, Rau and Stern 2010). For example, one study found that among sexually active women, HIV prevalence was 15.2% among women who reported having one partner, 23.1% among those with two concurrent partners, and 28.5% among those with three concurrent partners (Pettifor *et al*. 2007). MCPs are said to put individuals at a higher risk of exposure to HIV through overlapping sexual partners, especially during the initial period of acute infectivity (Epstein 2007). In long-term concurrent relationships, as in other long-term partnerships, sex is typically unprotected (Epstein and Morris 2011). Nonetheless, there is lack of consensus on the positioning of MCPs as a primary driver of

HIV in South Africa (Parker *et al*. 2007; Lurie and Rosenthal 2010). Critics argue that researchers lack a standard way to measure and define partner concurrency, and that the data does not indicate a significant association between concurrency and HIV incidence or prevalence (Sawers and Stillwaggon 2010). There is also concern that HIV-prevention interventions prioritizing concurrency could divert resources away from other HIV-prevention methods with better-known efficacy (Lurie and Rosenthal 2010). More research is arguably needed to obtain conclusive evidence on the role of MCPs in spreading HIV, evaluate the success of programmes to reduce MCPs, and the barriers to behaviour change (Epstein and Morris 2011).

Some research has illuminated how HIV-prevention interventions aimed at reducing MCPs will need to address gendered norms that foster MCPs among both men and women (Luke 2003; Hunter 2005; Leclerc-Madlala 2008; Mah and Maughan-Brown 2012). Leclerc-Madlala (2009a, p. 105) assessed how cultural scripts, referring to "statements that prescribe recipes for living," portray men as biologically programmed to need sex regularly and with more than one woman, justifying their engagement in MCPs. Such cultural scripts also promote norms of womanhood to understand and tolerate a man's infidelity in relationships as inevitable. Polygamy is practiced by some ethnic groups in South Africa and can be used to justify men seeking multiple partners (Mah and Maughan-Brown 2009; Hunter 2010). Focus group discussions with couples in Khayelitsha, Cape Town, found that financial incentives and a lack of sexual satisfaction dominated the participants' rationale for engaging in concurrency (Hunter 2005; Mah and Maughan-Brown 2009).

Transactional sexual relationships

Transactional sexual relationships, whereby men and women exchange sex for, or in anticipation of, material possessions or favours (such as money, clothing, transportation, school fees, rent or status) is a common phenomenon in South Africa (Wojcicki 2002; Dunkle *et al*. 2004; Jewkes *et al*. 2012c). This can be partly attributed to the decline in marriages and rise in casual partnerships (Hunter 2010). Unlike sex work, typically no explicit fee is negotiated in transactional sex and a wide range of goods and services can be exchanged (Jewkes *et al.* 2012b). It should be noted however, that what constitutes transactional sex is highly contested and complex.

According to Jewkes *et al.* (2012b, p.4):

> "…material gain is sometimes the only factor sustaining a relationship, multiple factors can be involved (even negative factors such as fear) and it can be difficult to distinguish between male fulfillment of a traditional provider role and relationships that could not be sustained if that provider role was not fulfilled."

Moreover, expressions of romantic love can be closely linked to gift-giving, which is also a cultural courting practice (Hunter 2010). African cultural norms regularly dictate that men should provide for women, which is institutionalised through the practice of *lobola* (bride price) before marriage (Jewkes *et al*. 2012b).

Transactional sex is most commonly between young women and older men, indicative of young women severely lacking income opportunities (Luke 2003). Transactional sex is often motivated by women's needs to meet basic survival and daily costs, driven by poverty (Leclerc-Madlala 2003; Luke 2003; Susser and Stein 2004). Girls may be pressured from parents to have a relationship with an employed, older man to acquire money and household necessities (Jewkes, Penn-Kekana, and Rose-Junius *et al*. 2005). Women can also be motivated to engage in transactional sex for gifts and other financial benefits, such as meals out, jewellery and cellphone airtime (Hunter 2002; Luke 2003). Regardless of the incentive, in such relationships, both partners often perceive that the relationship would not continue without the material exchange. Knowledge about men's incentives for engaging in transactional relationships is generally not well known (Jewkes *et al.* 2012b).

Research indicates that women who engage in transactional sex are very vulnerable to acquiring HIV as men who take on a provider role may feel entitled to decide the terms of sex including whether or not to use condoms (Jewkes, Morrell *et al*. 2012; Shefer, Clowes and Vergnani 2012). Some studies suggest that the greater the financial disparity between partners, or the greater the value of a good or service exchanged for sex, the less likely the sex will be protected (Luke 2003; Wojciki 2005). Other research has demonstrated that men who engage in transactional sex are likely to be more controlling, patriarchal and engage in intimate partner violence than men who do not engage in transactional sex (Dunkle *et al*. 2007; Jewkes *et al*. 2012c). Women may offer sex in exchange for alcohol, and the context of drinking has been shown to decrease the

likelihood of safer sex (Wojcicki 2002; Norris, Kitabi and Worby 2009; Jewkes *et al*. 2012c). Women who engage in transactional sex have been found to be more likely to have experienced forced sexual debut (Dunkle *et al.* 2004). Sexual coercion may be more accepted in scenarios where the perpetrator provided financial resources to a victim (Betron *et al.* 2012).

Sexual violence

Sexual violence contributes to the spread of HIV in South Africa in both direct and indirect ways (Jewkes *et al*. 2011). If the perpetrator of sexual violence is HIV infected, HIV transmission may occur directly during rape. Rape is more likely to result in abrasions and tears of the vagina, which increases the likelihood of the virus entering the bloodstream (Quinn and Overbach 2005). In South Africa, men who have perpetrated sexual violence are at heightened risk of being HIV-positive as they are more likely to have multiple partners, engage in higher-risk sex including transactional sex, and abuse alcohol or drugs (Jewkes *et al*. 2009; Jewkes and Morrell 2010). In addition, indirect factors link experiences of sexual violence to HIV risk. Being a victim of sexual violence can make women more susceptible to adopting subsequent HIV-risk behaviours, including having multiple partners, engaging in unprotected sex, participating in transactional sex, and drug or alcohol abuse (Jeejebhoy, Shah and Thapa 2005). Women who experience forced sex in intimate relationships often find it difficult to negotiate protected sex as initiating condom use may increase their risk of violence (Campbell 2003). Relationship inequity and intimate partner violence have also been found to increase women's risk of acquiring HIV. According to one study, an estimated 16% of new HIV infections in women could be prevented if women did not experience domestic violence from their partners (Jewkes *et al*. 2009).

Various factors including poverty and unemployment, and general high levels of other forms of violence have been positioned as contributors to the endemic levels of sexual violence (Segal 1990). It is also well understood that social constructions of masculinity, including men's sense of entitlement to women, aggressiveness and control, influence the rates of sexual violence in South Africa (Jewkes and Abrahams 2002; Dunkle *et al*. 2006; Ghanotakis *et al*. 2007). Notions of men's uncontrollable sexual appetite have been used to explain some instances of rape as 'biological' rather than 'sociological,' undermining the perpetrator's guilt (Jewkes, Penn-Kekana, and Rose-Junius 2005). A questionnaire found that 466 out of 1 686 men admitted to

having raped a woman, and that a feeling of sexual entitlement was the most common reason given by the men to explain why they had raped (Jewkes *et al.* 2011). Sexual violence can be used by men to dominate and humiliate women as it combines physical violence with a sense of shame and often self-blame by the victim (Moffett 2006; Hunter 2010).

A significant relationship between men experiencing sexual violence by another man and being a sexual perpetrator against women has been documented. Jewkes *et al*. (2009) found that 10% of men answering a household survey in the Eastern Cape and KwaZulu-Natal had experienced sexual violence by a man in the last year, and 50% of those who had experienced sexual violence themselves also admitted to ever having raped a woman. 82% of men who admitted to perpetrating violence against another man also admitted perpetrating violence against a woman. Men who experience sexual violence by other men are at greater risk of alcohol abuse and having HIV (Jewkes *et al.* 2006). Whether men's experiences of sexual coercion by women influences their sexual risky behaviours including perpetrating sexual violence is unknown. There is a paucity of literature around men's experiences of sexual coercion by women, which may be due to concerns that this neglects a focus on prevention of female victimization, who represent the majority of sexual violence victims. It may also reflect common societal beliefs that women cannot coerce men into sex, and that men are always willing to engage in sex with almost any woman (Sleath and Bull 2009). It has been found that when men do experience sexual coercion or force by a female, they suffer fewer negative consequences than women (Struckman-Johnson 1998). Nonetheless, there is some evidence that sexual coercion of South African men by women does exist, and that this can have psychological consequences including guilt, anger and depression (Jejeebhoy and Bott 2003). For instance, in a national school survey conducted in 1 200 schools across the country, 127 000 boys ages 10-19 were asked if they had ever been sexually assaulted, and if so, by whom (Anderson and Ho-Foster 2008). The study found that two out of five boys reported sexual assault, most frequently by an older female, followed closely by a male peer. Another survey with 1 371 men aged 15-26 in the rural Eastern Cape (Jewkes *et al*. 2006) found that 9.7% reported a coerced sexual experience perpetrated by a female, 3.2% said they had experienced one perpetrated by a male, and 2.3% reported being threatened or forced to have sex with someone who was not a partner. Sikweyiya and Jewkes's (2009) qualitative research with men in the Eastern Cape found that men framed sexual coercion

by women as much less traumatic than coercion by men, whereby only the later was perceived as rape. Nevertheless, repeated pressurized sex of men by women was shown to cause great anxiety and feelings of shame, particularly in inappropriate situations such as when female family members or much older women were involved. Overall, there is a need to more comprehensively understood men's experiences of various forms of sexual coercion, particularly given the documentation that this can influence men's use of violence against women and engagement in risky sexual behaviors.

Relational nature of hegemonic masculinity

The HIV/AIDS literature has been criticized for regularly depicting sexuality as a domain where men are dominant and women are passive without acknowledging "resistances, alternative discourses and contradictions in dominant discourses on heterosexual practices" (Shefer and Foster 2009, p. 270). As noted in the introduction, is important to understand women's role in the production and maintenance of hegemonic norms given that men can be encouraged to uphold such norms by men and women (Jewkes and Morrell 2010). Moreover, shifts in configurations of hegemonic masculinity necessarily promotes change in hegemonic femininity given that dominant masculine norms are premised in relation to feminine norms, often in dichotomous ways (Messerschmidt 2012). Talbot and Quayle's (2012) study revealed how differing forms of femininities prevail in certain contexts as they support situational masculinities. The study was conducted with middle-class women at a university who identified forms of masculine hegemony (e.g. being aggressive) as problematic in the contexts of work and school, yet they valued these traits in a romantic context, perhaps because "the stages of being in love are so tied up with hegemonic masculinity and submissive femininity" (Talbot and Quayle 2012, p. 275). Jewkes and Morrell's (2012) study with 16 isiXhosa women in three sites in the Eastern Cape revealed a dominant femininity that negotiated respect, independence, and non-violence within sexual relationships, while still maintaining culturally appropriate gender hierarchies. Pattman's (2005) work in Southern and Eastern Africa found that young men and women understood each other as dichotomous sexually with relatively little in common (Pattman 2005). Boys tended to be portrayed as subjects and initiators and girls as passive objects of sexual desire, which minimized potential for sexual negotiation and gender equality (Pattman 2005). Other research has challenged the passivity of women's sexual decision-making by revealing the desire of women to

have unprotected sex in order to meet their material needs (Susser and Stein 2004; O'Sullivan *et al*. 2006) or to procreate (Wood and Jewkes 2006). However, as Mfecane (2013) argues, women's agency around sexual decision-making should be understood within South Africa's pervasive gender power inequalities. Women's aspirations for motherhood and financial independence may reflect the societal pressure on women to prove their fertility and the limited economic opportunities available to women. Research that interrogates both dominant masculinities and femininities including how they relate to each other, is better equipped to avoid biases that reiterate divisions between men and women (Mane and Aggelton 2001).

The relationship between HIV risk and hegemonic masculinity

There is a wealth of literature that illustrates how dominant gender norms impact on higher-risk sex and poor SRH-seeking behaviour among men. Much research has demonstrated a link between an investment in patriarchal norms and HIV-risk behaviour (Wade 2008; Peacock *et al.* 2009; Jewkes *et al*. 2012c). Kauffman *et al*. (2008) found that an endorsement of traditional male roles, such as believing that men have the final say in the home, was positively associated with HIV-risk behaviour**.** Men who equate masculinity with risk-taking and sexual dominance (Peacock *et al*. 2009) have been found to be more likely to contract an STI, have negative attitudes toward condoms, and use condoms inconsistently (Noar and Morokoff 2002). In South Africa, men are socialized to drink more than women, and heavy drinking is strongly associated with unprotected sex (Peacock *et al*. 2008). Social norms frequently hold that it is the responsibility of men to acquire condoms and initiate protected sex (Barker 2005). Paradoxically, dominant norms also hold that contraceptive use is a female concern, which may hinder men's involvement in condom use (Flood 2003b; Campo-Engelstein 2013. Socio-cultural norms that treat childcare and parenting as women's issues also hinder men from participating in reproductive responsibilities, including contraception. Certain contexts may promote and exacerbate males' sexual-risk behaviour. For instance, according to Campbell (2001), the dangerous work environment and lack of intimacy associated with life in single-sex mining hostels created conditions where miners risked pursuing the physical and emotional connection provided by 'flesh-to-flesh' sex. Wood and Jewkes (2001) documented how men used misogyny and higher-risk sexual practices to gain status and control women in a resource-limited setting

characterised by fatalism and violence. In some study settings, HIV-positive heterosexual men have been found to have lower levels of education and greater social vulnerability (Sandfort *et al*. 2008)**.** Such studies attest to HIV-risk factors being strongly influenced by the social conditions in which men live and the related dominant masculine repertoires.

Men's uptake of SRH services

Various studies have shown that South African men are less likely than women to access SRH services (Orner *et al*. 2008; Cooper *et al*. 2009), including testing for HIV (Peacock *et al*. 2008). This is problematic, given that the HSRC's (2005) South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey found that people who knew their HIV status were more likely to use condoms (Shisana *et al*. 2005). Men are also less likely to access antiretroviral treatment (ART) than women and tend to have a lower CD4 cell count at treatment initiation (Pettifor *et al*. 2004; Peacock and Barker 2012). This is not surprising given that SRH services are not particularly male-friendly, are regularly perceived to be a woman's domain, and hegemonic norms expect men to be stoic in face of illness (Peacock *et al*. 2008; Robins 2008). For example, a survey conducted with 566 residents in Khayelitsha found that two-thirds of respondents agreed with the statement "men think of ill-health as a sign of weakness which is why they go to a doctor less often than women" (Medical Research Council 2007). In certain contexts, men's poor health-seeking behaviour is exacerbated by poverty, whereby men may migrate to find work or work long hours, with little time to seek healthcare even if it is available (Campbell 1997). Men's poor uptake of SRH care makes it harder to reach men with sexual-health messages (Cooper *et al*. 2009; Dwanda-Henda *et al*. 2011). Service providers and health facilities not being catered to men also create barriers to men accessing SRH care (Beck 2006). In a study by Orner *et al*. (2008), both women and men asserted that SRH services should be better suited to men's needs and work commitments. They also thought the number of male staff at clinics should be increased because prejudices and embarrassment often make it difficult for men to be treated by female healthcare providers (Orner *et al*. 2008).

Some studies have considered diverse forms of masculinities in relation to SRH health-seeking and care behaviour. For instance, Robins (2008) documented 'responsible masculinities' whereby HIV-positive men in a Cape Town township were given a safe space to discuss how

HIV, unemployment, and poverty affected their identities as men. The support groups contributed to higher levels of ART adherence and HIV-status disclosure and also resulted in the men's greater commitment towards their family and community. Lynch, Brouard and Visser (2010) found that being diagnosed with HIV could reposition men to engage in caring and supportive behaviours for themselves, and their families, which could also alter perceptions of normative masculinity. Mfecane (2011) found that the shock and fear from being diagnosed HIV positive could contribute to changes in concepts of hegemonic masculinity among men including safer sexual behaviours. Yet such experiences from an AIDS illness and commitment to therapy did not necessarily result in linear or sustained change in masculine beliefs and practices or the abandonment of all previously higher-risk behaviours. Hunter (2005) argued that the HIV pandemic has played a role in forcing acknowledgement of the damages of masculinity that is built on sexual prowess and encouraging men to be more open to discuss sex and safer sexual practices. For instance, forms of masculinity that are rewarded for having many partners have also been challenged for exacerbating one's susceptibility of acquiring and transmitting the HIV virus.

Summary and conclusions

This chapter has provided an overview of the context where the research took place and surveyed the literature relevant to thematic areas of the research topics, namely: early sexual and HIV awareness, the circumstances of sexual debut, the management of different types of sexual relationships including experiences of sexual coercion, the interface between HIV risk and hegemonic masculinity, and men's uptake of SRH services. Much of the literature attests to HIV/AIDS risk factors in relation to masculinities being rooted less in individual attitudes and behaviors of individual men than in the societal conditions in which they live. The literature also documents how knowledge of sexual risk in itself is not a guarantee of behavior change, and the limitations of understanding the relationship between masculinity and sexual health from an individualistic perspective. Applying a socio-ecological model to behavior change (McKee *et al.* 2000), that takes into account socio-cultural (including partners, family, peers, and community influences), economic and environmental factors as well as individual factors is gaining greater momentum in sexual behavior change initiatives (Parker and Borwanker 2012). Some of the literature documented the transformative potential for addressing harmful aspects of masculinities and promoting change in men (Morrell 2001). The manner in which masculinities,

particularly masculine sexual identities, are constructed through relations with women is another predominant theme of this review. Differences in men and women's sexual debut experiences, sexual relationships, and health-seeking behaviors, as documented in this review, identify the importance of understanding and appreciating both men and women's perspectives in the domain of SRH. Overall, this review necessitates an appreciation of the subjective, social, environmental and cultural dynamics of men's sexual agency and risk, diverse and alternative masculinities, and the way that men's sexual practices and gendered attitudes compare are produced by and through relations with women. Next, Chapter 3 presents and justifies the research design and methods.

CHAPTER 3: RESEARCH DESIGN AND METHODS

> "Oral narratives, the academics say, are driven by remembering core phrases and images that carry the distillation of the entire story. From these cores the action, the characters, the conclusion all unfold." Antjie Krog, *Country of My Skull*: *Guilt, Sorrow, and the Limits of Forgiveness in the New South Africa* (1998, 132: Vintage).

Introduction

This chapter describes the qualitative research methods used for the study. The rationale for the choice of qualitative research methods, and in particular sexual history narratives, is discussed. This is followed by a presentation of the research design, research setting, study population, data collection and data analyses. Ethical considerations for the research are also introduced. Lastly, the limitations of the study as well as steps taken to ensure rigor of data collection and data analysis, including reflexivity of the author, are presented.

Research design

A qualitative research design was chosen as an appropriate approach to understand and analyse respondent's subjective meaning within particular social contexts (Ulin, Robinson and Tolley 2005). A core objective of qualitative research is to uncover how people understand their 'life worlds' and make meaning of everyday phenomena, which is relevant to the study objectives (Mays and Pope 2000). A qualitative research design provides a suitable framework to deeply probe the inquiry of this study.

Sexual-history narratives

Sexual history narratives were used for this study to capture a holistic and nuanced perspective of men's sexual risk and agency. Eliciting stories can reveal how people see themselves and others, uncover what they do not intend to disclose, and answer questions that researchers may not even think to ask (Smith 2000; Cornwall 2007). How individuals construct stories relates to what particular experiences have had a pivotal role in shaping the topic at hand (Bauer and Gaskell 2000). A sexual history narrative approach is thus a valuable tool to assess the impact of

men and women's early sexual awareness and experiences on their subsequent sexuality — a primary aim of this study. Furthermore, narratives document the fluidity (or changes in expressions) of sexuality, as a result of interaction with social norms. This approach may thereby allow one to locate 'moments' when men are particularly susceptible to adapting gendered norms, as well as moments where they critically reflect on and sometimes reject them. Stories are used to make sense of lived experiences, which is useful to conceptualise in order to better understand how to target beliefs that can be damaging (Deleuze 1994). This approach gives a certain level of agency to interviewees because they are able to discuss what they feel is important, and suggest interpretations of their life accounts (Brittjin 2013). Through appreciating the uniqueness of individual life stories, sexual-history narratives make it possible to recognize multiple versions of masculinity, including 'counter-narratives' (Atkinson 2004; Coles 2009).

Research methods

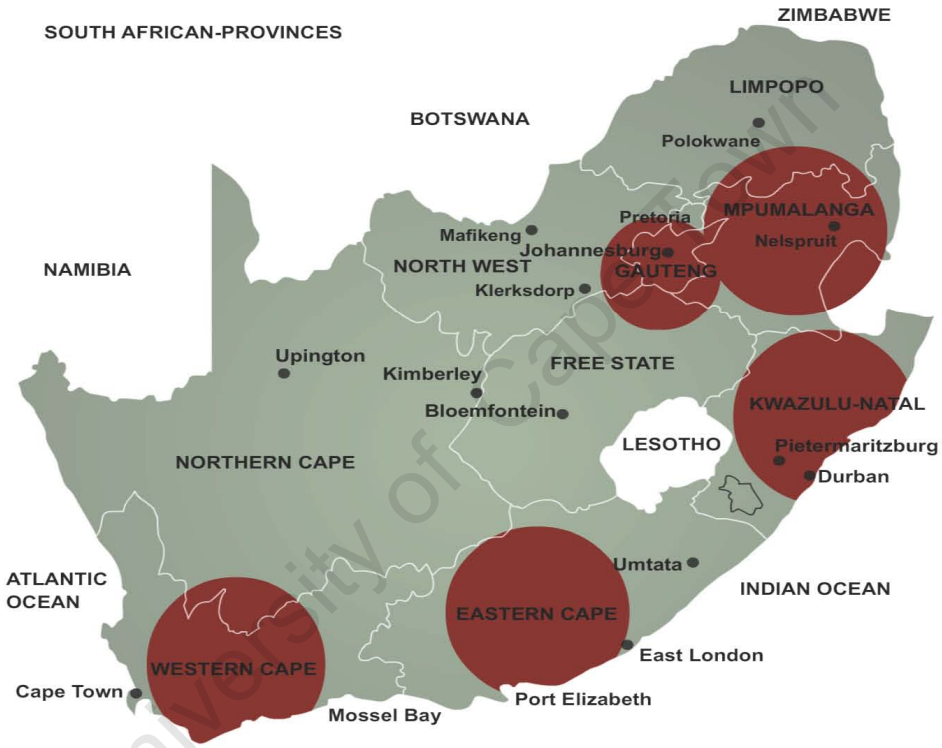
Study sites

Sexual life-history interviews were conducted at six sites across five provinces in South Africa (Eastern Cape [Grahamstown and Coffee Bay], Western Cape [Cape Town], KwaZulu-Natal [Pietermaritzburg], Mpumalanga [Nelspruit] and Gauteng [Johannesburg]). Culturally, economically, and socially diverse sites were purposively selected to enhance the representation of participants in order to appreciate how factors such as race, class, environment and culture intersect with dominant masculine norms. This is particularly important in the South African context, for being a diverse country with 11 official languages, which continues to be segregated along racial and cultural lines (Anderson, Beutel and Maughan-Brown 2007). The sites represent a variety of contexts including the major metropolitan city of Johannesburg, which has a population of approximately 4.435 million, the small town of Grahamstown with a population of approximately 124, 758, and the deep rural community of Coffee Bay with a population of approximately 600 people. A map (Figure 1) highlighting the study provinces, and Table 1 documenting the percentages of the predominant language and racial groups[·] in each of the study

[·] It is recognized that rigid language categorisatization and identification of participants in terms of racial groups is contested and problematic, particularly in the South African context given its history of racially entrenched denial of

provinces are presented below.

Figure 1: Map of South Africa



human rights under apartheid. However, historical race and language divisions in South Africa have created separation and inequity that continue to exist and may have a potential impact on the research enquiry.

TABLE 1: STUDY PROVINCES-LANGUAGE AND RACIAL DEMOGRAPHICS

Province	Majority Language Distribution (% of population)	Majority Racial Distribution (% of population)
Eastern Cape	78.6% isiXhosa	86.3% Black African, 8.3% Coloured, 4.7% White
Gauteng	19.8% isiZulu, 13.3% English 13.3%, 12.4% Afrikaans, 11.6% seSotho	77.4% Black African, 15.6% White, 3.5% Coloured
KwaZulu Natal	77.8% isiZulu, 13.2% English	86.8% Black African, 7.4% Indian, 4.2% White
Mpumulanga	27.7% isiSwati 27.7%, 24.1% isiZulu, 10.4% xiTsonga	90.7% Black African, 7.5% White, 0.9% Coloured.
Western Cape	49.7% Afrikaans, 24.7% isiXhosa, 20.2% English	48.8% Coloured, 32.8% Black African, 15.7% white.[7]

Statistics South Africa. 2012. *Mid-Year Population Estimates.* Pretoria, South Africa: Statistics South Africa.

At each site (apart from Coffee Bay), the research was conducted in both the urban centre and nearby rural areas to ensure a diversity of settings. There is a wealth of research that links patterns of HIV prevalence to poverty and inequality (see Farmer 2005); therefore, to account for socioeconomic inequities, the research was carried out in the poorest (Eastern Cape and Mpumulanga) and wealthiest (Gauteng and Western Cape) provinces in the country. KwaZulu-Natal and Mpumalanga provinces also have the highest HIV prevalence rates in the country, with a national HSRC household survey in 2012 finding an HIV prevalence of 27.6% and 26.0% respectively among individuals in the 15-49 years age group (Shisana 2013).

Participants

Sexual history narrative interviews were conducted with 50 men and 25 women for a total of 75 interviews. The limited sample of 75 individuals within the diversity of South African cultures and contexts is not sufficient enough to infer generalisations about a particular social or cultural group. Yet qualitative research does not aim to sufficiently generalise a phenomenon but rather generate rich insights around the study topic. By providing rich and nuanced descriptions, sexual history narratives provide insights that may be applied to other contexts (Moore 2013).

At each site, interviews were conducted with men and women in three age categories (ages 18–24, 25–54, and 55+ years) and from the dominant racial and cultural groups to assess variations among individuals along a host of categories, and changes within respondent's lifespan. Given the focus of this study, efforts were made to recruit participants who self-identified as heterosexual to assess how norms of masculinity are constructed and maintained by both men and women in and through heterosexual relationships. According to Butler (1991), it is by constructing oneself as a heterosexual being that people emphasize their gender differences. By comparing heterosexual men and women's sexual-history narratives, such differences in reported gender norms and sexual behaviours could be assessed. Whether participants also engaged in same sex relations as well was not probed. The participants represented a range of cultural groups and first language speakers and included 22 isiXhosa speakers, 10 isiZulu speakers, 6 siSotho speakers, 4 seTswana speakers, 4 xiTsonga speakers, 4 siSwati speakers, 4 siPedi speakers, 9 English speakers, and 12 Afrikaans speakers. Table 2 details the age, sex, language, racial and residential demographic break down of each of the participants.

TABLE 2: DEMOGRAPHIC BACKGROUND OF INTERVIEW PARTICIPANTS

Participant #	Sex	Age group (years)	First Language	Race	Location
1	Male	18-24	isiXhosa	Black	Grahamstown (rural)
2	Male	18-24	isiXhosa	Black	Grahamstown
3	Male	25-55	isiXhosa	Black	Grahamstown
4	Male	25-55	isiXhosa	Black	Grahamstown
5	Male	25-55	Afrikaans	Coloured	Grahamstown
6	Male	25-55	Afrikaans	Coloured	Grahamstown
7	Male	25-55	English	Asian	Grahamstown
8	Male	25-55	Afrikaans	Coloured	Grahamstown
9	Male	55+	English	White	Grahamstown
10	Male	55+	isiXhosa	Black	Grahamstown (rural)
11	Female	18-24	Afrikaans	Coloured	Grahamstown
12	Female	25-55	English	White	Grahamstown
13	Female	25-55	Afrikaans	White	Grahamstown
14	Female	25-55	isiXhosa	Black	Grahamstown
15	Female	25-55	isiXhosa	Black	Grahamstown (rural)
16	Male	25-55	isiXhosa	Black	Cape Town
17	Male	18-24	isiXhosa	Black	Cape Town
18	Male	18-24	Afrikaans	Coloured	Cape Town (rural)
19	Male	25-55	Afrikaans	Coloured	Cape Town
20	Male	55+	Afrikaans	White	Cape Town
21	Male	25-55	English	White	Cape Town
22	Male	18-24	Afrikaans	Coloured	Cape Town
23	Male	55+	Afrikaans	Coloured	Cape Town
24	Male	18-24	isiXhosa	Black	Cape Town
25	Male	25-55	isiXhosa	Black	Cape Town
26	Female	25-55	Afrikaans	Coloured	Cape Town
27	Female	55+	Afrikaans	Coloured	Cape Town (rural)
28	Female	25-55	English	White	Cape Town
29	Female	25-55	isiXhosa	Black	Cape Town
30	Female	55+	isiXhosa	Black	Cape Town (rural)
31	Male	18-24	isiZulu	Black	Pietermaritzburg (rural)
32	Male	25-55	isiZulu	Black	Pietermaritzburg
33	Male	25-55	isiZulu	Black	Pietermaritzburg (rural)
34	Male	55+	isiZulu	Black	Pietermaritzburg (rural)
35	Male	18-24	seSotho	Black	Pietermaritzburg
36	Male	25-55	seSotho	Black	Pietermaritzburg
37	Male	25-55	English	Indian	Pietermaritzburg
38	Male	55+	English	Indian	Pietermaritzburg
39	Male	18-24	English	White	Pietermaritzburg
40	Male	25-55	Afrikaans	Coloured	Pietermaritzburg
41	Female	25-55	isiZulu	Black	Pietermaritzburg (rural)

TABLE 2: DEMOGRAPHIC BACKGROUND OF INTERVIEW PARTICIPANTS

42	Female	25-55	isiZulu	Black	Pietermaritzburg
43	Female	25-55	Afrikaans	Coloured	Pietermaritzburg
44	Female	18-24	English	Indian	Pietermaritzburg
45	Female	25-55	seSotho	Black	Pietermaritzburg
46	Male	18-24	isiZulu	Black	Johannesburg
47	Male	25-55	isiZulu	Black	Johannesburg
48	Male	18-24	sePedi	Black	Johannesburg
49	Male	25-55	sePedi	Black	Johannesburg
50	Male	25-55	seTswana	Black	Johannesburg
51	Male	55+	seTswana	Black	Johannesburg (rural)
52	Male	25-55	seSotho	Black	Johannesburg
53	Male	25-55	English	Indian	Johannesburg
54	Male	18-24	Afrikaans	White	Johannesburg
55	Male	18-24	English	White	Johannesburg
56	Female	55+	English	White	Johannesburg
57	Female	25-55	isiZulu	Black	Johannesburg
58	Female	18-24	seTswana	Black	Johannesburg (rural)
59	Male	18-24	isiXhosa	Black	Coffee Bay (rural)
60	Male	25-55	isiXhosa	Black	Coffee Bay (rural)
61	Male	55+	isiXhosa	Black	Coffee Bay (rural)
62	Female	25-55	isiXhosa	Black	Coffee Bay (rural)
63	Female	55+	isiXhosa	Black	Coffee Bay (rural)
64	Male	18-24	seSwati	Black	Nelspruit (rural)
65	Male	25-55	siSwati	Black	Nelspruit
66	Male	25-55	Afrikaans	Coloured	Nelspruit
67	Male	18-24	xiTsonga	Black	Nelspruit (rural)
68	Male	25-55	xiTsonga	Black	Nelspruit (rural)
69	Male	18-24	isiZulu	Black	Nelspruit
70	Male	25-55	seSotho	Black	Nelspruit
71	Female	25-55	sePedi	Black	Nelspruit
72	Female	25-55	seSwati	Black	Nelspruit
73	Female	25-55	xiTsonga	Black	Nelspruit (rural)
74	Female	18-24	xiTsonga	Black	Nelspruit (rural)
75	Female	25-55	seSotho	Black	Nelspruit

To triangulate the data, 10 focus group discussions (FGDS), two in each of the provinces, were also conducted with 8–10 men per group. For each focus group, men from a similar age group and other demographic backgrounds were recruited to participate. Table 3 details the demographics of the focus group participants.

TABLE 3: DEMOGRAPHIC BACKGROUND OF FOCUS GROUP PARTICIPANTS

Focus group #	Gender	Age group (years)	First Language	Race	Site
1	Male	18-24	isiXhosa	Black	Grahamstown
2	Male	25-55	isiXhosa	Black	Coffee Bay (rural)
3	Male	18-24	xiTsonga	Black	Nelspruit (rural)
4	Male	25-55	seSwati	Black	Nelspruit
5	Male	25-55	isiXhosa	Black	Cape Town
6	Male	18-24	Afrikaans	Coloured	Cape Town
7	Male	25-55	isiZulu	Black	Pietermaritzburg
8	Male	25-55	English	Indian	Pietermaritzburg
9	Male	25-55	seTswana	Black	Johannesburg
10	Male	18-24	sePedi	Black	Johannesburg

Participant recruitment

Participants who shared particular characteristics, including age, racial, cultural, urban/rural and gender categories, were selected initially through purposive sampling. The recruitment strategy was as follows: 1) a project information sheet (Appendix 1) was prepared explaining the project, its purposes and uses and the benefits and risks of participating; 2) the information sheet was distributed by the PhD candidate to a community contact at each site (six in total) well acquainted with one rural and one urban community in each province; 3) the contact person was briefed to equip him or her to understand the recruitment needs of the study; 4) the contact person prepared a list of people in the community from a variety of domains who fit the selection criteria and discussed the list with the PhD candidate to ensure that the criteria for selected eligibility were met; 5) the contact person supplied the information sheet to people who met the eligibility requirements of the study; 6) after explaining the study, the contact person asked the selected participants whether they would be willing to participate in the study and could be contacted by the PhD candidate; 7) contact details of persons indicating a willingness to participate were provided to the PhD candidate; 8) the respondents were then contacted by the PhD candidate to confirm their willingness to participate and to set up a suitable time and venue for conducting an interview. Community contacts were developed through two NGOs: Centre of AIDS Development, Research and Evaluation (CADRE) (in Western Cape, Eastern Cape,

Gauteng and KwaZulu-Natal), and Sonke Gender Justice (in Mpumalanga and Western Cape). Community contacts could establish rapport with the interviewees, which was important given the sensitive and personal nature of the topic. The community contact was given R100 (~US$10.00) as a stipend for each participant recruited. To triangulate the purposeful sampling method, snowball sampling was also used to recruit further participants. Snowball sampling is a method in which initial participants recommend further eligible participants for potential study recruitment to the researchers (Browne 1981). An advantage of this sampling technique is that enables the inclusion of otherwise hard to reach participants. It can also reduce the bias involved in relying solely on community contacts for initial potential participant referral to researchers. Nine individuals who had previously shown willingness to participate were contacted but in the end did not wish to be interviewed (7 men of 50, and 2 women of 25). This may demonstrate greater reluctance for men to openly speak about their sexual histories.

Data collection

Data collection occurred over a 16-month period, between August 2010 and December 2011. The PhD candidate conducted most of the interviews with English-speaking women in order to facilitate communication and act as a translator. Among the remaining participants, experienced qualitative researchers were hired to conduct the interviews and FGDs. Appendix 6 details the expectations of the contracted researchers, including conducting the interviews with a non-judgmental approach, and maintaining interviewee confidentiality. The contracted interviewers were trained on how to elicit stories, and encouraged to act primarily as an attentive listener. Interviews and FGDs were conducted in the language preferred by the participants, and participants were paired with same-sex interviewers due to the sensitive nature of the topic. This also allowed for an appreciation of how men and women perform to constructions of masculinity and femininity in dialogue with members of the same sex. Interviewees were given R100 (~US$10.00) as a token of appreciation for their participation. Interviews were conducted in various locations that provided quiet and secure environments, including research, university, and NGO offices. On average, interviews lasted between one and one and a half hours, and FGDs lasted two hours. The duration of the interviews was useful to build rapport between the interviewees and interviewers and is also necessary in narrative research to sufficiently probe the interview topics.

The PhD candidate, in partnership with researchers from CADRE, developed the interview and focus group topic guides (see Appendix 2 and 5 for the interview and FGD topic guide respectively). Interview questions and probes were designed to encourage narratives. When participants gave information about their sexual relationship experiences, the interviewer asked them to elaborate on the circumstances in which such experiences occurred. Examples of the interview questions and probes include "what did it mean to you to have sex for the first time?," "talk about the events surrounding and leading up to that." Interview questions and probes were also designed to elicit attitudes to gender norms and engagement with these, for example: "Do men and women have different thoughts about the connection between love and sex?", "What makes you say this?", "Tell me stories that illustrate what you mean?"

Interviews began with accounts of early knowledge of sex and sexual experimentation, and explored the range of sexual relationships and experiences as well as reproductive health choices through adulthood. Risks of acquiring HIV infection and other sexually transmitted infections (STIs) and the participants' perceptions of masculinity norms were explored in relation to their own sexual experiences. Although all participants identified themselves as heterosexual, heterosexuality was not assumed as the norm for the questions around sexual debut and relationships. Rather, the questions were open-ended, which allowed participants to speak of same-sex relationships spontaneously if they so wished. The interviewers listened for content and meaning and asked participants to explain or elaborate on their responses. Socio-demographic data, including gender, age, current occupation, and where the participant grew up, was collected prior to the interview. All interviews were tape-recorded and then transcribed verbatim by the PhD candidate. The interviews not conducted in English were transcribed in their original language and then translated into English by a contracted researcher. The interviewers recorded notes on contextual details and non-verbal expressions immediately after each interview, which were also used for the analysis.

Data analysis

The data were analysed using both a narrative and thematic approach, which were both essential to address the research questions. A narrative analysis was done to assess how individuals

uniquely engage with gender norms and SRH, how this could change over time. A thematic analysis was done to extract key themes and compare the participants' attitudes and behaviours regarding masculinity and SRH. Using two forms of analysis provided a richer and triangulated set of data and enhanced credibility of the findings.

Narrative analysis

A narrative analysis not only pays attention to process (why a story has been told in a particular way), but also accounts for content, with a particular focus on the use of discourse based on the premise that language is not neutral but constitutes a particular worldview. Language reveals how individuals draw upon cultural and social resources to perform to a certain identity (Parker 2000) and how people categorise and label things and people (Foucault 1979). The language individuals use to describe themselves and others also partly assert their gender identity (Foucault 1979). A narrative analysis is interested in assessing the aim of an individual's story, and was used in this study to assess how men and women used language to 'perform' to gender norms and construct gendered identities. Key phrases that reflect dominant norms of masculinity and performances and constructions of a male identity were identified. Narrative analysis was used to highlight the values expressed or implied in the data including how the men and women valued and made sense of their sexual debut, and their sexual relationships. A narrative analysis is interested in how participants impose order on their experiences to make sense of events and actions in their lives, thus the analysis also examined the sequencing of themes within narratives (Bauer and Gaskell 2003). For this study, the participants' narratives were constructed as a temporal sequence of events in three parts and subsequent division of the thesis: 1) early awareness of sex and sexual debut experiences, 2) management of sexual relationships, and 3) management of SRH, including HIV risk, analyzed as case studies. Within each narrative element, shared concepts and themes were identified.

Thematic analysis

Thematic networks reveal prominent themes in a text at different levels (Attride-Stirling 2001) and so provide a rich, detailed and holistic account of the data (Braun and Clarke 2006). Thematic analysis was conducted using NVivo 10 software for qualitative data management, which ably assists with managing a large data set (QSR International 2010). The PhD candidate first immersed herself in the data to identify patterns. After carefully reading the transcripts, a

preliminary coding structure was established to analyse the data systematically. In this process, the PhD candidate analysed the responses to the research questions and mapped out the most important constructs shaping the participants' responses. The PhD candidate deliberately worked to bracket assumptions and so to build an inductive understanding of influences that might have shaped the participants' experiences. This ensured identification of themes that had not been anticipated during the background research. Coding was regularly discussed between the primary researcher, researchers from CADRE, and the contracted researchers (who conducted the interviews) for the sake of conceptual alignment on existing and emerging codes. Once all the text segments were given basic codes, the codes were organised into basic themes by allocating similar words or codes together. Some new basic themes were created during this process, which required continually going back to the text to select relevant latent meanings in the text. The data were reviewed for major trends, crosscutting themes were identified, and issues for further exploration were prioritised before the final analysis. An overall interpretation of the findings of the study was formulated, showing how thematic areas relate to one another and explaining how the network of concepts respond to the original study questions.

Ethical considerations

Ethical approval to undertake the study was obtained from the Research Ethics Committee in the Faculty of Health Sciences at the University of Cape Town (REC REF 115/2011), and from the Human Sciences Research Council (REF 3/23/06/10). Before each interview, informed written consent was obtained from the participant in adherence with the ethical approval guidelines given by the review boards. Information on the aims of the research and what would be expected was provided to all participants before being contacted by the PhD candidate to participate. Before the interview itself, the possible risks and benefits of participating in the study were discussed with each participant. It was also made clear that participants were free to withdraw from the study or chose to not answer certain questions, at any time and without penalty. Interviewees were informed that their answers were anonymous and confidential, and, if they agreed to participate, the interview would be digitally recorded and non-identifiable data would be used for a PhD dissertation. After each interview, participants were given a chance to ask questions and provide feedback. The participants were given a copy of the informed consent form with the contact details of the PhD candidate should they have questions or concerns to

discuss afterwards. Opportunities for debriefing and for participants to express any concerns following the research were provided given the sensitive and personal nature of the interviews.

Confidentiality and anonymity have been ensured in the following ways: all interviews were digitally recorded, no names were attached to the transcripts, and the participants are identified by pseudonyms in the dissertation and any other publications. The participants were assured that for all forms of dissemination, including publication and conference presentations, participants in the research would not be identified by name. Transcripts were kept confidential on the PhD candidate's computer with a secure password. Only those involved in the data analysis reviewed the data collected and managed. Digital recordings were erased once they had been transcribed so as to minimise the possibility of identifying participants.

The position of the researcher

Qualitative researchers cannot be detached and unaffected by their own experiences and values, which influences the data collection, particularly when using life histories which are communicated to and affected by the researcher. However, by being conscious of their subjectivity, qualitative researchers can better understand and limit their impact on the research process and interpretation of the findings (Ulin, Robinson and Tolley 2005). This is especially important to enhance the credibility of qualitative research where the "researcher is the instrument" (Patton 2002, p. 14).

As the primary researcher, the PhD candidate was aware of her identity as a white, middleclass, urban, Canadian female exploring the experiences of South African men and women from a variety of racial, cultural, economic and geographic backgrounds. As a result of this position, the PhD candidate most likely was perceived as an outsider by the participants, which may have limited the openness of responses about sensitive topics. At the time of the interviews, however, the PhD candidate had spent a few years in South Africa as a researcher engaged in gender and HIV issues, which enabled a level of insight and familiarity with the issues at hand. Moreover, participants may be more open with a foreign individual for being perceived as a 'safe space' or because concepts inherent to cultural understanding need to be explained in greater depth. This can lend to additional perspectives and rich data regarding social and cultural norms. To

minimise a biased interpretation of the findings, the PhD candidate checked whether she sufficiently maintained distinction between her own and the participants' ideas by opening the analysis process to inspection and verification by other South African researchers (from the NGO CADRE, and the contracted interviewers). The triangulation of the data analysis enhanced the credibility of the interpretation of the data, and overall rigour of the study. Checking the narratives for inconsistency and incoherence was done to account for how the narratives may have been influenced by the relation between the interviewer and the interviewees. Additionally, the PhD candidate aimed to be sensitive about social and cultural norms in the analysis and presentation of the findings, and to be self-critically aware of her position in presenting this research. This is particularly important given the inevitable power relations in research representing others' sexual narratives and because of the different demographic and social profiles of the PhD candidate and the participants. Moreover, since some research in the area of HIV and sexualities has tended to 'other' and demonize African sexualities and poor, black men in particular (Morrell, Jewkes, Lindegger and 2010), it is necessary to be critically aware of and reflexive of such dynamics and representations. This study interviewed a range of participants from different socio-cultural and geographical settings and hence avoided a predominant focus on African men's sexuality.

Limitations of the research

Reports of sexual history are, of necessity, retrospective and subject to problems of recall and faulty memory, which may have affected the reliability and validity of the narratives, although this is not a particular disadvantage to this approach only (Ojermark 2007). It is also possible that some men and women denied or minimised the effects of traumatic experiences, such as past experiences of sexual coercion. Men and women may also have narrated their preferred identities in response to gendered expectations, such as the higher reported levels of concurrent and casual partners among men than women. While it is impossible to estimate the magnitude of the participants' under- or over-reporting of their sexual behaviour and practices, with narratives there must always be concern about discrepancy between self-reports and reality. For instance, Pettifor *et al*. (2013) found that young women in Johannesburg valued equality and respect in sexual relationships where they had some decision-making power, yet only one-third of the women said they were in a relationship with no abuse or infidelity, and where they used

condoms consistently. As noted in the literature on masculinities, men's dialogues about their sexual behaviour may be more performative than a reflection of reality, and contrast between a *macho* persona and a more anxious and insecure self (Connell 1995; Frosh, Phoenix and Pattman 2002). Recognition of the way participants might use their gender identity to affirm 'appropriate behaviour' were accounted for to understand these biases. Prior experience of working in the field of HIV/AIDS and gender research made the PhD candidate aware of the possibility of eliciting socially desirable responses. Furthermore, the way men and women perform gender norms is insightful to the study objective or revealing socially desirable and hegemonic norms. The study also may be limited from only capturing participant's narratives at one point in time. Through a series of sexual narratives with the same Vietnamese young men more than once, Martin (2010) found that respondents modified their narratives and rejected aspects of previous narratives. If participants were interviewed on more than one occasion for this study, shifting narratives may have also been uncovered. The fact that the data was sometimes gathered in participant's first languages and then translated into English may mean that some amount of translator bias limited the accuracy of the transcripts.

The final data analysis has left aside many elements of the participants' reported sexual experiences that did not contribute to addressing the identified research questions. Thus, the findings must be regarded as limited by the range of biographies covered. The themes presented for discussion deserve more exploration: it is hoped that awareness of the limits of the research will spur further explorations of the complexities of men's sexuality in relation to the HIV epidemic.

Summary

This chapter set out to justify the research design and methods in relation to the inquiry. The appropriateness of a qualitative research design, particularly the value of narrative inquiry, was explored. Major aspects of the data collection process, including participant recruitment, approaches to the data analysis and ethical considerations, were discussed in detail. Reflexivity, a critical component of qualitative research, was also presented, and the steps taken to minimise and acknowledge researcher bias in the data collection and analysis were explained. The

limitations of the study were also presented. The next five chapters present the findings of this study.

CHAPTER 4: GENDERED DIFFERENCES IN THE PARTICIPANTS' SOURCES AND EVALUATION OF INFORMATION ON SEX AND HIV RISK

Introduction

This chapter presents the participant's reported sources of early information about sex and SRH, including HIV, where and how participants obtained such information, and their evaluation of the various sources of information. Such understandings are critical given that acquiring an awareness of SRH, especially knowledge of sexually transmitted infections (STIs), is a first step towards recognising and preventing higher-risk sexual behaviour. The chapter also explores gendered differences in access to and importance attached to SRH information. The narratives highlight how the sources and quality of such information can affect early attitudes towards sex as well as general SRH behaviours. The findings are situated in local SRH communication efforts so that context-specific recommendations can be offered.

Information acquired from family members

Many participants stressed the importance of sex education from family members. While this was often not positively evaluated, there was much concern expressed about the lack of or inadequate familial sex education. This attests to the perceived potential role of familial education.

Minimal familial education

Few participants spoke about getting information about sex or SRH from their parents. Many participants felt they were unable to be open with their parents, which included not seeking sex education from their parents and not being honest about the extent of their own sexual activity. Several men lamented the poor involvement of their fathers, who were said to be particularly unengaged in SRH communication. One man bemoaned the lack of a father figure in his life and believed that with the active involvement of a father, he would have waited longer to have first sex and would more likely have practiced safer sex:

> Number one, I didn't have a father figure. I believe that if a person had an opportunity whereby their parents would be sitting down with you at a certain age and telling you that there is something

> called sex, and one, two, three would happen in your life and these changes need to happen, you don't have to rush these things because there are consequences, I don't think I would be the person I am today. But because we learn a lot of things by mistake, and you learn them by yourselves and you get pressure from friends, there is no person telling you 'this is the reality.' I didn't get those lessons. (JNB M BLACK ISIZULU 18-24)

Many participants said they grew up without a father, and participants who had lived with their fathers often portrayed them as more unapproachable than their mothers regarding sexual matters. Several participants explained that it was culturally taboo in African families for parents to discuss sex with their children:

> For us blacks it's difficult for our mother to talk to us about that stuff; it was more taboo to talk about. Maybe they felt like they were giving us permission or a go-ahead to go do it. Maybe we will want to experiment or stuff like that, I don't know. But for them it was quite difficult. Even when I started menstruating, it was difficult for me to say 'Mom, there is something coming out. (NELS F BLACK XITSONGA R 25-55)

Rural communities were described as particularly conservative and not conducive to open communication about sex and its consequences, including STIs and pregnancy. Other participants discussed how young people could be encouraged to rebel against parents who refused to discuss sex with them:

> My parents were very strict. So I sometimes wanted to get out of that. They didn't want to talk to us about sex or anything. They don't teach you anything about this and this, no. (NELS F BLACK SEPEDI 25-55)

Regardless of culture and environment, the data overwhelmingly highlight the extent of poor communication between parents and young people around SRH topics. Several participants recalled hiding their first sexual relationships from their parents for fear of the consequences should they become aware. Some participants said their parents would become extremely discouraging or even aggressive if they brought up the subject of sex, which effectively prevented further enquiry. This was particularly the case among women, who more often related having their sexuality regulated by their parents than the young men did. For example, one woman said:

> But I didn't talk to her about it because, ya know, in the coloured community if you go to your parents and talk to them about that it's like you're just telling them to piss off. Cause they would go ballistic on you. They wouldn't talk to you about sex. If you asked them about it, they would say

> they don't know. So don't ask them about those questions. (GTOWN F COLOURED AFRIKAANS 25-55)

Another woman said she hid indication of her sexual activity from her parents because she would have been threatened or even beaten for being sexually active:

> You worry what your parents have to say; you will get home, you will get smacked, whatever, you get a backhand, whatever you did, you will get sworn at. But at that time you say [to yourself], listen, it felt good. At that time, I thought it was love; but when I think of it now it was just sex and experience. There was not much difference from the first one [sexual experience]. Except for this one, I didn't hate myself. Ultimately, it did stop after my uncle found out about it and I was beaten up by my uncle. (GTOWN F BLACK ISIXHOSA R 18-24)

This excerpt makes explicit the conflict between the attitudes of the young woman's family members and her own feelings towards her sexual activity. Although she stopped feeling guilty about engaging in early sexual activity, she also felt compelled to end the relationship after being beaten by her uncle. One woman said her father forbade her to date in school; thus, she subsequently kept him 'in the dark' about her relationships:

> My situation was I went to an all-girl school and I had a dad who was very overprotective and so I wasn't allowed to date in school. I kept him in the dark, definitely. (CPT F WHITE ENGLISH 25-55)

Another woman recalled hiding her sexual awareness from her parents; her lack of sexual-health information meant she was unaware of how to prevent pregnancy:

> We weren't allowed to talk about it [sex], unfortunately not, because our parents were very closed-doors and were very old fashioned. They weren't open-minded. They never encouraged us to participate in any discussion when it came to sexual intercourse. We would discuss it amongst our friends, yes, but at the same time we were told our parents would know if we had sex. So even though you would kiss, we were told 'listen, once you lose that shine, your parents know you've lost that shine.' So we tried to keep ourselves [virgins] 'til a certain time, maybe until about 17, 18 — but then you were in matric…and you are ready for varsity or something, and then you realise, okay, I can do this thing, so what? I mean I'm a big girl, hoping that you don't fall pregnant — that's the risk, basically. (PTZB F COLOURED AFRIKAANS 25-55)

One man first learned about sex by witnessing the act, although his parents reportedly never discussed sex with him. This experience reportedly shocked and confused him:

> I was 14 years old when I was exposed to sex when I saw adults doing it. I was visiting my friend and obviously I knocked and there was no response, so I just opened the door and then I saw

> people having sex. I was shocked. I saw two people naked and I didn't know adults just got naked like that, a female and a male.... I closed the door and I ran away. (JNB M BLACK ISIZULU 18-24)

Poorly evaluated familial education

Some participants reported receiving sexual education from their parents, yet poorly evaluated it. This familial education was often authoritative, didactic and did not involve open discussion. There was much description of how parents would attempt to regulate participant's sexual activities, which often seemed oppressive and coincided with a lack of openness about sexuality and relationships. Although one participant was instructed by her family members to not get pregnant, was given limited information about sex itself:

> I was brought up in a very rural community by a very strict person, a disciplinarian, my grandmother, as well as other community members, elderly members, who would tell me that [if] 'you engage in sex, you are going to have a baby. You have a baby, you are very young, it means you are not going to proceed with your education.' That was my biggest fear about it. I didn't know how it really was, painful or not, besides getting this information from the other girls at school. (CPT BLACK F ISIXHOSA 25-55)

Many young women recalled being told not to engage in any sexual activity to prevent pregnancy, particularly once they began menstruating, but were not adequately taught how pregnancy occurs:

> My mom used to frighten us! 'Don't play near boys, they will make you pregnant.' And the thought of boys making me pregnant just freaked me out. I thought that even if a boy touches me, if he wants me to be pregnant, then I can be pregnant. I only realised that, when I was 15 or 16, that you can only get pregnant when you actually sleep with him…my mom…wasn't explaining to me properly about sex. (NELS F BLACK XITSONGA 25-55)

> My mother said, 'Do not let men touch your breasts because you will probably get pregnant'; that's what we were told.' (PTZB F COLOURED AFRIKAANS 25-55)

Another woman discussed how at the onset of menstruation, her grandmother told her to no longer play with boys, to prevent pregnancy:

> When we first started menstruating, Ouma [grandmother] said 'when you menstruate you don't touch a boy!' In my frame of mind, I thought you don't touch him, because if you touch him, you're going to fall pregnant [laughs]. (CPT F COLOURED AFRIKAANS 25-55)

One woman (PTZB F BLACK ISIZULU 55+) said she was told to engage in sex between the thighs[8] as an acceptable sexual practice for young women, yet she felt unwilling to do this. This practice nonetheless indicates that traditional culture can also encourage a certain degree of sexual activity.

Many participants mentioned their frustration with parental rules about having sex as adolescents, and how this could impact their relationships. One man said the limitations on the evening movements of his girlfriend, enforced by her parents, encouraged him to seek out other sexual partners on the nights she was not available:

> Her parents were strict; she would only sleep over on Saturdays, and at times on Fridays I would go out with my friends; and in these places that we go to there are many girls, without you having to propose, the girl, she is already interested. (CPT M BLACK ISIXHOSA 25-55)

Some participants reported engaging in their early sexual relationships secretly, subverting their parent's rules. One woman recalled how this added to the excitement of meeting with her boyfriend:

> [My parents] actually went to Mass every Sunday and they said [sex] is wrong. So we went on our own and we did it *stilletjies* [on the sly]. So we did it without anybody knowing, but it was really exciting, I think. (CPT F COLOURED AFRIKAANS 25-55)

One woman (CPT F WHITE ENGLISH 55+) recalled how her mother told her there were 'the good-time girls' and 'they were the ones who never got married.' The participant described herself as falling away from being 'the good little X' and later enjoying being 'a good-time girl' — suggesting an act of rebellion.

Positively evaluated familial education

A few participants reported a strong appreciation of learning about sex and sexual health from their parents. They reported that learning about the consequences of having sex resulted in them being more equipped to protect themselves from STIs and teenage pregnancy. More women reported having received SRH information from their parents than the men, primarily from female relatives. One participant recalled that her mother encouraged her to always use condoms after her older brother died of AIDS:

[8] Sex between the thighs, known as 'ukosoma' is a traditional Zulu practice which is meant to allow sexual experimentation for young people without the risk of pregnancy.

> My mother always tells me to use condoms because of it. Even now, my mother says that, because my brother got sick. My younger brother and my mom think it's also the HIV. (NELS F BLACK SISWATI 25-55)

A few women reported being taught about sex, pregnancy or contraceptives by a grandmother or aunt rather than a mother. One participant said her grandmother became comfortable discussing contraceptives with her after her grandfather died:

> After my grandfather passed away in June…she wanted me to go for contraception. Her point was I am not going to tell her when I started sleeping with my boyfriend, so I started then. (CPT F BLACK ISIXHOSA 55+)

One woman recalled how she discussed safer sex with her niece who had become pregnant at the age of 14 because she had no knowledge of the consequences of sex:

> I was so shocked when my niece, who was 14, was pregnant. I was shocked! She's my younger sister's daughter. My sister was like 'no way are you going to have this child.' And they were like 'what were you thinking?' [My niece said] 'Ah, I was just tasting!' Tasting what?! I told her the next time you do it, use condoms. Cause right now there is a whole lot of things — HIV, STIs. She has to be safe. (NELS F BLACK XITSONGA 18-24)

One young woman said her father told her to withhold sex and 'keep her legs closed' in order to keep men 'interested' in her. She described how in some sexual encounters, she would delay penetrative sex, for example, by not removing her underwear, believing this would keep a man interested in her:

> Looking back on this now, after my dad told me what he told me about 'keeping things interesting' — I was hooking up with this guy…and he's quite a man-whore, and the first time we hooked up we were both completely drunk and I wouldn't even let him take my underwear off — I just decided it's just, you know — sleeping with guys doesn't get you what you want. (GTOWN F WHITE ENGLISH 25-55)

This suggests an attitude that withholding sex is a way to retain a man's desire, and detracts from the notion of women's agency and desire to initiate sex. Yet for this participant, these learned values were understood to be empowering and a tool of negotiation in relationships.

Hardly any men recalled receiving SRH information from their parents, but those that did highly valued this. One man said he had felt more comfortable asking his mother questions about sex because she was a nurse and had informed him that he could ask her questions related to sex:

P: Eventually I went to my mom and said to her, 'One of the kids at school brought this topic up, and, what is this?' And, she actually went about explaining — she sat me down and explained to me: sex, male/female, and that's how they go about making babies.

I: And what did you feel like as she explained it?

P [laughing]: Well, not having anyone else to go to at the time, um, it had to be my mom. But I was kind of embarrassed, speaking to my mom about that for the first time. But I remember that she, being a nurse, she had a little booklet lying around the house, and she said to me that 'I've explained it to you, in a way that hasn't made you feel too uncomfortable, or myself, so here's the book, and if you have any other questions, you know, just ask. (GTOWN M WHITE AFRIKAANS 25-55)

There was some discussion about how the seriousness of the HIV epidemic now compels parents to be more open with their children about SRH:

In these days we can talk to our kids...and they know that if you have sex you will be affected by HIV, you must use condoms, you must do this and that. Even last Saturday we had all organised a day for girls and boys. It was Women's Day, and children were taught about falling pregnant, how they are [infected] with HIV. One girl was bold enough to stand in front of that audience and narrate her story that she is nine years affected by HIV. She is about 30. (CPT F BLACK ISIXHOSA 55+)

One 46-year-old woman said she would have regular discussions with young people, including her own children, about the importance of practicing safer sex:

I tell everybody, I even tell my kids, I tell my son as well. I gave my daughter a condom and I said, 'Please keep two in your pocket. Use one; always make sure you have two in your pocket.' I tell my son, 'Keep one in your wallet'…. I make him aware of it. (PTZB F COLOURED AFRIKAANS 25-55)

One 52-year old woman, who did not receive SRH information from her parents, recalled how encouraged she felt once her own son was comfortable enough to ask her questions about sex:

He says 'when I see a girl, then I get excited,' and I said it's all part of growing up, my child. So I went to the library and I took out books for him and he's so interested in that. To think that he could come to me and ask me something like that, it's really good. (CPT F COLOURED AFRIKAANS 25-55)

An older man discussed the importance of parents informing their children about the need to practice safer sex:

> I always tell my son he must use a condom. Us, as old people, we must motivate the young people to use these things. (CBAY M BLACK ISIXHOSA 55+)

Religious values as guidance

Several participants reported to learn about sex through religious institutions and values. These religious values about sex were most commonly Christian and in this study, manifested in beliefs in no sex before marriage, and disapproval of certain sexual practices including masturbation and pornography.

Positive evaluation of religious sexual education

Some participants highly valued religious sexual education for being the only venue where adults taught them about sex, and acknowledged them as sexual agents. Religious education was generally said to acknowledge the pressure young people experience to engage in sex and for some participants, helped counter such peer pressure to be sexually active:

> They teach you not to have sex until you get married. To me, the Church was good, by that time, to tell us not to have sex. Because of friends, ya know, are telling you to do bad things. (NELS F BLACK SISWATI 25-55)

One young man said that sex within marriage is the only 'suitable' form of sex, which he reportedly learnt from church. He discussed how society does not support such values, particularly among men:

> In the situation where you are happily married, then it becomes suitable for society, or suitable for a man and a woman to make love, to show love, when you are married. But outside of the marriage, I don't think we can still say by having sexual intercourse I'm showing my partner love. So society takes that and just tries to shift and twist it so that they can benefit, especially guys. Guys, and young guys like us, we are doing this thing day by day. So yes, I think it's not supposed to be like that, but society makes it suitable and now…you don't even have to ask a lady anymore outside of marriage. (CPT M COLOURED AFRIKAANS 18-24)

This participant was critical of his peers for engaging in premarital sex, and of this general trend in society. He used a religious value system as a resource to act against the norms of his peer group and so exerted agency to make his own sexual decisions. Another young man (JNB M WHITE ENGLISH 18-24) said the values around sex and relationships that he learned in church encouraged him to treat women with respect, causing him to feel regret for sexually objectifying women and pursuing sex with multiple partners.

One woman discussed appreciation for her pastor for being one of the only adults to openly discuss sexuality with young people. She also reported how the pastor's messages encouraging sex for marriage could help young people resist peer pressure to have sex:

> I love that pastor. He was open to us about sex. Remember, we were teased at that time. And he would tell us sex before marriage is a sin. (NELS F BLACK SESOTHO 25-55)

Critiques of religious sexual education

Several participants also critiqued religious sexual education. The most commonly given limitation was that religious education tends to promote abstinence and 'shut down' all other forms of sexual expression:

> The same old story is being taught — no sex before marriage. But where religion lacks is they don't teach people substitutes for sexual needs. They shoot down every sexual thing — masturbation, pornography, and the physical act of sex. They shoot them all down. As far as I understand, the Bible only talks about the physical act of sex after marriage. Anyway, they take out one aspect without feeding the other, the control issue. If sex is taken away or even absent, the other aspects — understanding, communication, openness, intellectual compatibility — become way more important, and religion does not do enough to promote those other aspects. That is where religion bites the bullet or doesn't meet the requirement. (CPT M COLOURED AFRIKAANS 25-55)

One participant discussed how religious sexual education failed to educate young people how to protect themselves from rape and HIV:

> The only thing is, looking back, they didn't talk about protection or rape, or how to protect from HIV. No, they didn't tell us about that. (NELS F BLACK SESOTHO 25-55)

One participant (JNB M BLACK SETSWANA 55+) discussed his belief that no form of sexual education should be provided to young people for being a sin, and for inciting sexual curiosity and desire.

Some participants referred to the sexually repressive role that religious influences played in their lives including feeling guilt and shame about having sex before marriage. One man reported how such guilt compelled him to hide his sexual activity from his parents:

> At the time, you couldn't tell anyone. We were very young, so we hid it; sometimes you are afraid, you wouldn't tell our parents or anyone. You know you've done a sin. Done something wrong. So you couldn't tell anyone. (GTOWN M BLACK ISIXHOSA FG 25-55)

Women reported experiencing more pressure from the church to retain their virginity for marriage than men. For instance, one woman noted how the meaning of womanhood in her religious community was intimately tied to virginity:

> I was raised in a Christian family where to be a woman meant growing up, getting married, not having sex before wedlock. I rebelled from all this because I saw the world through different eyes and was exposed to different things, having friends from different backgrounds. I wouldn't say it was pressures, but just me being curious and wanting to know what it felt like. But I went to it with open eyes. But having knowledge I have right now, I wouldn't have done it then. (GTOWN F BLACK ISIXHOSA 25-55)

Indeed, more women than men expressed guilt for premarital activity, which conflicted with religious education:

> When I was finished, I felt guilt. I thought this think is wrong. It was illegal. I heard 'no sex before marriage' at church. At church they always preached that — no sex before marriage. (CBAY F BLACK ISIXHOSA 18-24)

School based sexual education

School classes— namely classes in Biology or Life Orientation, which is a mandatory part of South African education — were a source of SRH information for many participants.

Positive evaluations of school based sexual education

Some participants spoke highly of the sex education they had received at school and how it motivated them to practice safer sex:

> "We were told about HIV/AIDS very briefly in primary school, but it was only in high school during life orientation sessions we were explained what HIV/AIDS really is about. How you can contract it and what the consequences are if you do have it. A lot of the guys were shocked but it did make me aware to practice safer sex." (GTOWN M ASIAN ENGLISH 18-24)

This disputed the notion that having sex education from a young age makes one more likely to become sexually active earlier. One man said:

> I was young at the time; sex to me was something I did not know. But the idea of people coming and telling me about STIs, it made me aware that there are diseases out there. But it didn't make me active to sex or something. (GTOWN M BLACK ISIXHOSA 18-24)

Some participants reported learning how to prevent unwanted pregnancies from school-based sex education:

> They come with this Life Orientation where they started to teach much in saying there is a difference between a male and female. And this is gender, and sex is this, because we are differentiating between our private parts. So this shows this is a man, this is a woman, and when they engage, then a baby can enter and move out." (NELS M BLACK XITSONGA 25-55)

Another man discussed how learning about the biology of sex from school equipped him to better understand human sexuality:

> At the age of 10 in school, I learned about the vagina and a woman's system and periods. I learnt about those things and I put two and two together from learning about it in school that is what parents do when they lock the door. (CBAY M BLACK ISIXHOSA 18-24)

Negative evaluations of school based sexual education

The majority of the participants, however, did not highly value the sex education they received in school. Several participants discussed learning about biological sexual reproduction and functions in school to the neglect of other aspects of sex, including sexual desire, sexual consent, and practicing safer sex. One young man discussed how life orientation classes provided limited information and that he had learned more about sexual health from a friend who had had a STI than he did from school:

> In Standard 5, at the time we already understood these things, but even though it was not that much, simply through booklets, of course. You would have those classes at school, health classes, sometimes, even if you are going to the clinic, but to actually experience it through the person next to me, when I was 17, to actually see — to put it bluntly — a penis after being infected by an STI, it was something that I must not see at all, and it's something that I have always prayed to not come across it. (PTZB M BLACK ISIZULU R 25-55)

Some participants expressed concern that Life Orientation classes aim to generate fear among young people, and so create a closed and hostile environment about sexuality. For instance, one woman recalled how much of the information about sex that she received in school carried 'doomsday' messages that frightened young people into adopting behaviours in order to avoid dying. She suggested that sex education should instead be accessible, positive and supportive:

> Maybe there's a way of the education just going like, 'Hey guys this is what goes on, this is what you might come across, this is what you might feel, this is what you might feel uncomfortable with, this is what you might feel that you want to ask and that you don't know or that you can't ask or whatever.' Create that kind of support system rather than a 'do it to avoid something,' I think, that

would have been, that for me, I think, would have been really great to do. (CPT F WHITE ENGLISH 25-55)

Moreover, some participants, particularly those in rural areas, did not receive any sex education at school. One woman, who became pregnant as a teenager, stressed that the Life Orientation classes should have taught her how to prevent pregnancy:

> I grew up knowing my mom bought the babies. That's what they tell us. There are many things we were supposed to learn in school, but it was bad. Like, if I knew how to protect myself from being pregnant, it would never have happened. (CBAY F BLACK ISIXHOSA 25-55)

Another man, who went to school in the more urban location of Grahamstown, recalled how there was no sexual education at his school:

> P: No, none of the teachers spoke to me about it….
>
> I: So there was no sex-ed or anything at school?
>
> P: No, absolutely nothing; my sex-ed came from home, basically, with my mom being a nurse. (GTOWN M WHITE AFRIKAANS 25-55)

Information acquired through the media

Learning about and desiring sex through television

Many participants, particularly young men, discussed how they were first exposed to sex through television, which often awakened the desire for sex. One man's answer to the interview question 'How did you first become aware of sex?' was:

> P: Probably movies, the first time. I remember the first time I saw boobs on TV [chuckles]. Like action movies with lots of nudity.
>
> I: What were your thoughts then, the first time you had seen boobs on TV?
>
> P: I wanted it [laughs]. It wasn't really a hush-hush thing, especially with my family. I mean they let me watch some things and stuff, but, ja, it was just something that I needed to explore. (JNB M WHITE ENGLISH 18-24)

Another concurred:

> There used to be a TV program called Emmanuelle[9] that used to play at about 1 am…and seeing this show and also hearing from friends who said it's nice, it got me interested. (CPT M BLACK ISIXHOSA 18-24)

[9] Emmanuelle is the lead character in a series of French soft-porn movies based on a female character created by Emmanuelle Arsan in the 1959 novel *Emmanuelle*.

One participant said that television shows were one of the 'biggest external factors' (GTOWN M BLACK ISIXHOSA R 18-24) that had influenced his early views on sex. He recalled watching television as a child and seeing people kissing and how he thought this was 'sex.' He said this further taught him that there was 'no sex without going under the blanket with a person.' The disjuncture and subsequent misunderstanding of sex lies in the fact that this participant's parents evaded sex education, yet allowed him to watch unsupervised television programs with sexual content.

Young people's exposure to sex through television could also encourage parents to be more open about sex with their children:

> Parents, they were not open about sex. Ya, they were the same, but now the children know because a lot of things are happening in front of them. They [are] watching movies, they are watching TV. Even at home, their parents are now telling them about it. (PTZB M BLACK ISIZULU 25-55)

Some participants valued television programs for SRH communication content. Television could personalise and contextualise HIV-risk scenarios in a persuasive manner. Several participants cited the new drama 'Intersexions'[10]: a television series on HIV risk in multiple concurrent partnerships, as a source of SRH information. One man discussed the powerful message of Intersexions for illustrating how sexual risk behaviour affects not only individuals but also their families:

> Intersexions is running correctly. Because they are showing how HIV goes from older generation to new generation. If they can show that money is not the life, you can live even if you are not working. Don't sell your body because you need money. You are still young. Today I will be here. My grandchildren will be here. But today I am suffering for consequences of what I am done. And myself I am not suffering, but my children or my parents they are suffering from my consequences of mine that I am doing. Today people say you must do things for yourself. But when I get sick, these people, they will be responsible for life. So I need them. I don't say 'everyone for himself.' No, no. (NELS M BLACK XITSONGA 25-55)

Several older participants spoke about how young people's regular exposure to sex on television is a new phenomenon, with previous generations witnessing little sex on television:

[10] Intersexions is a South Africa TV drama series produced by Quizzical Pictures in partnership with John Hopkins Health Education South Africa (JHHESA) and SABC education. The series premiered in 2010 and examines how that which remains unsaid in love, relationships and sex can place individuals at the greatest risk of HIV infection.

> I think in general, it wasn't as open as it is today in magazines, on the television. It was something no one spoke about, and somehow, within myself as a little girl, I got the idea that you don't. Where it came from I don't know, that you don't talk about it. (JNB F WHITE ENGLISH 55+)

One 72-year-old man attributed the closed communication about sex within the older generation to British influence:

> In the last 30 years of course it's changed. We were aware that some countries like France, Holland, Germany, had a totally different view. But our view was probably entirely either from England; England also like Hollywood had the same kind of moral, morality, ya know, you could not kiss longer than 5 seconds or something. The British were Victorian. The English population multiplied extensively under Queen Victoria, but no one ever said they did anything. It was never mentioned. (GTOWN M WHITE ENGLISH 55+)

Limitations of television as an SRH communication tool

Some participants discussed limitations of television as an SRH communication tool. One participant reported how television did not provide opportunities for personal clarification:

> The most effective is mouth to mouth. The TV will tell you this person is not sick, they fake it you see? Workshops initiated by men so that they can be open; men to men are important. They can ask questions, men to men. Making it real. (NELS F BLACK SESOTHO 25-55)

Moreover, television was described as regularly glamorizing sex and often omitted suggestion of condom use in sex scenes. One man said:

> Movies in particular may show a love scene or show the main character getting frisky with his co-stars, but they don't, they will never ever mention HIV/AIDS or allude to the fact that ,yes, we have a persistent threat called HIV/AIDS whenever there is a sexual encounter. (GTOWN M ASIAN ENGLISH 18-24)

Another woman said that television had incited her desire to have sex, but that it also generated unrealistic expectations for her first sexual experience:

> TV and movies, because when you watch these programs and these movies, it's just so, the way they make it seem, it's like it's going to be beautiful, don't worry even if it's really uncomfortable, it's going to be beautiful. And they don't tell you that when you lose your virginity, it hurts like hell. They don't ever tell you that. (PTZB F INDIAN ENGLISH 25-55)

SRH media communication

A variety of media channels including radio, print media, Internet and cellphones influenced participant's perceptions and understandings of sex and SRH. Radio was accessible to most

households, even in rural areas, and was valued as an effective method of SRH including HIV communication. One man suggested that 'maybe every day the radio should play HIV information at the same time so people know when to listen to this information' (NELS M BLACK SISWATI R FG 25-55). Some individuals lamented how radio broadcasts are subject to misinterpretation since there are no opportunities for asking questions.

A few participants cited newspapers as a valuable source of information about HIV prevention:

> I think so far the government is doing well, ya know? Newspapers always have this information. You go everywhere. I think they are doing enough. (NELS F BLACK SESOTHO 25-55)

Several participants, mostly female, described researching sexual health information through print media including books and pamphlets as well as the Internet. A few participants discussed how research into sexuality marked a transition from ignorance and fear of sexuality to understanding and readiness for sexual debut or experimentation. Such research could also equip participants with the knowledge to protect oneself from STIs and unwanted pregnancies. One young woman who was exposed to HIV/AIDS information at school and church, where youngsters were encouraged to abstain and were warned that 'it is not 100% safe to use condoms,' became curious about the credibility of this claim and so did her own research. She discussed how the knowledge she gained from researching the physiology, consequences and risks of sex prepared her for her first sexual experience, including the importance of practicing safer sex:

> [I thought] Let me think about this very hard, cause there's gonna be consequences, and I wasn't even fully aware of what would happen if I did it. I hadn't done any proper research into any side-effects or diseases and stuff. So I read many books about it. I was very eager to know what happens. I think I was 17. So I'm thinking to myself, you know what, they've taught me so much about this, and obviously you have to be safe, and they've done it and their boyfriends are still with them. So let me just try this out and see what happens. (GTOWN F BLACK ISIXHOSA 18-24)

Similarly, another young woman who, on hearing that sex is not the only way to acquire HIV infection, reported that this stimulated her to learn more about what was being said in HIV/AIDS messages. Her first sex was with a condom and she attributed her subsequent regular condom use to 'the core knowledge and education that I got from my AIDS research on how to protect myself.' (GTOWN F BLACK ISIXHOSA R 18-24)

Another woman recalled learning about how to prevent pregnancy from books:

> As you get older you get educated, because remember, everybody comes with this knowledge and you contribute towards a topic. It's not like, that, you won't fall pregnant the first time, but eventually, and of course books as well, you start looking at it and you start realising, hey, hold on, this is not a game to play with. (PTZB F COLOURED AFRIKAANS 25-55)

Similar to television programs, book content was reported to awaken sexual desire among some participants:

> I liked reading a lot of books. Back then there were those books where there are pictures, people talking, and they end up kissing. So some of the things, I learned them there. (NELS F BLACK XITSONGA 25-55)

Print media, including newspapers and books, were said to not always be affordable and/or accessible, especially for those in rural areas where there is generally a higher illiteracy rate:

> Because newspapers, sometimes, they don't even read. Rural villages they don't even read. Cities they have more exposure. They read the newspaper also. They spend more time watching TV. They have Internet. They have so many things compared to rural areas. That information does make a difference. (NELS F BLACK SESOTHO 25-55)

Some of the participants, particularly those in the younger age group, sited the Internet as a valuable source of sexual health information, and mentioned popular channels such as Twitter and Facebook. One man discussed how he actively conducted Internet research around sex after hearing about sex from his friends and wanting to know more:

> And that's why I went to search it on the Internet. I really wanted to know what it's about, what it is. Since I heard from my friends that sex is so nice, I wanted to experience this thing. (CPT M BLACK ISIXHOSA 18-24)

A commonly given limitation of Internet communication was that it is not readily available to everyone, particularly those in rural areas. There was general consensus on the effective use of cellphone health messaging for being accessible to almost everyone:

> Cellphones are the best. I think everyone has got a cellphone. So like it or not, he or she can get a message. Even in these rural areas. (NELS M BLACK XITSONGA 18-24)

Having sexual health questions answered over cellphones was cited as effective because they could allow for personal clarification in an anonymous manner.

The major limitation of cellphones discussed was that not everyone has access to them:

> But for me, I have free line to call HIV and AIDS if there is something you don't understand. What about those who don't have cell phones? (CBAY F BLACK ISIXHOSA R 25-55)

Another participant said it was difficult to know whether cellphone messages are received and it was hard to follow up: 'Because sometimes when you send an SMS, some don't even read it' (NELS F BLACK SESOTHO 25-55).

Some participants said they were unaware of where to access SRH information:

> I'm not one of those responsible people who go looking for that information, I'm sure it's out there, I don't even know where I'd start. I suppose the Internet, maybe, like a government clinic; I don't know that anything like that is at my doctor's surgery. (CPT F WHITE ENGLISH 25-55)

Fewer men than women reported actively researching sexual health information through the media. One man surmised that:

> Women become more sexually aware earlier than men [do] and take the topic of sex much more seriously than we do. (CPT M COLOURED AFRIKAANS 25-55)

Information acquired through SRH campaigns

Several participants stated that multidimensional SRH campaigns were one of the most effective means to impart information on sex and SRH including HIV/AIDS — because 'there, people they do talk truth' (NELS M BLACK SISWATI 25-55). For allowing the target audience an opportunity for personal clarification, campaigns could generate a better understanding of HIV than once-off or one-dimensional communication methods, such as radio, billboards or television, where people may misinterpret the information presented. As one man said:

> People will ask questions seeking clarity, and when you clarify, you will assist more than 150 people who will clarify to each other. (NELS M BLACK SISWATI 25-55)

Several participants said they most appreciated active, dynamic campaigns, including dramas, for generating interest:

> If you put these things on paper, we don't love to read, but we love to see something live. Something moving. Something in action. (JNB M BLACK SEPEDI 25-55)

One man's narrative revealed that educational drama could have influential and lasting outcomes on individuals' HIV-prevention practices:

> Knowing about AIDS at a very young age from school drama performances helped me because it was something that crossed my mind every time I had to have sex. It haunted my mind that if I did not protect myself I could face such difficulties. So I have to make sure that each and every time I have sex with a girl I prevent, I try to protect myself. (JNB M BLACK SEPEDI 18-24)

Several participants attributed gaining information about sex and SRH to the 'loveLife' campaign.[11] They invariably appreciated the campaign's non-judgmental environment around young people's sexuality. One woman said that learning about HIV risk from 'loveLife' was her only source of SRH information and had encouraged her to protect herself and be aware of the health consequences of sex:

> I was 16 at the time. I went to 'loveLife' and they taught me about HIV, about relationships. I didn't even know about it and it wasn't like now, where you can find someone who talks to you and says, 'I am HIV-positive.' In those days, some of them, they didn't have that HIV and AIDS information; it was only at loveLife. But now because of what I learned I am protecting myself. With HIV, it's not that HIV is curable, but the others, I don't want them...I have been to workshops and I have been with loveLife. So I am kind of clear with these things. Very clear. STIs, HIV and stuff. (NELS F BLACK XITSONGA R 18-24)

Some participants expressed appreciation for the 'Brothers for Life Campaign'[12], which was said to effectively tackle gender norms that can be damaging to men's health by foregrounding how men's sexual risk behaviours can put themselves, their partners, and their families at risk of HIV:

> We are simple. We all care about life. Because life is good. My children or my partner, they must not suffer from consequences of mine that I am doing. (NELS M BLACK SISWATI 25-55)

One man, drawing on the concepts of brotherhood as promoted by the campaign concurred that:

> 'Each one teach one', because you know something, teach me. And then if I acquire that knowledge, I know something. Let myself teach another man. 'Each one teach one' because we want to beat this. (NELS M BLACK XITSONGA R 25-55)

Several women discussed how they appreciated the Brothers for Life campaign for targeting men with HIV prevention:

> One of my favourite ones is the Brothers for Life campaign. Because [others were] always aimed at women to make us more aware of our rights and we should ask the guy, but then I used to always

[11] The loveLife campaign is a national multimedia education campaign which was launched in 1999 with the goal of halving HIV prevalence among young people ages 12–17, within five years, based on a model that addresses the individual, social and structural factors that drive the HIV epidemic in South Africa (Parker 2003). The campaign emphasizes condom use and positive sexuality among youth. The campaign however has been a source of contention. The campaign typically represents young, beautiful, healthy people who are in control of their lives, accompanied by the message 'Love your life enough to not get infected' (see also Thomas 2004, p. 30). The campaign has been criticised for putting too much onus onto the individual and relying on rational behaviour, which fails to confront multiple social and economic factors that determine the spread of HIV. Moreover, critical issues such as sexual violence, cross-generational sex, sex work, and transactional sex were perceived to be neglected (Thomas 2004). By early 2006, the Global Fund for AIDS, TB and Malaria decided to defund LoveLife by $56 million already allocated because after 1999, HIV infection rates rose instead of declined. (Green and Witte 2006).

[12] John Hopkins Health South Africa's Brothers for Life Campaign was launched in 2009 and 'seeks to address the risks associated with having multiple and concurrent partnerships, sex and alcohol ,Gender based Violence and promotes HIV testing, male involvement in PMTCT and health seeking behaviours in general' (Brothers for Life 2013). The campaign draws upon concept of brotherhood and in doing so, recognizes that men's decisions are influenced by their social networks, communities and broader political and societal environment. The campaign rests on a variety of media including television, radio, print and outdoor media. Other activities include advocacy initiatives targeting all levels of government, traditional leaders, civil society, faith based and opinion leaders within communities around social constructions of men, male responsibilities (Peacock 2013).

> have this problem, what about the women in the rural areas? You know they come from a very strict traditional background, you can't tell your husband even though he's come from Jo'burg after four months, you need to use a condom. And what is great about the Brothers for Life campaign is that they're making it about the guy now, his responsibility. So this one I'm really liking because it's finally gotten all the burden off our shoulders alone, and it's onto the guy now as well. He must share it. (PTZB F INDIAN ENGLISH 25-55)

Another woman discussed how she appreciated Sonke Gender Justice's 'One Man Can' campaign[13] for engaging men and taking the burden off of women to prevent HIV transmission:

> When I got here earlier I did see that one advert where they say — they've always left it up to the women, previously, I think...that it's her problem, she's the one who falls pregnant, and also [gets] HIV — and people have always thought 'Well I'm on the pill, so I'm not going to fall pregnant' — they don't think about STIs, HIV, that kind of thing...so it's always been like the women's responsibility — but how it's changed, like I said, that one advert I've seen, 'A real man wears a condom' — so, I think they're making men take more responsibility for it, but I think it's a lot more out there, it's not taboo anymore: you can talk about it now — definitely that's the one thing that's changed. Whereas before you know how I said, it went from just the gays, and then the poorer people, to then 'It's taboo, you don't talk about it,' to now being out there in your face: it's not taboo. (GTOWN F WHITE ENGLISH 25-55)

Limitations of SRH communication campaigns

Some limitations to SRH education through HIV/AIDS education campaigns were also addressed. One man criticised a campaign that encouraged individuals to participate through offering material incentives:

> People were just talking as if they do understand; meanwhile they just want those T-shirts. It was more like a party with no direction you understand? (NELS M BLACK SISWATI R 25-55)

Several participants suggested women were more likely to attend campaign events than men since women tend to be more actively involved in health care activities:

> Healthcare is more to women than men. So when you say, 'Let's go there,' men are going to the shebeen[14], getting drinks. They are not looking after the children. They don't care. (NELS F BLACK SESOTHO 25-55)

[6]Sonke Gender Justice's One Man Can Campaign, promotes among other things, men's involvement as fathers, men engaging in healthy SRH behaviors and standing against sexual violence and frames masculinity as constructed and embedded in local contexts, as situational and fluid (Dworkin *et al.* 2012). They address a variety of issues through the campaign workshops and media including but not limited to fatherhood, medical male circumcion, access to justice, prisons and refugee health and rights.

[14] Informal neighbourhood drinking venue (Betron *et al.* 2009) .

Participants also talked about how men who attended campaign events were less likely than women to be open and seek information. One man said that peer educators should follow up with men in private, afterwards, to address this phenomenon:

> The good thing is that they can find out how many people want to get that information, take it privately and tell them after, you understand? (NELS M BLACK SISWATI 25-55)

Some participants expressed concern that interactive SRH campaigns were less accessible in rural areas. One woman in a rural area of the Eastern Cape explained:

> There are no workshops about HIV up here in the lollies [rural areas]. No workshops at all. But they listen on the television. But I think it's better if someone comes face to face and tells them what happens. So if they have questions they can ask. Cause if they listen to television they don't ask questions they need to know. (CBAY F BLACK ISIXHOSA R 25-55)

Men in rural areas were said to be particularly hard to reach because of the lack of active SRH campaigns. One woman commented on the implications of this:

> Because most of the campaigns happen in suburban townships. Meanwhile those who need the information are in rural areas. They don't have the information, they are clueless. That is still where there is a big problem in educating men in the rural areas also. If you compare them to the men staying in the suburbs or township, it's the culture thing. If you go to areas like KwaZulu-Natal and Nsikazi district here in Mpumalanga, you will understand, oh my god, men are just so arrogant. They still think if you go to the girls they tell you they have a virus; they will tell you, 'No it's not a virus, I know these things, it's just you are bewitched,' or just those African diseases. If maybe you can use more men in these campaigns, it will be better. (NELS F BLACK SESOTHO 25-55)

Pornography based sexual education

Some men recalled being introduced to sex through pornographic films or magazines:

> You know olden days, na? We had, actually it was a kind of porn book where guys take naked pictures of chics, paste it in the book, you page through. This is where it goes in, this is where it happens. Ya, something like that. (NELS M BLACK ISIZULU 18-24)
>
> My cousins introduced me to soft pornography before we entered high school. Soft core of course they don't explicitly show everything. But you can get a good idea from those videos. (GTOWN M ASIAN ENGLISH 18-24)
>
> You know, as technology develops, sometimes we see older guys watching pornography on TV. So you end up being interested. You know as you grow up you develop certain feelings in you. (JNB M BLACK SEPEDI 18-24)

This was less common among the older group of men interviewed, reflective of the fact that pornography was not as readily available to this generation since the Publication and Entertainment Act of 1963 and the Publication Act of 1979 prohibited the sale and possession of pornography (Maitse 1998).

There was much discussion of young men watching pornography in groups of peers and typically masturbating together. One man said his desire for sex was intensified by collectively watching pornographic films:

> Then you watch more and more pornos and look at more and more pornos and, yeah, I can't wait until I get this. You watch it [pornographic films] and your head nearly blows off your penis because all you want to do is do what they are doing on TV. (PTZB M WHITE ENGLISH 18-24)

Another man discussed how his friends used to carry pornographic magazines and would brag to each other about having them:

> Guys used to carry magazines around with them. You know, their father's magazines, they used to have one in their suitcase, and, you know, just brag to their friends, 'Hey, look at this,' you know. (GTOWN M WHITE AFRIKAANS 25-55)

Exposure to pornography was reported to leave many men with unrealistic expectations of sex, causing disappointment and misunderstandings at sexual debut. For instance, one participant said he did not understand why women would agree to sex if it caused them pain (which was inferred in some pornography). After his first sexual experience, however, he realised this was not necessarily the case:

> At first I thought that she was feeling pain because she was screaming and crying. But then later as time went by I realised that it was not that she was in pain, she was in excitement. Because she came back to me and said, 'Let us do it again.' That was where I realised that I was wrong in thinking that I was hurting her. She was actually enjoying, and it is natural. (JNB M BLACK SEPEDI 18-24)

Watching pornography with peers reportedly put pressure on some men to engage in sex in order to prove their manhood:

> At that time, we at home we had television. So they invited me to see it. 'Come with us, we are going to watch movies there.' Then, with that porn video we would watch. They would say we must do that to be a man. (NELS M BLACK XITSONGA 18-24)

Not only could exposure to pornography exacerbate pressure for men to have sex, but it could also inform their understandings of how they must perform during sex in order to satisfy their

partner. For instance, one man said pornography introduced him to different sexual positions, which he felt compelled to try in order to satisfy women sexually:

> Men just like those kinds of moves, actions you understand? Not like those old people who just lie down. Like sleeping all over, up until the end. Not those kinds of styles or whatever. You must entertain. Put on a performance. Like those pornos, you know? Guys are like that. They feel like what you see it's the only way to make a woman respond. Cause otherwise you don't feel you are doing something nice when she's not responding, na? (NELS M BLACK SISWATI 25-55)
>
> They watch blue movies [porn], these kids, and if you're not up to date with them, you not going to make it. They don't want you to be making them watch stars the whole night [refers to missionary position]. (CBAY M BLACK ISIXHOSA FG 25-55)

One man discussed the disassociation of the connection between love and sex that is commonly revealed in pornography:

> Well, I don't think love and sex is really connected, because for us men just looking at an ass you get horny. And you would f**k that woman if you don't know them, don't love them. You're not normal if you don't get horny seeing a naked woman, pornography or a good ass out there. So from my opinion I don't think it's connected. Even when you see videos like porn videos, they get you horny. And there is no love there. (NELS M BLACK SISWATI FG 25-55)

Learning about sex through pornography was overwhelmingly a male phenomenon, as none of the women discussed learning about sex from pornography.

Peer based sexual education

Several participants, mostly young men, recalled learning about sex from their peers, which often created pressure for them to conform to certain sexual expectations. For instance, many of the men reported learning from their peers that sex was intimately tied to proving one's manhood. As one man said: 'from my friends, I knew it that as a boy I had to date. '(JNB M BLACK SEPEDI 18-24) Another man said he felt compelled to have a girlfriend like his older friends, which is how he first became aware of sex:

> I grew up having friends who were older than me. So I knew about dating girls and stuff. But then I had not yet developed those feelings at the time. By just dating a girl I was happy, but not to have sex with her. By just meeting her and kissing that was enough, I did not have such strong feelings. But I knew it, that as a boy, I had to date. That is how I found out that a man and woman should unite. (JNB M BLACK SEPEDI 18-24)

One young man said he first became aware of sex after telling a friend he had kissed a girl:

> I reckon I was in standard 5 [when I first learnt about sex], whatever age that is. I gripped [kissed] a chick [a girl] and I told my one mate who is much older than me, I said, 'Hey bro, I kissed this chick.' And then he said, 'Hey bro, do you know about the birds and the bees?' I didn't know what he was talking about. Then he told me about vaginal penetration, and I had no idea what this *ou* [boy] was talking about. (PTZB M WHITE ENGLISH 18-24)

Learning about sexual experimentation through accompanying his older friends when visiting their girlfriends, provoked one participants' desire to have sex:

> While I was growing up, I used to like soccer, I played soccer and everything, and I had friends who were exposed to dating at that age. When they went to check their chicks, I went with them and sometimes obviously, at night in boarding school, you would see people kissing and everything, and something just happened, and I said okay, maybe I have to try it as well. (JNB M BLACK ISIZULU 18-24)

There was little evidence of peers discussing the importance of safer sex to prevent STIs and unintended pregnancies. One woman had asked her friends how to prevent pregnancy, but they told her she could not become pregnant from having sex:

> You realise that, 'Ja, but what happens if we have sex?' Then you say, 'Hey, won't fall pregnant the first time, it doesn't happen the first time.' It was out of naiveté, and it was wrong, they said, it doesn't happen the first time. It does happen the first time, it does. (PTZB F COLOURED AFRIKAANS 25-55)

However, there was some digression from this. One participant (JNB F BLACK SETSWANA 18-24) was influenced by her peers to practice safer sex, as they encouraged her that as long as she used a condom there would be 'no problem.'

Several men were critical of learning about sex primarily from peers, which was often accompanied by severe pressure to have sex and represented an inadequate source of sexual health information. One man felt that if he had received SRH information from people other than his peers, he would not have made as many mistakes: 'Whatever I know today, I have learnt from my mistakes and from the pressure that I have been getting from friends' (JNB M BLACK ISIZULU 18-24). Another man expressed similar concerns about the limitations of learning about sex through peers:

> No one is lecturing you or tutoring you on these issues of sex. You learn on your own. It's experience or a situation where you must try to manoeuvre yourself. Although your peers might

talk about these issues, I don't think they will help you that much individually. (CPT M COLOURED AFRIKAANS 18-24)

Discussion

Significant gendered differences in terms of access to and evaluation of early sex and SRH information were found. Women were more likely than men to get sexual health information from family members, through their own research, and through HIV/AIDS awareness campaigns. Women also reported more regulation around their sexuality than men, most often through family members and religious institutions. This could enhance the stigma of young women's sexuality and hinder open communication. For the most part, men were said to be more difficult to engage through SRH education. It has been suggested that hegemonic gender norms insist that men be well informed about and responsible for initiating sex, which may explain why they were more resistant to formalized sex education (Measor 2004; Barker 2005). The irony is that men reported fewer and less reliable sources of SRH information than the women did. Young men predominantly learned about sex through peers and sometimes exposure to pornography; taboo and hidden sources of information that were largely kept secret from adults. Sex education through peers and pornography was reported to enhance pressure for men to conform to a version of masculinity that is built on sexual prowess and domination and rarely enforced safer-sex practices.

Both men and women highly valued parental communication around sexual health and behaviour, yet few participants reported that their parents played an instructive and positive role in their sex education. Public media campaigns often urge parents to talk to their children about sex (McLaughlin *et al*. 2012). However, the participants' experiences showed that parents are commonly uncomfortable and uncertain how to do this. Some participants discussed the cultural taboo in African families for parents to discuss sex with their children, consistent with other findings (Gallant and Maticka-Tyndale 2004; Lambert and Wood 2005; Bastien, Kajula and Muhwezi 2011). Several participants reported having to hide their sexual activity from their parents for fear of aggressive and hostile reactions, which reveals the extent of stigma around young people's sexuality. When parents did discuss sex and SRH with their children, it was often authoritarian and top down, characterised by vague warnings against pregnancy and STIs rather

than open discussions including the positive components of sex and relationships. Such findings are similar to other studies including Aggleton and Campbell (2000) and Bhana (2007) who found that parents might be open to discussing the facts of HIV with their children, but are rarely open to discussing sex which is often constructed as dangerous, forbidden and taboo. Parents may also find it difficult to discuss the pleasurable sides of sex with children for contradicting the idealism and promotion of childhood innocence (Bhana 2007; McLaughlin *et al*. 2012).

Some participants recalled disregarding and rebelling against parental rules and protective discourses, and that they entered into higher-risk forms of sexual behaviour than they would have otherwise. Inadequate communication from parents left many participants growing up with uncertainties about their physical development, menstruation, what constitutes sex, and how to prevent pregnancy and STIs. The unsatisfactory level of early sex education received through parents, as expressed in the narratives, is significant given the literature that suggests a positive correlation between responsive and supportive parental involvement in sex education and adolescents' sexual health and awareness, and decreased sexual risk behaviours and teenage pregnancy (Campbell and MacPhail 2002; Breinbauer and Maddeleno 2005). A relationship between poor parent child communication and rebellious behaviour, enhanced vulnerability to peer pressure, and increased sexual risk taking behaviours has also been documented (Brook *et al.* 2006). Nonetheless some participants, mainly women, reported receiving comprehensive sex education from their family members, including parents, aunts or grandmothers. This predominantly occurred when women first menstruated. The fact that more women reported instruction about responsible sexual behaviour could reflect parental concerns of teenage pregnancy as well as the greater societal pressure for young women to retain their virginity. The neglect of family members to offer men sex education, including pregnancy prevention, could reinforce the idea that contraception is a woman's duty.

While some participants recalled learning about sex from religious affiliations, many criticized the regular reliance on 'abstinence only' messages. The limits of abstinence-only messages for HIV prevention has been documented elsewhere (Mitchell and Smith 2000; Campbell 2003; Bhana 2006; McLaughlin *et al.* 2012). Some participants, predominantly women, recalled how internalising religious views about sex could contribute to feelings of guilt around their sexuality.

Such narratives support other research findings, which highlight that religion can contribute to the stigmatisation of sexuality, especially women's sexuality (Mundell 2009). However, religious frameworks around sex also provided strength for some participants to be able to resist peer pressure to engage in sex. Some participants described religious messages as encouraging them to find more meaning, and respect in sexual relationships, and to consider the consequences of sex. Religious education was also appreciated for respecting the sexual awareness and agency of young people, and acknowledging the societal pressures they often face to engage in sex.

Younger men and women frequently related learning about sex at school through the life-orientation curriculum, although it was poorly evaluated for a host of reasons. The curriculum was said to focus on the biological aspects of sex to the neglect of sexuality relating to love and relationships as found in other studies (Campbell and MacPhail 2002; Gallant and Maticka-Tyndale 2004; Bhana 2007; McLaughlin *et al*. 2012). Some participants reported not receiving sexual education at school. The narratives attest to the stigma around young people's sexuality, which may limit a teacher's freedom to teach sex education (McLaughlin *et al*. 2012). Despite such criticisms, participants highly valued the important role of SRH education in the classroom. Some participants disputed the notion that learning about sex prior to sexual activity encouraged early sexual debut. This supports other findings such as an evaluation of 28 HIV-prevention studies among youths in sub-Saharan Africa, from 1990 to 2008. These findings showed that participants who were virgins at the time of exposure to an intervention reported a higher rate of abstinence after the intervention, less instances of sexual intercourse in the past months, and higher intentions to use condoms (Michielsen *et al*. 2010).

Several participants recalled learning about sex through television. Yet many of them also lamented the fact that there was no real anchoring of sexual knowledge in the person's experience and life world, and that therefore television communication did not prepare them for their first sexual experience including how to ensure safer sexual behaviours. One-way communication technologies such as radio and television could also result in misunderstandings around HIV risk and were often not readily accessible in rural areas. Cellphone communication was valued for being highly accessible, and providing the potential for follow-up while retaining anonymity. Several women reported researching about sex and sexual health through reading

print material and from the Internet. This was said to enhance their understanding of how to practice safer sex and prepare readiness for sexual debut. In contrast, men were less likely to actively seek information about sex, and were less aware of where to access such information. This may reflect the fact that men are less likely to seek advice sex and sexual health given hegemonic norms that portray men as tough and invulnerable, and expect men to be well informed about sex (Peacock *et al.* 2009). Multidimensional SRH campaigns were valued for a variety of reasons including personalizing one's perceptions of HIV risk, communicating information in creative, and dynamic ways, and addressing misunderstandings of sexual diseases through providing follow-up opportunities. A flourish in SRH campaigns that target men was also highly appreciated by the participants. This is particularly the case since there was general consensus that it is more difficult to engage men in SRH health-seeking behaviours.

None of the women recalled learning about sex through pornography, which reflects the highly gendered appropriateness of this form of sex education. Some of the men appreciated pornography for teaching them about sex and sexual techniques. The fact that men watched pornography in groups and acquired pornography magazines reveals the societal acceptability of men's use of pornography. Watching pornography in groups "may enhance the collective acceptance of the value systems embedded in pornography and normalisation of the particular sexual practices shown" (Flood 2010, p. 167). For some men, pornography created sexual performance pressure, in congruence with research suggesting that pornography tends to focus men's sexuality around penis size, promote constant male sexual readiness and men's domination of sex (Flood 2007; McLaughlin *et al*. 2012). Pornography rarely informed men about the importance of practicing safer sex, and could also influence men's expectations and understandings of sex, including women's sexuality. The consumption of pornography, particularly violent types but also non-violent, has been shown to exacerbate men's tolerance for and participation in aggression and sexual violence against women (Flood 2010). Moreover, most mainstream pornography is said to encourage sexually objectifying understandings of women where sex is divorced from intimacy and dominance over or violence towards women prevails (Banyard 2010; Artz 2012). However, as Artz (2012, p.11) notes, "the relationship between pornography and sexual behaviour is complex, and other media can also teach men gender stereotypes (including rape-supportive attitudes)." Yet, because pornography was one of

the primary sources of early sex information for men in this study, the role of pornography consumption on men's attitudes towards sex and women arguably warrants special attention.

More young men than young women recalled learning about sex from their peers. The finding that young people are particularly susceptible to peer influences around sexual decision-making and risk-taking, particularly young men, is concurrent with much of the literature (MacPhail 2003; Brook *et al.* 2006; Seliow *et al*. 2009). Peer disapproval of condoms and pressure to be sexually active has been found to reduce condom use and increase sexual activity among boys (Campbell and MacPhail 2002). Peer 'education' rarely involved the importance of practicing safer sex and some participants recalled learning inaccurate information from their peers.

Conclusions

The major forms of early sex and SRH communication were presented through the narratives and significant gendered differences were found. Young women were more likely than men to learn about SRH information from family members, campaigns and through self-seeking information. Women also reported more regulation around their sexuality than men, most often through family members and religious institutions, which could enhance the stigma of young women's sexuality and hinder open communication. Although men reported less protective discourses around their sexuality, the narratives reveal that men have fewer and less reliable sources of SRH information than women. Men predominantly learned about sex through pornography and peer education, which was reported to enhance pressure for men to conform to a version of masculinity that is built on sexual prowess and domination, and does not take into account the necessity of practicing safe sex. There seemed to be little communication about sex from sources other than peers, which may explain their critical influence. The lack of adequate SRH instruction for young people as revealed through the narratives had significant and often negative implications on men and women's early safer sex behaviours as will be presented in Chapter 5 on circumstances of men and women's sexual debut.

CHAPTER 5: PATHWAYS TO AND INTERPRETATIONS OF EARLY SEXUAL EXPERIENCES

Introduction

This chapter details the experiences of and meaning given to participant's early sexual experiences. While a few participants had reportedly never had sex, all the participants reported engaging in some level of sexual activity. SRH practices at sexual debut were also was examined given the pivotal role of sexual behaviours at first sex on later safer sex practices. This is important given the potential impact on participant's subsequent attitudes towards and engagement with sex, gendered norms and SRH practices. The chapter also presents any gendered differences found between men and women's narratives of sexual debut, and documents how this could impact on participant's sexual development.

Sexual debut experiences among women

Partner pressure for women's sexual debut

Many of the women spoke of debuting sexually not primarily because of their own sexual desire or readiness but in response to partner pressure. Especially, women recalled debuting sexually in order to maintain the relationship and keep their partner 'interested':

> I had this huge crush on him — I thought that sleeping with him would then make him like me more…I didn't have sex again until I was almost 18. I didn't enjoy it — I guess I had fun, but I didn't really know what was going on, but it was over so quickly, and then...I don't know if it really changed anything. (GTOWN F WHITE ENGLISH 18-24)

Another woman said she felt compelled as a girlfriend to have sex with her first partner, but she did not enjoy sex the first time and for a few years afterwards:

> It was pain. It was a lot of pain. And he told me, 'No it will be ok when you do it often, you see.' Because I love him and then I have to do that. But I didn't enjoy anything from the ages of 17 to 20. (NELS F BLACK SISWATI 25-55)

A few women commented on the pressure to have sex with their partners to maintain the relationship and to prevent them from seeking sex elsewhere:

> If I do it, maybe I'll keep him. You know, you have that, because remember, this guy is good-looking and maybe other women want him as well. So if you keep him and you satisfy him, if I can put it that way, he will be yours, but it's a game. It's a gamble that you take as well. It's up to you as a woman, and it happens throughout, almost most teenagers, they go through the very same thing. (PTZB F COLOURED AFRIKAANS 25-55)

Although one woman felt privileged that her partner did not pressure her into sex to 'prove her love' to him, as was often the case, she nonetheless expressed concern that he could seek out a willing sexual partner elsewhere:

> I was lucky as well that he didn't use that term 'Prove your love to me' — he didn't do that. That was a term that I was used to, like 'If you love me, you will do it.' No, that wasn't used with us. With us, it was more like we were worried that if I don't do it, one of my friends are going to take him from me and they are going to give it to him anyway. So if I do it, at least he will be with me. (JNB F BLACK ISIZULU 25-55)

One woman recalled how her first partner ended their relationship because she refused to have sex with him:

> It was like he wanted to have sex with me but I wasn't ready. And then he left me because of that. (NELS F BLACK SISWATI 25-55)

Many women recalled a sexual debut experience with an older partner, which often affected their sexual agency. One interviewee said she felt tricked into having intercourse with an older partner:

> Actually, I think he already knew about sex because he was older, he knew what he wanted from me, I did not know. But he spoke to me until I agreed to have sex with him…I tried to refuse but he tricked me, I ended up agreeing…I was a shy person. At times, it was not easy to refuse what he was asking me to do because I loved him. [Afterwards] you feel pain, you feel sad, you feel sorrow…. When I was with him I was not free, I was always ashamed, not liking what has happened…. The issue of sex made me very shy. (PTZB F BLACK SESOTHO 25-55)

One woman described feeling naïve and inadequate in comparison to her first sexual partner who was six years older than her and sexually experienced. She felt uncomfortable with him and saw herself as "not even a novice, [but] an amateur…I didn't know what to do half the time.' (PTZB F INDIAN ENGLISH 18-24) Women sexually debuting with older partners, who often had greater sexual experience, was said to be a common phenomenon:

> Obviously, he's done it before. Either he's with you in matric or he's not with you in matric. When you are in matric, you don't date the guys who are in matric, you date somebody that is out

> of matric. Like my boyfriend was out of matric, so he was experienced. (PTZB F COLOURED AFRIKAANS 25-55)

One participant recalled the fact that her first partner was not only older but also had more money, which made her feel compelled to have her first sex with him:

> He influenced me with money to have sex for the first time. He was older, already working, and I was at school. (PTZB F BLACK SESOTHO 25-55)

Peer pressure for women's sexual debut

In contrast to the men's narratives, several women said they had felt compelled to keep their early sexuality hidden from their peers to avoid being stigmatised:

> If word gets out in school that we are having sex, what are we going to be called? Oh, please, 'They are loose or they are easy' or something. So we had to keep it amongst ourselves. We had to be tight as much as possible. (PTZB F COLOURED AFRIKAANS 25-55)

This is in congruence with the fact that dominant gendered norms typically condone men as hypersexual and women as asexual and passive. Another woman reflected on how she kept her sexuality mostly hidden from her peers, and those she did speak about sex with did not pressure her to have sex:

> No, they didn't pressure me to do it. It was my own decision. We didn't talk about it a lot cause my close friend, she was staying close to me, the other one we didn't talk much about sex. (NELS F BLACK SEPEDI 25-55)

One woman reported that her friends persuaded her boyfriend to pressure her to have sex because, in the words of her friends, she was 'being hard':

> They pressured me and then they went to my boyfriend and told him to force me. And then my boyfriend told me about it after. My friends used to say, 'Why don't you have sex? It's nice.' And then they went to my boyfriend.' (NELS F BLACK SISWATI 25-55)

This reflects some women's perceptions that men expect sex in relationships, and are bound to use force to ensure this. Several women said that peer pressure to have sex occurred at a certain age in adolescence, whereby having status as a woman was intricately tied to having a boyfriend:

> As I grew up it wasn't any conversation with my parents, it was really just through my friends and media, I think, about what this sex thing was. And so we all got to about 15, 16, and there was just this pressure, because it was like, okay, now's the time to have sex, everybody's having

> sex. So I was like, okay, cool, get into a relationship at 16, have sex. Terrified. (CPT F WHITE ENGLISH 25-55)
>
> Oh, it was more peer pressure. If you don't do that then you don't fit into this group. I said, 'But it isn't like that.' So they said, 'No, but it must, you must try this or else....' They interrogate you and they force you to do things. (CPT F COLOURED AFRIKAANS 25-55)
>
> At school, my friends used to tell me how they meet the boys and having sex, I was an outcast to my friends as I don't go out with boys; my parents were very strict; it was difficult for me to go out with a boyfriend. (GTOWN F BLACK ISIXHOSA R 18-24)

One woman felt pressure from her close friends to have sex and become pregnant as a teenager since her friends already had children, indicative of the status in this context linked to a woman's fertility:

> We were four [friends]. And I got pregnant after all three already had children. And they called me stupid that I don't have a child because they were younger than me. I was 18 and they were 16. (NELS F BLACK SISWATI 25-55)

Sexual debut experiences and meaning among women

For many of the women, losing one's virginity was a negative experience. One woman related her sense of loss after her first sexual experience:

> I felt like he took something away. Remember I was a virgin and here was this guy. I felt he had taken something away. (NELS F BLACK SESOTHO 25-55)

The experience of losing one's virginity was significantly undermined for the women whose first partner was unfaithful to them:

> "I was heartbroken, but other than that I was still the same person. At the time it felt like I was connecting with this person for life. But then things didn't work out. It seemed like he was just using me to get sex. But my personal experience, I felt like it was special. But then afterwards I just forgot about it. Because then I realised it wasn't special for him, you see. So it didn't change. (GTOWN F COLOURED AFRIKAANS 18-24)

Another woman expressed regret and self-blame after discovering her first partner was unfaithful to her:

> After having sex, I regretted having sex. The boyfriend was not going out with anyone except me, but after having sex with him, I saw him going out with other girls; I thought he just wanted to have sex with me. I also thought there was no love; it was curiosity to me, whereas to him it was

> just sex. I hated myself and never shared that with anyone in my family. (GTOWN F BLACK ISIXHOSA R 18-24*)*

For one woman, the combination of anxiety and physical pain during her sexual debut caused her to stop the encounter:

> I think it was more just kind of like, if it didn't hurt then, I don't think I would have had such a problem with it, but because it was anxiety mixed with pain, it was like, okay, you need to stop now. (CPT F WHITE ENGLISH 25-55)

For many of the women, having sex for the first time outside of marriage made them feel 'dirty' or guilty, indicative of dominant norms of femininity that promote chastity and virginity until marriage:

> Like afterwards, you go through these mixed emotions: Is he going to respect me now, what happens from here? What did I just do? Have I just allowed him to take something special from me? Is he going to appreciate that? You go through those mixed emotions, and it's negative emotions. (PTZB F COLOURED AFRIKAANS 25-55)

The fact that the participant doubted if her partner would respect her revealed her understandings of men's disrespect for 'promiscuous' women. Another woman expressed similar sentiments of guilt and regret for having sex outside marriage, but also noted how she reconciled this with time:

> Obviously, I didn't take the advice [to wait for marriage], and so straight afterwards, I regretted it first, and then I like cried, and then like mourned. I was like in mourning. I was like, 'Man, how can I let myself get into this?' And I was so, I was so disappointed with myself. Because I always thought the man I have sex with is the man I'm going to marry; and it changed me because then afterwards, although he and I stayed together for a while, it did end eventually. And it ended on very bad terms. So it changed me, as then I figured out for the first time that you know life is not always about, sex is not about every guy I meet is going to want to make love to me and marry me…. If I want to have sex again then I'm going to have to be prepared to take the power into my hands and not the other person. Not leave it in their hands. So that's how it changed me, I became stronger. (PTZB F INDIAN ENGLISH 25-55)

After her first sexual encounter, which was before marriage, another woman believed she had lost respect, especially in her religious community:

> To be a woman meant growing up, getting married, not having sex before wedlock. I rebelled from all this because I saw the world through different eyes and was exposed to different things. So, having friends from different backgrounds. I wouldn't say it was pressures, but just me being

> curious and wanting to know what it felt like. But having the knowledge I have right now, I wouldn't have done it then…I would have much respect from friends, family, my church, now, if I had my virginity now. Because now obviously they know I'm sexual. They know any man that will marry me will know I'm not a virgin. I also know myself, I don't carry myself the way I would have if I was a virgin. (GTOWN F BLACK ISIXHOSA 18-24)

A few women described waiting to have sex in marriage or with a partner whom they intended to marry because it would enhance the value and meaning of losing their virginity:

> My mom was very old-school, and they said once you're married you take your vows and that was sacred to them. That is how I was brought up, and I thought, okay, fine, we'll leave it like that. It was really an experience. We were both virgins at the time, so it was a great experience for both of us. (CPT F COLOURED AFRIKAANS 25-55)

One participant recalled her sexual debut as special because she intended to marry her partner:

> And so it was like, okay, great, so now like I've had sex, this is something that I've experienced with him and I've shared with him. It was one of those new things that I could share with somebody that I really loved, which was great. And of course, I mean, sex is fun, so that was quite cool. And the romanticism that 'you're my first love' and 'you're the first person I've slept with and you're the only person that I'll sleep with' and that kind of thing. It was really exciting. (CPT F WHITE ENGLISH 25-55)

Women's sexual risk behaviour at sexual debut

Many of the women described how their male partners initiated their first sex, and that either they did not know about condoms or felt uncomfortable initiating condom use at sexual debut:

> At my age there was no HIV and AIDS, it wasn't taken that seriously at that time. But now, everywhere I go, I use a condom. (NELS F BLACK XITSONGA 18-24)

One woman said her first sex was enjoyable and had enhanced her desire to have sex again, yet she worried about becoming pregnant:

> I said, 'I don't want to fall pregnant,' but he says, 'It's fun.' He tells you, 'Listen, I'm not going to cum in you,' so you hope in hell, I'm hoping that he doesn't, but you don't know what the meaning of that is, he's 'not going to cum' in you. But still, the fact remains you are scared.... But you want to go back for a second time. But the problem is that now you realise, okay, you don't know whether you are going to fall pregnant. You don't know whether he pulled out the same time or didn't pull out, you don't know all that. (PTZB F COLOURED AFRIKAANS 25-55)

Her story revealed her lack of knowledge of sex, and that the sexual decision-making was primarily made by her male partner.

One participant (PTZB F INDIAN ENGLISH 18-24) said she refused to use a condom with her first partner because it made her feel 'dirty', which reflects norms of femininity that disapprove active sexuality. However, there was evidence of some women having insisted on condom use at their sexual debut:

> I went after school and visited him in his home, and his parents were not there. I sat in the couch; he moved and sits next to me, he kissed me first. He was the one who initiated sex; I asked him to use a condom. I did know about condoms from school, friends and TV. (GTOWN F BLACK ISIXHOSA R 18-24)

Given the infrequency of protected sex at sexual debut as related in the narratives, a few of the women had become pregnant through their sexual debut, predominantly those in rural areas:

> So I just feel that if I didn't lose my virginity then maybe I wouldn't have been pregnant. Maybe I would not have slept with this guy. It's just my thinking. (NELS F BLACK XITSONGA R 25-55)

Most of these women related that their partner did not want to be involved in the pregnancy, and, in some cases, had ended the relationship. For instance, one woman's (PTZB F COLOURED AFRIKAANS 25-55) main reasons for having sex were to keep her boyfriend interested in her, and curiosity around sex. She enjoyed her first sexual experience and dated her partner for a few years. At the time, her peers were not using condoms, so she and her partner did not use protection. She kept her sex life confidential from her friends. She fell pregnant with her boyfriend's child at the age of 18. Her boyfriend lost respect for her after she got pregnant and they eventually broke up. Such scenarios are indicative of women having to assume the primary responsibility for pregnancy and child-rearing rather than sharing this with men:

> I only slept with the man, and when I became pregnant he left me and went away. When the child became sick I didn't know he had to get injections. The child then was taken to hospital, and [the father] came to me and wanted to know why the child was sick. My answer to him was, 'May the Lord take this child away.' It was too difficult for me. I had to work for the child all on my own. (CPT F COLOURED AFRIKAANS 55+)

Men's sexual debut experiences

Early sexual desire among men

Many of the men's early accounts of sexuality were marked by an innocence of desire and infatuation. They described how during their early teenage years, their focus was not wanting or demanding to have sexual intercourse with someone, but to connect with someone emotionally whether through kissing or expressing love. One man discussed his first experience of kissing a girl with a sense of infatuation:

> We did that kissing and I took her home. Upon her going home, I couldn't sleep that night — I couldn't sleep that night with joy! Like joy, it was like I could see her just now, because she was my first lover. (GTOWN M BLACK ISIXHOSA R 18-24)

Another man portrayed his first intense feelings of being in love:

> The first time was with that girl in Standard 1. I was her debutante partner. Wow, she had these Asian type eyes. She was a little bit taller than I was. She had a little hawk nose, I can still picture her face. She was just wow! [laughs] When I think back, it's almost as though she has a halo around her. That was my first experience of love.... I don't know if it was physical. I think it probably was, but at the time you didn't make the connection. (CPT M BLACK ISIXHOSA 18-24)

One man described a love letter he wrote for the first girl he was first attracted to:

> It talks about how beautiful the girl is and tells her she is the sun, and so, which shows that I was not looking for just what is in between her legs, but I was actually looking towards loving her, my future and hers would be so and so (GTOWN M BLACK ISIXHOSA 25-55).

Another man discussed being content with other forms of affection including kissing, and how he did not insist on sex:

> Like right now, I might see a girl passing by and look at her sexually, and so on. But at that time [when I was a boy] I had not yet developed [sexual feelings], I would just tell her that I love her, but even if we were not so close I did not mind. I was only happy to have a girlfriend but not go deep into the sexual issues. (JNB M BLACK SEPEDI 18-24)

One man reported similar sentiments, although reported that he was not very interested in dating but understood that he had to do this 'as a boy':

> I knew about dating girls and stuff, I had learnt all about dating from my older friends. But then I had not yet developed those feelings at the time. By just dating a girl I was happy, but not to have

> sex with her. By just meeting her and kissing, that was enough, I did not have such strong feelings. But I knew that as a boy I had to date...but it didn't consume me at all, I was more interested in ball sports. (JNB M BLACK ISIZULU 18-24)

Another man related how he waited for a year to first have sex with his girlfriend. He described his love for her and how he believed in an inherent connection between love and sex:

> I'd been waiting a whole year for her to say let's have intercourse, because it [virginity] was hers to be broken. The concept of virginity didn't mean anything to me. We loved each other. I thought they went hand in hand. You only had sex if you were in love (PTZB M WHITE ENGLISH 18-24).

His early attitudes towards sex revealed patience and respect for his first sexual partner. Such qualities contrast to dominant conceptions of men's sexuality being detached from emotional intimacy.

Men's early homoerotic experiences

Although none of the participants identified themselves as homosexual, a few participants reported their first sexual experiences to be with other men. Such experiences were mostly regarded as sexually exploratory and not characterised as homosexual acts of desire. One interviewee noted how at a boys-only boarding school there was widespread same-sex sexual exploration. He noted that although this was never discussed, there was little stigma attached to such acts, except by those who were more religious. Yet, the participant referred to these acts as something men commonly go through, but also that one 'grows out of':

> R: All the boys masturbated. Some of them masturbated each other. Cause there were no girls. We didn't know there was anything called girls. I suppose I must have been 11, 12. Boys mixed with boys.
>
> I: Were boys quite open about it?
>
> R: No. Some of them were totally not and unapproachable. Perhaps they had parents who brought them up to only go with girls. I suppose we were all more or less homosexual in those days. There were no women. But it's been like that for hundreds of years in England. And our boarding schools descended from the schools in England. They had the same behaviour. There were always some religious children who had parents who taught them something. Those of us who did it, didn't discuss it with those who didn't. Then, there was no such word as homosexual. Just a

normal part of growing up. It's only much later in my life that I hear such words as homosexual, bisexual, heterosexual.

I: Do you feel that, those kind of homo erotic feelings, that they continue throughout one's life? Do you think there's an element of it that remains there?
R: I doubt it. I think one just grows out of it. It's part of growing up, particularly in boarding schools. You just grow out of it. Well some people don't grow out of it. But for me I can't imagine. (GTOWN M WHITE ENGLISH 55+)

A few other participants mentioned how as young men their peers used to masturbate each other, and this was not specifically considered to be a homosexual experience, at least until later, when it was more likely to became taboo in the eyes of peers. One interviewee (PTZB M BLACK ISIZULU 18-24) described how at around the age of 12, he and a friend would visit a man who would bathe in front of them, and he recalled that this experience had an erotic element to it. This man said that he did not have significant homosexual feelings later in his life, and it is an example of the more open character of young boys' sexuality, which was not particularly focused on desire for another person of the same sex. Descriptions of early homoerotic experiences suggest that at this point, sexual feelings were not particularly oriented to the other person as a desired partner, so much as centered on pubescent boys exploring their own developing sexuality.

Peer pressure for men's sexual debut

Many of the men related experiencing pressure from their peers to sexually debut:

My friends used to tell me I am an idiot. Why don't I have a girlfriend? Why haven't I had sex? And it used to make me mad. I was 15. (CBAY M BLACK ISIXHOSA FG 25-55)

We all get that pressure, when you are that age, even the girls make you feel like shit if you are not taking your opportunities. They will go and seduce you and if you are too slow you will hear them talking badly, making fun of you. That's when the real pressure comes from your friends. Once you do get sex, you notice the difference. You start dressing up smartly, start taking care of yourself. (CBAY M BLACK ISIXHOSA FG 25-55)

And for many men, 'the peer pressure did contribute, to an extent, actually in a big way contributed, to my first sexual intercourse' (CPT M COLOURED AFRIKAANS 25-55). Having sex for the first time could result in men feeling accepted by their peers:

> My friends pushed me to a point where I had asked the lady if we could go to my house to get sex. The friends pushed me to get sex. After that I got accepted and people stopped teasing me. (CBAY M BLACK ISIXHOSA FG 25-55)
>
> To be honest, it was because of pressure. At that time I was in boarding school, and when I was doing it, it was school holidays. I mean when you are talking to your friends and [they are] saying, 'Okay, have you ever had sex?' and all those things, at some point in time you will lie and say, yes, while you didn't. So it was all pressure, and I felt like I was being left out since everyone had done it and I was the only one who had never had sex. (JNB M BLACK ISIZULU 18-24)

Many men recalled boasting to their peers about their first sexual experiences, likewise indicating peer pressure as a primary motivator to engage in early sex:

> I told my friends [after his first sexual experience]. The peer pressure. There was a competition to see who did it first in the crew. Those who stayed behind felt most pressure. (NELS M BLACK ISIZULU 18-24)

Similarly, another man (CPT M BLACK ISIXHOSA 25-55) said that after he first had sex, he immediately told his friends and then felt like he had been 'born again' in terms of gaining their admiration.

One man reported lying to his friends about having had sex before his actual sexual debut:

> *Amajita*[15] had always lied and said that I was doing this thing [sex]. I used to lie to them [by saying I already had sex too], you see, because *amajita*…talk and say that I have done this thing [sex] (GTOWN M BLACK ISIXHOSA 25-55)

This participant asserted the peer pressure to have sex in order to gain status as the driving factor behind his first sexual experience:

> I would say that what made me really want to have sex was *amajita* [the cool guys]. Because most of the guys that I grew up around loved girls very much, so we were always talking about girls.

However, once he realised his peers had lied about having had sex, he related being angry for being misled into having sex because of the assumption perpetuated by his peers that everyone has sex at a young age. Another man discussed how he had to prove to his friends that he had actually had sex because they presumed him to be lying:

> P: I don't know, they all thought I was lying.

[15] Xhosa term for 'mates' often in reference to one's direct peer group.

I: So what did you do to really show them that you weren't lying?

P: [Laughs] I actually showed them one night. I took this girl and I went there to them and then I started touching her and fingering her. (JNB M WHITE AFRIKAANS 18-24)

Pressure from peers to sexually debut was often accompanied by sexual performance expectations:

> First time I had sex, I must have been about 15, 16. Ya, there was a bit of pressure because the first time I had sex, my friends were watching through the door. This girl came in and the guys introduced her to me. They had already done her friends, so they found pressure for me. I had to last the longest for the first time. That was the main focus. To make sure it lasted long and that's what I did. (GTOWN M BLACK ISIXHOSA FG 25-55)

Another man immediately told his friends about his performance after his sexual debut. Feeling the need to meet his peers' expectations, the meaning of his first experience was closely tied to sexual performance:

> Firstly, obviously you have to go back and say to your friends, 'I have done one, two, three.' They were asking me, 'Did you ejaculate?' And I didn't know what that was about. I said yes, and then they said, 'How many rounds?' So I said four. I was answering questions about things I didn't even know what they meant at that time, because obviously there are things called rounds, there are things called cum and ejaculation and all those things. I just answered the questions, but some of the guys could tell this is a lie. (JNB M BLACK ISIZULU 18-24)

Pressure to have sex could also come from family members; most notably, older brothers. One young man (GTOWN M BLACK ISIXHOSA R 18-24) reported that his major motivation for first sex was in order to make his [older] brother proud. Another man recalled experiencing familial pressure to sexually debut with a beautiful sex worker:

> Everyone around me was naughty. The influence around me was always such an extent that, and to a degree I influenced them. To a degree I played my part with them. Because from a young age I was very selective about the type of person I wanted to be with, even though they were working people, they were very attractive. And that's the type of woman I have always wanted next to me. A lot of my cousins also had their first sexual experiences with working girls. Where they model during the day; you think they are supermodels. They walk around amongst us. And then at night you see them in a very different light. (PTZB M INDIAN ENGLISH 25-55)

For some men, associating themselves with peers who did not pressure them to engage in sex was helpful to resist such peer pressure. One man's counter-narrative recalled focusing on his schoolwork instead of seeking peer approval through having sex:

> I know I'm quite good-looking and my friends knew this; they would always kind of just say 'Why don't you get a girlfriend?' or like 'You can just get with her.' I kind of just shrugged it off. A big factor though that prevented me from actually just playing around and just experimenting was I was very much into my schoolwork and I didn't really have time. (JNB M WHITE ENGLISH 18-24)

Sexual debut experiences and meaning among men

Sexual debut was regularly perceived as a rite of passage to manhood. One man described the aftermath of his sexual initiation:

> I did not have much time at home anymore; my mother started to have problems with me, I began to feel that I was a *groot* man [mature man], I started to grow a beard. These are some of the small things that made me change a little after I had my first sexual intercourse. It was also my personality. It made me feel a little more that I am slowly busy moving forward. (CPT M COLOURED AFRIKAANS 18-24)

However, in many of the men's descriptions of sexual debut, what happened had been unexpected and did not meet peer-led expectations. For example, one man said his sexual debut was less enjoyable than he anticipated, and the expectations of sex as generated by his friends were not met:

> But it was *kak*! Jis, bro, I thought it was the most overrated thing I had ever experienced. I expected there to be fireworks and lightning bolts…. It was two *okes* having no idea what they are doing. One is going out, the other one is going in. It was like trying to dance with someone and you kept on standing on their feet…. I was like, is this what all the stories are about?... I'm like come on, it's got to be more than this! (JNB M WHITE ENGLISH 18-24)

One man said there was little intimacy accompanying his early experiences because, in his opinion, he engaged in sex due to 'forced' peer pressure:

> At the time when you have been forced by your friends, there is not love in it, the sex is cold. It has no warmth. No love. (CBAY M BLACK ISIXHOSA FG 25-55)

Another man expressed a similar sentiment:

> It meant nothing to me. It was just because of pressure. There was no condom, there was nothing. (JNB M BLACK ISIZULU 18-24)

Many of the men's narratives revealed feelings of shame, intimidation and sexual inadequacy at first sex, in contrast to society's general portrayal of men as powerful, confident and in control of

sexual encounters. One man recalled his uneasiness and feelings of inadequacy about his sexual debut:

> I did not know what to do, it was the girl who was proactive. She was lying on the bed and she was telling me that she is horny and hot. She told me to undress, and I undressed. After that I stripped, and she stripped. I was so shocked. It was like I wanted to go away, but I don't have a way to go. Because I want to be a man at that time, you see. A real man. No, I'm going with her, on top of her body. She took my penis and put it in her and I didn't know which way I could go. Now, upon having sex, it was like things you see that are unbelievable. I had arrived on another planet. (GTOWN M BLACK ISIXHOSA R 18-24)

When he told his friends they mocked him and said that as a man he was meant to initiate sex rather that the woman. Having originally felt that sex with this partner was about the intimate connection they had, his peers made him feel anxious, 'lost' and have 'mixed feelings' about the act. This made him fear that his first sexual partner would leave him:

> They asked how I had done it. No guys, she held me [in the penis]. They become like, ahhh, and they laugh at me. I asked, 'Why are you guys laughing at me?' 'No, man, you're supposed to go with her, you see to do this, everything you connect, you connect with a girl'; no man, guys, I really do not know what kind of love that I had at the time. And they advised me that I should have initiated the sex, and done this and that, because they are older than me, you see. I now thought, ey, I'm lost, and had mixed feelings and thought that this girl would never come back to me. (GTOWN M BLACK ISIXHOSA R 18-24)

Whereas he felt quite content for his girlfriend to have initiated the sex, his friends conveyed to him that he was meant to initiate sex as a man.

Another man recalled his feeling of vulnerability and shyness during his sexual debut. He expressed concern for his first partner's future and his own readiness to commit to her should she become pregnant, which counteracts dominant conceptions of young men's sexuality and irresponsibility:

> I first had sex with a girl in 2004 when I was in matric. I did it because I saw that experience somewhere. But the time when I had sex with her I was shy, like, it was not easy to look at her in the eye. Because we did it, only when she was gone that was when I became happy. I understood that, that was what men do. So after sleeping with that girl, I felt some changes in my body. There were such bodily changes in such a way that I could feel that my blood was rising.... I was afraid that if she falls pregnant I had to be responsible for the baby. I was also afraid of how my parents

would react if she fell pregnant and how the girl's future would be like. Will I marry her? (JNB M BLACK SEPEDI 18-24)

One man recalled a combination of sentiments towards his first sexual experience, especially anxiety and disappointment over his sexual performance as someone very inexperienced, how it made him 'feel like a man,' and the importance of telling his friends about it afterwards:

> I made mistakes and made mistakes, but eventually I ended up entering her, and she ended up taking over, right, but it did not last a very long time, it didn't even last for three minutes you see, but after that I kinda felt like a man. For me, for me it was just so that I can go and tell my friends that I did it today, you know what I'm saying (GTOWN M BLACK ISIXHOSA 25-55).

While he gained status with his friends for having debuted sexually, he also recalled being mocked by friends for sexually debuting with a young woman who was considered unintelligent, unattractive and sexually experienced. This reflects a double standard where men are pressured to gain sexual experience and women are stigmatised for being sexually active:

> She was quite advanced about things, you see, in the bed, sexually; so *amajita* were teasing me because since she not was very good-looking [laughs]. And in class, you see, she was not very intelligent as well. (GTOWN M BLACK ISIXHOSA 25-55)

Men's sexual risk behaviour at sexual debut

Several men reported that peer pressure to have sex was often not accompanied by the need to practice safer sex. Many of the men relayed misunderstandings of the consequences of sexual activity and their sexual debut was often unprotected. One man said he had not contemplated the possibility of pregnancy at his sexual debut:

> You don't have the thought of her getting pregnant. I wasn't even at the stage of knowing if you put in your thing, there will be kids as an end result. You just put it in. There was no condom. (CPT M BLACK ISIXHOSA 25-55)

Another man recalled learning about reproduction in school but admitted that he did not think about preventing pregnancy during his first sex:

> Honestly speaking, I did know about this thing called HIV, but we did not use a condom at all. We just went down. It was when I was doing Form C, and we did a reproductive chapter or whatever, about sexual or whatever, you have chances of having a baby or whatever, but still, it never clicked in my mind at that time that we might be creating a baby or something. I never thought about contraceptive pills, I never thought about a condom. All I thought about was to get down with this lady and that was it. (PTZB M BLACK SESOTHO 25-55)

Another man (CPT M COLOURED AFRIKAANS 25-55) greatly anticipated his sexual debut, but was not prepared for how he would feel afterwards, namely feelings of guilt and worry about the sexual risks he had taken. For the most part, men did not feel as 'responsible' for or worried about pregnancy from sexual debut as much as women did. Given the high frequency of unprotected sex at sexual debut, a few men reported contracting an STI from their first sexual encounter:

> Ya, it was painful because I got an STI because I didn't use protection. (NELS M BLACK XITSONGA 25-55)

The few men who said they used a condom at first sex were often in an established relationship and they discussed feeling more adequately prepared for their sexual debut including practicing safer sex. As one man said:

> My initial reaction was, 'I've done it, yes!' [laughs] But I'm glad I was in a position that I was involved with someone on an intimate level that we went down that road for the first time [together]. It really did strengthen the relationship and the whole cliché about how you never forget your first love. It was a major influence in the relationship in a positive fashion. And we talked about pregnancy and contraceptives. (CPT M WHITE ENGLISH 25-55)

Another man discussed how he and his established partner had an open conversation about their sexual readiness and contraception options. This reflects a responsible and mature form of masculinity at sexual debut:

> At first we were both a bit hesitant, but, as anything goes, things tend to develop after a while. At school you don't actually want to become a dad. And just actually started talking about, you know, um…are you taking anything, you know, birth control, so and so forth. And, we talked about STDs and that kind of thing, and that's when we basically decided that, that, a condom would be the best way to go, you know — and to prevent numerous effects from having intercourse. (GTOWN M WHITE AFRIKAANS 25-55)

Discussion

Men and women generally reported quite different sexual debut experiences and meanings. Women were more likely to recall sexual debut as an uncomfortable and negative experience, and in large part as a result of partner pressure. Men were more likely than women to report positive first sexual experiences, which were commonly framed as a pathway to signify manhood. Yet some men reported that their sexual debut significantly motivated by peer pressure

before they were ready, and that their peer-led expectations were not fulfilled. Most of the men's first sexual partners had been the same age or younger, whereas the women's first partners were generally a few years older in congruence with other findings (Luke and Kurz 2002; Leclerc-Madlala 2003; Pettifor *et al*. 2009). The narratives depict men as having greater decision-making power than women do at sexual debut, which includes when to have sex and whether the sex is protected; this finding is not surprising given the generalised age differences at debut and the predominant gender norms that are often related (Varga 2003). Many participants recalled how condoms were not used at sexual debut because they were not aware of how to protect themselves from pregnancy or STIs, did not perceive themselves to be at risk of sexual consequences, or did not consider the broad consequences of sexual activity. As a result, their early sexual behaviours placed them at risk of HIV, other STIs, and unplanned pregnancy, as found in other studies (Anderson, Beutel and Maughan-Brown 2007; Cooper *et al*. 2007; Zuma *et al*. 2011). The extent of unprotected first sex is worrying given the Third HIV National Communication Survey 2012 which showed that the probability of condom use with one's most recent sexual partner was greater (68%) if a person used a condom the first time he/she had sex than if they had not (43%). Self-reported HIV positive status was also found to be significantly lower among those who used a condom the first time they had sex (3.5% for males; 6.2% for females) compared to those that did not use a condom at first sex (13.6% for men and 18.5% for females) (JHHESA 2012).

Most of the women reported that their sexual debut experiences were insignificant and disappointing. Many women recalled being pressured into sex by their first partner or having sex before they felt ready in order to maintain their relationships. Some women recalled how they hoped first sex could deepen their emotional relationship with their partner and lead to long-term commitment, yet these expectations were often not met. The perceived 'insignificance' of first sex was exacerbated among those women who discovered their first partner's infidelity. The narratives support other findings that women find it more difficult to initiate or insist on condom use at sexual debut (Cooper *et al*. 2007; Pettifor *et al*. 2009). Many women reported that their first sexual experience was with an older partner who had more decision-making power over the type of sex including whether or not to use protection. Several women indicated a low level of SRH awareness at the time of their sexual debut, such as not knowing how to protect themselves

from STIs and unwanted pregnancy. The latter was the predominant concern among women after first sex. A few young women reported becoming pregnant at first sex, which they tended to assume sole responsibility for. This reflects the normalization of young men's poor involvement in teenage pregnancy and childcare. More women than men expressed guilt for having sex before marriage, indicative of the greater societal pressures for women to retain their virginity than men. The narratives of sexual debut experiences also reveal a lack of positive discourse about female sexual desire. The women who reported their first sex to be emotionally satisfying and physically enjoyable were invariably those who said they had their first sex in a trusting and committed relationship. Such narratives attest to the fact that some men acted as responsible and respectful partners at sexual debut.

Men's early descriptions of their sexuality were described as quite distinct from sexual arousal. However, they were nonetheless a powerful physical experience, (described by one respondent as 'glowing'), involving attraction and an intense desire to be close to another person. Descriptions of these early sexual experiences did not appear to involve elements of wanting to own or possess one's partner, but seemed to be characterised by the qualities of respect, patience and intimacy. MacPhail and Campbell (2001) write that, contrary to perceptions of men in general as sexual predators, young men's masculinity is often accompanied by a desire to disguise the vulnerability that they feel when engaged in sexual relationships with women. The narratives confirm this sense of vulnerability and insecurity at sexual debut and contest some common conceptions of young men's debut sexual experiences as men as being 'in control' and demanding of sex (Schneider, Cockcroft and Hook 2008). In talking to the young men, there was a marked change, and sometimes tension, between their descriptions of a relatively innocent and vulnerable early sexuality and their eventual socialisation into modes of sexual behaviour they felt compelled to adopt to be accepted. The dynamics of this desire often took on increasingly physical dimension where expressions of sexual interest were increasingly tied to notions of masculine identity and power. Foucault (1979) noted that disciplinary power works not only by punishing behaviors that steps outside of social norms, but also through rewarding acts that are valued and one way of 'receiving this kind of gratification and reward is through being 'the good sexual subject' (Gavey 1996, p. 146). A few men spoke spontaneously about their first sexual experiences being with other men. Their experiences were not conceptualized as

homosexual but as forms of sexual exploration and experimentation. It is possible that the conceptualization of such experiences as within heterosexual constrains reflects hetero-normative culture and assumptions in South Africa, and a taboo of being labeled as homosexual. None of the female participants spoke of early sexual experiences with other women,

Many men recalled severe pressure from their peers to debut sexually in order to be esteemed as men, often before they felt prepared for sexual activity. This commonly reported scenario supports other findings that man's sexual debut is more likely than a woman's to be self-willed, however that there is likely to be great social pressure involved and so it is not entirely self-willed (Barker 2005). While all members of society are influenced by the norms of their social group, this is understood to be particularly prominent among young men (Holland *et al*.1994a; MacPhail 2003; Simpson 2005). Some of the men's narratives support the literature suggesting that a young man's sexuality will typically be questioned by his peers if he does not have sex with a girl by a certain age (Kimmell 1994; Flood 2003a). Some men recalled having to lie to their peers that they had sex before doing so in order to meet such pressure. This supports the suggestion that young people frequently overestimate the proportion of their peers who are sexually active — and attempt to align their own behaviour with these perceived norms (Messer *et al*. 2011). Peer pressure for men to sexually debut rarely included the need to practice safer sex and many of the men said their first sex was unprotected.

Yet, in contrast to the women's narratives, most men recalled the peer status that accompanied their sexual debut and a general positive feeling post-sex, which has been documented in other studies (MacPhail and Campbell 2001; Selikow *et al*. 2009). Although men felt compelled to be sexually knowledgeable and initiate sex, they also reported misunderstandings of sex and sexual infections at sexual debut. Some men experienced that it was not enough to sexually debut to gain status with their peers; their first sex also had to conform to certain expectations. For instance, they were expected to have sex with an attractive woman, and to also initiate the sex. Moreover, contrary to dominant perceptions of young men's sexuality, many men recalled that their peer-led expectations about first sex were not met, that they did not feel as 'changed' as much as was expected; many men simply described feeling unprepared, vulnerable and confused by the experience of first sex. Peer-generated expectations of men's adept sexual performance at

debut could contribute to men's fear of inadequacy and disappointment with themselves. Several men reported how there was little emotional intimacy and significance accompanying sexual debut for being primarily motivated from peer pressure.

Conclusions

Overall, the women's early sexual experiences were reportedly disappointing, and insignificant. While some of the men's early sexual experiences were disappointing, they were generally perceived as a right to manhood and related in a much more positive way. Both the male and female participants reflected on their early sexual experiences with feelings of inadequacy, misunderstanding and 'un-readiness; which contrast with expectations of men's early sexuality. Men appeared to hold greater decision-making power than the women did at sexual debut, indicating the need for interventions that target men with SRH awareness, and the need to teach young men and women sexual-negotiation skills. For both men and women, sexual debut oftentimes involved the risk of pregnancy or HIV. The impact of one's sexual debut experience on either men's or women's sense-making of sexual experiences, gender expectations and higher-risk behaviour can be well captured by a narrative approach. Chapter 6 assesses these factors in men and women's subsequent sexual relationships.

CHAPTER 6: MEANINGS, EXPECTATIONS AND SEXUAL BEHAVIOURS IN DIFFERENT TYPES OF SEXUAL RELATIONSHIPS

Introduction

This chapter discusses the relational nature of gender by investigating the ways that the men and women participants appeared to conform to or resist hegemonic gender norms in and through their heterosexual relationships, and how this could influence their SRH practices. Gendered differences in relationship desires, expectations and SRH practices, were identified. The data indicate that HIV-prevention behaviour may be strongly determined by the type and quality of one's sexual relationships — this attests to the importance of studying men's sexual HIV-risk behaviour from a relational perspective. The findings are presented according to three major types of sexual relationships identified: established relationships, casual relationships, and multiple concurrent partnerships.

Established relationships

Both men and women asserted the value of established relationships for being associated with intimacy, trust and perceived minimal risk of HIV transmission. Established relationships were said to often involve long-term plans and require commitment through difficult times. While both the men and women recalled experiences of established relationships, women spoke of fewer barriers to their involvement than men, which was justified by perceptions of dominant masculine and feminine heterosexuality.

Characteristics of established relationships

In order to be in an established relationship, it was generally agreed upon that one must be willing to make compromises and put aside one's own needs:

> I can get into a relationship with my principles and my rules and my regulations, but there is somebody else involved, it is not just about me; and if I want it to work, then it must be about us, because we are in this thing together. (CPT M COLOURED AFRIKAANS 18-25)

One participant asserted that men are not as capable of being selfless and understanding as women are, which were said by several participants to be critical factors for established

relationships to succeed. This reflects dominant conceptions of masculinity that are meant to repress forms of emotion, openness, and intimacy:

> I guess guys are selfish and they only think of themselves, especially in terms of emotions. They need to learn that you have to listen to your partner in anything. (PTZB F BLACK ISIZULU R 25-55)

One man suggested that men learn from women for being better at communicating and understanding their emotions. This reveals respect for dominant perceptions of femininity, as well as the limitations associated with masculine norms that do not condone these elements:

> Men need to know that a woman needs to feel loved, feel safe. They need to know how to respect a woman. They need to know how to have a successful woman next to them and the confidence of having a powerful woman next to them. Because women have been suppressed. For generations and still are. For the small minority that is out in the workforce they have made a massive impact. I think most men are intimidated by women to a large degree, for their success. The manner in which they are able to control and are able to understand their emotions, much better than guys do. Most guys don't know they have emotions let alone trying to understand their emotions. Unfortunately, some women like to be the boss and be overpowering and overbearing, and some guys like to be boss and overpowering and overbearing. But it's understanding of their dynamic. Communication is key to the success. (PTZB M INDIAN ENGLISH 25-55)

Timing was mentioned as critical to the formation of established relationships, since they require 'work' and readiness:

> There's no point in me getting into a relationship if it's going to be for two months...or three months or six months. But if I'm going to get involved with someone, I must know that there are securities in place, otherwise I just don't bother. (CPT M WHITE ENGLISH 18-24)

Also, the compatibility of partners was said to be critical for forming an established relationship because of the level of effort required. As one man said:

> Everyone has his own perception what he wants from the relationship. So the lady is in the relationship for her reasons, I am in the relationship for my reasons, and if the relationship does not give me what I want, I leave the relationship. That is how relationships break up and that is why people cannot stay in relationships. So I will say it is important that a person does what your partner asks, but also that it benefits you, that you are satisfied with it so that it doesn't become a stumbling block later in the relationship. (CPT M COLOURED AFRIKAANS 18-24)

One man expressed his concern that he was not prepared for the effort that established relationships involved:

> The minute I feel challenged in the relationship, then I'll run to somebody else to get validation from them, because...it's simpler. So, yes, I want to have just one relationship now; I'm just concerned about whether I can or not, really. (CPT M WHITE ENGLISH 25-55)

He felt that he did not have sufficient ability to work through difficulties in a relationship and so would seek new relationships when he encountered challenges. He also recalled how he became more interested in and committed to relationship compatibility with age and experience:

> I'm also a lot more focused on compatibility now, which definitely wasn't a concern of mine when I was in my teens and very early 20s. I guess the sort of novelty of sex has worn off, and the whole stage of experimenting with casual sex. So I guess I have put more emphasis on terms of appeal I find in a woman I can have something real with. (CPT M WHITE ENGLISH 25-55)

His narrative revealed that adhered to masculine norms can change within one's life span. Indeed, established relationships were regularly said to require a level of maturity and responsibility:

> It changed my life because from now on, I have changed my behaviour in short. And I have changed the kind of play as a child or whatever. I am a boyfriend now, you see? So I have a responsibility. I don't have to behave like that to my girlfriend. (NELS M BLACK SISWATI 25-55)

Many participants said that established relationships are best formed when partners are aware of each other's needs and expectations:

> It's just that men should try first of all to know what they want, to know what they want out of this relationship, to know why they are in a relationship, to know why they are involved with this woman, and if they have that straight, I don't think there will be so many complications. Because then you will handle the woman, then you would be feeling and the woman would be feeling that this man understands me, this man knows what I want. She will be like a woman you can understand, and a woman, which you will like. (PTZB M BLACK ISIZULU 25-55)

Open communication in relationships was regularly said to be an essential avenue to assess and ensure compatibility with one's partner. One man recalled an open conversation with his partner about their relationship needs and expectations to ensure mutual compatibility and satisfaction:

> Then we put our personal feelings and experience and we sat and talked, asked what her interests are, if we are sexually active, what does she think, or what are her expectations, what does she expect from me, what am I not doing for her, what should I do for her. She asked me the same

> questions and I said to her this is what I want you to do, and she said that to me. So we had a whole, intimate, deep conversation about it. (CPT M WHITE ENGLISH 25-55)

Open communication about sex was described as useful for understanding a partner's preferences, and ensuring that both partners were comfortable in the sexual relationship. Sexual satisfaction was deemed to be an imperative component of an established relationship:

> If your partner doesn't tell you that you are crap or that it doesn't satisfy her, you won't know and you won't have a chance to save the situation. If you are not open to talk about sexual things, you will keep on not satisfying your partner. If there is no harmony in the bedroom, no matter the amount of money you are going to make won't keep your wife from straying. (CPT M COLOURED AFRIKAANS R 25-55)

One older man discussed how the ability to be open about sex was more prevalent among the younger generation:

> I never mixed with anybody who discussed sex. We never discussed sex. It's not like now when everybody discusses, I mean the Kinsey report, and all that, changed things. (GTOWN M WHITE ENGLISH 55+)

There was general agreement that in the changing social context of South Africa, women have greater agency around what to expect from a partner:

> In olden days you didn't say, 'No, I don't want him.' You have to say, 'Yes, I love you.' Even though you don't want to have a man, you need to say yes. So nowadays if I don't want that boy, I say, 'No, I don't want and I don't like you,' you see? It's different than olden days. (NELS F BLACK XITSONGA 18-24)

One woman reported that she felt more empowered after attending university; as a result she and her boyfriend became less compatible and the relationship ended:

> The kind of relationship I had with him, because I'm in the city and he's in the village, I think he was conservative, and because I was becoming more exposed to things at varsity. I'm learning about being a woman, I'm being empowered, I developed assertiveness. I could say what I wanted or what I think, and he had this thing that 'I am a man, the last word is mine and you cannot argue.' I am a woman, I cannot argue my case. I became irritated and disappointed and I thought that kind of conservativeness and patriarchal thinking, he would have left behind. That's when we began to clash and it became too much. (CPT F BLACK ISIXHOSA 25-55)

Her relationship expectations clashed with gendered norms tolerating the male partner's control in relationships including having the 'last word'. One man discussed how it was acceptable and

desirable for a man to have a partner who was a few years younger: 'She can't be your own age, you see, she kinda must be nice, young, beautiful.' (GTOWN M COLOURED ARIKAANS 25-55) An older man recalled having been pursued by a woman more than 20 years older; although he felt the age difference was too great, eventually he conceded to the relationship:

> Well, I put her off for a long time, because she was too much older than me. But that gradually fell away…. Well, it bothered me for quite a long time. Then we became friends. Friends first and then became lovers. (CPT M WHITE ENGLISH 55+)

Not all men conformed to dominant perceptions that men should have a younger female partner. As a counter-narrative, some men also expressed a preference for older female partners:

> Since I think it used to be more taboo, even, younger girls dating older men. I think back then the age difference was maybe two or three years. But now you can find a 26-year-old with a 40-something, because he is riding a nice car, he's doing one, two, three for her. And even the younger guys these days, they do date older women, not for financial reasons, I don't know why. The one I am telling you about, he is way younger than me, he is 10 years younger than me. I don't know why they are going into relationships with older women. Maybe it's my body, I don't know! (NELS F BLACK XITSONGA 25-55)

Age disparity could have consequences on the sexual compatibility of partners. One woman reported how her partner, who was 15 years older, had a different level of sexual energy and drive than she did:

> The age didn't make that much of a difference for me. It did for him. He said at that stage it bothered him, umm, I tired him. He said to me that 'at almost 40-something, dating someone in your 20s, the physical challenge is just too much.' I understand it now, but I didn't then because I didn't think that sex was supposed to be so challenging. (GTOWN F COLORED AFRIKAANS 25-55)

There was frequent mention that partners need to trust each other for a relationship to endure, and that this would lay a foundation for open communication and honesty about partners' needs and expectations. One participant said he ended a relationship because of a woman's dishonesty:

> My problem was that she was lying. I think that was the whole basis of me actually saying 'No, I cannot take this one.' (PTZB M BLACK ISIZULU R 25-55)

A few women reported their expectations that established partners financially provide for them in congruence with dominant perceptions of men's provider role:

> He is very much a hoarder of money, he won't spend. He doesn't believe in anniversaries, he does not believe in sending flowers, and does not believe in taking women out for supper, he does

> not believe in spending money and all that. And I don't want to be stuck with somebody like that. I want to be spoiled rotten. I want to get a flower, even if it's one flower that you bring me between your teeth, bring it to me, drop it off on my breast, I don't care. To me that's fun, adventurous, but he doesn't believe in that. I was unemployed for about five months, not even in that time did he ever say to me let's go shopping and buy you half a pocket of potatoes, no, let me buy you bread and milk, no. He just did not do that…. To me he does not put bread and butter on your table. He does not put the food on your plate. So then, does he have rights to own you. I don't care what anybody says, he does not. And it seems to me it's a common thing amongst women now, if any guy wants to own her, you got to look after me, financially. (CPT F COLOURED AFRIKAANS 25-55)

Several men discussed feeling compelled to provide financially for their partners. Some men discussed feeling anxious that their partner would seek out another partner if they were unable to do so:

> It's very important [money], if you want a girl. There's no free lunch. Because sometimes a girl is attracted to the way you are dressed. Not because she love you. She loves where you are coming from. Maybe your house is nice. Now people are starting to know about love and everything. If a girl loves you, she loves you. No explaining to her. But sometimes the way life is. If she is beautiful, looking gorgeous, there are other guys that are giving her nice car, giving her R100/day, you won't be able to give her the same, she will be asking, 'Why aren't you buying a drink or something?' (PTZB M BLACK ISIZULU 25-55)

Sexual satisfaction in established relationships

In contrast to dominant perceptions of masculine sexuality, both men and women asserted that sex was more meaningful and rewarding in established relationships. Both the men and women positively evaluated established relationships for typically being accompanied by emotional intimacy, with kissing and cuddling being an integral part of sexual expression.

> The sex was good. It wasn't just sex, it was making love. I really enjoyed that. The cuddling as well afterwards. With the one-night stands, you don't do that, you don't cuddle. You just f**k, and when you're done, you look the other way. But with someone you love it's different. After sex, you cuddle, my bro, and you talk...that got me attached emotionally. (GTOWN M BLACK ISIXHOSA 25-55)

> My opinion of sex, it can just be a physical act, but in terms of relationship, it can become a lot more than that, as it can be an expression of emotion. (CPT M WHITE ENGLISH 25-55)

> Whereas if you don't love him you won't enjoy it. But if you love him you will enjoy everything! (NELS F BLACK SEPEDI 25-55)

Due to the emotional connection and intimacy that tended to accompany established relationships, sex was regularly said to be more satisfying, respectful and genuine for both men and women. One man said he found established relationships more fulfilling than casual sex, especially as he matured:

> It changed over time, but it has to do with age. When I had the opportunity to be flippant in my younger years, I did not have the disposable income, so I didn't have the opportunity to go out and hunt. When I was older, I had the disposable income, but the desire to hunt wasn't there anymore. So when I couldn't, I did, and when I could, I didn't want it. Based on the one-night stands I did have, and the one or two relationships after that, the relationships were more fulfilling. (CPT M COLOURED AFRIKAANS 25-55)

This participant's narrative also revealed the common finding that norms of masculinity can change within one's life span. Some women expressed surprise when they discovered men could also value emotional and physical intimacy in an established relationship, indicative that women also expect men to adhere to dominant norms of masculine sexuality. One woman reflected on the stereotypical perceptions she had once held about men's sexuality:

> I think when I was growing up it was just like, you know, they get hard, they stick it in, they blow their load and then they're out, and that's pretty much as simple as a man is. And I don't think it is actually that simple, I think they do actually have emotional responses to their bodily sensations and what they're feeling. It's all about how we can satisfy them, but I don't know where I've gotten that from. I don't know whether I've watched too many movies or if it's society, like I don't know whether it's actually a reality-based thing or whether it's something that I've created out of nothing. I have it like most men are just out there to have a good time and they don't really care about women. Like it's actually more a minority of men that do that than the majority of men, which I've got switched around. But I have spoken to a couple of other guys and they're like, 'No, actually men do care,' men are actually nervous about women and wanting to treat them properly and looking good and impressing them. Men are quite insecure about those things, they just don't make it as apparent as we think. (CPT F WHITE ENGLISH 25-55)

Nonetheless, some gendered differences around sexuality were noted. One man described his understanding of the difference between male and female sexual desire:

> The sexual desire; men tend to have a need for more sex than females to keep that close feeling at the surface, the love aspect. I think most men attribute love, the emotion of love, to physical

> intimacy. We put it on the same bar. So lack of physical intimacy, lack of sex, we notice that, a lack of love, it goes hand in hand. A woman is slightly different where they don't actually need that frequency of sex to still love you. That is what I have observed as well. (CPT M COLOURED AFRIKAANS 25-55)

The interviewee attributed the break-up of his relationship to him wanting more sex than his partner did. He was disturbed by her waning interest in sex, following initial interest that matched his own. After a separation the couple were reunited and 'in the second phase there wasn't any sex really; but then other aspects, emotional aspects became more important.' Ultimately he said he needed the 'emotional fix' that sex could give him, and in the absence of this he decided to 'call it quits.' One man likewise expressed a belief in a fundamental difference between men and women regarding the association of emotions and sex. He went on to say that sex in relationships is less 'important' to women than it is to men:

> Because women are more emotional than us, and men are physical.... If you have frequent sex, you can kind of put everything else in the background, and that to me is good enough. I suspect that is good enough for any man out there. Sex is more of a way of keeping the guy if she likes him, and having the emotional connection to sex is a kind of bonus. At least that is what I have observed over the years. I can say that women connect more emotion to sex than men, period. (CPT M COLOURED AFRIKAANS 18-24).

This was typical of the general downplaying of women's sexuality as evident in the men's accounts of their experiences with women in relationships. Men tended to characterise women as less sexual and also suggested that women are not as capable as men of enjoying sex outside of an established relationship. Some women recalled their partners wanting to have sex more than they did:

> I said, to me he was experienced already, so it was up to me, it was my feelings that were at stake. He respected me still, but I found that he demanded more from me, and more frequently, if I can put it that way. Whereas before I said 'No,' and no is no, and now he demanded it more frequently. Because remember, we have had it, so what? What are you worried about now? It became more frequently, if I can put it that way. I think with all my friends as well it was more frequently. (PTZB F COLOURED AFRIKAANS 25-55)

However, for the most part, this view did not accord well with women's accounts of their own sexuality, which was often described as important to them. Some women complained that their partners were more concerned about their own sexual satisfaction:

> He was not giving me enough love, he was like, those old-fashioned men, you are too young, you won't understand old-fashioned men [laughter]. He did not give me enough time to develop sexual emotions towards him, when he is sexually aroused he just penetrates with turning me on. Always want to be on top, sometimes you want someone from behind. Sometimes I would be not aware that he wants to have sex and he would just get on top of me to have sex. By the time my body gets turned on, he will be satisfied by then. What can I say! It is something painful at times, it is depressing. (PTZB F BLACK SESOTHO 25-55)

Although dominant norms of femininity seemed to hinder many of the women's openness about their sexual desires with their partners, such norms were regularly perceived to be changing:

> Women, even if they want to have sex, they are shy to tell a guy that 'I am having these feelings, these desires today.' We grew up in an environment where men must start everything. But I think now it is going to change. (NELS F BLACK SESOTHO 25-55)

Predominantly older women reported openness about their sexual desire in relationships, which also indicates the fluidity of dominant feminine norms:

> Because, you know, when you get before that, you are more trying to please the man or whatever it is. When you get to our age, it's a partnership.... So 'I'm not pleasing you, you're not pleasing me, we're here to please one another.' I mean at my age now, I'm not going to be stuck with somebody where he does not satisfy me, he does not give me what I want. (PTZB F COLOURED AFRIKAANS 25-55)

> I am now more in touch with myself. I know what I want sexually. If want it [sex], I want it. If they can initiate it, why can't I? (NELS F BLACK XITSONGA 25-55)

> If you do not like it when a man is on top of you, you must tell him. These days we watch TV and movies; you can buy a movie and show him what you want. (PTZB F BLACK SESOTHO 25-55)

Monogamy in established relationships

Monogamy was another regularly mentioned characteristic of established relationships. Generally, women reported more pressure to be monogamous than men. This may reflect that dominant norms of masculinity, unlike femininity, do not typically encourage monogamy:

> I have had two or three girlfriends in my lifetime and the sexual needs of the partner vary, but in my opinion, for a healthy sexual relationship, sexual intimacy is very important with the understanding that it's monogamous, it's with one partner only. (CPT M COLOURED AFRIKAANS 25-55)

> But with me I guess all women, it's my opinion, all women want to have a serious relationship, want to have security in their lives. You cannot find a woman marrying someone who is not working or who does not have a stable home. Because that is what we are looking for. I need stability in my life. With a casual one there is not stability, there is no security, it might end any time. (NELS F BLACK XITSONGA 25-55)

However, some disagreement was expressed about this view:

> There are certain societal pressures on women to be more monogamous or more stable in terms of boyfriends, but once they are in a relationship, I think it is pretty much an even playing field. (CPT M WHITE ENGLISH 25-55)

Indeed, there was some discussion of how such norms of heterosexuality are challenged. Exposure to positive role models and peers with similar values could encourage faithfulness in a relationship. One man said that associating himself with his church peers helped him to be monogamous, as opposed to his school peers who pressed him to have multiple partners. He also discussed how attitudes towards sex transformed after becoming more religious through attending church, and after reflecting on the damage he had done to his female partners:

> Something hit me one day and struck me about how wrong everything I was doing was. The one night I was getting a blowjob outside a nightclub and I thought I've got to change this, the way I'm doing it. I went to see that schoolgirl for one last time, and after then I was like, there's got to be more to life than this. That's when things started changing. I started going to church. That voice inside of my head and my conscience had changed, the way I view life changed, the way I looked at women had changed. My whole life, I was a totally different person. (PTZB M WHITE ENGLISH 18-24)

Indicative of the critical position he took of his demeaning attitudes and treatment towards women after becoming religious, he wrote apologetic letters to many of the women he had treated badly. He said he was not currently in a relationship, but that he was happier to not engage in casual sex and would wait to have sex in a committed relationship.

For a few participants, religious values could influence monogamy. For instance, one man (CPT M COLOURED AFRIKAANS 18-24) said he had been waiting to have sex with the woman he intended to marry because of the values of monogamy and commitment he learned through attending church. Another man discussed the importance of parental and religious education, which had encouraged his friend to be monogamous:

> He would never cheat on his wife because of the advice his father gave him about being honest with a sexual partner. His father-in-law is also a priest and spoke with him about never cheating on his daughter. (GTOWN M COLOURED AFRIKAANS 25-55)

One woman's experience made her realise that all men are different and should not be perceived to be homogenous:

> When I got the second guy, I realised the first one was better because he treated me well, I stayed with him as his girlfriend. But when I got the second guy, he hurt me a lot, I saw him as a horrible guy. That scared me a lot. That was where I realised that men are not the same. Some are good and some are bad. That was where I got to see. (JNB F BLACK ISIZULU 55+)

Although monogamy was asserted to be the ideal among most participants, many individuals reported experiencing infidelity by an established partner. Both men and women expressed feeling great disappointment or pain as a result of infidelity in an established relationship:

> The serious relationship is so draining to tell you the truth. With the casual one, even cheating is ok with me, it's his own life. With the serious relationship, if he cheats on me I am so emotionally drained, I sleep with a broken heart, I cry myself to sleep. (NELS F BLACK XITSONGA 25-55)

Experiencing partner infidelity resulted in many participants becoming more sceptical about trust and love in a relationship:

> This guy also, very giving, he would go out the way, he would always ask me, 'Are you ok, do you need anything?' When I had problems with my son as well he sent people to come help me. That's how he was. There were no boundaries. I found out afterwards that he was dating another white chick, same time he was dating me, and that broke my heart. I cried for three flipping weeks. And I realised after that, I'll never fall in love again. (PTZB F COLOURED AFRIKAANS 25-55)

> I know most of the time we should not listen to rumours, but that girl in the rural area, I often hear bad rumours about her. That she was cheating constantly, so I end up losing trust in her. So if you do not trust a person, your love for her becomes less. But not to say when you see a girl full time, that means she can be trusted. (JNB M BLACK ISIZULU 18-24)

> I found out afterward that he had a lot of partners. But luckily, we used condoms, so, ya, I was pretty terrified, because I mean he shared something with me and he shared it with plenty of other women. So that made me feel dirty. And I couldn't trust men after. (GTOWN F COLOURED AFRIKAANS 18-24)

A lack of trust in a partner's fidelity was also said to hinder commitment to one partner, particularly for men:

> I think it won't work for me because I'm just thinking in terms of loving one person, but what if that person leaves you one day? Because you will never understand chicks. (JNB M BLACK SETSWANA 18-24)

In many cases, discovering a partner's infidelity had propelled participants to end an established relationship. For instance, one woman left her husband after discovering he was unfaithful:

> And then he's got that demand in him, and I said, 'No, I just don't want you to touch me because I don't know where you were before you came here...I don't want you anymore, just leave me alone, please.' To think that he could do something like that was really heartbreaking and it made me heart-sore. I said, 'I'm going to spend the rest of my life with you and this is what you do to me?' (CPT F COLOURED AFRIKAANS 25-55)

One woman explained her boyfriend's controlling and jealous behaviour because his ex-girlfriend had been unfaithful to him:

> Because he always tells me, 'I'm gonna hit you, why don't you answer your phone? Where were you?' I have to report to him. He is jealous. Maybe it's because of his ex-girlfriend. And then he thinks maybe I can do that again. Because this girlfriend, he found her with another man, he said. So that is why he is so strict to me. (NELS F BLACK SISWATI 25-55)

Both men and women expressed similar anxieties that if they did not satisfy their partner sexually, they were more likely to be unfaithful:

> If I can have sex with a woman and do not satisfy her, it is more likely that one day, if she can cheat on me, and feel satisfied by another man, it is very easy that I can lose her. (JNB M BLACK SEPEDI 18-24)

> I think it does help us because if I tell him that he was reading a newspaper, he will then know that he did not satisfy me. Me, too, if he tells me that I was boring, maybe if we go for a second round I will try to push and give him what satisfies him. Actually, to satisfy your husband or boyfriend sexually is to actually prevent him from cheating on you. Why must he cheat if you satisfy him? Sometimes if you tell him that you are tired, 'Do not touch me,' he will go outside to look for sex. Others will give him what he wants, then you complain. (PTZB F BLACK SESOTHO 25-55)

Another woman said her boyfriend would accuse her of being unfaithful if she did not want to have sex with him:

> It's the end of the world. Oh, we'll have a fight. Oh yes, we'll have a fight, because then he gets frustrated. The first thing he thinks of is, 'Who are you seeing, who are you busy with?' They are automatically negative. I said to him, 'But the other day you were tired.' He says, 'But I'm not tired.' (NELS F BLACK XITSONGA 25-55)

Her story reflects conceptions of men as typically demanding and expecting sex, and also being possessive and jealous of their partners. It also indicates a double standard held by some men whereby men are allowed to refuse sex in a relationship, but women are not. One woman described anxiety about needing to satisfy a partner sexually for the relationship to last as she recalled being told by peers, 'Your guy will leave you if you don't give him any [sex]' (GTOWN F BLACK ISIXHOSA 18-24). This statement also revealed her perceptions of men as sexually demanding.

One woman recalled reluctantly having sex with her husband to prevent his infidelity:

> I give my husband what he wants. Then he will not go and look for it from another woman. I do not want to [have sex] anymore, but if I give him his love and I am his wife, then I do not believe he will look for it from another woman. (JNB F BLACK ISIZULU 25-55)

Another woman said she gave into sex with her partner to prevent him from getting angry or seeking sex workers:

> Even if you do not want, you have to give him [sex]. If a man does not get sex, he becomes angry. So that can make him cheat and have a partner outside. That is why a lot of men buy prostitutes. (PTZB F BLACK SESOTHO 25-55)

Sexual behaviours in established relationships

In contrast to dominant norms of masculinity sexuality, various participants said they preferred having an established relationship not only because of the benefit of emotional and physical intimacy, but also because they were safer in terms of HIV risk:

> I learnt that if you had one partner...you can escape this thing of HIV and AIDS, because if you are going around sleeping around with any Tom, Dick and Harry, you are going to get caught up in it. (PTZB M BLACK ISIZULU 25-55)

Unprotected sex was commonly reported among the participants, yet it was generally agreed that this would be more appropriate in the context of an established relationship where there was a

perception of trust. According to one woman, one should only have sex with a well-known partner:

> For my friends, it's kind of like, what the heck, sex is sex. It's made to be done now. It's not like you have to do it with somebody special, it's not a special thing — sex is sex. But for me now it's kind of like I have to know you first, I have to be sure you deserve it. (PTZB F BLACK SESOTHO 25-55)

Condom use was routinely described as neglected in established relationships as it detracted from sexual satisfaction, which was deemed a critical component of such relationships. A lack of condom use appeared to be inconsistent with the ideals of intimacy and fidelity. Yet, some participants remarked that presumed trust with a partner could happen too quickly, even within one week, without knowing a partner's HIV status:

> When you are with someone, you use a condom the first time you have sex with them, second time, by the third time you are used to that person and you almost trust them. No one uses a condom longer than that. And that's when you can still die. (NELS M BLACK SISWATI FG 25-55)

One woman said she often regretted trusting a partner and having unprotected sex too quickly:

> In the beginning and then, I don't know where I get this false sense of security from, and it's like, no, it's fine, we don't have to use it anymore. Then I'd have an attack of conscience and [say to myself] bloody hell, what did you do? And it's like, I need to go and make the appointment. So I might put it off for a little while or I'd tell myself, well, you've got to wait three months anyway because it's that sort of window period, but then I'll ultimately go and have it done. And I'll sort of sit in the waiting room and just freak out, when, you know, it gets to the point where she's going to tell me about whether I do or don't have it [HIV], and then I run through all the different possibilities of what if. Um, and then it's like, you're so stupid, how could you have done this? And then I promise myself not be stupid again. (CPT F WHITE ENGLISH 25-55)

Men, in particular, spoke of assessing whether to trust a woman based on her attractiveness, hygiene, or her reputation as seeming healthy, that they therefore perceived to be free of HIV infection:

> I was just looking. This one is fat, so she is healthy. Whereas this one, if she is too skinny, maybe she is sick [HIV-positive]. (NELS M BLACK XITSONGA R 25-55)

One man said that he would look at a woman's vagina to assess whether she had a sexually transmitted infection before having sex with her: 'Because to African people some of these other

sexual diseases you can see' (GTOWN M BLACK ISIXHOSA 25-55). A woman said she would smell a man's penis to assess his sexual hygiene:

> If you go down to give a guy a blow job, smell it first, see if it's a good smell, if it's a bad smell, don't go down there. (PTZB F COLOURED AFRIKAANS 25-55)

Some women believed that attractive men were less likely to be monogamous, which may reflect the masculine norm that men are less able than women to resist sexual temptation:

> I looked at him and was like, 'Oh my god, this guy is handsome and I know he's not attracting me only.' So he might have attracted someone, and then, no way, in case maybe something else happens. Because sometimes you engage in sex unexpectedly, so I told him we need to go [for an HIV test]. He was so open. (NELS F BLACK SESOTHO 25-55)

One participant believed that women have great pressure to sexually satisfy an attractive partner as women are bound to regularly tempt an attractive man:

> Remember, this guy is good-looking and maybe other women want him as well. So if you keep him and you satisfy him, if I can put it that way, he will be yours, but it's a game. It's a gamble that you take as well. It's up to you as a woman, and it happens throughout, almost most teenagers, they go through the very same thing. (PTZB F COLOURED AFRIKAANS 25-55)

One man admitted to conniving to have protected sex for the first few encounters, until a woman grew to 'trust' him, despite the woman's preferences for contraception. This reflected an attitude towards sex as a domain controlled by men, without consideration for a partner's desire for contraceptive use:

> You are busy with her, but you're not satisfied until you don't use a condom. So because you want to earn her trust, you use a condom, but then one day you end up penetrating without using a condom. Then she will be shocked and maybe say, 'Use a condom!' But if she doesn't ask about the condom, then you carry on without it. Those are some strategies that a man uses. (CPT M COLOURED AFRIKAANS R 18-24)

This raises the issue of trust in relation to HIV-preventive practices. A lack of trust in one's sexual partner may have preventative benefits. When the partner is suspected of having other sexual partners, this could promote protective sex. One woman's narrative around the differentiation of sexual practices based on levels of trust supported this:

> With Thando there was only once we didn't use a condom, but I was sure he was safe because we would talk and I knew I was only female in his life then. With Luando I made sure we always used a condom because he was a 'player.' (GTOWN F BLACK ISIXHOSA 18-24)

Several women expressed similar convictions to always use condoms because of a lack of trust:

> In fact, there is no other way of managing the risk. It's just to use a condom. There is no other way, because you cannot tell where your partner has been, so the condom is the only option. (PTZB F BLACK ISIZULU R 25-55)

> P: And the only guy that I never used condoms with was my first boyfriend. Somehow we just trusted each other. Since then, no ways.
>
> I: And what made you do that, is it because of HIV?
>
> P : It's just partially that, yes, also the fear as well, I don't know. I've come to the stage where I realise a lot of the guys are also like kind of 'movers,' and when a guy plays innocent, that's when you don't trust him. You just know the sweet-talkers and you read between the lines. This guy is a sweet-talker, and I know he loves women. It's fine; what you don't see you never know, so the best thing to do is safeguard yourself. (PTZB F COLOURED AFRIKAANS 25-55)

Overall, condom use was reportedly rare in established relationships. Among the participants who reported regular condom use in an established relationship, the most commonly given motivation was to prevent pregnancy. An older woman said she was no longer able to insist on condom use with her husband after menopause since they had previously used condoms primarily to prevent pregnancy:

> P: My husband and I, we do not use such things, condoms, because we are not having sex for babies or such.
>
> I: Has this ever worried you?
>
> P: I spoke to him about these things, but he does not want to. He just says to me, 'My ma, you do not decide for me.' Now what must I do? I have spoken to him so many times, but I leave him because he will not listen to what you say to him — ma will never turn him the wrong way, only helping him out of the temptations. He does not want to hear about it. (CPT F COLOURED AFRIKAANS 55+)

Casual relationships

Both the men and women spoke of engaging in casual sexual encounters, yet often cited different reasons for this. Men reported having a higher number of casual sexual encounters on average than did the women, although there may be a discrepancy between the participants' responses and their actual behaviour due to socialised gender expectations encouraging a large number of sexual partners among men and a low number of sexual partners among women. The meaning and definition of a 'casual relationship' varied from person to person, but there was near

consensus that casual relationships are seldom monogamous or long-term, and that they require less time and effort than an established relationship.

Characteristics of casual relationships

Casual partnerships were a dominant feature in many of the participants' lives, especially among those aged 18–24 years. Several participants discussed how casual relationships are 'a stage' that some people go through, eventually progressing with age to commitment in established relationships: 'It's a stage that people have to go through. It doesn't last long as people grow up' (NELS F BLACK SEPEDI 25-55). Indeed, older men and women spoke much less about engaging in casual relationships than the younger participants did. Several participants said they were less particular about what they looked for in a casual partner as opposed to a committed partner. One man said, 'You don't check, as long as it's a woman, it's fine' (PTMB M BLACK ISIZULU 25-55). Both men and women generally agreed that casual relationships do not involve long-term plans:

> It's something that you don't feel anything, you just go because at that time you don't want to be lonely, so you just go with the flow. You don't know where it's going to end, and if it ended now you wouldn't even care. (PTZB M BLACK SESOTHO 25-55)

For many participants, casual relationships often did not last long:

> They last only a few weeks. I would try and have them sort of last as long as possible just to have them sort of in the back, or to be there whenever I wanted them, so it was either if I got bored or if they got bored, whoever got bored first, and then it would be over. (CPT F WHITE ENGLISH 25-55)

Among many male participants, particularly the younger group, a need for status among peers or in relation to women was a key motivation for having casual partners: 'Even chicks will not like you if you had not had sex because they look down upon it' (CBAY M BLACK ISIXHOSA FG 25-55). This represents the status bestowed on men for having many partners in congruence with dominant trends of masculinity. One man reflected on his various casual sexual relationships as a source of status among his peers:

> Those casual things are just to pass time. Sometimes there is a chick that has elements you like. Maybe a chick is really well-built. So sometimes I think I can use them, like a trophy. Just to show my friends, like this is what I have got this weekend. To show I'm the boss in this game. I run this. And for future youth to also see I am a man. So that the young ones can grow up knowing that you have to be a player. (CPT M BLACK ISIXHOSA 25-55)

One man reported how he competed to have sex with as many women as possible to prove he was 'one of the guys.' He adopted a performative way of speaking about his sexual experience during this time, as he boasted about the number of casual sexual partners he had:

> I was barking out loud, chasing after women like you wouldn't believe, bra. I used to go home a lot [to Bisho[16]], a lot so as to get some shine from the area. Probably my self-esteem is boosted by whatever when I am there in Bisho, maybe there is no self-esteem in Port Elizabeth[17], but in total, bra, I have had maybe 50 girls, or something, in total. So many that I should get a trophy or something! (GTOWN M BLACK ISIXHOSA 25-55)

His use of the term 'self-esteem' alluded to having sex, and his perception of self-esteem is synonymous with having a large number of sexual partners. He also described many episodes of casual and unprotected sex, often in the context of drinking alcohol:

> When we drank alcohol, we could for instance in December, you know, we have a schedule so that so we want to check who is going to f**k as many girls as possible. Some of the young guys went to boarding school, so we would say to them that we will come to their boarding school and that we want them to set us up with the hottest-looking girls at their school, just to prove a point *emajiteni* [peer group] and that you-are-a-guy type of thing.

Another man reported how he pursued sex with women as a 'game to be won' among his peers:

> It was just the guys who were hanging around at the time, we were all bad for each other and we were all trying to outdo each other, or trying to see who could literally do the most unspeakable things with women. So it became a competition, which I unfortunately was going to lead for some time. (PTZB M WHITE ENGLISH 25-55)

This highlights the significant impact of his peers on his sexuality, who he noted were 'all bad for each other.' In doing so, he revealed that he did not accept his peer norms as a right kind of masculinity, but he nevertheless followed these norms. He also indicated that he pursued sleeping with virgins for the perceived status this brought him.

Sexual assertiveness featured in his developing sexuality as he gained experience, which also revealed how performances of masculinity change within an individual's life span:

[16] Bisho is the capital of the Eastern Cape province. The Provincial legislature and many other government departments are headquartered in the town.
[17] Port Elizabeth is one of the largest cities in South Africa with a population of approximately 1.5 million (Statistics South Africa 2011).

> Then I got a bit older, a bit more confident. Girls started to notice me more than they did in the earlier stages in my life. Then I went through a stage when I was a dog, where I wanted to break as many girls' virginities as possible. So I would only sleep with a chick if she was a virgin. I had gotten nasty.... It was like, I can take something that means something to someone and not care about it.

This is in sharp contrast to his younger self when he had recognised a connection between love and sex, and respected the significance of virginity for his partners.

Another participant reported an analogous sentiment that a man's pursuit of casual relationships, and the number of women he can have, inflates a man's status and self-worth. In this example, sex is about 'winning' as many women as possible:

> P: Our need is just to chow as many chicks as you can. It's about having sex, because every conversation that we have is about sex. We will use our money, we will use our cars and everything, just to have sex. That's all we want. It's all about winning…. Remember, it's a status how many girls you f**k a day…. It is status. You can ask any man, or you can ask me, I mean...very, very well. It does boost your ego.
>
> I: Okay, should it happen that you get this woman, she is tough, she doesn't easily buy your story. Do you go after her?
>
> P: You leave her. She is wasting your time. Remember, you are counting here. You might be the record-breaker, so if this person is wasting your time, I mean if you feel Northcliff is too big for her, you go to Soweto. (JNB M BLACK ISIZULU 18-24)

Customary practices in African isiXhosa traditions were said to motivate a few participants' engagement in casual sex. A young man said he was expected to have sex with a girl that he did not know, and was not going to fall in love with, following his traditional male circumcision experience:

> There are some guys, they believe that when you are coming back from the bush, you gonna [have to] have some other girl, without your girl, you see, to say that *ukhuphaifutha* ['all the dirt from the mountain'], you sleep with this girl because you do not have a love with her. You are not falling in love with her. (CBAY M BLACK ISIXHOSA 18-24)

One Xhosa-speaking woman expressed her collusion in this belief that it is important to have sex with a male, post-initiation[18], as he was now 'a man':

> When I slept with him, it was after he had been to initiation school. So, at some point while I was growing up, I told myself that I would sleep with a boy. So, I agreed to sex also; it's like, okay, now he is a man so we are kind of grownups. (CPT F BLACK ISIXHOSA 25-55)

Sexual satisfaction in casual relationships

Less emotional intensity and intimacy often accompanied casual sexual relationships — for example, less kissing before and after sex, less cuddling after sex, and fewer forms of intimate affection*:*

> There is a difference when it comes to having sex with someone you do not love…when you are having sex with someone you do not love, no kisses. For example, when you are in a tavern, drinking, drinking, drinking and have some girl, go through down, and strip and have some condoms, and dig her [have sex with her] like hell [laughs]. (GTOWN M BLACK ISIXHOSA R 18-24)

Some men used hostile language to describe how women sometimes confused casual and established relationships in terms of their expected level of affection:

> There is no way I will respect you for that. I don't know how many men you have been sleeping with, and now you want to hold me, you want to explain stories as if we are in love, and I mean there was only one objective and that was only to f**k. So, just after sex, I mean a woman wants to sit down with you and hold you and everything. They forget that it was just a one-night stand. (JNB M BLACK SEPEDI 18-24)

This man also expressed how he was less concerned about a casual partner's sexual satisfaction than and established partner:

> With regard to satisfying my woman, I would say there are times when I would feel guilty, especially with my steady girlfriend because I mean, come on, she also has to ejaculate. But with other women I don't care. The objective is for me to cum and then it's over. I don't care in terms of whether they are satisfied or not…. I mean after sex, you ask the person, 'Are you leaving now or what?

[18] The Xhosa initiation custom involves a period of seclusion, a circumcision ritiual, an education process, a and, finally, a celebratory feast. Boys who undergo this transition to manhood are known as *abakhwetha* (initiates).

The disassociation between love and sex was often expressed as a male characteristic, portrayed in opposition to women's tendency to associate sex with intimacy and love:

> Like, it's easy for a woman to become emotionally attached after the sex. But for the guy, ya, it's easy for the guy to become emotionally detached after the sex. (GTOWN M BLACK ISIXHOSA 25-55)

> Most of the women they have love. Most of them they really love their men with all of their hearts. But the men didn't love their women. They just want to sleep with them. With guys, you can do it and just move one. It's so easy for them to do that. With us it's not easy, you stay connected somehow after the initial process. (NELS F BLACK XITSONGA 18-24)

> Women are vulnerable. We get easily intimidated, we easily fall in love, we easily express our emotions, we easily say, wow. Guys would never say 'I've got a thing for you,' never. To me as a woman, you've got to take care of yourself and don't trust any man that will come and say, this is who I am and I love you and all that crap. As far as I am concerned men don't know what love is. Women know what love is because they know how to get hurt, they've got feelings and they know how to fall in love and they know how to fall out of love as well. Men just pull up their zip, they can go anywhere, and if they like any woman, they are going to approach that woman. (PTZB F COLOURED AFRIKAANS 25-55)

One man admitted that the best sex for him was in intimate relationships where cuddling is part of the sexual experience. Although his preferences were contrary to typical masculine sexuality, he spoke of a relationship where he conformed to the allegedly male tendency to disassociate love and sex:

> But I didn't love her enough to be her boyfriend, right. But whenever we got drunk we'd end up sleeping together. And because of that she ended up falling in love with me, right. But I'd just be having sex, know what I mean? [laughing] That's what I'd be doing…. Women are fragile. They're not like us. We are very egocentric. We don't care. And we'll say things to one another that will hurt the next man. But then again, because he's a man, he's not supposed to get hurt by certain things or hurt easily. So men have generally got that approach to life: I can say whatever I wanna say, do whatever I wanna do. (GTOWN M BLACK ISIXHOSA 25-55)

He thereafter embarked on various casual relationships, usually under the influence of alcohol, but regularly regretted these experiences for putting himself at risk of acquiring STIs and because of his actual preference for emotional intimacy and commitment in sexual encounters.

Many participants asserted that men's ability to disassociate sex and love or intimacy motivated their regular involvement in casual sex. One woman explained:

> They claim they want to experience. If sometimes he's dating a skinny girlfriend and then he sees someone curvy. And he thinks, 'Oh my god, I can go see what it's like to have sex with a curvy one.' So easy. They are not so attached as us women. Men can have sex with you, the following day he forgot about you. (NELS F BLACK SESOTHO 25-55)

Nonetheless, some women also reported being able to disassociate love and sex. One woman used the perception of men's weakness for sex to her advantage:

> I could influence men sexually or by flirting with them, then it was like, okay, well, I'm actually going to turn the tables on you and I'm going to take the upper hand. It actually just makes things weird, like the power play and how sex is used as that, it's just so cruel. Sex is a tool that you can use. As a woman it's a tool that you can use to get what you want or manipulate men, like you can use your sexuality as a power play. (CPT F WHITE ENGLISH 25-55)

Several participants said it was becoming more acceptable and prevalent for women to openly seek casual relationships where love and sex was separated:

> In olden days if I want sex with a man they gonna call me a bitch. But nowadays it's changed. It's because it's the new South Africa, maybe. (NELS F BLACK SISWATI 25-55)

Formation of casual relationships

Despite these perceived societal changes, many male participants reported lying about their intentions or said they used strategies, such as expressing false love to initiate casual sex, since dominant conceptions of femininity generated expectations that women would refuse men's casual sexual advances:

> You have to lie to women to get what you want. If you can practice the truth, you will never have sex. If I see you for the first time and I say to you, 'After these drinks, can we go and have sex?' — you will think I am disrespecting you, I am making you out to be a bitch and a prostitute and whatever; so I have to lie and say I love you. (JNB M BLACK ISIZULU 18-24)

Another man discussed his strategy of expressing love to get sex without actually feeling it:

> There is a girl that you are thinking about, maybe she would have lied [and said] 'No man, I love you,' I love you and so and so, but you will find that you do not love her, you will be able to call her, and when she arrives, you take her straight away and put her on the bed, no discussion or talk, you communicate by the penis and the vagina only, you see? (GTOWN M XHOSA R 18-24)

One man (PTZB M BLACK ISIZULU 25-55) criticized the dominant trend for men to lie about their feelings to convince women to have casual sex with them. He expressed his belief that both men and women should be honest about the terms of casual relationships.

Casual relationships among women were reportedly commonly formed out of loneliness or a failed previous relationship. As one woman said:

> I mean it's like you don't care about each other. It seems as if there is someone else between you. It's because they are lonely. Or maybe they have had a serious relationship that failed a lot. (NELS F BLACK SESOTHO 25-55)

Both men and women described having casual sex after consuming alcohol, which was said to lower sexual inhibitions. One woman discussed the commonality for women to gain confidence in order to seek casual partners under the influence of alcohol, although to 'pick up different guys' was said to be impolite:

> I am at that point that I want to be satisfied. I'm at that point and I'm not going for any *kashela* [old man]. I'm not going for anybody where I know, listen here, I'm not going to be happy here, no ways. When you get to let's say 38, 39, 40, your hormones change. You have this drive within you, and normally a certain time you have this passion. Most of the time now with women, if you drink, somehow you get horny. They say if you go to a bar and a woman has something to drink, she is automatically loose. You go to any bar and you see women, they get louder, they start becoming bold. You walk in there; do you feel you will make eye contact if you haven't had a few sips of wine or something? You won't, because you are not bold enough. Have a couple of wines, my girl, and you will see why you start scouting from corner to corner, because you automatically start being bold. As I said, it's hormones. Somehow they just play around with your mind and with your body as well. You start scouting around and saying, okay, that's fine, although being a woman, you shouldn't go to a bar and pick up different guys because it's not polite. At the same time you've got to maintain your dignity and your self-respect. (PTZB F COLOURED AFRIKAANS 25-55)

Many of the men stated that having and spending money was also central to creating opportunities for casual sex with women:

> They will hook me up with someone, because at that time, R20 or R30 was enough to spoil a girl a little bit. (PTZB M BLACK SESOTHO 25-55)

Several participants reported that sex that involved transactions was more likely to be characterised by a large age difference between the partners; often between younger women and older men:

> With the younger ones, it can be about money, because they love material things. With the Blackberries and you know, so they go into a relationship looking for financial security from older men. They don't really go with guys their own age, those looking for money. They just look for sugar daddies. (NELS F BLACK XITSONGA 25-55)

> The rich guys f**k up the world for the rest of us. They date younger girls because they do have money. If you flash money, all girls will come. Predominantly, you will find young girls are getting pregnant regardless of the education they got at school about sexual diseases. (NELS M BLACK SISWATI 25-55 FG)

This man alluded to sex in such relationships as frequently unprotected. One woman reported her concern in this regard:

> Look at it now, where is the high HIV at the moment? It's amongst the youngsters because they are exploited by the sugar daddies. That I do not like. A lot of them are going for money, they are going for airtime. Remember, they come from homes that are battling. You look at it now, if I don't have money for the Levi pants, I don't have it. What happens if somebody else comes by, somebody else's husband comes by and says, 'Hey, baby, I can get that for you,' whatever. Takes the child shopping and you can basically spend R200 on this young little girl, R500 and you got the whole package. Oh mommy, I got it from somebody, I got from whatever. You are not going to go in and check in and say 'Oh, where you got this money from?' and look into it. You won't. You are just going to keep quiet, but you are going to nag and irritate you. You know what happens? She's moving out with this man. Is she using a condom? No she's not. Is this man using a condom? He's not. Eventually he's going home back to his wife. (PTZB F COLOURED AFRIKAANS 25-55)

Critiques of casual relationships

One man critiqued his reliance on the social status derived from having sex with as many women as possible. Yet his attitude about the importance of men needing or gaining this status suggests that he does not see this as easily changing:

> Personally, I know that it's wrong, but I get those credits and then my ego goes up. It's a good thing. It's every boy's dream. Not a man, a boy, because a boy is an immature person. It's the

> dream of every boy. Remember, I will be chowing here. It's a credit, it's status. You will never change us. The reason why we want to be successful. (JNB M BLACK ISIZULU 18-24)

Throughout the interview he described himself as a 'good boy' led astray by his peers — such as when he moved to boarding school — and he expressed greater preference for his original rural identity than for his urban (peer-influenced) identity:

> I am more confident with the rural person than the fake person I am currently. I have an identity with the rural person. I knew what I wanted and everything, now everything is just following the crowd. As much as I know it's wrong, I will just do that. So I'm more comfortable with the rural-area boy.

A lack of future direction was also given as a reason for disapproving of casual relationships:

> I don't approve them, because you don't know where you are going. You don't have a direction. But when you are going with someone you really want, they know exactly where you are going. (NELS F BLACK SESOTHO 25-55)

Sexual behaviours in casual relationships

Many participants reported that they were more likely to use condoms with casual sexual partners because of the greater health risks they perceived to be associated with such encounters. Although the majority of participants asserted the importance of practicing safer sex in casual relationships, their condom use was not consistent. Several participants, particularly men, said condom use was less likely if they had been drinking alcohol. For others, it was simply spontaneity, or 'the heat of the moment,' that hindered condom use during casual sex. And men were seen as more eager for sex in congruence with hegemonic norms of masculinity, which was said to undermine consistent condom use:

> They know that we are weak. We are weak, we are not strong, in the sense that when a random girl comes and grabs my penis the first thing I think about is sex, you see. So I think that is the common thing. We [men] are very weak when it comes to issues involving sex you see. But we are strong on the physical side you see. Not mentally [laughs]. (GTOWN M BLACK ISIXHOSA 18-24)

Several men discussed a reluctance to initiate condom use in casual sexual encounters and suggested that women should always carry condoms to compensate, which respects the agency

of women to make sexual decisions. Many women also expressed an ability to initiate consistent condom use in their relationships:

> Actually, he buys them [condoms] in his room, I also buy some [condoms] for my room because we are not staying together. (NELS F BLACK SESOTHO 25-55)
>
> So I'm kind of like, 'No, if you don't want to use a condom, then you had better be gone.' (PTZB F BLACK ISIZULU R 25-55)

Yet there was some divergence on this view. For instance, one woman perceived condom use to be stigmatized for being associated with casual sex:

> He initiated it [condom use]. It might sound really ridiculous, but at that point I kept saying to him I just don't want to have sex with a condom because I feel, even back then, the condom thing was stigmatised in my mind. I don't want to feel like, you know, I'm just some booty call, that's what I feel like when a guy uses a condom, she's a booty call, he doesn't want to really be with her, and he said to me…we have to use it. He initiated it, we used condoms. (PTZB F INDIAN ENGLISH 25-55)

Multiple concurrent partnerships (MCPs*)*

Some participants discussed having multiple concurrent partnerships (MCPs), meaning sexual relationships with two or more partners at the same time. Reasoning on suggested 'cultural' grounds and notions about men's sex drive were most often used to justify men's engagement in MCPs. Some women also spoke of engaging in MCPs, with relationship dissatisfaction and economic incentive given as the primary motivators. More men than women openly spoke of engaging in MCPs. The participants largely agreed that there is greater disapproval of concurrency for women, which may have discouraged the women's reporting of engaging in such relationships.

Characteristics of MCPs

Several men who spoke of engaging in multiple partnerships discussed how they would treat their main partner differently from their side partner(s):

> To my stable partner I do my level best, everything that I think I know, I want to impress her. But to a casual partner I just want to relieve the pressure and move on. So there is a lot of difference. Because the woman I love I have to continue doing it [sex] with her but the casual partner I might not even want to do it again if she does not impress me. (JNB M BLACK ISIZULU 25-55)

One man referred to his 'side 'partners as 'stolen,' meaning they were hidden from the main partner and also had conditions imposed on them that the main partner was not subject to:

> The main one is also allowed to go to your house at any time and see your family members. The stolen one is not welcome at your house. She is not to be known. You put rules on the stolen one, which is also the difference. Like don't call me, I'll call you. She knows, and you have told her you have a girlfriend. She knows we will be stealing each other. (CBAY M BLACK ISIXHOSA 25-55)

Another term regularly used to describe side partners was *khwapeni*, a Xhosa word used to refer to a sexual partner 'who is kept hidden.'[19] Both terms suggest that concurrent side partners are meant to be kept secret from the main partner. Several men felt compelled to keep these partners hidden from their main partner who would be upset knowing about them:

> Sometimes these girls ask me for my number. And then they call anytime. Sometimes the phone rings when you are with your girlfriend, the real one. And she would ask 'Who is that?' And she can see your mood changed when you get the call. Now there are no numbers exchanged. We just do a one-night stand. Straight up. (CPT M BLACK ISIXHOSA 25-55)

Yet some men commented on a main partner's understanding and acceptance of their multiple partners. For women to tolerate men's concurrent partners supports dominant perceptions of men having an uncontrollable sexuality and an inability to commit to one woman:

> When I go to the house to sleep in the township, I have a girl there. Every night I am with her, every night. But if the girlfriend who is now in Port Elizabeth is coming back for the holiday, she understands that the girl is my lover, and I tell her when she is around. She will give me space to be with her. (GTOWN M BLACK ISIXHOSA R 18-24)

A few men described their 'side' partners as aware of their tenuous position, and stated they remained in the relationship out of a desire to become the main partner:

> They do it because they love you and want to be the main one with you. They don't like the fact that they are the stolen one. It's not nice for them but they just do it because they do love you. She will then push to try and be the number one girl. And the other one is no longer competing because she knows she is the main one. (NELS M BLACK SISWATI FG 25-55)

Men's motivations for MCPs

MCPs were most commonly reported as prevalent in the rural areas among black men. Both the men and women highlighted cultural pressures on African men in particular to have concurrent

[19] From the Xhosa word *ikwapha*, which translates to 'armpit.' In Xhosa culure, *khwapeni* is frequently used to suggest a sexual partner that would be hidden, as if tucked under the armpit.

sexual partners to gain status. One participant said he might have been monogamous if not for such pressure:

> Really, I'm a man. If it was my own decision or if I was just taking the decision in my own way, maybe I would have been with her even now and never had another girlfriend. But we grew up in the township where there was this peer pressure [laughs], so in order to show off that you are...it's nature. It's us as African men. (PTZB M BLACK ISIZULU 25-55)

Having multiple partners was sometimes justified by the African male participants as stemming from the cultural practice of polygamy, which in this case, represented a particular form of hegemonic masculinity:

> It makes a man feel proud to have many women, yes [laughs]. I don't know, but in most cases if a man has got lots of women, the same as our president, Jacob Zuma, he feels proud [laughter]. (JNB M BLACK SETSWANA 25-55 FG)

In contrast, cultural norms were generally said to disapprove of women having multiple partners:

> You know cultural things. They will tell you men can have two wives. But women can't have two husbands: that's impossible in our culture. (NELS F BLACK SESOTHO 25-55)

Engaging in MCPs was often portrayed as a signifier of male social status; as a result, many men expressed an unwillingness to be in a monogamous relationship. One man expressed it as: 'You can't have the same meal for dinner every night' (NELS M BLACK SISWATI R 25-55). Seeking multiple partners was viewed as especially important for men who suffer from low self-esteem, as having multiple partners could enhance one's social status. Men could also be assigned a negative and emasculating image if they have only one or no sexual partners:

> There are lots of bad words which are attached to a person who had fewer girlfriends...they call you 'she-man' and stuff like that. It's more embarrassing. (PTZB M BLACK ISIZULU 25-55)

Although the men frequently reported seeking multiple partners due to a perception that they had a high sex drive, a few men discussed an alternative strategy of masturbating as a release to prevent them from seeking casual sex or multiple partners:

> 'I decided to control my promiscuity with manual satisfaction instead of chasing after every girl I met' (PTZB M COLOURED AFRIKAANS 25-55)

> There's a solution to that if you want to call it a problem. And it doesn't necessarily have to involve sex. Ja, that's not a problem. You can physically solve the situation and you don't have to have sex every week. (GTOWN M WHITE AFRIKAANS 25-55)

In my personal opinion, I would also rather masturbate than go out and, you know, pick up a girl and have intercourse with her. Like I said, it's more acceptable [morally] for me. (CPT M COLOURED AFRIKAANS 25-55)

One participant felt the same applied to his girlfriend:

I mean, if my girlfriend masturbates, it's not like she's cheating on me. So for me, it's a lot more acceptable than cheating. (CPT M COLOURED ARIKAANS 25-55)

Infidelity as a motivation for MCPs

Several participants asserted that an experience of sexual betrayal or rejection could be an instigator to seek multiple partners:

She cheated on me. She bust me, so from that day onwards, no chick is ever doing that again, and I'm just going to break girls virginities and I'm not going to care. I went on and on and on for a while, till I was about 22. (CPT M WHITE ENGLISH 25-55)

Several men spoke about the pain of a girlfriend's infidelity having caused them to disassociate intimacy from sex, thereby motivating them to seek concurrent sexual partners:

Yes, and after that, the second time [betrayal], I decided never to fall for a girl like that again, or as deeply as I did. I put barriers in place after that. (CPT M COLOURED AFRIKAANS R 18-24)

It's because I know that most of the times I do not satisfy her because it's about me, and it's about the revenge I'm talking about. I was hurt before, so now it's about me. (GTOWN M BLACK ISIXHOSA 25-55)

After, I heard she was jumping around. That actually hurt me. That's why I did it. I started fucking around with girls. She hurt me. That was my first love, eh? My first love. It actually hurt me a lot. That's why I felt like doing the same thing. (CPT M COLOURED AFRIKAANS 18-24)

Indeed, many of the men alleged an inability to deal with and recover from feelings of rejection and hurt, which appeared to have alienated them from the possibility of future commitment in an enduring relationship. For instance, one man said his first girlfriend caused his first heartbreak when he found out she was unfaithful, which he attributed to being an inadequate lover. From this and a subsequent experience of being cheated on, he decided that to keep a woman interested, a man needed to embark on multiple partnerships:

I learnt thereafter a lot that when you want a girl to love you, but she is doing funny things on the side, you have to pull her back to you by another girl, you see. I learnt that on my own [through that experience], you see. (GTOWN M BLACK ISIXHOSA R 18-24)

not tired now, it's okay,' so I must not be tired now as well? (PTZB F COLOURED AFRIKAANS 25-55)

One man (CPT M BLACK ISIXHOSA 25-55) reported that he had a girlfriend at the time he went to the isiXhosa practice of initiation. When he returned, he went against the ritual norm of having sex with a woman other than one's own girlfriend. Instead, he had sex for the first time after his circumcision with his girlfriend, who he said he loved. Later, he was led to believe that she had been unfaithful to him while he was away and so the relationship ended; thereafter, according to him, he became a 'cheater.' His relational world appears to have been stripped of the likelihood of having an enduring emotional relationship with one person, with its commensurate feelings of trust, intimacy and longing.

There was occasional discussion of how women, likewise, might seek multiple partners after a partner's infidelity in order to recover:

> I always admire girls who are doing it, but not for the sex part, but just how to screw them at their own game in retaliation, or avenging others to who that would have been done. Maybe the person would have three and would have one kind of person that she loves very much, but with these others, she is doing it to be spiteful. (CPT F BLACK ISIXHOSA 25-55)

> Before, I wasn't engaging in sex that much, but now, along the way I have been hurt by guys. For now I don't care about guys. I sleep with whoever I sleep with. So, it has changed because before I didn't used to sleep with guys that much, so now I am playing guys. They used to play us, so now I'm playing them also [laughs]. (PTZB F BLACK ISIZULU 25-55 R)

> When I got married I was communicating with him, but I loved my husband, I did not love him [boyfriend]. When I saw that my husband was not satisfying and he had a girlfriend outside, then I thought that was an advantage for me to get someone who has been proposing me for long time so he can give me some love. (PTZB F BLACK SESOTHO 25-55)

Women's motivations for MCPs

Women were more likely to be motivated to seek multiple partners to alleviate pain and disappointment inflicted by a main partner. For instance, one woman said she felt inclined to seek other partners whenever she had a fight with her fiancé:

> I fight a lot with my fiancé. So we can go one or three months without seeing each other. So in between that there has to be a casual someone. But then he has to know I have a serious relationship, it can end anywhere. That is my own benefit. I don't think a lot of women do that.

> Only me. Because I'm kind of naughty. Let's say if I don't have a casual someone and I fight with my boyfriend, I'll be depressed. So if we are fighting and someone calls me 'Hey baby how are you?' everything just lifts off. (NELS F BLACK XITSONGA 25-55)

This participant saw it as increasingly acceptable for women to seek multiple partners. But she cited different reasons for why men and women sought MCPs:

> Men are hunters. They are forever hunting, conquering. I think it makes them feel good or it makes them feel like they are still out there, got the game, I don't know. With women, most women only do that when they are stressed. But my mom never do that, she never did, only seriously, she never did that. My father has got kids all over. And my mom knew about that but she is still there, but she never cheated, not once. I guess it goes with the times. The younger generation can't tolerate those kinds of things. The younger women, even if I do want stability, 'Ok, this is my boyfriend I'm not going to leave him,' then I have my thing [casual partner] on the side. Even though I'm not going to show him. I just eat and wipe my mouth. (NELS F BLACK XITSONGA 25-55)

One woman in her early 40s complained about how men get grumpier, more frustrated and spiteful with age and are 'not so pleasing anymore.... My boyfriend is 50. It's a bad age' (PTZB F COLOURED AFRIKAANS 25-55). She contrasted him with another partner she also dated, who was younger, exciting, adventurous and sexually satisfying — and explains why middle-aged women may seek younger partners:

> A lot of women, when they get to a certain age, because there are not enough guys that share the same interests, they go a generation behind. They start finding an outlet a generation behind where they start hitting on younger guys because then they've still got that energy and the young guy has got that energy as well, whereas an older guy, or a guy equivalent to their age, doesn't have the same energy or the same interests.

Several women also reported seeking MCPs because of economic need or desire:

> You find, too, you might love this guy a lot, but he does not have money, he does not take you out a lot...but you still love him. And you find the other guy can take you anywhere, anywhere, but the love is not that much [laughs], you see? The intimacy and connection is not there. (NELS F BLACK SESOTHO 25-55)

> The other one who was working, I didn't love him very much. And I was having some small feelings for him, so the other one who wasn't working, I was have full feelings for him. But it was because of the money. And if I want something he would go and buy it for me. But the other one wasn't working. (NELS F BLACK XITSONGA 18-24)

Women engaging in multiple partners may reflect changing norms of femininity and that women can exert greater agency around their expectations in relationships. Yet, the fact that such relationships were often economically motivated indicates fewer employment and material opportunities for women, which could create a dependency on the financial provisions of their male partners.

Sexual behaviours in MCPs

The majority of participants had a strong awareness of the association between having multiple partners and the risk of HIV. For the most part, sexual behaviour with a side partner imitated that in casual relationships, where there was more evidence of regular condom use. With main partners, sex was more likely to be unprotected, as was mostly the case for the participants in an established relationship. As one man said:

> There is a difference between *khawpeni* and my wife. Because my wife, I have had some blood tests with her and then I trust her too much. And I know she is faithful even though myself I am not faithful. But with *khawpeni*, I don't give them love. I always use condoms with them. (NELS M BLACK XITSONGA 25-55 FG)

Indeed, many men expressed how 'condomizing' with side partners was particularly important to protect one's main partner from HIV infection:

> I don't take a chance with my stolen ones. Only with the mother of my child, who I love. I don't want to infect her with these diseases. People mustn't tell my kids, 'Your parents died because your dad infected your mother with AIDS; your parents died because of your stupid father.' (CPT M BLACK ISIXHOSA 25-55)

Some participants did not differentiate between safer sexual practices according to the kind of relationship:

> I don't choose. I don't differentiate whether it's casual sex or my wife. With everyone I use a condom. (CBAY M BLACK ISIXHOSA 25-55 FG)

This suggests some sense of responsibility on behalf of men for their main partner's health. However, there was some divergence from the idea of responsibility for a main partner's wellbeing. A few women lamented how female 'main partners,' particularly married women, were at greater risk of STIs if their partner had MCPs, since sex in marriage was less likely to be protected:

> And these are all married women, not single women. That's the sad thing. A very good married friend of mine also experienced it, she had to go and get a test done and get an antibiotic to clear herself. (CPT F COLOURED AFRIKAANS 25-55)

Another woman recalled how a friend had contracted HIV from a husband who had multiple partners. When she consequently became sick and eventually died of AIDS, her husband left her:

> And when she was dying on her dying bed, he pulled out of the relationship, he left her alone. That angered me. That really angered me, I promise you. To think that you were the one that was moving around, but now if she's in that position, now you are finding it like a shame to be part of it. You contributed to that. That really angered me. It was just such a private cremation. That's because her kids were ashamed. (PTZB F COLOURED AFRIKAANS 25-55)

Discussion

The participants' sexual-history biographies exposed variations in the norms and subjective meanings of different types of sexual relationships. Many of the men and women constructed their gender identity in their sexual relationships via 'othering' through gender binaries. For instance, men were viewed as driven by irrepressible sexuality, which could be used to justify men's higher-risk sexual behaviour, including a reluctance to use condoms and a pursuit of MCPs. Women were perceived as focused on love-based relationships and also expected to adhere to gender scripts that are relatively passive in the domain of sexuality. In comparison with women, men were often said to lack relationship skills, such as being emotionally expressive, open to intimacy, and disclosing personal information as noted in other studies (Seidler 2006; Gevers *et al*. 2012). Both men and women condoned such norms in relationships, which may explain why they can be so resistant to change. Yet the narratives also support the idea that gender norms in sexual relationships are changing in South Africa (O'Sullivan *et al*. 2006; Dworkin *et al*. 2011) and that it is simplistic to assume a dichotomy in relationships wherein men have absolute sexual decision-making power and there is no acknowledgement of women's agency. In contrast to hegemonic conceptions of men's sexuality, some men expressed a preference for emotional intimacy and commitment in relationships, concern about their own and their partner's sexual health. Some were critical of norms of masculinity that condone multiple and casual partnerships as an avenue to gain status and/or men's domination in relationship and sexual decision-making. Many women, particularly women in their early thirties and upwards, reported an ability to initiate sex and be open about their sexual desires and expectations in

relationships, as similarly found by Shefer and Foster (2009). This appears to indicate that societal attitudes about women's sexuality are progressing.

Open communication and compatibility was said to be associated with positive and successful relationships as noted in other studies (eg., Gevers *et al.* 2012). However, preparedness to be in a lasting emotional and sexual relationship was described as challenging, particularly for men. This finding is in congruence with Seidler (2006) who argued that hegemonic enactments of masculinity promote performative activities and hinder relational intimacy, and acknowledgment of emotional vulnerability. In personal relationships "love becomes problematic, as emotions [with the exception of anger] are a sign of weakness" (Seidler 2006, p. 70). Commitment and monogamy in established relationships were highly valued by the participants, although women were generally expected to adhere to this more than men. Participants described various factors that promoted commitment to one partner including having peers with similar values, parental examples or education of monogamy, and certain religious beliefs and guidance. Fear of HIV infection led some participants to value and adhere to monogamy in an established relationship, as found in other studies (Parker 2012a). Although participants expressed their ideal desire for monogamy, there were various reports or concerns of experiencing infidelity by an established partner. It was seen as critical to ensure the sexual satisfaction of one's partner to prevent infidelity. Sexual satisfaction was deemed to be a critical component of established relationships and both men and women expressed the sexual benefits derived from factors that tend to accompany such relationships including familiarity, comfort, and emotional intimacy. Some men said they felt compelled to provide financially to prevent a partner's infidelity in support of dominant perceptions of masculine responsibility. Women also expressed such expectations in established relationships. Experiencing infidelity in an established relationship was a significant source of stress for both men and women. This was reported to cause feelings of distrust, jealousy and pain, in line with the findings of other studies (e.g., Gevers *et al*. 2012). Several participants noted how an established partner rejecting sex could make them suspicious of infidelity. Wood and Jewkes (2001) study with Xhosa men in an Eastern Cape township also found that the most prominent explanation for a partner refusing sex is that they had another partner.

Although many of the participants said they preferred unprotected ('flesh-to-flesh') sex, it was generally agreed this should only happen in established relationships where there is perceived to be trust, and thus reduced HIV risk. This line of reasoning among participants is consistent with other findings (Cusick and Rhodes 2000; MacPhail and Campbell 2001; Corbett *et al*. 2009; Selikow *et al*. 2009). Several participants acknowledged that they had sometimes had unprotected sex with a partner who they had come to trust too quickly or because they had perceived the sexual partner as having good physical health. This has been noted among participants in other studies (Waldby, Kippax and Crawford 1993a; Flood 2007). Some participants recognised that this sense of minimal HIV risk in an established relationship could be flawed, as many individuals said they were distrustful of notions of fidelity by both partners, which has been documented elsewhere (Baumgartner *et al.* 2010). Several participants claimed they were willing to engage in unprotected sex in an established relationship since pregnancy might be welcome. This suggested a sense of responsibility on behalf of some men in relation to their potential for fathering a child. This finding differs from studies reporting on the commonness of men's denial of paternity, especially with regard to teenage pregnancy (Hunter 2006; Nduna and Maseko 2008). Alternatively, condom use in an established relationship appeared most common among couples that did not wish to conceive. This is reflective of condom use for contraception not conflicting with notions of fidelity (Cusick and Rhodes 2000). While established relationships were perceived to be safer from HIV risk than casual relationships are, given that reported condom use in such relationships was low, HIV risk in an established relationship could be present nonetheless. Various studies have reported the risk that established relationships can pose to HIV infections (Cusick and Rhodes 2000; Campbell *et al.* 2008; Corbett *et al*. 2009; Pettifor *et al.* 2013). Since many established relationships seemed to form relatively quickly, the timeframe for couples to be engaged by HIV interventions, including promotions of HIV testing is limited.

Casual relationships were defined in opposition to established relationships. Casual relationships were frequently reported to require less commitment and characterised by less emotional and physical intimacy, and little or no projection into the future. More men than women discussed having numerous casual sexual encounters, although there may have been discrepancy between the participants' responses and reality because of socialised gender expectations. Indeed, it was perceived to be more acceptable for men to engage in casual relationships because a

disassociation between love and intimacy was portrayed as a male phenomenon, while women were more regularly viewed as needing love and intimacy. Such differences were regularly attributed to biological difference, such as notions of men's uncontrollable sexuality, rather than socialized gendered disparities. Among some male participants, particularly the younger group, the need to gain status within one's peer group was a key motivation for having casual sex. A strong trend for men was to perform to peer led norms using at times misogynist and aggressive language when speaking about the desire for casual sex with women, for example the desire to 'chow' women. Women's association of intimacy and love was a discourse frequently used by men to manipulate women into having sex with them, as found in other studies (Shefer and Foster 2009). However, there was also discussion about how it is becoming more common and acceptable for women to seek casual partners. Among female participants, financial need and loneliness were given as primary motivators for engaging in casual sexual encounters, which supports other studies including Campbell and MacPhail (2002) and Jewkes and Morrell (2012).

Many men and women reported meeting their casual partners in bars, with drinking alcohol often leading to having casual sex, as has been noted in other studies (Wojcicki 2002; Pettifor *et al*. 2005). Excessive alcohol consumption fostered loss of control and unprotected sex among both men and women, as similarly reported by Parker (2012a). The participants noted there was less open communication with casual partners about emotional needs, sexual practices and HIV status than occurred in established relationships. Casual relationships were perceived as having a greater HIV risk than established relationships have, and thus more likely to warrant condom use. Yet the often spontaneous nature of these relationships combined with drinking alcohol resulted in inconsistent condom use. Some men reported the necessity to have money to spend in order to develop casual relationships with women. Casual relationships were also more likely to be transactional and age-disparate, which minimised the likelihood of condom use. This is in line with literature suggesting that transactional and/or age-disparate relationships are often characterised by unprotected sex, where the older partner/provider holds more sexual decision-making power (Jewkes *et al*. 2012c).

A few men and women criticised casual relationships for being disconnected from love and intimacy or as marking a phase of immaturity. There was also some awareness on behalf of men

of the damage done to female sexual partners and sexual risks associated with certain hegemonic norms, and some men reported transition towards healthier (SRH) behaviors, and more gender-equitable relationships as they aged. The ability to feel contrition, which was present in most of the narratives, draws on gender discourses that invoke the importance of respect of their partners and protecting them from SRH risks. The older participants reported less engagement with and desire for casual partners than the younger participants did.

More men than women reported MCPs, and men were less likely to identify monogamy as a way to protect themselves from HIV, in congruence with other findings (Parker *et al*. 2007). Notions of men's irrepressible sexuality and cultural gender norms were used to justify men's engagement in MCPs. Having multiple partners was regularly reported to be a source of social status for men, and some men discussed severe pressure to have multiple partners. For the most part, multiple partners were hidden from one's main partner, who was typically known to the 'side' partners. Side partners and main partners were differentiated through personal treatment, including the amount of time that a couple would spend together and the level of effort and feelings invested. It was commonplace to have sex with love with a main partner, but sex without love with one's side partners. Under this set of norms, being faithful shifted from a concept of fidelity towards keeping infidelity secret in order to 'protect' one's main partner (e.g., Parker *et al.* 2007). Maintaining discretion about side partners was seen as sign of respect for the main partner (Parker 2012a). Side partners were said to accept the arrangement either because the relationship was indeed casual, or out of a desire to become the main partner. This meant that a side partner might opt for having unprotected sex, an indicator of an established relationship, in order to progress to being the main partner. Nonetheless, most participants reported hiding their side partner(s) from their main partner, implying that the latter would be uninformed about the potential health risk of sex. Women's regular tolerance of men's concurrent side partners may reflect their support of dominant norms that men are unable to commit to one partner.

Many participants noted that it is less socially acceptable for women to have MCPs, although several women reported engaging in MCPs. For both women, experience of a poor relationship and sexual dissatisfaction were the primary motivators for involvement in concurrent relationships, as observed by Mah and Maughan-Brown (2012). Experiencing infidelity was also said to be a pivotal motivator to engage in MCPs. Men's description of the pain caused by a

partner's infidelity conflicts with stereotypes of masculine sexuality being detached from emotions and vulnerability. Economic incentive was also cited as a major motivator for women having multiple partners, which has been well documented by other researchers (Leclerc-Madlala 2009a; Jewkes *et al*. 2012b). Both men and women who experienced infidelity in a relationships discussed being more prone to engage in MCPs or said this made them cynical and distrustful about future relationships, as found in other studies (Parker 2012a). The majority of participants expressed awareness of the link between HIV risk and having multiple sexual partners, and many felt that it was critical to use condoms with side partners, not only to protect themselves, but also their main partner. This may support Hunter's (2005) assertion that HIV/AIDS education has generated an understanding of the dangers of MCPs, however men's continued engagement with MCPs indicates that alternative models of successful masculinity have not been fully formed.

Conclusions

The narratives allow an appreciation of how individuals made sense of their sexual experiences, and they uncover the range of meanings and definitions that men and women attributed to their sexual relationships. Some of the narratives reveal ways in which the deployment of masculine sexuality gives men more power and control over women where sexuality is framed as domain of agency men control. Yet, any of the narratives disrupt the essentialist binary of men and women's sexuality, which calls for a shift away from understanding men as controlling and women as passive in sexual relationships, and reveals how dominant norms of masculine and feminine sexuality are changing. Nonetheless, this must be understood within deeply embedded gender-power inequalities in South Africa. Chapter 7 presents the participants' accounts of sexual coercion; in turn, the impact and sense-making of such experiences reveals the predominance of hetero-normativity and unequal gender power.

CHAPTER 7: GENDERED SCRIPTS OF SEXUAL COERCION

> "It happens every day, every hour, every minute, he tells himself, in every quarter of the country. Count yourself lucky to have escaped with your life…There must be some niche in the system for women and what happens to them." JM Coetzee, *Disgrace* (1999: Vintage Books).

Introduction

Sexual coercion encompasses a wide range of behaviours — from the sexually inappropriate to aggressive — inflicted on another against the person's will, through means of verbal pressure to physical force (Byers and Glen 2011). A broad understanding of sexual coercion is used in this chapter to capture the range of participants' experiences. This definition is consistent with South Africa's rape law which was amended in 2007 to broaden the scope of coercion as it encompasses non-consensual behaviors that are not strictly penile-vaginal, recognizes that non-consensual sex can be perpetrated by means other than the use of actual force, for example by verbal threats, and it clarifies that both males and female can be victims of rape (Ngwena 2005). The participants were not explicitly asked about past experience of sexual coercion; instead, their mention of such experience was unsolicited and came about as a result of being asked about previous sexual relationships, and specifically about their sexual debut. This approach may have minimised participant bias in relation to the topic of sexual coercion.

This chapter seeks to understand how the men and women's understandings of dominant male gender norms could affect their perceptions and sense-making of a sexually coercive experience in a heterosexual relationship. The chapter also attempts to assess how performing to and condoning dominant forms of masculinity influence men's use of sexual coercion in relationships.

Women's experiences of sexual coercion

Different forms of sexual coercion were mentioned in the narratives, including cases of intra-familial sexual abuse, coerced sex by an intimate partner within a relationship, and sexual abuse perpetrated by a stranger. The majority of participants who reported ever being sexually coerced

were women; in a few instances, men also reported experiences of pressurized sex with women, usually an older female partner.

Intimate partner coercion

Intimate partner coercion was the most commonly reported type of sexual abuse reported by the women. One woman gave a detailed account of how her boyfriend sexually abused her in a variety of ways, including stripping her, tying her up, and forcing her to watch pornography. When she refused sex, he still physically abused her:

> I was still young then, I was about 15. This guy would force me to do what he wants me to do at his own time. He would hit me, try to have sex with me, close the door, tie me to have sex with him…. But he did not do anything, he just stripped me but did not do anything. (JNB F BLACK SETSWANA R 18-24)

This participant also experienced violence in subsequent relationships, including with a boyfriend with whom she became pregnant; she reported how he would force her to have sex during her pregnancy, and if she refused, he would abuse her physically. Another woman said she became pregnant because of forced sex with her first boyfriend, yet her family convinced her to not press charges for fear that the perpetrator might retaliate:

> And he forced to have sex with me and he slept with me and I became pregnant. But I didn't know it was pregnant. I can't tell you how painful it was.... When I came back I told my aunt what my boyfriend did, I told her I have to go report this, because it wasn't right. She said, 'Please don't say anything because you are going to have to open a case, and he might come back and threaten you.' I said, 'A case needs to be opened because he raped me, there was no agreement between me and him.' She kept asking me, 'Please, please.' I ignored opening a case although the anger and hurt, it was still inside my heart. It was as if I committed suicide. Then I had a baby. (CBAY F BLACK ISIXHOSA 25-55)

This woman also discussed feeling guilt and shame about being violated and also being too young to have experienced sex.

> You know what makes me say I felt like committing suicide? I was still young. No one at 16 was allowed to sleep with a man. You had to wait till 18 or 21. I was too young. (CBAY F BLACK ISIXHOSA 25-55)

Her scenario reflects trends of masculinity encouraging older men to have younger female partners, albeit through the use of force. One woman said she had developed an abscess on her vagina and did not want sex with her partner, as it would be painful, yet he refused her rejection:

> I had this wound, an abscess. And he wanted me to have sex with him. And I told him, 'This is so sore, it's painful.' But he was like, 'No ways, I want to have sex, I am so horny.' He forced me. It was painful. He held me down physically. And I didn't even enjoy it. It was all about him. I was so disappointed. I trusted him, so I was angry. I didn't even speak to him for a week. Of course he did apologise. They always do, you know men. He did apologise and swear it will never happen again. (NELS F BLACK SESOTHO 25-55)

While she recalled how painful the experience was, she also condoned this as masculine behaviour and accepted his apology and promise that it would never happen again. Another woman discussed the commonality for men to demand or insist on sex in a relationship, without this being labelled as sexual coercion:

> Guys don't take that [rejection], if you tell him you are not in the mood or you don't feel like. If he needs to do it, then it must be done, but it's not like pressure. (PTZB F BLACK SESOTHO 25-55)

Another woman reported that a friend was subjected to sexual coercion by her husband and contracted HIV as a result:

> She didn't sleep around, her husband did that. That's what happened. We used to go jazzing, yes, but she, never ever; we used to sit together, we used to drink at home like ladies get together. It wasn't her, it was her husband. He used to go out to the bar and come home in the early hours of the morning. When he comes back, he used to force himself on her and he used to hit her if she didn't want to. Basically, that's how she got it [HIV]. (PTZB F COLOURED AFRIKAANS 25-55)

One woman reported being pressured into sex by her partner, who also was unfaithful to her, which compounded her inability to trust men afterwards. However, she eventually came to enjoy a relationship where she developed trust for her partner. It was important to her that her partner show her respect around sex and that the relationship was not only centred on sex:

> Well he doesn't really act disappointed. Because with us spending time doesn't mean necessarily we're going to have sex. We can spend the whole day together, ya know, watching movies, just hanging around. It doesn't mean we're going to have sex. It just happens, through time, through the day. He doesn't act upset, I've never seen him upset not getting sex. (GTOWN F COLOURED AFRIKAANS 18-24)

Some women discussed feeling unready for sex because they did not know how to adequately protect themselves from the consequences of sexual activity, predominantly pregnancy. Despite such preferences, one woman recalled being forced to have sex before being ready:

> So we started dating at that time.... And he forced me to have sex with him. But I loved that guy at that time, I did. And he broke my virginity. But I mean I wasn't ready. Because I know when you have sex you become pregnant. (NELS F BLACK SISWATI 25-55)

While intimate partner sexual coercion was frequently positioned as hurtful, disappointing, and even traumatic, it was often also normalized and not conceptualized as a criminal activity or rape. This could also influence women's understandings of masculine sexual behaviour as sexually controlling and pressurizing in subsequent relationships.

Sexual coercion by non-intimate partners

A few women gave accounts of sexual coercion by strangers or non-intimate partners. Such experiences were more likely to be conceptualized as rape rather than a coerced sexual experience by an intimate partner. One woman said she was sexually violated by an acquaintance at age 14:

> I was 14. It was a situation where I actually knew the person, but not well. We were again on a farm alone on a weekend. And I never went back there either. I woke up in a hospital. (GTOWN F WHITE AFRIKAANS 25-55)

She did not report the incident because she did not want her mother to know. This traumatic experience made her cautious in choosing sexual relationships, avoiding any situation that could lead to unwanted sex. Consequently, she did not have a sexual relationship until she was in a stable long-term relationship and could choose to have sex voluntarily:

> I didn't have sex because I associated it with evil for four years after that. I only started having sex when I was just about finished with school. I dated someone for a long, long time. We actually were together for four years. And I realised that if things that I thought were as horrible before, it's actually quite pleasant. So like I said, when I was 19 I had my first voluntary situation.

Thus, she eventually achieved stability and resolution through a relationship that was affectionate and communicative. She talked extensively about how this partner fulfilled her needs and she could exert control over when and how they had sex. She saw her control over sex and her need for a communicative partner as linked to her agency and recovery from the original forced experience of sex:

> Now we sit and discuss things. Because I forced him...I broke out when I was 19 and I decided there was not going to be, whether I participated or not, there was not going to be a sexual act that

> I didn't understand or didn't know about, because nothing like that is going to ever catch me off guard again.

She also conducted research around sexual pleasure to understand why she found sex enjoyable with subsequent partners in a consensual relationship:

> When I was 19 I started reading, because that was my first and only way to educate myself, because I didn't understand how anything I thought was so horrible was actually something nice, pleasant, and that I wanted to do again. And so I started reading.

Another woman described an incident of rape by an acquaintance, which she never told anyone about. She blamed herself for walking home so late, which revealed her acceptance of societal norms about rape that place a certain level of onus on women:

> I was 19 and was going to my gran's place and I met him on the way and he was like, 'Where are you going?' And I told him, and he said, 'Let me just take you half way.' So I thought, ok, fine. Somewhere along the way we are just walking, he never said anything, he just slapped me across the eyes. He picked up a stone this big and he said, 'If you don't go this way, I am going to hit you with that stone.' And he was like 'lie down.' And I did, took off my panties. And he was like some people, just had his way with me. While I was crying he was busy kissing me. He said, 'Please don't cry.' He was enjoying himself and I am crying. That was that. When I went to my grandma's place, I never even told anyone. I just got hot water, I felt so dirty, I scrubbed myself. I never reported it or did anything. I told myself maybe I kind of deserved it, why was I going at that time, because it was just getting late? That's what I was thinking then. But now I know I was going where I was going; no one has a right to do that. (NELS F BLACK XITSONGA 25-55)

With time and awareness, she came to understand that she was not responsible for having been raped.

One woman advised her friends what to do in case they should find themselves in a potential rape situation, which speaks to the normalisation and prevalence of sexual violence in her community:

> You weren't scared until he forced himself on to you, that's rape. You scream, you make sure that you scratch him to show that this man forced himself onto you. Don't just allow him to get it on. (PTZB F COLOURED AFRIKAANS 25-55)

After being raped as a girl, another woman reflected on feeling unable to speak to her parents about this because they were continually drunk and consistently unsympathetic:

> When I woke up in the mornings, I said to myself to go and sort the matter out with the school, but I could not. I would cry and they asked, 'What is it?' Was I sick or did I hurt? I did not talk. I could not talk. I felt that if I would talk about these things, when my parents were drunk they would scold me, [in case] they said to me 'You wanted that,' because my father was very unsympathetic with me during my childhood. (CPT F COLOURED AFRIKAANS 55+)

This participant also reflected on her perception of the increasing societal awareness of the crisis of sexual violence including a better understanding of a victim's right to report sexual violence:

> Yes, I came back, because I got through this. I told my girl child you must not get involved with an older man, because it is a rape story. You know, when I see how much people are now against rape, and in those days nothing happened. Now, when it comes to rape it is an important matter. In those days people did not do anything.

Interfamilial sexual abuse

Women's reports of sexually coercive experiences within families were often traumatic and could affect their subsequent relationships and normative ideas about sex. A young woman described being raped as a child by her uncle:

> Well, I think at the age of 10 or 11, my uncle molested me, but I didn't realise what was happening, because I didn't know what it was. But then when I spoke to someone, then they told me about sex between a man and a woman, but I still wasn't well aware of it. But I just knew at the time that what was happening to me was, it felt very uncomfortable. (GTOWN F COLOURED AFRIKAANS 18-24)

As a young woman, she recalled having little early interest in sex or having a relationship, and in this respect she compared herself to her peers, saying that her friends had found some meaning in losing their virginity, whereas her experience was imposed and insignificantly endured:

> Most of my friends say when they lost their virginity it made them feel like a woman. I just still felt like this little girl that, ya know, just went through something.

Another woman described the trauma of being abused by an uncle as a young girl, which was complicated by the thought that her family would not believe her:

> This broke me. I was at the stage of committing suicide, that's how I felt. I did not want my parents to hear these things. I slept as a child, and this man, he was drunk. And we did not have

> beds, we were lying on the floor and he slept there that night, and in the night I felt this man now by me, and my parents were lying drunk, and I do not have the strength against this man. Then he came to me in the night. Oh, I pleaded and talked to him and said, 'Please leave me alone,' and I called out, and when I called he closed my mouth [sniffs]. I did not talk to my parents about it, they'd have said to me, 'You are talking nonsense, he will not do this to you, he is your uncle.' (CPT F COLOURED AFRIKAANS 55+)

This participant said she later entered into a number of sexual relationships where sex was forced or coerced. Yet she reported that she was currently married to a man who allowed her to decide whether or not she wanted to have sex. This relationship was reportedly an enjoyable one. She said they lived together for a year before having sex. She reported that her partner made this decision, stating that he did not want to pressure her early in the relationship because of his religious background. Given her experiences with pressurized sex, she welcomed this motivation to delay sex:

> No, he said he does not want to pressure me, how can I say, to put something on me…. He then said to me he loves me very much and wants me to be his wife, he does not want us to now [have sex]…only when we lived together under one roof for a year did we have sex.

Some participants described having witnessed sexual coercion in their home. One woman recalled how she would hear her father pressure her mother into sex:

> My dad wanted to have sex and my mum didn't. And it was more kind of like, we'll just do it, you know, and like forcing her into doing it. So that's, I think, where I got the whole men want sex whether you want it or not and you've got to give it to them. So there's no sort of freedom around that, so I think that's what I grew up with quite a lot when I was younger. I kind of remember lying in my bed going like, that's horrible, that doesn't sound great. That sounds like some person dominating somebody else, I don't like that. (CPT F WHITE ENGLISH 25-55)

Telling her story allowed the participant to reflect on how this experience might have shaped her understanding of normative sex in a heterosexual relationship:

> I'm just suddenly thinking about it now, I think it's probably from when I was a kid, when like, my dad was like, this is what I want and you must give it to me, I probably draw it from that. It doesn't matter what the woman wants or if she does or doesn't, it's like that's what you have to give over.

Men's perpetration of sexual coercion

Some of the men reported using various forms of sexual coercion in their relationships. One participant spoke about a girl that was 'hard to get,' which he found enticing and so he kept trying to have sex with her. Eventually he resorted to forcing her to have sex. He reported using violence to exert control over his partner and as an expression of jealousy when he suspected his girlfriend had other sexual partners. He noted that his use of violence came from the example of having a father who hit his children, where force seemed a normal way of disciplining a person. And, although he stated that he wanted to stop treating women this way and was critical of norms that tolerate violence perpetrated my men, he reported that he could not see an alternative to being violent — apart from leaving a relationship when he felt 'provoked':

> We need to change the way we treat woman, and I have told myself that I will never hit a girl. It's like we have turned into animals, because my father used to hit us and we grew up thinking if someone doesn't listen, you must hit them, so you need to stop. Now when someone is trying to provoke me to hit them, I will rather leave the relationship. (CPT M BLACK ISIXHOSA 25-55)

One man said he persuaded one girlfriend to have sex with him although she was a virgin and wanted to wait until marriage. His biggest concern was that she might accuse him of rape and that he would then have difficulty dating:

> It took a really long time to get her to open up, because she was a Christian. She did not even want to have sex before marriage, but I persuaded her, in different ways. You know how when you want something, you explore different ways to have it. I think it took about two months. We had started dating in April. Around June, I finally persuaded her. But she was crying and crying and I stopped, you see. She was still crying and dumping me and leaving and going home. I found myself lost because it was going to seem like I had raped her. I had a problem because now I was thinking, who was I going to date? I do not have a person to be with. (GTOWN M BLACK ISIXHOSA R 18-24)

This man also related that if one of his current girlfriends did not want to have sex with him, he would manipulate them by threatening to pursue other women. Another man recalled differentiating his treatment between women he loved and women he did not love. Among women he loved, he would respect their desire to wait for sex, although he might lose interest in them, but among women he did not love, he would pressure them into sex:

> Even if she explains to me the reasons why she does not want to have sex, even if I do not understand those reasons I am going to say, ok, I understand. I will wait for when you are ready.

> To her I will be understanding; when I am alone I will get angry and lose interest in her. To sleep with someone does not mean that you love her or him. If I love someone, obviously, I will not sleep with her in a rough way or in a way that seems like I want to destroy her. But then there are those girls that you find that you sleep with the whole week, you do not care about her.... Because if you do not love someone and you try to sleep with her, if she refuses and give you some reasons, you will not want to understand them. You will insist, force your way and try to convince her until you have sex with her. (JNB M BLACK SEPEDI 18-24)

Yet another man asserted the opposite sentiment: that his wife, unlike his casual partners, did not have the right to refuse sex:

> I: Do you think a woman has the right to say 'no' to sex?
>
> P: No. That's bullshit. Not my wife! A prostitute that I buy sex from, she has a right to say no, but not my wife! Because if I go outside and f**k around outside I'll get diseases and all kinds of things. She is living in my house, she is my wife. I need to be able to get sex when I want it. (NELS M BLACK SISWATI FG 25-55).

One participant described how men often buy alcohol for women with the intention of getting sex, and if a woman refused sex after accepting a man's drinks, he is prone to becoming violent with her:

> If you drink my alcohol, I have to sleep with you, you have drunk my money. That is when sex happens, because men can buy someone that they do not love with alcohol. When the woman is drunk also, she drinks a man's alcohol even though she does not know him. If she doesn't, she can get beat up. He buys her alcohol and the alcohol takes away the woman's brain and they go and sleep with each other. (CPT M BLACK ISIXHOSA 55+)

A few men said they opposed the use of sexual coercion in relationships, and norms that condone men's use of violence. One man explained that because of South Africa's amended constitution and the growth of human rights, it is no longer tolerable to force women into sex: 'Now it is like you are going to rape them, you can't do these things anymore' (GTOWN M BLACK ISIXHOSA 25-55 FG). Another man recalled an opportunity he had to take advantage of a woman when she was drunk, but did not because he could not ensure he had her consent:

> I told her, I would prefer things to happen between us when we are both sober so we know what we are saying and doing. Because right now we don't know what we are doing. You're drunk and think you are seeing me, but you don't see me actually. What needs to happen is that tomorrow when you are sober, let's speak. When I told [a friend] the next morning what happened, he said I am stupid [laughs]: 'That's the easiest way to get sex, when a girl is drunk.' He actually was

> known to once get a girl very drunk. They say he even put drugs in her drink to get her to sleep with him. (CBAY M BLACK ISIXHOSA 25-55)

His account highlights the expectation for men to hold attitudes in support of pressuring or tricking women into sex. Another participant said his older brother manipulated girls into having sex according to his own desires, but witnessing this turned him against the idea of using coercion in a relationship:

> My brother, he would always say how he manipulated a girl into getting with him, and I never liked that. After he slept with a girl he would be like, 'Oh, ja, we did this and whatever,' and it just seemed a bit like he was just getting his own way. (JNB M WHITE ENGLISH 18-24)

Men's experiences of sexual coercion

Several men recalled situations where mostly older and more sexually experienced women had initiated a sexual encounter they felt unready for or when they were uninterested in the woman sexually.

A few men recalled being pressured to engage in sexual acts as children. One young man described being touched sexually, when he was 10, by his cousin who was five years older:

> She once touched us on our privates, you see. Well, now they say it's abuse or what what, but to me it never felt like it…. I was confused at that time, you see, but it was basically just touching, man, and banging on top of her panty, we would have sex on top of the panty, you see. In fact, she would climb on top of us, and then start having 'sex' with us. (GTOWN M BLACK ISIXHOSA 25-55)

Another man recalled his first sexual experience, at age 7 with a 17-year-old girl, which would meet the definition of rape according to South Africa's 2007 Sexual Offences Act (SOA), as one partner was younger than age 16 and the other was older than age 16 (the legal age of consent). He recounted how the girl would buy sweets for him and his friends to persuade them to go to her house. He reflected on his worries about the wrongfulness of the situation and his physical displeasure during their encounters. Even at such a young age, he recalled there was enormous pressure from his peers to be sexually responsive to a woman, which seemingly overrode his emotional worries and physical discomfort:

> Even at a young age, man. I mean even by the time I was 6. If I ran away from a woman offering herself to me, I'd be called gay. Even from the peers at my time. By the time of 6, you know what people are doing out there, and you're trying to emulate what they are doing…. So there was a lot

> of pressure involved for my first time, because the person who came to fetch me from my house was my friend…and this woman was his next-door neighbour, so it had a lot to do with peer pressure. (GTOWN M BLACK ISIXHOSA 25-55)

From a very young age, this participant was familiar with the dominant sexual norms he felt compelled to conform to in order to be recognised as a heterosexual male.

A few men reported how women drew on male sexual norms, such as being sexually aggressive and having a lack of self-control, to convince boys or men to have sex:

> And, then, by that time, she called me and then she just kissed me. And then I said stop: I don't wanna do that, because she was not of my age. She was three years older than me. So she asked, what kind of guy am I? And then I said, 'I'm like other guys.' She said, 'No, can a dog bark at meat?' Then I said, 'No.' 'You should eat it,' she said. And she asked you, why you are barking and not eating? So I just looked down, and that was it. (NELS M BLACK XITSONGA R18-24)

In this excerpt, the participant recalled shame at the prospect of sex with an older woman (even though the age gap was small) — and even greater shame at having his masculinity questioned, which he asserted to be a predominant incentive for him to agree to sex.

Another man used hostile language when talking about a woman who consistently pressured him to have sex with her:

> But she would attack me. It took her three years for me to get into bed with her. She was always trying to convince me when I didn't want it. But she was a *hoe*[20]*r*. I didn't know she was a *hoer* at the time. (CPT M COLOURED AFRIKAANS 18-24)

Through his use of derogatory language (calling her a *hoer*) he may have sought to reclaim his masculinity, which appeared to be threatened as a result of a woman consistently pressurizing him to have sex.

One man said he feared sexual intercourse when he was younger for fear of pregnancy, STIs, and in case his partner's father might find out about the encounter. Even though his girlfriend pressured him for sex, he refused her advances because of these worries. One time when she demanded sex in an especially aggressive way, he had run away:

> I was never the kind of guy to go around and just thump. Not that I was offered it for a while. I never really had the opportunity, until one time when a chick nearly raped me. I had to climb out

[20] 'Whore' in Afrikaans.

> of her apartment veranda, slide down the drainpipe and run as if my life depended on it. I was scared of sex for some reason. (PTZB M WHITE ENGLISH 18-24)

He recalled a subsequent experience of sexual harassment by a young woman:

> She told me if I don't sleep with her she's going to rape me.… How do you sleep with a girl when she tells you she's going to rape you? I thought I was going to get murdered that night…I was turned off and it was fear, but mainly turned off. She proceeded by punching me in the back of the head and scraping me with her nails.

He reported feeling that this woman had been demanding because she was beautiful and did not expect him to refuse her sexual advances.

Another man discussed how a casual partner put him at risk of HIV by refusing to let him use a condom and forcing sex on him when he was drunk:

> I was drunk, like seriously drunk at the time, you see. I woke up and this girl was on top of me, and this girl she was doing it for herself on top of me. I tried to stop her because there was no condom, but she wasn't paying attention to what I was saying and she wouldn't stop, you see. (GTOWN M BLACK ISIXHOSA 25-55)

Discussion

The broad definition of sexual coercion employed in the research captured the men and women's wide range of sexually coercive past experiences. This included emotional pressure or psychological manipulation and use of aggression or physical force, variously perpetrated by family members, intimate partners, acquaintances, and strangers. The narratives revealed some ambiguity and ambivalence between consent and non-consent, which could affect how sexual experiences are classified (Muehlenhard and Peterson 2005). This includes whether they were perceived as sexual coercion and criminal behavior. Among the men and women, a common theme throughout these experiences was how men and women men responded to and understood such situations because of social expectations of masculine and feminine sexual behaviours and scripts (Marston 2005). For both men and women, coercive experiences often occurred at a young age- a time of great vulnerability and sexual inexperience. Experiencing or witnessing sexual coercion could teach men and women damaging gender norms and influence their expectations and attitudes in subsequent sexual relationships.

Women were more likely than men to experience coercion through the use of physical force and verbal aggression, perpetrated by intimate partners, acquaintances or family members. While the women frequently recalled these experiences as traumatic, incidents of sexual coercion were generally not reported to criminal justice authorities. The normalisation and minimization of certain forms of men's use of coercion in relationships may have hindered reporting, as has been documented elsewhere (e.g.,Wojcicki 2002). Research has documented that women who know their perpetrator often have more societal pressure not to report an incidence of sexual coercion, and are more likely to be intimidated by or fear retaliation by the perpetrator for reporting the crime (Wood and Jewkes 1998; Jewkes, Penn-Kekana, and Rose-Junius 2005). Several studies have also identified embarrassment, shame, not wanting family members or friends to know about the rape, and wanting to avoid the stigma of rape as major barriers to reporting (Wood and Jewkes 1997; Jewkes and Abrahams 2002). Some women spoke of feeling partly or fully responsible for experiencing sexual coercion, and such beliefs have been also been shown to hinder reporting of rape (Jewkes, Penn-Kekana, and Rose-Junius 2005). While sexual coercion committed by strangers and family members was more likely to be perceived as a criminal activity, none of the women recalled reporting these experiences to criminal justice authorities. While reasons for this were not assessed in this study, this may demonstrate, among other factors, poor confidence in the justice system considering the estimation that only 14% of perpetrators are convicted for rape in South Africa (Kapp 2006).

Coercive sexual experiences could also inform women's normative ideas about men's sexual behaviours, such as men being unable to control their sexual urges and dominating sexual encounters. For some women, this fuelled a lack of trust in men or desire for sex and relationships, in congruence with other research (e.g., Jewkes and Abrahams 2002). They could also be linked to women's subsequent risk behaviors including poor agency over sex and increased vulnerability to sexual abuse, as has been documented in the literature (Jewkes 2005; Jeejebhoy, Shah and Thapa 2005). Yet some of the female participants who reported being sexually abused in the past also spoke of developing a level of trust and respect in a subsequent non-abusive relationship. This also speaks to the diversity of men's treatment of their female partners. Reaching resolution about a previous coerced sexual experience often involved deconstructing norms of men's use of coercion and moving beyond self-blame and guilt. Some

women reported how sharing their stories could enable reflection on this process, which indicates the importance of providing women with spaces to deconstruct men's normalized use of sexual coercion. There was also some indication that sexual coercion is taken more seriously than it was in the past, which may reflect the efforts of the government and civil society to address violence, including the implementation of the 2007 SOA. These legal changes may also have contributed to changing conceptions and normalization of men's use of violence against women.

Some men reported perpetrating sexual coercion including forms of emotional pressure and manipulation, in their relationships. Witnessing other men's use of violence against women influenced some men's toleration of sexually coercing their female partners. Some men reported their expectations that their partner, particularly a wife, would have sex with them even if it was unwanted; and that they would use force if necessary. Alternatively, some men noted that they were more likely to use force with casual partners who warranted less respect. Some men expressed their belief that a woman's consent to drink a man's alcohol as being equivalent to a woman's consent to sex, in congruence with other findings (Wojcicki 2002). Impatience with a woman's resistance to sexual advances could be drawn on to justify men's use of sexual coercion. Some men were also critical of dominant norms that condone sexual coercion, such as taking advantage of a woman sexually when drunk, reflected on the damage that could be done to women through sexual coercion, and reported being against the use of sexual coercion.

A few men reported pressurized sex by another woman (who was usually older) as children (meaning they were under the legal consent age of 16 years). Although these experiences met the definition of rape according to SOA, the participant's stories reflect how the understanding that men must always respond to sex, even if unwanted, takes hold from a very young age. A few men also relayed engaging in unwanted sex with their female partners or acquaintances. Sex was regularly framed as a signifier of manhood and status and an opportunity that should not be resisted. Thus, in most cases, pressure for men to engage in sex did not only come from their female partner but also by men in their social group. Nonetheless, such unwanted situations often caused men shame and anxiety, and were overall unpleasant. Men predominantly reported emotional pressure from a partner, such as being taunted for their lack of virility, or their manhood being questioned. Yet as Sikweyiya and Jewkes (2009) asserted, men coerced by

women through temptation should not be treated the same as men or women who are physically forced to have sex as unlike the later, temptation can be resisted. According to many of the men, women initiating sex conflicted with the cultural and social codes whereby men are meant to be the sexual instigators. Thus, unwanted sex challenges the dominant male narrative where men are expected to demonstrate sexual prowess and be unable to resist sex (Moore, Madise, and Awusabo-Asare 2012). Female agency alone may make the situation undesirable for conflicting with dominant norms of masculinity, particularly if the woman's interest is unwanted. Indeed, the men's negative reactions seemed linked to the fact that the presumed 'sexual' experience did not fit the stereotype of sexually controlling and dominant masculine behaviour.

While such instances are not the same as sexual coercion, it should be noted that succumbing to sexual aggression from a woman violates the hegemonic role of men as strong, invulnerable, and the sexual initiator, and is likely to pose a threat to the man's self-esteem, possibly leading him to deny or minimize any negative effects (Krache, Scheiberger-Olwig and Bieneck 2003). Framing and reporting sexual coercion could result in men being marginalized by both men and women. Numerous studies show that sexually abused children (male-to-male and male-to-female) are more likely to engage in high-risk HIV behaviors including having a greater number of partners, using condoms less consistently, and engaging in sexually violent perpetration (Jejeebhoy, Shah and Thapa 2005; Jewkes *et al.* 2009). Some studies suggest a link between unwanted sexual experiences and negative psychological-health outcomes including guilt, anger, fear and depression. Indeed, some of the men's situations involved emotional or verbal abuse, including threats of physical abuse, and being taken advantage of when drunk. Moreover adhering to 'performance' of a certain kind of manhood that is built on sexual prowess and lack of emotional engagement or interest could influence men's sexuality. Better understanding of the emotional consequences of unwanted female sexual contact and the relationships between men's experiences of sexual coercion, and their subsequent sexual behaviors, is warranted.

Despite the relatively high prevalence of South African men experiencing sexual violence by other men (Jewkes *et al.* 2009), none of the male participants reported this. This may be the case since men's experiences of sexual violence by other men were not specifically probed in the interviews and focus groups. It may also reflect the fact that sexual violence by men is perceived

to be a greater threat to one's masculinity than sexual violence by women, as noted elsewhere (Sikweyiya and Jewkes 2009).

Conclusions

While the men's and women's accounts of an experience of sexual coercion had different meanings and perceived consequences, interpreting this among the participants was often guided by heterosexual relationship norms that condone some degree of sexual coercion. Ideas tolerating coerced sex could promote men and women's vulnerability to sexual risk behaviour including women's exposure to and normalisation of men's domination of sexual encounters, men's use of sexual coercion, and a conception of masculinity built on sexual prowess. These factors all increase HIV risk. Chapter 8 discusses other factors, as revealed in the narratives, that were found to increase men and women's HIV risk, including barriers to practicing safer sex and poor uptake of SRH care.

CHAPTER 8: SEXUAL AND REPRODUCTIVE HEALTH AWARENESS AND SAFER-SEX PRACTICES

> "Sizwe's failure to test [for HIV] is not simply a tale about healthcare services: it is a tale about men." Johnny Steinberg, *The Three Letter Plague* (2009: Vintage).

Introduction

This portion of the research addresses men and women's knowledge of and engagement in SRH care and HIV prevention by considering psychological, cultural and social factors that may impede or enable men's sexual-health behaviour. The men and women's engagement with and access to SRH care, particularly concerning HIV prevention, are compared.

HIV-prevention behaviour

Despite a good level of HIV- risk awareness among the participants overall, several factors appeared to impede men and women from assimilating safer-sex messages. Many participants conceded that there were barriers to converting their knowledge into practice, even though all recalled being reached by some form of SRH awareness programme:

> Every home has a radio, a TV. Even here. So if people continue to be ignorant, it means the media is reaching them but they choose to be ignorant. (CBAY M BLACK ISIXHOSA FG 25-55)
>
> If you don't use them [condoms] it's your choice, you don't care. (CBAY M BLACK ISIXHOSA 25-55)

The difficulties of practicing safer sex

Many participants noted a disjuncture between what they felt they should be doing and their lived sexual behaviour. Some men expressed a lack of sexual 'self-control,' a trait that is often associated with dominant norms of male sexuality. One man admitted:

> I don't have self-discipline. I'm trying, but I don't think I'm trying hard enough. I told you about my friend that died of HIV. But even so, I can still have sex with a girl without a condom and I

> can sleep with several girls without it. It showed me that I was living in denial. (CPT M BLACK ISIXHOSA 25-55)

Similarly, one woman said she was aware of the risks of unprotected sex yet did not act on this knowledge:

> I don't know. I suppose I was just crossing my fingers that I hope this person doesn't have this and doesn't have that. I know how painful it is, I just don't want to get it. So I have been careful in my head, though not really practicing, taking precautions, which is why I mean it would be a couple of months and I would be pregnant. (CPT F BLACK ISIXHOSA 25-55)

One young man from a rural South African province recalled that he and his classmates did not think HIV affected their province when they first learned about it at school, associating it with urban areas:

> We thought that this virus is not in the province of ours. It might happen at Gauteng and Western Cape. Not in Mpumalanga or Limpopo, Northwest, no, no. These are the cleanest provinces according to us. I wasn't scared yet. The thing is, I was young. (NELS M BLACK XITSONGA 25-55)

One woman from a rural province related the perception in her community that HIV is not a virus but a sign of being bewitched:

> If you tell someone they have a virus, they will tell you 'No its not a virus I know these things its just you are bewitched it's those African diseases. (NELS F BLACK SESOTHO 25-55)

Failure to think about HIV risk and to practice safer sex could also derive from sexual ebullience and naiveté. Youngsters discovering their bodies and the delight of sex were said to often neglect the connection between sex and risk:

> To be honest, I thought — I'm young, I'm just going to have sex and it's just like playing. So we didn't even think to take precautions. (JNB M BLACK ISIZULU 18-24)

Along similar lines, one participant asserted that HIV prevention efforts should target young people given their poor awareness of HIV risk:

> So to me, kids are what the target should be, because as you get a bit older you are more mature, you know what you want. I'm at this stage where I can look after myself, but the kids in that age bracket, what do they know about love? They are just experimenting; they are just experiencing as well. They know absolutely nothing. (PTZB F COLOURED AFRIKAANS 25-55)

Another barrier to practicing safer sex was a feeling that sex needed to be consummated in the 'heat of the moment.' For example, some men said it was difficult — even emasculating — for them to interrupt a sexual impulse to put on a condom. One woman explained:

> They are kissing and stuff and they are caught up in the moment of making love. And if there is no condom he just goes, 'Shit I will face the consequences,' and in he goes. (NELS F BLACK XITSONGA 18-24)

One woman agreed that 'the heat of the moment' also impeded her condom use. In addition, she worried that she her partner would judge her for suggesting condoms:

> I suppose it is sort of contradictory. I mean, I know it's there, and I know I should, and most of the time I have been good at using a condom and being protected, but sometimes, like, in the moment, it's just like, ah, it's not important, it will be fine. Or I don't want to be judged by the person that I'm with, [saying] like, 'You know, do you have one?' And if he goes, 'No,' [I'm] going, 'Okay, I'm not having sex with you unless you do.' And then going like, 'Oh no it's fine, we'll go ahead anyway.' (CPT F WHITE ENGLISH 25-55)

In contrast, other participants reported being able to create a space between sexual impulse and consummation. One young man remarked: 'The most powerful equipment I always try to have about me, it's my brains, my thinking ability.' (CPT M COLOURED AFRIKAANS R 18-24)

Several participants spoke of knowing someone who is HIV-positive as motivating their HIV-prevention practices:

> Right now many people who are HIV-positive are seen with our own eyes. We learn more as we read newspapers. My older sister died from HIV. From seeing her I no longer have that urge to go and sleep around. (PTZB F BLACK SESOTHO 25-55)

There was some consensus that HIV-positive people were particularly effective at delivering SRH messages since people are more likely to believe that you can live with and manage the disease if given the opportunity to meet a healthy-looking person living with the virus. One woman said she realised that HIV is something you can live with after one of her close friends was diagnosed as HIV positive:

> I thought if someone is HIV-positive you can't eat with that person, you can't even touch that person. But now I know that it's just a disease like any normal disease. You can stay with the person who is HIV-positive. (NELS F BLACK SEPEDI 25-55)

Perceptions about male condom use

Male condoms were regularly spoken of as the most preferred, effective and accessible HIV-prevention method. One man, who referred to HIV as *umbulaliwesizwe*, which translates from Xhosa and Zulu to 'the killer of our nation,' said:

> This one is the one that kills. It has no cures. It is only prevented using these condoms. There is no other way. (CBAY M BLACK ISIXHOSA 55+)

Most participants perceived condoms as the best means of protecting themselves from HIV. However, numerous barriers to practicing consistent and regular condom use emerged from the men's comments. A key barrier among them was the feeling that a condom decreased their sexual performance:

> When I use a condom I can go only five minutes a round, but when I don't have a condom I can go 15 minutes a round. (NELS M BLACK XITSONGA 25-55 FG)

Similarly, another participant commented on people's regular desire for flesh-to-flesh sex: 'You can't have a lollipop with the wrapper on' (CPT M BLACK ISIXHOSA 25-55). Some men were concerned that condom use could hinder a woman's sexual pleasure: 'A woman will never feel pleasure with plastic. They won't need us' (NELS M BLACK SESWATI R 25-55 FG). In contrast one man perceived use of condoms to be proof that he had sex, that this would leave his virility unquestioned and raise his status among his peers:

> Remember, you take that condom as some of the guys will not believe you.... So you can believe me or not, it's your choice, but this is the condom, this is the proof, this person is taking a shower there. And then I've got my status, I've got my credit. Maybe I'm the one who won that weekend. (JNB M BLACK ISIZULU 18-24)

Several participants remarked that condom use was less likely after they had consumed too much alcohol. Women spoke of the difficulty of negotiating condom use when a partner was drunk. Many of the men mentioned their dissatisfaction with the quality of Choice© brand condoms, which are freely issued in the public sector by the South African government. They said they felt these condoms were too small, smelt bad, were inadequately lubricated, and caused them to lose their erections. Dislike of condoms was not an entirely male characteristic. One woman expressed her dislike of the government provided condoms:

> I don't have a problem. Just that I make sure that the guy buys the right one. You know, the one that have the flavours. I don't like the Choice [brand], the government ones. I don't like the way they smell. (NELS F BLACK SESOTHO 25-55)

However, another woman preferred the government issued Choice brand condoms and lamented the dryness and itchiness of other brands of condoms. She felt thisundermined sexual pleasure:

> Condoms are good. Choice [brand] is nice and it's not the same like the ones you buy in town. The ones you buy in town they are itchy a bit, and you get dry, I like Choice. I don't have a problem with them. (CBAY F BLACK ISIXHOSA 25-55)

For the most part, however, a reluctance to use condoms was perceived by both men and women as being a predominantly male phenomenon. One woman said she encouraged men in her community to use condoms*:*

> I have friends of men, they say they don't like condoms. Most of them. And I used to tell them, 'Guys, please use condoms.' (NELS F BLACK SESWATI 25-55)

Another woman reported feeling that it is a woman's responsibility to persuade men to use condoms and encourage them to be monogamous:

> Guys are stubborn, so it's our duty to encourage them to use a condom. I don't know, guys need to learn it's possible to have one partner, so long as they understand. (PTZB F BLACK ISIZULU R 25-55)

Beliefs that condoms are not effective against HIV transmission could have a negative impact on their use. One participant revealed a fatalistic attitude because of misconceptions about HIV transmission:

> HIV! You can get it from everything we buy in shops. Even soap and food and everything. It's poisonous. Even the cows, we give them medicine to make them have more milk. There are so many genetic products now. So we all have AIDS. (NELS M BLACK SESWATI 25-55 FG)

Another man from a rural area stated that 'condoms were a Western tool. They do not work here in Africa' (NELS M COLOURED AFRIKAANS R 25-55). A further participant from a rural part of Kwazulu-Natal province (PTZB M BLACK ISIZULU R 25-55) believed that HIV could be transmitted from 'cuts, anything' but suspected that the risk from casual contact is minimal. Some men also expressed their belief that it is healthy for women to have sperm enter them because of 'vitamins' in sperm, thus discouraging their condom use. Overall, mistaken beliefs about the effectiveness of condoms were rare among the participants, and were mostly mentioned in rural areas, where knowledge of SRH practices and technologies is often lower than in urban areas.

Notions of men having an incontrollable sexual urge was also said to hinder men using condoms. One woman recalled a man who assumed a sense of fatalism rather than opting to use condoms with his multiple partners:

> He loves girls. He has three women already. He tells you straight, 'Why must I use a condom?' Just like that. He just tells you straight off, 'If I die, I die anyway.' (PTZB F COLOURED AFRIKAANS 25-55)

Despite negative perceptions about condoms among many of the men and the women's common observation of men's reluctance to use condoms, some positive changes in men's attitudes towards condom use emerged. For instance, one man related that his own attitude towards condom use changed because of heightened awareness of HIV risk, despite his physical preference for non-use:

> At a very tender age I was in a stable relationship, so I never had opportunities to use these condoms much, and I realised I enjoy having sex without a condom better than I do with a condom. But only now I prefer to use condoms, because I am now well aware that I might just lose my life. (CPT M COLOURED AFRIKAANS 25-55)

A woman commented on young men's increasing willingness to use condoms because of improved awareness of the dangers of HIV, especially in the case of having known someone who died of AIDS:

> Nowadays it is rare that you find a guy saying 'I will have sex without a condom.' Now more guys understand. Especially the young ones, because they now see the reality, the side-effects. Sometimes you find a family member dies of HIV and you realise that this thing is real. (NELS F BLACK SESOTHO 25-55)

Knowing someone who had died of AIDS was said to motivate condom use by some participants, mostly women:

> Like now, friends are [HIV] positive and family members have died. It made you, as a person, think that this person is really, like, AIDS is killing. It makes me think whenever I go to a guy, I must have a packet of condoms myself in case he says 'I don't have' and then I will say 'I do have, so let's use it.' (PTZB F BLACK ISIZULU R 25-55)

> No one gets intimate without that [condoms], no, you can't. [AIDS] is a fear. I had a friend of mine that died of AIDS, a very good friend of mine, and my daughter used to go bathe her, she helped out. She went from nice to absolutely thin, she couldn't eat. She'd bring everything up. So I know what it's like. That is my fear at the moment. (PTZB F COLOURED AFRIKAANS 25-55)

> So my older sister died from HIV. So as a person you must; actually I no longer have that urge to go and sleep around. My current partner, in the beginning we did not use anything. But eventually I had a problem that after sleeping with [him] I would feel some itching. Then we ended up deciding to use a condom. We have about two years now of using condoms. (PTZB F BLACK SESOTHO 25-55)

The notion of taking personal responsibility for condom use arose several times in the data, with condom use frequently mentioned as a habit that needed to be fostered. As one male participant said:

> I do not want to teach myself to get used to not using a condom so that I can put other people's lives in danger. (GTOWN M BLACK ISIXHOSA 25-55)

Another participant felt that while taking responsibility is a personal attribute, responsible action ultimately depended on both partners in a relationship:

> It has to do with whether the person's mind-set revolves around protection. It only takes one person in the couple to persuade the other to use or not to use a condom. It's a personality thing and will depend on who you are and who you are with. (CPT M COLOURED AFRIKAANS R 18-24)

Both men and women mentioned that, in their social contexts, there was stigma attached to initiating condom use, including carrying and buying condoms. This shows the great influence of broader social norms on people's sexual behaviour. Such stigma was more pronounced among women than men, with the latter generally being expected to carry condoms and initiate condom use. Yet, some men felt a burden of this responsibility or were not disinclined to consistently initiate condom use, saying that women should also carry them and initiate their use:

> It would be good if they kept condoms in their purses. So if she meets a guy she mustn't be dependent on a guy having it or being a proactive one. Because we as guys can excuse things. We can sometimes do it purposely and say 'I don't have a condom' when you know you have got. So if she's going to sleep around, even if she's not carrying a purse, there must be a condom in her pocket. (CPT M BLACK ISIXHOSA 25-55)

One man pointed to the acceptability and importance of every individualinitiatingcondom use for the sake of their health; 'Because we are talking about my life, not someone else's' (NELS M BLACK XITSONGA 25-55 FG).

Such narratives reveal some men's respect for the decision-making power of their partners in relation to condom use:

> At first I didn't want to use protection. She told me, 'No, it's better to use a condom than not using a condom,' because she doesn't actually know if she is clean or not clean. So I used a condom. (JNB M WHITE AFRIKAANS 18-24)

> With my steady girlfriend I will use a condom. That's the agreement between the two of us.... She is a strong woman; she can stand on her own feet. (JNB M BLACK ISIZULU 18-24)

Some women, usually older participants, felt they did not experience barriers to negotiating condom use with their partners

> I say I will not do it without a condom. But he had it with him anyway. If he didn't, I had one packet too…. Of course, I've got it as well. Everyone has their own fit. If they tell me that it won't fit, I don't care…. He can't react to it, it's my body, he just has to put it on and keep quiet. I tell them, 'I can't [so] put this on and enjoy it, never go without this.' What he says [in response], I don't care. You find a lot of them are now getting so used to it. (PTZB F COLOURED AFRIKAANS 25-55)

One woman noted that men may feel responsible for carrying and initiating condoms, but nonetheless believe that ensuring contraception use is a woman's responsibility:

> I think most men do carry [condoms], and then some don't. It's either because they don't think they have to or that it's the women's responsibility or they just don't really think about it, they just don't care. Um, but I think most of the men out there do actually carry protection with them just in case. (CPT F WHITE ENGLISH 25-55)

Nonetheless, several female participants referred to the stigmatisation of women initiating condom use. One woman said: 'he says, 'Oh, do you have condoms?' I was like, 'No, it's not my responsibility.' (GTOWN F WHITE ENGLISH 25-55) Another woman noted she was not the type of woman who would carry condoms, although she practised safer sex, indicative of the stigma to do so:

> Not that I was against it, but he always made sure he had a condom. I'm not the kind of person that carries around condoms in my bag so I won't know what happens next. But whenever I'm in a sexual encounter I make it my point to know there is a condom around. (GTOWN F BLACK ISIXHOSA R 18-24)

One male participant, who implied that he was HIV-positive, claimed to always use condoms to avoid transmitting the virus to his partners:

> I was not really worried about me. I was worried about other people, of putting other people's lives in danger. I think the most depressing thing is to think that other people can die because of

> you. Even today that is the reason that makes me use a condom — as a responsible person. You get what I am saying? (GTOWN M BLACK ISIXHOSA 25-55)

His story, and those of others, affirms that most people who know they are living with HIV do not intentionally infect a partner.

While condoms were said to be easily accessible in a variety of locations including petrol stations, garages, taverns, police stations, general stores and clinics, some participants in rural areas had difficulties acquiring them:

> In rural areas, they are not accessible — condoms. Because you find there is no clinic there. If you want the clinic, you have to travel many, many kilometres. (CBAY M BLACK ISIXHOSA 25-55 FG)

HIV testing

The majority of participants reported knowing where to go for HIV testing, which seemed to be highly accessible, apart from in some rural areas. Many participants reported that they had tested for HIV. Among those who said they had not tested, a major reason was fear of the implications of being HIV-positive. For instance, one man said he had never tested because he did not want to be confronted with illness and possible premature death:

> Cause, man, I mean I'd rather die not knowing I'm gonna die than die knowing I'm gonna die on a certain day. Ya know what I mean? I think that's gonna get me even more skinny. I'm gonna get sick and I'm gonna lose weight. If I don't know, I think I'll be better. (JNB M BLACK ISIZULU 18-24)

Another man's (PTZB M BLACK SESOTHO 25-55) articulated fears about HIV testing suggested a gross lack of knowledge. He believed that that a person could monitor their body from the 'inside out' and that going for an HIV test would 'shut down his system' or suppress his immune system.

Overall, more women than men reported testing and testing regularly, for HIV. Several women recalled becoming aware of the importance of HIV testing from clinics, which they initially attended for contraception, a PAP smear, or antenatal care:

> So the first time I tested for HIV, I was pregnant. Now when I go for female [family] planning I get tested every 2 months. (NELS F BLACK XITSONGA R 25-55)

One woman reported testing for HIV when she went to have a PAP smear, indicating that she saw it as mandatory when having a PAP smear, even though this is not legally the case:

> I went to go and test because if you get a pap smear, you are obliged to go and test. (PTZB F BLACK SESOTHO 25-55)

One woman reported great fear of testing for HIV testing, but noted that this would be overcome if she became pregnant, possibly to prevent possible mother to child HIV transmission:

> I have never got tested, but I do use condoms and I am eating healthy food. I am not ready to test. I think I will test only when I am pregnant. I don't think there is anything that can be done to change me. (GTOWN F BLACK ISIXHOSA R 18-24)

One woman said she first tested for HIV after discovering her partner had another partner, and continued to do so every four months:

> No, information didn't motivate me. It's knowing that my boyfriend has somebody else, that's what motivated me to test. (PTZB F BLACK ISIZULU R 25-55)

Men were less likely than women to access SRH clinics and thus learn about HIV testing through this avenue. A major barrier to men testing for HIV testing derived from notions of social norms that discourage men from seeking help and attending clinics. For instance, one woman (PTZB F BLACK SESOTHO 25-55) said she tested for HIV but her partner, despite her persistence, was not prepared to out of fear and unwillingness to go to the clinic.

Among men who did test for HIV, the most common motivator was encouragement from a woman in their lives (be it their mother, sister, and most commonly a girlfriend or wife) and in instances when their partner became pregnant. One woman commented on this phenomenon:

> Women, they encourage men since I am the one who goes to the female clinic and I get tested and my partner didn't go to the female planning. So when I come back, when they teach me about HIV and AIDS, it is then my turn to tell him. Women are helping men. (NELS F XITSONGA R 18-24)

One man (CPT M BLACK ISIXHOSA 25-55), who was coughing and not feeling well, had been encouraged by his partner to go for a TB test. He asked her to accompany him, and, because it was simply a matter of 'turning a corner' to reach the HIV-testing venue, they decided to test together for both HIV and TB. Another man overcame his fear to test for HIV when his partner became pregnant:

> I thought, okay, my child is due any time now, in a couple of months, and I have to have things like policies. (JNB M BLACK ISIZULU 18-24)

Testing for HIV in this situation showed the men's commitment to preventing their regular partners and their infants from becoming HIV infected. Another woman, while supportive of

women encouraging their partners to test for HIV, also expressed her concern that HIV testing must be an individual's choice and not done because of partner pressure:

> I used to encourage him, he said he is not yet prepared. So according to me a person must go to test when he feels like it, not because I push him. A person must test because he feels like that, because if he goes to test because I push him to do so; if he finds out that he is [HIV-]positive, he is going to be stressed. But if he goes voluntarily because he wants to test, this person will go there being already counselled, he would have counselled himself. He will not need to stress. (PTZB F BLACK SESOTHO 25-55)

Several participants reported testing for HIV with their established partner before having sex without condoms, although there was little mention of the unsafe window period between HIV testing and having unprotected sex. When couples tested together, this seemed to promote safer-sex practices. For example, a man (GTOWN M WHITE AFRIKAANS 25-55) reported that he and his partner started out having unprotected sex but both feared HIV because of the publicity it received, so they decided to test together and wait for the results before resuming their sex life. However, many couples reported having unprotected sex in established relationships without testing for HIV, as they perceived no HIV risk based on the quality of the relationship, reputation, personal appearances, and hygiene. Repetitive HIV testing by couples was reportedly rare.

One man was motivated to have an HIV test as a result of a 'loveLife' campaign encouraging individuals to take care of their health:

> Because I went to 'loveLife' and learnt that one has to know where you are as a person — you have to know and understand everything that is happening to you and care about your life, because no one can care about your life like you — all those [ideas] motivated and forced me to go and get tested. (GTOWN M BLACK ISIXHOSA R 18-24)

There was evidence of individuals who tested HIV-negative feeling encouraged to maintain this HIV status by testing regularly and taking more precautions in their sexual encounters:

> Yes, you know before I got tested I wasn't using condoms. After I tested my status, I started using condoms. When I realised I was [HIV] negative I wanted to stay that way. (JNB M BLACK XITSONGA 25-55 FG)

> Yes, I was happy that I went to test. Secondly, after I did some test I no longer have sex without a condom. So I think I am free because I do not have many partners. That is what I think. (PTZB F BLACK SESOTHO 25-55)

Hence some narratives mentioned individuals testing regularly to check whether they had maintained their HIV-negative status.

One man felt respected in his community for testing regularly:

> Even now the people respect me when I go to these things. And they say, 'This man checks himself!' Because I decided to go and test when I heard about it. And I test regularly. (CBAY M BLACK ISIXHOSA 55+)

Another man said he continued to have unprotected sex with his girlfriend after she was diagnosed HIV-positive. He became depressed because he assumed that he too was HIV-infected and might have been responsible for infecting his partner. When he eventually tested HIV-negative, his relief over his status and not being responsible for his partner's HIV infection motivated him to assume responsibility for his own and his partner's sexual health through consistent condom use: 'I cannot, if I love someone, put them at risk by not using a condom' (GTOWN M BLACK ISIXHOSA 25-55). His story illustrated successful movement away from the difficulties of adopting safer-sex behaviours.

There was widespread agreement that HIV-prevention messages have progressed from shocking and scaring people towards informing people about the virus in a more sensitive manner:

Initially it was something to fear from, scaring people. It was shocking them into discipline, and then it sort of evolved and graduated to be more sensitive to HIV testing, to some of the human rights around that, so that it was not just saying 'Hey let's do this and that.' (GTOWN M BLACK ISIXHOSA FG 25-55) Many participants appreciated this HIV testing education approach, for diminishing fear and stigma around the disease, which could allow people to be open about their HIV status and seek treatment.

Gendered differences in contraception and family planning

The narratives reveal the absence of men's involvement in contraception and family planning, with numerous men and women mentioning that pregnancy and preventing it is the domain of women. One man said:

> From the guy's perspective, contraception is more of a woman's problem. When we ejaculate and we have healthy sperm, if the girl is not on birth control, she is going to get pregnant, period. So if you want unprotected sex with a monogamous partner and you are a female, it is your responsibility, unless the guy always, always, always uses condoms. (CPT M BLACK ISIXHOSA 25-55)

Generally men had limited knowledge about any contraceptive method other than condoms and were unaware of what form of contraception (if any) their partner(s) used. Several participants discussed how women often learned about contraception by attending an SRH clinic:

> They [women] are aware, because at the clinic they do tell you these are the types available. So yes, they are aware, it's just that it's the person's choice to use them or not. (PTZB F BLACK ISIZULU R 25-55)

> The women go to clinics all the time. I always see them. They go for protection [from] pregnancy, for injection for pregnancy. (CBAY M BLACK ISIXHOSA 18-24)

Contraception was reportedly not commonly discussed in relationships, but was rather regarded as a woman's own affair:

> I am not sure because with a girlfriend we don't share those things. Myself, we just want those funny things [condoms] when we go out. (NELS M BLACK SISWATI 25-55)

There was also evidence of men having limited knowledge of the female reproductive cycle. For example, one man believed that women are most fertile during menstruation, and another believed that a woman could become pregnant only from the first round of intercourse:

> In the first round I use a condom, because you know the first round is that one that really produces the sperm. And then, second round sometimes I don't use it. And I pull out sometimes. (CPT M BLACK ISIXHOSA 25-55)

One participant felt his father's lack of involvement in his life influenced his own poor involvement in contraception in his adult relationships:

> At least, whatever, I don't know, I don't care about it. It might happen that she [had my number], but she didn't communicate to me. Maybe she didn't even abort, she had a child, but I don't know. Just like me, my father was not there, so, I mean — life continues. (JNB M BLACK ISIZULU 18-24)

A few older women related having to hide contraceptives from a partner who did not like them. One woman had hid the fact that she used a contraceptive with her partner for 20 years:

> He did not like them. He was an old-fashioned man who said a woman who uses some contraceptives is not healthy. He had such complaints. He did not like them. So I was using them on my own. (PTZB F BLACK SESOTHO 25-55)

Yet for some men, consistent condom use was motivated by pregnancy primarily, the fear of fathering a child with a woman they were not in love with or committed to:

> P: ...So you had these opportunities for casual sex, turned it down, and your main motivation was fear of consequences that come with casual sex. Like, you have sex with a chick once, you think it's casual, meanwhile this chick wakes up in the morning and tells you that she's pregnant, and then you find yourself in a world of shit.
>
> I: So how would that have differed if you had had a stable girlfriend?
>
> P: Oh, you would have known that you are her boyfriend. If you had made her pregnant, you would have been like, hey, listen, I love this chick, I can have the kid, I don't mind, because if you have a chick you don't mind if you have to have a kid, or she has to have your kid, but if you just met a chick on the sly, give her a rogering, wakes up four months later and says, 'Listen, I'm...pregnant,' then you're in trouble. (PTZB M WHITE ENGLISH 18-24)

This suggests that certain men recognised the responsibility that would come with fathering a child: 'I didn't want a child with that girl, I was not seriously involved with her' (CPT M BLACK ISIXHOSA 25-55). Some isiXhosa and isiZulu men spoke of a traditional cultural norm that promotes men's involvement in contraception. They were strongly motivated to prevent pregnancy out of wedlock because of a culturally imposed fine that may be imposed on them:

> I was worried about certain things: she could get pregnant. And as I said if you get a girl pregnant in my tradition, you pay big penalties. And I would still be a student under a parent and now I would have to pay big money. (CBAY M BLACK ISIXHOSA 25-55)

One woman discussed how with age, women tend to feel more comfortable involving their male partners in decision-making about contraceptives:

> We sat down and discussed it. I said I could go on the pill, I'm happy to do it again, but I just don't see why. He totally agreed with me. He said he's not quite ready to go for a vasectomy, but condoms can work. I know it's not the most romantic thing under the sun or the most romantic alternative for contraception, but, at this stage at our lives, I think it comes with being older, comes with being comfortable, just easy to talk to. If we didn't have this ease with being able to talk to each other then I don't think that would have been the case. I probably would have been on the pill. (GTOWN F WHITE AFRIKAANS 25-55)

Forms of contraception

Overall, male condom use was the most common form of contraception mentioned by the participants (if any contraception was used). A few used dual methods of contraception in their sexual relationships:

> We'd agreed that condoms were his department and contraception was mine, and so I just needed to get my bum into gear and get it done, which I took a while to do. (CPT F WHITE ENGLISH 25-55)

An older male participant recalled a traditional practice to protect against pregnancy, particularly an ill-spaced pregnancy:

> When a child is still a toddler, the mother went back home [to her family]. There were no contraceptives that time. Without the mother going back home you will have many babies following each other. That is no good. Children should follow one another with at least a gap of two years. (JNB M BLACK SETSWANA 55+)

He used this, and other examples, to emphasise abstinence as a way of preventing unwanted pregnancy. Several participants mentioned interrupted sex (withdrawal from intercourse) as a way to prevent pregnancy. This was particularly common among older women, who reported to not have had as readily available access to condoms as the current generation does:

> In our times the contraceptives were scare. Things like condoms were not yet there. If a man sleeps with you, he will sleep with you and ejaculate outside so that you do not fall pregnant. (PTZB F BLACK SESOTHO 25-55)

> The only fear still is falling pregnant, because at that time there were no condoms. As I said, there were, but we weren't allowed to know about those condoms, or whatever, and if we went on contraceptives, we were in big trouble. Our parents would know we are sleeping around. So we had nothing, we just had to rely on that the guy should not cum in us. (PTZB F COLOURED AFRIKAANS 25-55)

Another woman (JNB F WHITE ENGLISH 55+) had three children, which she regarded as too many, because she relied on withdrawal. So after having her last child, she began to get hormonal contraceptive injections (injectable progesterone contraceptive [IPC]). Several women mentioned using the oral contraceptive pill and IPC, but problems such as weight gain discouraged their consistent and regular use. Some women related the inconvenience of having to take a birth-control pill every day:

> No, we didn't use them. I think the very first time we slept together we used it, because with contraceptives they tell you it's two weeks before or after, or a month [that it is effective in preventing pregnancy], so I was waiting for that month for it to be effective. But then it wasn't going to be effective because I kept on forgetting to take the pill. (CPT F BLACK ISIXHOSA 25-55)

Some men in rural areas said they preferred their partner(s) not to use the contraceptive injection, since they believed that sex with a woman using this contraception may cause a man to develop a backache.

A few men expressed their belief that certain forms of contraception, namely the pill and IPC, are not effective in Africa since they are Western practices and have negative health consequences for women:

> Somebody who is often getting an injection will experience health problems. For example, she will get infections, water in her body, soft flesh in her body. (PTZB M BLACK ISIZULU 25-55)

The influence of some cultural customs on individual's sexual practices was also revealed. 'Thigh sex' (*ukusoma*, an isiZulu practice where the penis does not enter the vagina), was mentioned by a few participants as a method to protect youngsters against premature sexual debut and unwanted pregnancy. A few isiXhosa men in a rural area of the Eastern Cape mentioned a cultural, customary contraceptive method:

> We used to have a thing we tie around our waist called an ox tail. And the woman you sleep with would not be pregnant. (CBAY M BLACK ISIXHOSA 55+)

Female condoms were not widely spoken about, but one woman expressed their value as a pregnancy-prevention device that could be hidden from a partner:

> There is no person who does not know right now there are many different kinds of contraceptives. There are pills, there are female condoms, there are male condoms. A person who falls pregnant is because they like it. Why am I saying this? If your partner does not like a condom and you do not want to fall pregnant, you can use a female condom, he will not even find out. That will be your secret. (PTZB F BLACK SESOTHO 25-55)

Unplanned pregnancies

The men and women's accounts suggested that unplanned and teenage pregnancies are common, particularly in rural areas, which may attest to poorer SRH education and services in these areas. One woman became pregnant as a teenager, and attributed it to impulsive unprotected sex:

> I fell pregnant in matric [Grade 12]. My one friend also fell pregnant as well, and we were like we didn't do it the first time or whatever, but towards the end, but you know, things happen. As I said, you get caught up in the heat of the moment and you forget this and you forget about that. (PTZB F COLOURED AFRIKAANS 25-55)

Some women lamented the occurrence of fathers who did not provide child support in the case of an unplanned pregnancy:

> Women must be stronger. They must tell their partners. Most men in our culture they gonna get me pregnant, sometimes they gonna leave us [for] another girl. Then they not gonna support our kids. (NELS F BLACK SISWATI 25-55)

> If you fell pregnant the first night, he would leave, because now, remember, you've got that responsibility; you've got that burden, if I can put it that way. That burden becomes your burden, not his burden, and that's exactly what I felt. (CPT F COLOURED AFRIKAANS 25-55)

One woman said her partner pressured her to abort an unplanned pregnancy. She chose to have the baby but her partner did not provide any support:

> P: I'm not sure what my first thought was when I got to know, let's say the doctor confirmed my suspicions. But I know that I became very sad and informed him and he told me to get rid of the baby, the foetus. My disappointment was: one, he is telling me this over the phone, he doesn't care what I think, he is just telling me over the phone…and he doesn't care about what I think and what I feel, even about the pregnancy for that matter, let alone the abortion that he is suggesting.
> I: So you decided to keep the baby, and what kind of communication did you have around that?
> P: We didn't. He just left me like that, and I would call just to say 'Hi, how are you doing?' I mean, obviously, I wanted him to support me, but he would just say, 'There is nothing to write home about it.' That is his expression, I've kept it all this time — 'There is nothing to write home about.' Oh, okay. (CPT F BLACK ISIXHOSA 25-55)

One woman ended a relationship after her partner failed to provide child support: 'The reason why we stopped is he wasn't supporting the baby. So I decided to leave him' (CBAY F BLACK ISIXHOSA R 18-24). Another woman believed that the need for contraception has become more common because in the past, women were more likely to have sex with only one partner, compelling him to provide support in the case of pregnancy.

> But then it wasn't implanted in us to have contraception, because one partner, you stuck to one partner, so that was it. So if you have a child, it was more acceptable. (GTOWN F COLOURED AFRIKAANS 25-55)

In some cases an unwanted pregnancy encouraged men to become more involved in contraception, subsequently. For instance, one man said a casual partner became pregnant when he was 25 years old; he told her he would not be responsible for the baby since she was not his main partner. His partner had an abortion. However, the incident motivated him to start using condoms for the first time. Nevertheless, typically after three months of being with a partner, he stopped using condoms. He argued one could not trust a woman's claim that a particular man is the father of her child. He used this to justify men's lack of involvement in contraception and unplanned pregnancies:

> A chick says what she wants and the guy will pretend as if he's giving her what she wants. But he's not intending to mean it or honour it. So you get some situations where there are reasons for him to want to leave. He just leaves even if the chick says to him, 'Hey I'm pregnant.' There is that kind of guy who will just leave regardless of the situation. And he tells you, 'Hey that's not even my child,' and he leaves. (CPT M BLACK ISIXHOSA 25-55)

A lack of trust in women to take the emergency contraceptive pill, when necessary, motivated one man to be proactive in this regard:

> Should it happen, I would have to go and buy the morning-after pill and give it to her and then she has to take them in front of me, because I never trust women. (JNB M BLACK ISIZULU 18-24)

There was some discussion of men becoming increasingly aware of their responsibility for family planning and child rearing, which motivated their involvement in contraception:

> Nowadays couples do talk about such things and agree on them. Men these days do realise that [having] a lot of children are a burden. (PTZB F COLOURED AFRIKAANS 25-55)

Conversely, some men expressed pride about impregnating a partner even if it was unplanned. For these men, pregnancy was seen as testimony to their virility and they avoided contraception for this reason. For instance, one man (GTOWN M COLOURED AFRIKAANS FG 25-55) said he did not have any children and refused to use condoms. He also stated that he would be angry with his girlfriend for insisting on condom use because of his preferences, despite the fact that his partner did not want children.

STI awareness and prevention

Whereas participants mentioned steps they took to prevent HIV infection, preventing other STIs was rarely mentioned. For the most part, the participants demonstrated little understanding that

having another STI may make one more vulnerable to HIV. Moreover, there seemed to be general consensus among the men and women that since STIs can be easily treated, they are not as threatening or worrying as HIV infection. One man said:

> You don't care if you have an STI. You just want to f**k the girl, period. There is no problem what she gets. That's the mind-set many men have: 'It's not my problem.' I use a condom, that's fine. It doesn't matter how many warts I have around the penis, as long as I don't get AIDS. (CPT M COLOURED AFRIKAANS 25-55)

Fear, as a deterrent to higher-risk sexual behaviour, was a common theme throughout the narratives; the participants seemed more concerned about preventing HIV infection than another STI, which would be curable. One man said:

> If I don't see the need to either change my lifestyle or curb my sexual activity, the topic of health is not an issue. Unless something happens to me, I'm fine. (PTZB M COLOURED AFRIKAANS 25-55)

Women generally reported more knowledge of STIs than the men did. Mostly, they recalled learning about these from an SRH clinic. Several women noted how they were much more concerned about HIV acquisition and an unplanned pregnancy than acquiring STIS (other than HIV):

> P: Women mostly are thinking about preventing pregnancy. They do not think about preventing diseases.
>
> I: In your opinion, what is the reason for that?
>
> P: I think they do not take the sexually transmitted diseases seriously. (PTZB F BLACK SESOTHO 25-55)

> I found out he'd slept with seven girls and I'd still been sleeping with him. I felt dirty, I felt gross. I checked for STIs, but funnily enough not for HIV — because I'm too scared. (GTOWN F WHITE ENGLISH 25-55)

However, others took STIs seriously in both prevention and response.

One woman said she had ended her relationship after being diagnosed with an STI:

> There was one time it was feeling weird, it was feeling itchy down there. I said to him, 'I don't think we should date anymore,' and that there was something definitely wrong, so I told him he should go and test for STIs. I had one, so I just said to him that I don't want anything to do with him because he might be having other partners as well, you see. (GTOWN F COLOURED AFRIKAANS 18-24)

Another woman described a vaginal discharge she experienced and how this motivated her to always use condoms with her partner:

> There was a time I had a creamy vaginal discharge; it lasted for four days. I decided to go to the clinic, the [nurse] told me to use condoms; she also said if I contract the discharge again, she will refuse to treat me! I decided to be strict again in using the condoms with my partner. I was given treatment for that discharge. (GTOWN F BLACK ISIXHOSA R 18-24)

> I have had one instance when I did have an STI. It wasn't that much, but I had a discharge and it was itchy when I urinated. I went to the clinic and they told me I've got an STI and then they gave me an injection. That was the only time. But I know, but the one — HIV and AIDS — that's the scary one. (PTZB F BLACK ISIZULU R 25-55)

Some women had learnt about STIs through friends who had been infected with one:

> We weren't really exposed to STIs and all that. If it affects somebody within our group, or somebody within our circle of friends, then you become aware. If it doesn't affect one, your interest won't be there, unless of course you experienced it. (PTZB F COLOURED AFRIKAANS 25-55)

Through learning about STIs from her friends, this woman was motivated to always use condoms to prevent transmitting one:

> Because if you have a condom you are much cleaner, and how I know as well is, you see when you have sex with a guy, you know if you have a discharge or something like that, and if you use a condom, no ways you're going to have a discharge. No ways you are going to feel funny down there, and I find it's much cleaner as well with a condom, much, much more cleaner.

Men demonstrated much more reluctance than women to attend a clinic for STI testing or treatment, despite STIs being frequently asymptomatic in women and frequently symptomatic in men. However, men tended to go for STI treatment once the condition became sufficiently painful. One man (NELS M BLACK XITSONGA 25-55) said he once had an STI but waited five days to go to a clinic because, as a man, he felt compelled not to seek healthcare but to instead endure the pain. However, when the pain became unbearable he went to the clinic and was given medicine that healed him. Once again, this example underscores how some conceptions of masculinity discourage health-seeking behaviour in men. After this experience, the participant said he consistently used condoms with all his casual partners. Encouragingly, this man's story reflects the experiences of several male participants who said they were compelled to visit a clinic for STI treatment, and then as a result underwent HIV testing or were

counselled about HIV prevention, leading to safer-sex practices. One man explained that men tended not to see themselves as being at risk for STIs until they actually experienced one:

> But it's a pity because one still engages in unprotected sex. I guess it's a weakness of some of us men. But also on the other side I can say that inasmuch as one happened to come across issues of STDs, in a second person, men, maybe the outcome now for me to actually still engage in sex would have not been the same if I had actually experienced it myself. It would have been seeing something there and actually experiencing it yourself are two different things. (PTZB M BLACK ISIZULU R 25-55)

Similar to HIV testing, sometimes it was only upon a woman's encouragement that men were convinced to test for STIs:

> Regarding STIs — her 'older' partner did once have genital warts, and while he wanted to brush this off saying it was nothing, she insisted that they both go to the doctor — which they did — and they were treated. (GTOWN F WHITE AFRIKAANS 25-55)

Several men appeared to lack knowledge about different STIs and their symptoms. One participant (GTOWN M BLACK ISIXHOSA 18-24) was unsure how to tell if his partner had an STI and thought that only having 'small pimples' was a sign. Another man's statement highlighted the need for correct information on STIs, as he stated: 'Use a condom because otherwise something will happen and your private parts will go green' (JNB M INDIAN ENGLISH 25-55). These comments demonstrate the continued need for promoting both correct information on the consequences of STIS about the links between HIV and other STIs.

Discussion

The narratives draw attention to the many ways that social ideals of manhood make men and women vulnerable to HIV. This supports the idea that HIV-prevention programmes should do more than attempt to alter individual behaviours, but should promote a broader social change in conceptions of masculinity and femininity (Jewkes and Morrell 2010). The finding that most participants were aware of male condom use as a highly effective means of protecting themselves from HIV infection suggests good knowledge about condoms. Condom use at first sex has dramatically increased among young people; the Third National HIV Communication Survey, conducted across all provinces with 10,034 respondents between the ages of 16 and 55

found that two-thirds of people who had sex for the first time during the last 3 years reported using a condom at first sex (JHHESA 2012).

Yet, the narratives also demonstrated much resistance to consistent condom use. A lack of self-control was given by both men and women to explain poor condom use, although men more frequently asserted this than women. A study with coloured adolescent men in the Western Cape found that a central theme around their beliefs of masculine sexuality was an uncontrollable physiological sex drive, something outside of individual cognition or rational control (Lesch and Bremridge 2006). Perceptions that understate HIV risk occurred throughout the men's narratives and impeded their engagement in HIV-preventive behaviours. This is similarly documented elsewhere in the literature (e.g., Anderson, Beutel and Maughan-Brown 2007; Napper and Fisher 2012). In this study, knowing someone who had died of AIDS increased some participants' perceived level of HIV risk. For such reasons, SRH campaigns were said to be particularly effective at addressing and undermining HIV stigma if conducted by people living with HIV. Palekar *et al*. (2008) likewise found that knowing someone who died of AIDS positively influenced sexual behaviour change. Poor use of condoms was in part linked to the men's insecurity about their ability to satisfy their partners. Both men and women expressed a dislike of condoms for being perceived to be too small or poorly lubricated, particularly the government-provided Choice© condoms.

More men, particularly young men, reported alcohol use as a barrier to safer sex than women, which supports other literature reporting that heavy drinking can lead to sexual inhibition, especially among casual partners (Foreman 1999; Flood 2003b; Pettifor *et al*. 2004; Morojele *et al.* 2006; Kalichman *et al.* 2007; Parker 2012a). This is not surprising given that alcohol use, particularly binge drinking on weekends, is higher among men than women in all age groups, provinces, and populations (Peacock *et al.* 2008). The rate of alcohol use in South Africa is also said to be rising, especially among adolescents (Peacock *et al.* 2008). Some women fro ma variety of racial and language groups were reluctant to initiate condom use because of its association with promiscuity. This speaks to the pervasiveness of feminine norms that dissuade women from initiating condom use. However, some men discussed their belief that women should also carry condoms and initiate their use: this reveals the possibility of the emergence of a

tendency towards more gender-equitable masculinity in this regard, one that respects the agency of women to make decisions about a couple's sexual behaviour.

The participants generally knew where they could access HIV testing, which seemed to be highly accessible, apart from participants in some rural areas. This is unsurprising given the dramatic rollout out of HIV counselling and testing (HCT) in South Africa through a major government-launched campaign in 2010. Since its implementation, the HCT campaign has made a notable impact on HIV-testing uptake. Between April 2010 and June 2011, approximately 12 million South Africans tested for HIV and came to know their HIV status through the campaign — representing a six-fold increase over the previous year. Of those who tested, 2 million individuals were found to be HIV-positive and were referred for further care (South African Department of Health 2013). In this study, more women than men recalled testing for HIV and testing regularly, with many being motivated to test for the first time when they were pregnant and continuing to test afterwards to track their HIV status. The finding that more women than men report ever testing for HIV has also been reported by other studies (Peacock *et al*. 2009; Lynch, Brouard and Visser 2010; Parker 2012). HIV-testing barriers among men often derived from conceptions of masculinity that encourage men to seek help only when very ill. Those who said they did test for HIV often did so upon encouragement from their partner or when their partner became pregnant; this is an entry point for HIV prevention worthy of expansion. Some men's commitment to test for HIV to protect their children from HIV infection suggests a link between HIV awareness and the availability of prevention-of-mother-to-child-transmission programmes, as well as men's concern for their children's health, Mother-to-child HIV transmission decreased from 30% in the mid-1990s (Gray 2008) to 3.5% by 2010, and is now estimated to be less than 2% (Goga *et al*. 2012).

While some couples tested for HIV together, there was little mention of the window between testing for HIV and being truly HIV uninfected. There was also little reporting of follow up testing among those who said they had first tested for HIV. Encouraging follow up HIV testing is challenging because of perceptions that steady relationships are 'safe'. Nevertheless, repeat HIV testing among couples in long-term relationships could be promoted as a form of mutual care. Couples testing for HIV together did seem to promote safer sexual behaviour which supports

other findings that couples testing for HIV together may be more effective at altering HIV-risk behaviour than individual testing (Kelly 2009). There was some evidence that individuals who tested HIV-negative were encouraged to maintain that status by testing regularly and were more cautious about their sexual behaviour.

Some men were actively involved in contraception to prevent pregnancy in a relationship, but this was the exception. Those who were involved cited cultural reasons, family conversations promoting contraception, or good knowledge about the human reproductive system. However, the majority of male participants reported poor involvement in contraception decision-making, misunderstandings about the female reproductive cycle, and poor knowledge of effective contraceptives. Several men mentioned a lack of a positive fatherly influence in their own lives as a factor militating against engaging in protected sex, including pregnancy prevention. Several participants recalled an unplanned teenage pregnancy. Women's reported lack of knowledge of how to prevent pregnancy, poor access to contraception and low levels of sexual decision-making may have contributed to the high rate of unplanned pregnancies. Some of the men expressed pride in a pregnancy, even if accidental, as a testimony to their virility and they avoided contraception for this reason. In such cases, the man who became a father often provided little or no involvement or financial support for the child. This is in congruence with Campo-Engelstein's (2013) observation that the responsibility for contraception and child-rearing unduly falls onto women (including health-related, social and financial responsibility). Men's default on child-maintenance obligations is a well-recognised phenomenon in South Africa (Peacock and Barker 2012). However, in some cases, an unplanned pregnancy encouraged male participants to become more involved in contraception to avoid future unwanted pregnancies. This is in line with research that found an increased uptake of contraception among both men and women following an unplanned pregnancy (Cohen 2008). Some men expressed how concern for a child's or partner's health had persuaded them to change their sexual behaviour or to test for HIV. Education campaigns could draw on the anxiety of premature fatherhood and more intensely frame condom use in terms of men's joint responsibility for the couple's sexual health and pregnancy prevention (Waldby, Kippax and Crawford 1993b; Campbell 1995; Flood 2003a). In a study by Lesch and Bremridge (2008) in the Western Cape, men were eager to be involved

in antenatal care but felt they lacked the necessary skills to do so, highlighting the need for health professionals to engage and train men accordingly.

Campaigns such as the Global Fatherhood Campaign to promote men's involvement as fathers and as caregivers, and 'Brothers for Life' which promotes positive images of being a caring and responsible father, brother and sexual partner have been effective at promoting men's active responsibility in pregnancy and child support and should be built upon. Fathering itself can also be a useful entry point for promoting gender equitable attitudes and behaviours among men and involving men as responsible fathers will help to challenge stereotypical beliefs about different appropriate roles for women and men (Peacock *et al.* 2009; Swartz *et al.* 2013). Some men expressed a desire to be more involved in contraception yet felt unequipped to do so. The notion of personal responsibility (even duty) to protect oneself and one's partners against HIV, which motivates safer-sex practices, arose in many of the men's narratives. This sentiment suggests that more men might aspire to care for the women and children in their lives given a clearer opportunity and role to do so. The participants' concerns to not endanger the wellbeing of others in is line with the findings of a recent study by Rhodes and Cusick (2012) and goes against an oft-repeated belief that HIV-positive individuals might seek to deal with the angst of their HIV positive status by intentionally infecting others. This conduct in a few cases in developed countries has been sensationalised in the media, thus fuelling this misunderstanding.[21]

Fear as a deterrent to higher-risk sexual practices was a common theme in the narratives; the men and women tended to be more concerned about HIV infection than other STIs, which they observed as curable. This demonstrates the continued need for promotion of information about the links between HIV and other STIs. However, as an HIV-prevention strategy, fear is limited in its effectiveness (Green and White 2006). A few participants also criticized the strategy of scaring people into safer sex behaviours. Women had a greater awareness of STIs than the men did, and predominantly learned about these at SRH clinics. However, fewer women discussed actually receiving treatment for an STI than men. This could reflect the fact that STIs are more

[21] After the publication of Shilt's (1987) book *And the Band Played On*, which includes extensive discussion of Canadian flight attendant Gatean Dugas's many sexual liaisons and his progression from HIV infection to death, the book received extensive media coverage concerning Dugas's 'demonized' role in spreading HIV on the continent. Dugas was defamed in the press, particularly by Canadian media, as bringing an offence to their nationhood, despite the fact that he could not have fully understood HIV transmission in the early stage of the pandemic.

commonly asymptomatic in women than men and that they therefore go untreated in women (Cooper *et al.* 2004). In line with other findings, many of the men perceived SRH care as 'women's business' (Cohen 2008; Kelly 2009). The men described being reluctant to visit a clinic for STI treatment until their infection became severe, illustrating how hegemonic norms that expect men to not show weakness through illness can negatively impact on men's health. Colvin *et al.* (2010) also found that beliefs that real men can tough it out translated into men's failure to access care and other forms of support on time. Some men who were diagnosed and treated for STIS were encouraged to undertake safer SRH practises to better protect themselves.

The participants noted that SRH services, including for HIV prevention, were less accessible in rural areas. Some men in rural areas mistrusted the quality of condoms, perceived condoms to be a 'Western tool,' or thought there could be negative side effects from oral and injectable hormonal contraceptives — even for a woman's male partner. Participants who had experienced an unplanned teenage pregnancy were most commonly from a rural area. This may be attributed to poor knowledge of contraception and contraceptive services. It may also support the finding that stigma around being sexually active, particularly as a youth, tends to be greater in more traditional rural than urban environments (Steinberg 2008). There was also some HIV and AIDS denialism apparent among participants from rural areas. This is unlikely to be common currently but may be a remnant at the time of the interviews of the HIV denialist period during the presidency of Thabo Mbeki (Kalichman 2009). In addition, this attitude resonates with Farmer's (2001) concept of rhetorical defiance wherein conspiracy theories prevail among marginalised groups in society, such as in rural areas. Overall, misunderstandings about HIV, condoms and contraception were more pronounced in the rural areas. Such differences in relation to the participants' SRH awareness according to rural or urban environment attest to the importance of conducting research in sites that are diverse economically, culturally and geographically.

Conclusions

The narratives reveal that dominant norms of masculinity have the capacity to leave men and their sexual partners vulnerable to STIs, including HIV. The perception that men should be stoical in the face of illness or pain was prevalent of the participants in this study. Hegemonic masculine norms hindered men's involvement in SRH care, including poor uptake of SRH

services, lower levels of HIV testing than among women, poor involvement in contraception. It also underscored the popular concept that it is acceptable for men to have a supposed lack of control in practicing safer sex. Yet the data also documented men who took steps to protect the health of themselves, their partners and children, and who encouraged a woman's capacity to make SRH-related decisions in relationships. This underlines that some men counter hegemonic sexual norms and practices. The final chapter presents recommendations to more adequately target and engage men in safer sexual practices, and HIV prevention specifically.

CHAPTER 9: RECOMMENDATIONS AND CONCLUSION

The lived stories as revealed through the sexual-history narratives are more nuanced and complex than what is usually portrayed in the body of HIV-related behavioural research. The narratives reveal a diversity and fluidity of men's sexual identity underpinned by an individual's developmental and socio-cultural context. This underscores the need for caution in making general prescriptions for improving men's awareness of and commitment to various aspects of SRH. Nonetheless, participants' subjective and social dynamics of men's sexual agency and, above all, risk behaviour, reveal a number of opportunities for addressing problematic aspects of men's expressions of sexuality that can negatively affect the SRH of men and women. Key recommendations are presented based on the major findings of one of the main research questions: What aspects of male sexual identity contribute to men's engagement in HIV prevention and sexual behaviour change through a gender-transformative approach?

Recommendations

Comprehensive SRH education from early adolescence

The majority of men and women appeared to lack access to accurate and safe SRH information in early adolescence. They frequently reflected on their early sexual experiences with feelings of inadequacy, misunderstandings and a general lack of readiness. Men's particularly few opportunities for adequate and informed sources of SRH warrants special attention. Targeting preadolescent (10-13 years of age) men with comprehensive sex education is necessary given the vulnerable and intimate nature of young men's sexuality that seems to become threatened as they approach adolescence. Participant's generally poor evaluations of the Life Orientation classes suggest that these channels of sexual education should be reviewed with a view to diversification, tailoring these to the various social realities of young people. As the narratives attest to, many factors other than knowledge including perceived risk, self-efficacy and poor self-esteem affect engagement in risky sex (Coates, Richter and Caceres 2008). Given that many participants reported that they did not perceive themselves to be at risk of HIV at sexual debut, the disjuncture between sexual risk behaviors and perceptions should be more comprehensively addressed in school-based and other youth SRH education. Low self-esteem, common in many

participants' stories at the time of sexual debut, can also enhance HIV risk behavior for young people and needs to be addressed by HIV prevention efforts targeting young people (Harrison *et al.* 2010). Some participants valued learning about sex from religious institutions for perceiving their sexual agency to be acknowledged and counteracting the societal pressure for young people to be sexually active before they were ready. In these circumstances, the involvement of religious leaders and institutions in SRH education may equip some young people with skills to resist pressure to engage in sex and impart to them more responsible attitudes towards sex. The development of such skills would be particularly important for young men. Yet, reliance on abstinence as an HIV prevention strategy is an inappropriate response in the context of young men relating severe pressure to engage in sex and young women reporting high rates of partner pressure to engage in sex, including sexual coercion. Hence, sex-education programs should more comprehensively take into account the range of societal realities young people are faced with, including how this differs between men and women, and provide them with a choice of options to protect themselves from sexual risk.

Given that many participants reported that parents found it daunting and uncomfortable to speak about sex with them, educational materials to teach parents how to approach these safer and consensual sexual issues should be more readily available. More women than men recalled parental education, but also regulation of their sexuality. This is a highly gendered response mirroring greater concern about female sexuality, as well as greater risks of sexual coercion in girls and them bearing the burden of unintended pregnancy. While individual and community initiatives in this regard are important, a key strategy would be to address these gendered biases at a broader societal level. Opportunities for parents to address their concerns about imparting sexual health education to their children with health educators, including reflection on their own gendered biases, would be valuable. Where feasible, parents should be encouraged to have open and honest discussions with their children as a number of participants reported learning limited or misleading sexual health information from their parents. Fathers, who in this study were less less likely to provide sex education than mothers, should be targeted to educate their children about safer sex and sexual consent. Strengthening father-child communication may be especially important for boys who regularly lamented the lack of fatherly input. Those participants that did receive open and accurate sexual education from their parents highly valued this, which speaks to the significance of this form of communication. There is a wealth of research that suggests a

positive correlation between adolescent contraception use, for example, and frequency and comfort of discussions with parents (Aggleton and Campbell 2000; Bastien, Kajula and Muhwezi 2011). Other channels for discussing sexual health issues with youth should be strengthened. For example, many female participants recalled being informed about sex by a female relative other than their mother, and some men recalled being informed about sex from their older brother. Hence it would be helpful for youth oriented programs to stress the involvement of other family members in providing safer sex messages (Ott *et al.* 2012). In some cases, this may be more acceptable to youth and parents.

Many participants, particularly those in the younger age group, cited the media as a prominent source of SRH information for being anonymous, accessible and easy to relate to. The HIV-prevention field should continue to embrace the use of social media, such as Facebook and Twitter, to target young people. Given that men were less likely than women to learn about sexual health by accessing SRH services, communication through social media could play a critical role in reaching men with SRH information. However, participants acknowledged that not all people in South Africa have sufficient Internet access to allow for engagement with online social media, particularly those in rural areas. SRH communication should thus use varied media strategies to reach individuals in rural areas including cellphone and radio communication. Locally appropriate social media channels such as the cellphone chat program, Mixit, which has a high user rate in rural areas, should be explored for providing sexual information and messaging. The role of pornography as an inadvertent source of 'education' about sex and gender roles for some men warrants attention. Since many young men valued pornography as one of the only accessible tools to learn about sex and sexual performance, more diverse sexual education materials are required for young men, which may reduce the appeal of porn (Flood 2010). If men are educated to view porn critically, they may be more resistant to violent and sexist themes that tend to accompany mainstream pornography (Maitse 1998; Flood 2010; Artz 2012). Forms of pornography that counter gender-inequitable behaviour and can instead "eroticize consent, respect and intimacy, and be pronounced without participants' coercion or harm" could also be promoted (Flood 2010, p. 178).

The narratives revealed that men's peer groups acted as a primary reference point for learning about sex and gender norms – the normalizing attitudes, beliefs and values relating to gender that are meant to be adhered to in order to be accepted within society (Campbell and MacPhail 2002;

Parker 2012b). Even if the majority of men do not conform to such gender norms, they can significantly influence men's behaviors (Peacock 2013). Among many of the male participants, gender norms communicated through peers encouraged sexual risk behaviour. One prominent example is the notion that men should have sex with multiple partners, and should always initiate and be in control of sex (Lindegger and Quayle 2009; Gevers *et al.* 2012). Peer education, which seeks to target social norms in non-judgmental spaces by using a group of individuals as peer educators, has been found to be a valuable way to improve men's sexual health (Swartz *et al.* 2012). Peer educators who share socio-economic circumstances with participants, yet challenge stereotypical norms and attitudes and are understood to be more accessible, credible and influential to participants (MacPhail and Campbell 2001; Evans and Tripp 2006). Indeed, men in this study reported feeling most comfortable discussing sex with their peers. Peer education has demonstrated effective health outcomes at individual and social levels, such as increasing condom use, delaying sexual debut, and fewer reports of MCPs (Campbell and MacPhail 2002; Foss *et al.* 2007; Visser 2007; Cornish and Campbell 2009; Mash and Mash 2012). Some participants in this study recalled adopting a critical distance from their peers so as to make more independent choices about their sex lives, which often resulted in having safer sexual relations. Peer sexual education programs should thus promote men's awareness of their vulnerability to peer group influence, provide skills for and encourage resistance from the norms and expectations of their peer groups that can be damaging to their sexual health. Since some participants reported the effectiveness of having HIV positive people provide SRH education to decrease the stigma of HIV, peer education campaigns should continue to use people living with HIV as SRH educators, where appropriate.

Organizations including Sonke Gender Justice and 'Brothers for Life' have initiated peer workshops that reach nearly 25,000 men a year to challenge constructions of dominant masculinity that drive sexual risk-taking behaviors. For instance, Sonke Gender Justice hosts 'One Man Can' workshops, which provides a space for critical reflection on masculine socialization, attitudes and gender equality. Research indicates that those who participated in these peer workshops have better awareness of women's rights and embrace more gender-equitable norms in their relationships. These include respect, open communication, more equal sexual decision-making, and greater sharing of household duties (Dworkin *et al.* 2013). One

impact evaluation noted that 50% of men who had participated in these workshops reported taking action to address acts of gender based violence in their community, 25% accessed HIV HCT and 61% reported increasing their use of condoms (Colvin *et al.* 2009). Participation also contributed to more involved and responsible fathering, improved communication with children, and less use of violence as a discipline method. However, the researchers (Dworkin *et al*. 2013) also noted the limitations of examining changes in men's views and practices of dominant norms of masculinity through using self-reports, without observing the men's actions in their relationships, families and communities after attending the workshops. Further evaluation impact studies of such peer education programs would be valuable.

While peer education programs have had some success in sexual behavior change, as mentioned previously, creating supportive interpersonal and social support for alternative masculinities to be adopted is essential for greater and sustainable success (Campbell 2004; Sideris 2004a; Matthews *et al.* 2012). Working at these levels is necessary given that despite SRH awareness levels, people do not always have the motivation or ability to adopt safer sex behaviors (Campbell 2003; Coates, Richter and Caceres 2008), and also to support and sustain any personal change (Parker 2012b). Some studies have found that peer education initiatives are limited without addressing the broader environment (Mukoma *et al.* 2009; Matthews *et al.* 2012). For instance, the 'Rutanang' program trained peer educators to conduct sessions for 15-16 year old students during life orientation classes. The primary aims of the program were to delay the age at which students began having sex, and to increase condom use among those who had already started to have sex. A study by Marson-Jones, Matthews and Flisher (2011) compared 15 schools that received this intervention with 15 other schools that continued to receive standard Life Orientation classes. Learners (n= 4,000) in the intervention and control groups completed self-completion questionnaires before and after the intervention. The study found that the proportion of students reporting condom use and the age of first sex did not vary between intervention and comparison schools. The intervention program had no significant effect on students' attitudes and skills in relation to broader future, goals and decision-making. Explanations for this include that the non-governmental organizations training the peer educators were poorly coordinated and that some faith-based organizations involved were uncomfortable with open discussion of sex and condoms, preferring to concentrate on abstinence. The authors suggested that peer education programs such as "Rutanang' would ultimately have a greater impact if they involved the wider

community and tackled influential social issues, such as poverty and gendered power relations.

SRH campaigns targeting men

Several participants expressed an appreciation of the increasingly prevalent HIV-prevention programs that target men. These include programs such as Sonke Gender Justice's 'One Man Can Campaign', and John Hopkins Health South Africa's 'Brothers for Life' Campaign (Ratele, Shefer and Botha 2011). Such campaigns were said to be particularly important since men are often neglected by or harder to reach with SRH communication through SRH clinics. They also present men as capable of playing a positive role in the health of their partners, families and communities. Since men who live out more equitable masculinities may be marginalized in their communities, such campaigns are able to offer support through role models who promote gender-equitable and responsible SRH behaviors and practices (Dworkin *et al.* 2011). The diverse masculinities identified in this study stress the importance of campaigns being sensitive to how factors such as class, ethnicity, and age shape expressions of manhood. Based on this, interventions should be tailored to different perceptions of groups of men (Flood 2007). Interrogating men's narratives, which reveal the complexity and diversity of men's attitudes and behaviours as well as the broader social context in which these are situated, could assist campaigns in undermining homogenous understandings of masculinity (Lindegger and Quayle 2009). Through foregrounding masculinity as 'performance' of gender, a social construct rather than being 'natural', such campaigns can inform men how adhering to certain gender norms expose them to physical and emotional health costs, and how these norms can be dismantled (Clowes 2013). The benefits of new gender norms, such as advantages of committed and equal relationships, can be made salient. Campaigns are more likely to be effective if the messages are tailored to men's values, needs and interests, with relevance to their socio-cultural context. Hence opportunities for men to express their concerns and barriers to sexual health as occurred in this study are a key component for men's health campaign programmers (Ntshebe, Pitso and Segobye 2012).

In challenging hegemonic male norms, communication campaigns should be wary that they do not reinforce the differences between men and women that they seek to overturn (Flood 2003a). Appeals to prove one's masculinity have been used in marketing condoms to men (Campbell

1995; Foreman 1998; Flood 2003a), and sexual violence campaigns have encouraged men to protect their partners. This can reinforce dominant notions of masculinity that women are in need of protection from men by other men (Morrell and Jewkes 2011). For instance, in 2001 the imminent Anglican Archbishop Desmond Tutu headed a commendable Men's March on National Women's day with placards announcing 'Hands off our women.' However, this was criticized for alluding to women as men's property (Moffett 2006). Campaigns targeting SRH also risk portraying the act of sex as central to men's identity to the neglect of the vulnerable and relational nature of men's sexuality (Lindegger and Quayle 2009). As Seidler (2006, p. 100) argued:

> "Concentrating on the negative aspects of functional sexuality such as sexual conquest, or failure to use condoms, these projects and interventions may unintentionally reinforce the notion for men/boys that 'their bodies [are] machines that they need to control."

Campaigns targeting men should focus on encouraging shared responsibility for sexual decision-making and the development of respectful and equal relationships with women. Campaigns could promote the acceptance of both men and women as financial providers in recognition of the fact that women have increasingly taken on financial provider roles (Sideris *et al.* 2004b). This would also ease the burden on men, congruent with dominant masculinity roles, to be the sole financial provider or main breadwinners for their female partners in the context of severe unemployment (Walker 2005). This could encourage greater gender equality. Campaigns targeting men's involvement in SRH should be evaluated to assess their broader positive effect on change towards more equitable gender relations. Campaigns could also appeal to certain notions of culture that would support alternative masculinities. For instance, values such as personal discipline, responsibility and generosity could be used to construct more positive conceptions of masculinity (Morrell 2003; Sideris 2004a).

A relational approach to HIV prevention

Given that the participants' SRH practices and gendered norms were situated in the types and subjective meaning of their sexual relationships, HIV-prevention efforts should address hegemonic forms of masculinity according to different categories of relationships among both men and women. Since sex in established relationships was reportedly more likely to be unprotected sex, equating 'trust' to no need for condom use needs to be interrogated, particularly

since this notion of trust of trust described by participants was often arrived at relatively quickly and without knowing the partner's HIV status. Rather than promoted chiefly as a method of HIV-risk reduction, safer-sex practices could be promoted as an expression of mutual care, openness and love (Cusick and Rhodes 2000). Condom use was most frequently reported among couples in order to prevent pregnancy; hence, condoms could be more strongly promoted as contraception, which does not conflict with notions of partner fidelity. Promoting condom use as form of reliable contraception in established relationships may be effective in giving men more of an opportunity to be directly involved in contraceptive responsibilities. While women may be reluctant to rely entirely on men for contraception, where possible, dual method use could be encouraged. Men's anxiety about sexually satisfying their partners while using condoms was common, which provides a potential avenue to more actively involve men in contraception. For instance, SRH campaigns could highlight ideas that good lovers use condoms and are desirable and that safer sex is a good sexually satisfying technique (Waldby, Kippax and Crawford 1993a; Flood 2003a). This is more likely to be implementable with young people before they start their sexual lives.

Most participants displayed knowledge of and use of condoms in casual relationships and this is encouraging, yet alcohol consumption was cited as regularly impeding condom use in relationships. Hence behavioural programmes that seek to reduce unhealthy alcohol consumption and provide education to people about the relationship between alcohol use and sexual risk are important (Peacock and Barker 2012). The Minister of Health, Aaron Motsoledi, has attempted to address alcohol abuse through initiatives that include restricting drinking hours, alcohol sales, and banning alcohol adverts (Khumalo 2011). A variety of other global programs and policies have successfully reduced harmful drinking. These have included raising alcohol taxes, the legal drinking age, decreasing the legal blood alcohol concentration limits for drivers, training of alcohol servers to monitor and control unhealthy alcohol use, and community education about the health consequences of alcohol (Peacock and Barker 2012). Given that more men than women reported how alcohol use hindered safer sex, programmatic efforts of this nature tailored to men's specific motivations and underlying gender norms for drinking are warranted (Breton *et al.* 2012).

In cognisance of the fact that several men and women reported responding to a partner's temporary lack of sexual interest with hostility and resentment, greater encouragement is needed

for partners to discuss their feelings of rejection and differing sexual needs. Guidance and counseling services should be more readily available through public health and social welfare services for men and women to deal with a partners' perceived or actual infidelity as well as relationship difficulties. Hegemonic norms that link concurrency to masculinity also need to be addressed by HIV-prevention efforts (Leclerc-Madlala 2009a; Mah and Maughan-Brown 2012). Many participants indicated that women on the whole tend to tolerate men who have multiple sexual partners and to accept the notion that men have uncontrollable sexuality. This highlights that programmes aimed at partner reduction may best succeed if they target both men's and women's normative masculine expectations (Leclerc-Madlala 2009a).

'Stepping Stones' is an example of a HIV behavioural intervention that provided training around HIV, communication and relationship skills to both men and women to pursue greater gender equality and safe sex practices. An evaluation two years after implementation of the programme in the Eastern Cape province showed that men reported a lower proportion of transactional sex, greater condom use among men (not women), and there was a reduction in some STIs but not in HIV incidence (Jewkes *et al.* 2008). 'Creating Futures' is another structural intervention that seeks to encourage reflection among young people on their livelihoods through participatory activities to strengthen economic power, education, getting and keeping jobs, and access to social resources. 'Stepping Stones' and 'Creating Futures' were piloted in urban informal settlements in Durban with 233 young men and women (Gibbs and Jewkes 2013). The initial evaluation found that participant's main relationships were strengthened, which suggests a potential reduction in concurrent partnerships. There was also a significant change in men's risky practices including higher condom use, less transactional sex and less substance abuse (MRC 2007). While there was no decline in women reporting having had transactional sex, fewer (a decrease from 71.5% to 55.2%) reported that the last time they received a benefit for sex, this would not have occurred without the financial reward. This demonstrates that structural interventions, such as poverty reduction schemes like 'Creating Futures' can strengthen the impact of relationship educational programs like 'Stepping Stones' program. Interventions such as these should continue to be scaled up, supported and continued evaluation should occur. More attention should be given to what relationship and social factors need to change to enable women's sexual behaviour change and longer term sustainability of behaviour change in men needs to be tracked.

Addressing gender norms condoning sexual coercion

Many of the men who admitted to using sexual coercion in relationships endorsed harmful gender norms like men's supposed entitlement to sex with women and misogynist views that tolerated men's use of aggression or violence in an intimate relationship. This speaks to the need for interventions that challenge such harmful norms of masculinity including asserting masculinity through sexual dominance and control (Jewkes *et al*. 2011). Some of the male participants regretted their use of sexual coercion, and others rejected sexual coercion completely. 'Men for Change' (MFC), an NGO based in the township suburb Alexandria, Gauteng, is an example of an intervention that seeks to provide counselling and support for men who have engaged in gender-based violence and have indicated willingness to change. Walker (2005) noted how it was a significant challenge for young men involved in MFC, who had previously perpetrated sexual abuse, to achieve a masculinity that was non-violent, responsible, and monogamous. Research with men revealed the pervasiveness of violence in men's lives; having experienced or witnessed sexual violence at home and as 'normal' in their relationships. This speaks to the necessity of providing support, through the likes of such interventions, to men who are critical of gender norms condoning gender-based violence.

Sexual violence interventions that address gendered norms at the community level are critical since societal tolerance for sexual violence has been found to be a potential predictor of men's perpetration of sexual coercion and community inaction (Flood and Pease 2006; Parker 2012b). Prevention in Action (PIA) is a community based sexual violence intervention, which sought to reduce HIV transmission by addressing social norms related to sexual violence against women (Parker 2012b). The initial research for the project found that although violence against women was generally understood to be wrong, it continued to be perpetrated as a product of silence, inaction, and lack of understanding how to address such issues (Parker 2012b). The project attempted to stimulate action in response to violence against women with a strong orientation towards promoting relationship dialogue, gender sensitivity and family values. The program enhanced critical consciousness including participant's understanding that sexual violence was not acceptable or tolerable. In the project evaluation, approximately a third of participants felt that sexual violence had decreased in intervention communities over the previous year. This was attributed to increased action by the police, community members, and family members. It was acknowledged that both men and women experience physical partner violence in relationships,

and although women experience it more frequently, there were concerns that the concept of violence against women (VAW) was too narrow and alienated men. Participants stressed their preference for a more holistic concept of gender-based violence. They also felt that physical violence as well as psychological or economic violence were important forms of coercion to address. PIA reveals how community models represent a sustainable, relevant and effective avenue to target societal gender norms condoning gender based violence.

South Africa's 2007 Sexual Offences Act (SOA) is very comprehensive and includes a range of sexual offences including human trafficking for sexual exploitation and compelling others to commit offence. However, many participants (both as perpetrators and victims) appeared to be unaware of the criminal nature of forms of sexual offence, underscoring the need for the nature of sexual coercion and the rights of sexual violence victims according to the SOA to be more thoroughly communicated. An example of a program that does this is the 'Shukumisa' Campaign, which was created in 2008 and aims to educate all South Africans about the SOA, their rights under the law and the services within the Criminal Justice System to which they should have access. The campaign strives to ensure policies related to sexual offences are implemented through monitoring sexual violence legislation and criminal and justice services. This includes police stations, courthouses, and hospitals to determine what services are in place for rape victims, as required by the SOA and its implementing policies. 'Shukumisa' submits its monitoring reports to the South African Police Service (SAPS), the Department of Justice and Constitutional Development and the Department of Health. Programs such as this are important in ensuring implementation of good legislation. The narratives revealed that incidents of sexual coercion were sometimes erroneously interpreted as being acceptable due to gender stereotypical behaviour. For example, these included that men are almost always willing to engage in sex and that sexual coercion did not occur when emotional force or manipulation was used. Psychological distress as a result of women experiencing sexual coercion has been found to promote the women's acceptance of a man's dominance in relationships, including abusive behaviour. This stresses the need to challenge hegemonic norms supporting men's use of violence with women as well as men, and also for counselling and social support to be readily available to women break this 'vicious cycle' (WHO *et al*. 2013). Several women who had experienced sexual coercion held 'victim blaming' attitudes, whereby they felt fully or partly

responsible for the incident of sexual coercion. Sexual violence educational programs must work to dismantle such attitudes with men and women.

It is also important to address whether men's use of violence in South Africa can be transformed through shifting men and women's attitudes and norms, given the relationship between men's use of violence and the marginal economic and social conditions of many men's lives (Meer 2013). Successful interventions must also address structural causes of sexual violence (Clowes 2013). This includes, among other things, effective implementation of policies and programs that allow individuals to leave abusive relationships, enabling women to have greater financial autonomy, and protecting children from exposure to domestic violence and to physical punishment (Kim *et al* 2007; Heise 2012). This is particularly important given the links between men's experience of, and even witnessing of sexual violence, and subsequent use of violence that have been documented (Dunkle *et al.* 2004; Jeejebhoy, Shah and Thapa 2005).

The study findings on some men's experiences of sexual coercion by women and men's intense peer pressure to engage in sex, suggests the need to broaden our current view and understanding of sexual coercion. It submits that it is "over-simplistic to view pressure as something that comes exclusively from the partner" (Marston 2005, p. 294). The potentially coercive role of peer pressure needs to be better acknowledged and addressed. It is critical that young men are given opportunities to acknowledge an experience of sexual coercion for their own sake and so that they are sensitized to the sexually coercive experiences of girls and women (Jejeebhoy, Shah and Thapa 2005).

Promoting SRH services and HIV prevention among men

The men's lower likelihood of testing for HIV, reduced involvement in contraception, and infrequent attendance of SRH clinics show the need to better engage men in SRH and its links with HIV prevention and care. The lesser concern of men and women contracting an STI confirms the need to scale-up STI and HIV links among both men and women as part of broader SRH. Men who were diagnosed and treated for STIs reported taking more responsibility for SRH care thereafter. This can provide a window of opportunity among men for greater involvement in SRH and in HIV testing and care. HCT has also been effectively applied when coupled with reproductive decision-making and since men are often excluded from these domains, better

integration of SRH services should be promoted (Kelly 2009; Mills *et al.* 2009). Campaigns to promote HCT and increase male involvement in PMTCT services, such as those done by the One Man Can and Brothers for Life Campaign, should be scaled up (Betron *et al.* 2012). SRH clinics seeking to involve fathers in childcare, including PMTCT, should direct their services towards parents of both sexes, regardless of their marital status (Swartz *et al.* 2013).

Participants repeatedly emphasised that SRH care is a woman's domain; interventions need to promote public and private clinics committed to engaging men and to finding creative ways to improve men's uptake of SRH services. SRH services in South Africa have historically focused on maternal and child health issues, and are oriented to engaging with women more than men. Furthermore men's SRH are often seen as secondary to those of women, as they bear a lesser burden of reproductive ill health. Although it is the Department of Health's policy to involve and engage men in SRH, more needs to be done for practical implementation of this policy within the health system (Cornell, McIntyre and Myer 2011). Possibilities for stronger support from the South African Department of Health include activities to encourage men to accompany women to clinics and establishing special clinic times for men (Orner *et al*. 2008), as has been done in some areas of South Africa. Examples of this include NGO and government supported health services committed to working with men such as Health4Men's Clinics, which have been opened in various locations in Cape Town and Johannesburg. These male health centers provide access to sexual health services in an environment that is conducive to men's SRH needs, including HIV testing and counseling, condom distribution, treatment of STIs, TB screening and other health issues. Informal drinking venues, sports clubs and cultural events that take care to not reinforce existing gender stereotypes, could be considered for SRH promotion among men.

Value of sexual history narratives

Without being prompted, many participants showed intrinsic interest in the interview topics and expressed a spontaneous sense of the importance of discussions about the sexual and reproductive issues in heterosexual relationships. As one participant said:

> I would have to say I was hungry for an interview like this one. Just to get a chance to express myself, to get something out, because I didn't know this was part of what I am carrying all the years, so just to get something out made me feel much better. (CPT M COLOURED AFRIKAANS 18-25)

This may reflect the limited opportunities for people to reflect on and discuss their sexual relationships and behaviors, suggesting a widely unmet need in this area. As one woman said:

> I haven't spoken to my husband about this. There are many days that this heavy mood is still hanging onto me. And now I have opened up and I am so grateful that I found somebody to whom I could open up (JNB F BLACK ISIZULU 25-55).

The process of articulating and structuring one's sexual history, in a neutral space without pressure to accommodate one's peer group, can provide an opportunity for critical reflection and redefining one's sexual practices and attitudes. In this way, the sexual history narratives represent not only research but also a potential form of intervention that should be built upon. Lindegger and Quayle (2009, p. 11) note that "critical engagement with and reflection on these vulnerabilities, as well as the skills for managing them, are essential for men, individually and collectively, to live out more positive masculinities, and so reduce the risk of increased HIV transmission and infection." The reflexive dimension of informant's narratives as an effective component of HIV/AIDS intervention resonates with Walker's (2005) work in South Africa and Barker *et al.'s* (2004) research in Brazil and USA, which encouraged men to construct alternative narratives, and reflect on their roles and responsibilities in more positive ways. Providing such opportunities can also generate a better understanding of men's differing views on sexual identities and gendered norms, as well as how hegemonic masculine norms change within an individual's life span. Overall, sexual history narratives provided a rich and dynamic tool to engage participants around the subject of inquiry, and can add significant value when used in this study domain.

Areas for future research

While this study has contributed to the understanding that HIV-related behavioural research cannot be divorced from an appreciation of gender norms, relations and identities, more research is needed to understand under what conditions men can circumvent rigid gender norms that can be damaging to individuals' health. Further research could explore for example, in greater depth the factors that enhance males' vulnerability or resistance to male peer pressure to engage in sexual risk behaviour. Further research that examines practices and attitudes of men who subvert norms within their contexts could provide insights into both subjective and structural dimensions

of change (Sideris 2004b). Both larger-scale and more in-depth life-history studies that go beyond the categories so far adopted as meaningful indicators of HIV-risk behaviour, are necessary.

Conclusion

The sexual narratives generated a contextualized understanding of men's sexual risk and agency, and the structures, experiences and meanings that underlie it. The diverse sexual attitudes, practices and behaviors found among men in this study provide alternative and competing perspectives on masculinity in the South African context. The narratives also reveal the tension, ambiguities and interplay between men's subjectivity and societal norms. This tension represents a platform for hegemony, as well as conditions under which men resist certain norms, and alternative notions of manhood can be formed. Yet as Hunter (2010) argues, hegemonic masculinities are typically connected to patriarchal power, which is not readily undermined. Through focusing on men's individual practices and interpersonal relationships, there is a "danger of celebrating the potential of individual agency while ignoring power of social structures that sustain relations of domination and cultural representations that perpetuate fantasies of power" (Sideris 2004b, p. 47). HIV prevention efforts need to target individual and broader social norms of masculinity that impact on men's risky sexual behaviours, as well as aspects of power and control that advantage men (Hearn 2004). Such efforts not only tackle norms and practices that are damaging to men and women's SRH but additionally challenge the underlying structures of patriarchy. Hence, the longer-term search for social justice and the more immediate strategic pragmatic activities are intertwined in the quest for the transformation of hegemonic male norms in South Africa. This necessarily impacts on the gender inequity that lies at the core social underpinnings of the HIV epidemic.

REFERENCES

Aboim, S. 2010. *Plural Masculinities: The Remaking of the Self in Private Life.* Surrey, UK: Ashgate Publishing.

Aggleton, P., and C. Campbell. 2000. Working with young people - towards an agenda for sexual health. *Sex and Relationship Therapy* 15(3): 283-296.

Aggleton, P., and K. Rivers. 1999. Behavioral interventions for adolescents. In: *Preventing HIV Infection in Developing Countries*: *Biomedical and Behavioral Approaches*, edited by L. Gibney, R. DiClemente and S. Vermund. New York: Plenum Press.

Anderson K., A. Beutel and B. Maughan-Brown. 2007. HIV risk perceptions and first sexual intercourse among youth in Cape Town South Africa. *International Family Planning Perspectives* 33(3): 98–105.

Anderson, N., and A. Ho-Foster. 2008. 13,915 reasons for equity in sexual offences legislation: A national school-based survey in South Africa. *International Journal for Equity in Health* 7(20); doi: 10.1186/1475-9276-7-20.

Anderson, N., A. Ho-Foster, J. Matthis, N. Marokoane, V. Mashiane, S. Mhatre, S. Mitchell, T. Mokoena, L. Monasta, N. Ngxowa, M. Salcedo and H. Sonnekus. 2004. National cross-sectional study of views on sexual violence and risk of HIV infection and AIDS among South African school pupils. *British Medical Journal* 329(952); doi: http://dx.doi.org/10.1136/bmj.38226.617454.7C

Artz, L. 2012. 'Porn norms': A South African feminist conversation about pornography. Agenda 26(3): 8-18.

Atkinson, P. 1998. The life history interview. *Sage University Papers Series on Qualitative Research Methods* 44. Thousand Oaks, CA.

Attride-Stirling, J. 2001. Thematic networks: An analytical tool for qualitative analysis. *Qualitative Research* 1(3): 385–405.

Banyard. K. 2010. *The Equality Illusion: The Truth about Women and Men Today*. London: Faber and Faber.

Barbarin, O., and L. Richter. 2001. *Mandela's Children: Growing Up in Post-Apartheid South Africa*. London: Routledge.

Barker, G. 2005. *Dying to be Men: Youth, Masculinity and Social Exclusion*. London: Routledge.

Barker, G., M. Nascimento, M. Segundo and J. Pulerwitz. 2004. How do we know if men have changed? Promoting and measuring attitude change with young men: Lessons from Program H in Latin America. In: *Gender Equality and Men: Learning from Practice*, edited by S. Ruzton. London: Oxfam.

Barker, G., and D. Peacock. 2009. *Making Gender Truly Relational: Engaging Men in Transforming Gender Inequalities, Reducing Violence and Preventing HIV/AIDS.* Johannesburg, South Africa: Sonke Gender Justice and the Men Engage Network.

Barker, G., C. Ricardo and M. Nascimento. 2007. *Engaging Men and Boys in Changing Gender-based Inequity in Health: Evidence from Programme Interventions.* Geneva: World Health Organization (WHO).

Bastien, S., L. Kajula and W. Muhwezi. A review of studies of parent–child communication about sexuality and HIV/AIDS in sub-Saharan Africa. *Reproductive Health* 8(25); doi: 10.1186/1742-4755-8-25.

Bauer, M., and G. Gaskell. 2000. *Qualitative Researching with Text, Image and Sound: A Practical Handbook.* London: Sage Publications.

Baumgartner, J., N. Lugina, L. Johnson and T. Nyamhanga. 2010. 'Being faithful' in a sexual relationship: Perceptions of Tanzanian adolescents in the context of HIV and pregnancy in prevention. *AIDS Care* 22(9): 1153–1158.

Beck, D. 2006. *Men and ARVs: How does being a man affect access to Antiretroviral Therapy in South Africa? An Investigation among Xhosa-Speaking men in Khayelitsha.* Cape Town: Centre for Social Science Research, University of Cape Town.

Beksinska, M., J. Smit and F. Guidozzi. 2011. Weight change and hormonal contraception: Fact and fiction. *Expert Review of Obstetrics & Gynaecology* 6(1): 45-56.

Bennett, J. 2008. *Challenges were many: The one in nine campaign, South Africa.* Toronto: AWID.

Betron, M., G. Barker, J. Contreras, and D. Peacock. (2012). *Men, masculinities and HIV/AIDS: Strategies for Action.* International Center for Research on Women, Instituto Promundo, MenEngage Alliance, and Sonke Gender Justice Network.

Bhana, D. 2007. Childhood sexuality and rights in the context of HIV/AIDS. *Culture, Health and Sexuality* 9(3): 309–324.

Bhana, D., and R. Pattman. 2009. Researching South African youth, gender and sexuality within the context of HIV/AIDS. *Development* 52 (1): 68-74.

Braun,V., and V. Clarke. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology* 3(2): 77–101.

Breinbauer, C., and M. Maddaleno. 2005. *Youth: Choices and change: Promoting health behaviors in adolescents.* Washington: PAHO.

Brittijn, M. 2013. "We're not boys anymore, we need to be courageous": Towards and understanding of what it means to be a man in Lavendar Hill. *Agenda* 27(1): 49-60.

Brook, W., N. Morojele, C. Zhang, and J. Brook. 2006. South Africa adolescents pathways to risky sexual behavior. *AIDS Education and Prevention* 18(3): 259-272.

Brothers for Life. 2012. Home page. Online at: <www.brothersforlife.co.za> [Accessed 8 November 2012].

Browne, K. 1981. Snowball sampling: Problems and techniques of chain referral sampling. *Sociological Methods & Research* 32 (1): 148–170.

Burgard, S., and D. Treiman. 2006. Trends and racial differences in infant mortality in South Africa. *Social Science and Medicine* 62(5): 1126–1137.

Burgoyne, A. and P. Drummond. 2008. Knowledge of HIV and AIDS among women in sub-Saharan Africa. *African Journal of Reproductive Health* 12(2): 14–31.

Butler, J. 1999. *Gender Trouble: Feminism and the Subversion of Identity.* New York: Routledge.

Byers, S., and S. Glenn. 2011. Gender differences in cognitive and affective responses to sexual coercion. *Journal of Interpersonal Violence* 27(5): 827–845.

Campbell, C. 1995. Male gender roles and sexuality: Implications for women's AIDS risk and prevention. *Social Science and Medicine* 41(2): 197–210.

Campbell, C. 1997. Migrancy, masculine identities and AIDS: The psychosocial context of HIV transmission on the South African gold mines. *Social Science and Medicine* 45(2): 273–381.

Campbell, C. 2001. Going underground and going after women: Masculinity and HIV transmission amongst black workers on the gold mines. In: *Changing Men in Southern Africa*, edited by R. Morrell. Durban, South Africa: University of Natal Press.

Campbell, C. 2003. *Letting them Die: Why HIV/AIDS Intervention Programmes Fail.* Oxford: James Currey.

Campbell, C. 2004. Creating environments that support peer education: Experiences from HIV/AIDS-prevention in South Africa. *Health Education* 104(4): 197–200.

Campbell, J., M. Baty, M. Ghandour, J. Stockman, L. Francisco and J. Wagman. 2008. The intersection of intimate partner violence against women and HIV/AIDS: A review. *International Journal of Injury Control and Safety Promotion* 15(4): 221–231.

Campbell, C., and F. Cornish. 2013. How can community health programmes build enabling environments for transformative communication? Experiences from India and South Africa. *AIDS and Behavior* 16(4): 847–857.

Campbell, C., and S. Jovchelovitch. 2000. Health, community and development: Towards a social psychology of participation. *Journal of Community and Applied Psychology* 10(4): 255–270.

Campbell, C., and C. MacPhail. 2002. Peer education, gender and the development of critical consciousness: Participatory HIV prevention by South African youth. *Social Science and Medicine* 55(2): 331–345.

Campo-Engelstein, L. 2013. Raging hormones, domestic incompetence, and contraceptive indifference: Narratives contributing to the perception that women do not trust men to use contraception. *Culture, Health and Sexuality* 15 (3): 283–295.

Coates, T., L. Richter, and C. Caceres. 2008. Behavioural strategies to reduce HIV transmission: how to make them work. *Lancet* 372: 669-684.

Coetzee, J. 1999. *Disgrace.* London: Vintage Books.

Chant, S., and M. Gutmann. 2002. 'Men-streaming gender?' Questions for gender and development policy in the 21st century. *Progress in Development Studies* 2(4): 269–282.

Clowes, L. 2013. The limits of discourse: Masculinity as vulnerability. *Agenda* 27(1): 12-19.

Cohen, S. 2008. Hiding in plain sight: The role of contraception in preventing HIV. *Guttmacher Policy Review* 11(1): 2-5.

Coles, T. 2009. Negotiating the field of masculinity: The production and reproduction of multiple dominant masculinities. *Men and Masculinities* 12(1): 30–44.

Colvin, C. 2009. *Sonke Gender Justice Network report on formative research conducted in seven South African provinces on men's attitudes and practices related to gender and HIV*. Cape Town: Sonke Gender Justice.

Colvin, C., O. Human, and D. Peacock. 2009. *Report on Formative Research Conducted for Sonke Gender Justice Network's "One Man Can" Campaign.* Cape Town: Sonke Gender Justice Network.

Colvin, C., S. Robins and J. Leavens. 2010. Grounding responsibilization talk: Masculinities, citizenship and HIV in Cape Town, South Africa. *Journal of Development Studies* 46(7): 1179–1195.

Connell, R. 2011. *Confronting Equality: Gender, Knowledge and Global Change.* Cambridge, UK: Polity Press.

Connell, R. 1987. *Gender and Power: Society, the Person and Sexual Politics*. Stanford, California: Stanford University Press.

Connell, R. 1995. *Masculinities.* Los Angeles: University of California Press.

Connell, R. 2006. The New Right Triumphant: The Privatization Agenda and Public Education in Australia. In *Education"s Iron Cage, special issue of "Our Schools/Our Selves*, edited by G. Martell, pp.143-162. Ottawa: Canadian Centre for Policy Alternatives.

Connell, R., and J. Messerschmidt. 2005. Hegemonic masculinity: Rethinking the concept. *Gender and Society* 19(6): 829–859.

Cooper, D., J. Harries, L. Myer, P. Orner, H. Bracken and V. Zweigenthal. 2007. 'Life is still going on': Reproductive intentions among HIV-positive women and men in South Africa. *Social Science and Medicine* 65(2): 274–283.

Cooper, D., J. Moodley, G. Zweigenthal, L. Bekker, I. Shah and L. Myer. 2009. Fertility intentions and reproductive healthcare needs of people living with HIV in Cape Town, South Africa: Implications for integrating reproductive health and HIV-care services. *AIDS and Behavior* 23(3): 335–342.

Cooper, D., C. Morroni, P. Orner, J. Moodley, J. Harries, L. Cullingworth, and M. Hoffman. 2004. Ten years of democracy in South Africa: documenting transformation in reproductive health policy and status. *Reproductive Health Matters* 12(24): 70-85.

Corbett, M., J. Dickson-Gomez, H. Hilario and M. Weeks. 2009. A little thing called love: condom use in high-risk primary heterosexual relationships. *Perspectives on Sexual and Reproductive Health* 41(4): 218–224.

Corbin, J., and A. Strauss. 1998. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory.* London: Sage Publications.

Cornell, M., J. McIntrye, and L. Myers. 2011. Men and antiretroviral therapy in Africa: our blind spot. *Tropical Medicine & International Health* 16(7): 828-829.

Cornish, F., and C. Campbell. 2009. The social conditions for successful peer education: a comparison of two HIV prevention programs run by sex-workers in India and South Africa. *American Journal of Community Psychology* 44(1/2): 123-135.

Cornwall, A. 2007. Men, masculinity and gender in development. *Gender and Development* 5(2): 8–13.

Courtenay, W. 2000. Engendering health: A social constructionist examination of men's health beliefs and behaviors. *Psychology of Men and Masculinities* 1(1): 4–15.

Cusick, L., and T. Rhodes. 2000. Sustaining sexual safety in relationships: HIV-positive people and their sexual partners. *Culture, Health and Sexuality* 2(4): 473–487.

De Fina. A., and A. Georgakopoulou. 2008. Analysing narratives as practices. *Qualitative Research* 8(3): 379–387.

Deleuze, G. 1994. *Difference and Repetition.* New York: Columbia University Press.

Doyal, L., J. Anderson and S. Paparini.2009. 'You are not yourself': Exploring masculinities among heterosexual African men living with HIV in London. *Social Science and Medicine* 68(10): 1901–1907.

Dunkle, K., and R. Jewkes. 2007. Effective HIV prevention requires gender-transformative work with men. *Sexually Transmitted Infections* 83(3): 173–184.

Dunkle, K., R. Jewkes, H. Brown, G. Gray, J. McIntyre and S. Harlow. 2004. Transactional sex among women in Soweto, South Africa: Prevalence, risk factors and association with HIV infection. *Social Science and Medicine* 59(8): 1581–1592.

Dunkle, K., R. Jewkes, M. Nduna, N. Jama, J. Levin, Y. Sikweyiya and M. Koss. 2007. Transactional sex with casual and main partners among young South African men in the rural Eastern Cape: Prevalence, predictors, and associations with gender-based violence. *Social Science and Medicine* 65(6): 1235–1248.

Dunkle, K., R. Jewkes, M. Nduna, J. Levin, N. Jama, N. Khuzwayo, M. Koss and N. Duvvury. 2006. Perpetration of partner violence and HIV-risk behaviour among young men in the rural Eastern Cape, South Africa. *AIDS* 20(16): 2107–2114.

Dwadwa-Henda, N., S. Mfecane, T. Phalane, K. Kelly, L. Myers and H. Hajiyiannis. 2010. *Social Mobilisation and Communication to Prevent Mother-to-Child Transmission of HIV*. Johannesburg, South Africa: Centre for AIDS Development, Research and Evaluation (CADRE).

Dworkin, S., C. Colvin, D. Peacock and A. Hatcher. 2012. Men's perceptions of women's rights and changing gender relations in South Africa: Lessons for working with men and boys in HIV and anti-violence programs. *Gender and Society* 26(1): 97–120.

Dworkin, S., M. Dunbar, S. Krishnan, A. Hatcher and S. Sawires. 2011. Uncovering tensions and capitalizing on synergies in HIV/AIDS and anti-violence programs. *American Journal of Public Health* 101(6): 995–1003.

Dworkin, S., A. Hatcher, C. Colvin and D. Peacock. 2013. Impact of a gender-transformative HIV and anti-violence program on gender ideologies and masculinities in two rural, South African communities. *Men and Masculinities* 16(2): 181-202.

Eaton, L., J. Flishera, and L. Aarob. 2003. Unsafe sexual behaviour in South African youth. *Social Science and Medicine* 56 (1):149 -165.

Epstein, H. 2007. *The Invisible Cure: Why We Are Losing the Fight Against AIDS in Africa.* London: The Penguin Group.

Epstein, H., and M. Morris. 2011. Concurrent partners and HIV: An inconvenient truth. *Journal of the International AIDS Society* 14(13); doi: 10.1186/1758-2652-14-13.

Evans, D., and J. Tripp. 2006. Sex education: the case for primary prevention and peer education. *Current Paediatrics* 16(2): 95-99.

Farmer, P. 2001. *Infections and Inequalities: The Modern Plagues.* Berkeley, California: University of California Press.

Farmer, P. 2005. *Pathologies of Power: Health, Human Rights, and the New War on the Poor.* Berkeley, California: University of California Press.

Flisher, A. 2005. Non-consensual adolescent sexual experiences: Policy and implications. In: *Sex without Consent: Young People in Developing Countries*, edited by S. Jeejebhoy, I. Shah and S. Thapa. London: Zed Books.

Flood, M. 2003a. *Addressing the Sexual Cultures of Heterosexual Men: Key Strategies in Involving Men and Boys in HIV/AIDS Prevention.* Brasilia, Brazil: United Nations Expert Group Meeting, 21–24 October 2003.

Flood, M. 2003b. Lust, trust and latex: Why young heterosexual men do not use condoms. *Culture, Health and Sexuality* 5(4): 353–369.

Flood, M. 2007. Involving men in gender policy and practice. *Women for Women International* 5(1): 9–14.

Flood, M. 2010. Young men using pornography. In: *Everyday Pornography*, edited by K. Boyle. London: Routledge.

Flood, M., and B. Pease. 2006. *The Factors Influencing Community Attitudes in Relation to Violence against Women: A Critical Review of the Literature*. Melbourne, Australia: Victorian Health Promotion.

Foreman, M. 1998. *AIDS and Men: Taking Risks or Taking Responsibility?* London: Panos Institute and Zed Books.

Foss, A., M. Hossain, P. Vickerman, and C. Watts. 2007. A systematic review of published evidence on intervention impact on condom use in sub-Saharan Africa and Asia. *Sexually Transmitted Infections* 83(7): 510-516.

Foucault, M. 1979. *Discipline and Punish: The Birth of the Prison.* New York: Random House.

Frosh, S., A. Phoenix and R. Pattman. 2002. *Young Masculinities: Understanding Boys in Contemporary Society.* New York: Palgrave.

Gallant, M., and E. Maticka-Tyndale. 2004. School based HIV-prevention programs for African youth. *Social Science and Medicine* 58(7): 1337–1351.

Gavey, N. 1999. Unsexy sex: unwanted sex, sexual coercion, and rape. In *Just Sex? The Cultural Scaffholding of Rape*, edited by N. Gavey. New York: Routledge.

Geisler, G. 2004. *Women and the Remaking of Politics in Southern Africa: Negotiating Autonomy, Incorporation and Representation.* Uppsala: Nordiska Afrikanstitutet.

Gevers, A., R. Jewkes, C. Matthews and A. Flisher. 2012. 'I think it's about experiencing life, like': A qualitative exploration of contemporary adolescent intimate relationships in South Africa. *Culture, Health and Sexuality* 14(10): 1125–1137.

Gevers, A., R. Jewkes, and C. Matthews. 2013. What do young people think makes their relationships good? Factors associated with assessments of dating relationships in South Africa. *Culture, Health & Sexuality.* In press.

Ghanotakis, E., M. Bruins, D. Peacock, J. Redpath and R. Swart. 2007. Stop prison rape in South Africa. *Agenda* 21(74): 68–80.

Gibbs, A., and R. Jewkes. 2013. *Stepping stones and creating futures: Preliminary outcomes of a behavioural and structural pilot intervention for young people in urban informal settlements in South Africa-January 2013*. Durban: HEARD/Project Empower/MRC.

Goga, A., T. Doherty, D. Jackson, D. Sanders, D. Colvin, M. Chopra and L. Kuhn. 2012. Infant feeding practices at routine PMTCT sites, South Africa: results of a prospective observational

study amongst HIV-exposed and -unexposed infants from birth to 9 months. *International Breastfeeding Journal* 7(4); doi: 10.1186/1746-4358-7-4.

Golafshani, N. 2003. Understanding reliability and validity in qualitative research. *The Qualitative Report* 8(4): 597–607.

Gray, G. 2008. Walking the tightrope in prevention of mother-to-child transmission of HIV infection. *Clinical Infectious Diseases* 46(4): 622–624.

Green, E., and K. Witte. 2006. Can fear arousal in public health campaigns contribute t othe decline of HIV prevalence? *Journal of Health Communication* 11: 245-259.

Gregson, S., C. Nyamukapa, G. Garnett, P. Manson, T. Zhuwau, M. Carael, S. Chandiwana and R. Anderson. 2002. Sexual mixing patterns and sex-differentials in teenage exposure to HIV infection in rural Zimbabwe. *The Lancet* 359 (9321): 1896–1903.

Harrison, A. 2005. Young people and HIV/AIDS in South Africa: Prevalence of infection, risk factors and social context. In: *HIV/AIDS in South Africa*, edited by S. Abdool Karim and Q. Abdool Karim. Cape Town, South Africa: Cambridge Press.

Harrison, A. 2002. The social dynamics of adolescent risk for HIV: Using research findings to design a school-based intervention. *Agenda* 17 (53): 43–52.

Harrison, A., M. Newell, J. Imrie and G. Hoddinott. 2010. HIV prevention for South African youth: Which interventions work? A systematic review of current evidence. *BMC Public Health* 10(102); doi: 10.1186/1471-2458-10-102.

Hearn, J. 2004. From hegemonic masculinity to the hegemony of men. *Feminist Theory* 5(1): 49–72.

Heise, L. 2012. *What works to prevent partner violence: An evidence overview. London: DFID.*

Hendriksen, E., A. Pettifor, and S. Lee, J. Coates, and H. Rees. 2007. Predictors of condom use among young adults in South Africa: the Reproductive Health and HIV Research Unit National Youth Survey. *American Journal of Public Health* 97(7): 1241-1248.

Holderness, W. 2012. Equipping educators to address HIV and AIDS: A review of selected teacher education initiatives. *SAHARA-J* 9(1): S48–S55.

Holland, J., C. Ramazanoglu, S. Sharpe and R. Thomson. 1994a. Achieving masculine sexuality: Young men's strategies for managing vulnerability. In: *AIDS: Setting a Feminist Agenda*, edited by L. Doyal, J. Naidoo and T. Wilton. Southport, United Kingdom: Taylor and Francis.

Holland, J., C. Ramazanoglu, S. Sharpe and R. Thomson.1994b. *Wimp or Gladiator: Contradictions in Acquiring Masculine Sexuality.* WRAP/MRAP Paper No. 9. London: Tufnell Press.

Hunter, M. 2005. Cultural politics and masculinities: Multiple-partners in historical perspective in KwaZulu-Natal. *Culture, Health and Sexuality* 7(4): 389–403.

Hunter, M. 2002. The materiality of everyday sex: thinking beyond 'prostitution.' *African Studies* 61(1): 99–120.

Hunter, M. 2006. Fathers without *amandla*: Zulu-speaking men and fatherhood. In: *Baba, Men and Fatherhood in South Africa*, edited by L. Richter and R. Morrell. Cape Town, South Africa: HSRC Press.

Hunter, M. 2010. *Love in the time of AIDS: Inequality, Gender and Rights in South Africa*. Durban, South Africa, University of KwaZulu-Natal Press.

Johns Hopkins Health and Education in South Africa (JHHESA), loveLife, Soul City, Health and Development Africa. (2012). *South Africans take action: Key findings of the third south African national HIV communication survey.* Online: <http://jhhesa.org/sites/default/files/ncs_survey_final_23_july_2012.pdf> [Accessed 13 January 2012]

Jejeebhoy, S., I. Shah and S. Thapa. 2005. *Sex without Consent: Young People in Developing Countries.* London: Zed Books.

Jejeebhoy, S., and S. Bott. 2003. Non-consensual sexual experiences of young people: A review of the evidence from developing countries*. South & East Asia Regional Working Paper* (no. 16). New Delhi: Population Council.

Jewkes, R. HIV and Women. 2005. In HIV/AIDS in South Africa 25 years on: Psychosocial perspectives. In *HIV/AIDS in South Africa 25 Years On: Psychosocial Perspectives,* edited by P. Rohleder, S. Kalichman, L. Swartz, and L. Simbayi. New York: Springer.

Jewkes, R., and N. Abrahams. 2002. The epidemiology of rape and sexual coercion in South Africa: An overview. *Social Science and Medicine* 55(7): 1232–1244.

Jewkes, R., K. Dunkle, M. Nduna and N. Shai. 2012a. Transactional Sex and HIV incidence in a cohort of young women in the Stepping Stones trial. *Journal of AIDS & Clinical Research* 3(5): 1-8.

Jewkes, R., K. Dunkle, M. Nduna, J. Levin, N. Jama, N. Khuzwayo, M. Koss, A. Puren, and N. Duvvury N. 2006. Factors associated with HIV sero-positivity in young, rural South African men. *International Journal of Epidemiology* 35(6):1455–1460.

Jewkes, R., J. Levin, N. Mbanga and D. Bradshaw. 2002. Rape of girls in South Africa. *The Lancet* 359 (9303): 319–326.

Jewkes, R., and R. Morrell. 2010. Gender and sexuality: Emerging perspectives from the heterosexual epidemic in South Africa and implications for HIV risk and prevention. *Journal of International AIDS Society* 13(6): 1-11.

Jewkes, R., and R. Morrell. 2012. Sexuality and the limits of agency among South African teenage women: Theorising femininities and their connections to HIV risk practices. *Social Science and Medicine* 74(11): 1729–1737.

Jewkes, R., R. Morrell, Y.Sikweyiya, K. Dunkle, and L. Penn-Kekana. 2012b. Transactional relationships and sex with women in prostitution. BMC Public Health 12(325); doi:10.1186/1471-2458-12-325.

Jewkes, R., M. Nduna, J. Levin, N. Jama, K. Dunkle, A. Puren and N. Duvvury. 2008. Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: Cluster randomised controlled trial. *British Medical Journal* 337: a506; doi: 10.1136/bmj.a506.

Jewkes, R., R. Morrell and N. Christofides. 2009. Empowering teenagers to prevent pregnancy: Lessons from South Africa. *Culture, Health and Sexuality* 11(7): 675–688.

Jewkes, R., R. Morrell, Y. Sikweyiya, K. Dunkle and L. Penn-Kekana. 2012c. Men, prostitution and the provider role: Understanding the intersections of economic exchange, sex, crime and violence in South Africa. *PLoS One* 7(7): e40821.

Jewkes, R., L. Penn-Kekana, and H. Rose-Junius. 2005. "If they rape me I can't blame them": Reflections on the social context of child sexual abuse in South Africa and Namibia. *Social Science and Medicine* 61(8): 1809-1820.

Jewkes, R., Y. Sikweyiya, R. Morrell and K. Dunkle. 2009. *Understanding Men's Health and Use of Violence: Interface of Rape and HIV in South Africa.* Pretoria, South Africa: Medical Research Council.

Jewkes, R., Y. Sikweyiya, R. Morrell and K. Dunkle. 2011. The relationship between intimate partner violence, rape and HIV amongst South African men: a cross-sectional study. *PloS One* 6(9): 1-6.

Jewkes, R., C. Vundule, F. Maforah and E. Jordaan. 2001. Relationship dynamics and adolescent pregnancy in South Africa. *Social Science and Medicine* 52(5): 733–744.

Johns Hopkins Health and Education in South Africa (JHHESA), loveLife, Soul City, Health and Development Africa. 2012. *South Africans Take Action: Key Findings of the Third South African National HIV Communication Survey.* Pretoria: JHHESA.

Johnson, B., L. Scott-Sheldon, T. Huedo-Medina and M. Carey. 2011. Interventions to reduce sexual risk for human immunodeficiency virus in adolescents: A meta-analysis of trials, 1985-2008. *Archives of Paediatric and Adolescent Medicine* 165(1): 77–84.

Johnson, S., L. Kincaid, S. Laurence, F. Chikwava, R. Delate, and L. Mahlasela. 2010. *Second National HIV Communication Survey 2009.* Pretoria: JHHESA

Jones, L. 2006. Sexual decision-making by urban youth in AIDS-afflicted Swaziland. *African Journal of AIDS Research* 5(2): 145–157.

Kahn, A. 2003. Calling it Rape: Differences in Experiences of Women Who Do or Do Not Label Their Sexual Assault as Rape. *Psychology of Women Quarterly* 27 (3): 233–242.

Kalichman, S., L. Simbayi, M. Kaufman, D. Cain and S. Jooste. 2007. Alcohol use and sexual risks for HIV/AIDS in sub-Saharan Africa: Systematic review of empirical findings. *Prevention Science* 8(2): 141–151.

Kalichman, S. 2009. *Denying AIDS: Conspiracy Theories, Pseudoscience and Other Tragedies.* New York: Springer-Verlag.

Kapp, C. 2006. Rape on trial in South Africa. *The Lancet* 367 (9512): 718–719

Katz, I., and D. Low-Beer. 2008. Why has HIV stabilized in South Africa, yet not declined further? Age and sexual behavior patterns among youth. *Sexually transmitted diseases* 35(10): 837.

Kauffman, M., T. Shefer, M. Crawford, L. Simbayi and S. Kalichman. 2008. Gender attitudes, sexual power, HIV risk: a model for understanding HIV risk behaviour of South African men. *AIDS Care* 20(4): 434–441.

Kelly, K. and P. Ntlabati, 2002. Early adolescent sex in South Africa: HIV intervention challenges. *Social Dynamics* 28(1): 42–63.

Kelly, K., A. Rau and E. Stern. 2010. *Community Entry Points: Opportunities and Strategies for Engaging Community-Supported HIV/AIDS Prevention Responses*. Johannesburg, South Africa: Centre for AIDS Development, Research and Evaluation (CADRE).

Kelly, K. 2009. *Review of HIV-prevention needs and strategic intervention projects.* Background Document for UNFPA Africa Regional Office HIV-Prevention Strategy Meeting, 12–14 August 2009.

Khumalo, G. 2011. 'South Africa: Health minister set to drive ban on alcohol advertisements.' Online at: <http://allafrica.com/stories/201107201301.html> [Accessed 30 March 2012].

Kim, J., C. Watts, J. Hargreaves, et al. 2007. Understanding the impact of a microfinance-based intervention on women's empowerment and the reduction of intimate partner violence in the IMAGE study, South Africa. *American Journal of Public Health* 97(10): 1794-1802.

Kimmell, M. 1994. *Masculinity as Homophobia: Addressing and Involving Men and Boys to Promote Gender Equality and End Gender Discrimination and Violence*. New York: UNICEF.

Krache, B., R. Scheiberger-Olwig and S. Bieneck. 2003. Men's reports of non-consensual sexual interactions with women: Prevalence and impact. *Archives of Sexual Behavior* 32(2): 165–175.

Krog, A. 1998. *Country of My Skull*: *Guilt, Sorrow, and the Limits of Forgiveness in the New South Africa*. London: Vintage.

Lambert, H., and K. Wood. 2005. A comparative analysis of communication about sex, health and sexual health in India and South Africa: Implications for HIV prevention. *Culture, Health and Sexuality* 7(6): 527–541.

Leclerc-Madlala, S. 2009a. Cultural scripts for multiple and concurrent partnerships. *Sexual Health* 6(2): 103–110.

Leclerc-Madlala, S. 2009b. *HIV Prevention: Community Responses to Immediate Drivers of HIV*. Southern African AIDS Trust, SHARE Series, Johannesburg, South Africa.

Leclerc-Madlala, S. 2008. *Multiple and Concurrent Partnering in Southern Africa: The Ethnographic Perspective*. Paper for the PEPFAR Technical Consultation on Multiple Concurrent Partnerships, Washington, D.C., 29-30 October 2008.

Leclerc-Madlala, S. 2005. The socio-cultural aspects of HIV/AIDS in South Africa. In HIV/AIDS in South Africa 25 years on: Psychosocial perspectives. In *HIV/AIDS in South Africa 25 Years On: Psychosocial Perspectives*, edited by P. Rohleder, S. Kalichman, L. Swartz, and L. Simbayi. New York: Springer.

Leclerc-Madlala, S. 2003. Transactional sex and the pursuit of modernity. *Social Dynamics: A Journal of African Studies* 29(2): 213–233.

Lesch, E., and C. Bremridge. 2006. Safer sex and constructions of young male sexuality in one semi-rural Western Cape community. *South African Review of Sociology* 37(2): 128–142.

Lindegger, G., and M. Quayle. 2009. Masculinity and HIV/AIDS. In *HIV/AIDS in South Africa 25 Years On: Psychosocial Perspectives*, edited by P. Rohleder, S. Kalichman, L. Swartz, and L. Simbayi. New York: Springer.

Lindegger, G. and G. Maxwell. 2006. Teenage masculinity: the double bind of conforming to hegemonic standards. In: *From Boys to Men: Social Constructions of Masculinity in Contemporary Society*, edited by T. Shefer, K. Ratele, A. Strebel, N. Shabalala and R. Buikema. Cape Town, South Africa: UCT Press.

Luke, N. 2003. Age and economic asymmetries in the sexual relationships of adolescent girls in sub-Saharan Africa. *Studies in Family Planning* 34(2): 67–85.

Luke, N., and K. Kurz. 2002. *Cross-Generational and Transactional Sexual Relations in Sub-Saharan Africa: Prevalence of Behavior and Implications for Negotiating Safer Sexual Practices.* Washington, D.C.: ICRW/PSI.

Lurie, M., and S. Rosenthal. 2010. Concurrent partnerships as a driver of the HIV epidemic in sub-Saharan Africa? The evidence is limited. *AIDS and Behavior* 14(1): 17–24.

Lynch, I., P. Brouard and M. Visser. 2010. Constructions of masculinity among a group of South African men living with HIV/AIDS: Reflections on resistance and change. *Culture Health and Sexuality* 12(1): 15–27.

Machisa, M., and R. Jeweks. 2011. *The War at Home: Gender-based Violence Indicators Project*. Johannesburg, South Africa: Gender Links.

MacIntyre, K., N. Rutenberg, L. Brown and A. Karim. 2004. Understanding perceptions of HIV risk among adolescents in KwaZulu-Natal. *AIDS and Behavior* 8 (3): 237–250.

Macleod, C. 2007. The risk of phallocentrism in masculinities studies: How a revision of the concept of patriarchy may help. *Psychology in Society* 35(1): 4-14.

MacPhail, C. 2003. Challenging dominant norms of masculinity for HIV prevention. *African Journal of AIDS Research* 2(2): 141–149.

MacPhail, C., and C. Campbell. 2001. 'I think condoms are good but, aai, I hate those things': Condom use among adolescents and young people in a southern African township. *Social Science and Medicine* 52(11): 1613–1627.

Mah, T., and B. Maughan-Brown. 2009. Social and Cultural Context of Concurrency in Khayelitsha. Cape Town, South Africa: AIDS and Society Research Unit, University of Cape Town.

Mah, T., and B. Maughan-Brown. 2012. Social and cultural contexts of concurrency in a township in Cape Town, South Africa. Culture, Health and Sexuality 15(2): 135–147.

Mahala, S. 2007. *When a Man Cries*. Durban: University of KwaZulu-Natal Press.

Maitse, T. 1998. Political change, rape and pornography in post-apartheid South Africa. *Gender and Development* 6(3): 55-59.

Mane, P., and P. Aggelton. 2001. Gender and HIV/AIDS: What do men have to do with it? *Current Sociology* 49(23): 23–37.

Manning, W., P. Giordano and M. Longmore. 2000. Hooking up: The relationship contexts of 'non-relationship' sex. *Journal of Adolescent Research* 21(5): 459–483.

Manzini, N. 2001. Sexual initiation and childbearing among adolescent girls in KwaZulu-Natal, South Africa. *Reproductive Health Matters* 9(17): 44–52.

Martin, P. 2010. 'These days virginity is just a feeling': Heterosexuality and change in young urban Vietnamese men. *Culture Health & Sexuality* 12(1): S5-18.

Marson-Jones, A., C. Matthews, and A. Flisher. 2011. Can peer education make a difference? Evaluation of a South African adolescent peer education program to promote sexual and reproductive health. *AIDS and Behavior* 15(8): 1605-1611.

Martson, C. 2005. Pitfalls in the study of sexual coercion: What are we measuring and why? In *Sex Without Consent: Young People in Developing Countries,* edited by S. Jejjebhoy, I. Shah and S. Thapa, pp. 287-301. London: Zed Books.

Mash, R., and R. Mash. 2012. A quasi-experimental evaluation of an HIV prevention programme by peer education in the Anglican Church of the Western Cape, South Africa. *BMJ Open* 2(2): 1-9.

Matthews, C., L. Aaro, A. Grimsrud, A. Flisher, S. Kaaya, H. Onya, H. Schaalma, A.Wubs, W.

Matthews, C., H. Boon, A. Flisher, and H. Schaalma. 2006. Factors associated with teachers' implementation of HIV/AIDs education in secondy schools in Cape Town, South Africa. *AIDS Care* 18 (4): 388-397.

Matthews, S., N. Abrahams, L. Martin, L. Vetten, L. Van der Merwe and R. Jewkes. 2004. *Every Six Hours a Woman is Killed by Her Intimate Partner: A National Study of Female Homicide in South Africa*. Tygerberg, South Africa: Gender and Health Research Group, Medical Research Council.

Mays, N., and C. Pope. 2000. Assessing quality in qualitative research. *British Medical Journal* 320(7226): 50–52.

McKee, N., Manoncourt, E., Chin, S., and R. Carnegie. 2000. *Involving people, evolving behavior*. New York and Penang: UNICEF and Southbound Press.

McLaughlin, C., S. Swartz, S. Kiragu, S. Walli and M. Mohamed. 2012. *Old Enough to Know: Consulting Children about Sex and AIDS Education in Africa*. Cape Town, South Africa: HSRC Press.

Measor, L. 2004. Young people's views of sex education: gender, information and knowledge. *Sex Education: Sexuality, Education and Learning* 4(2): 153-166.

Medical Research Council. 2007. Evaluation of stepping stones: A gender transformative HIV prevention intervention (South Africa). Online at: http://www.mrc.ac.za/policybriefs/steppingstones.pdf [Accessed June 30 2013].

Messer, L., E. Shoe, M. Canaday, B. Sheppard and A. Vincus. 2011. Reported adolescent sexual norms and the development of a social marketing campaign to correct youth misperceptions. *Journal of Children and Poverty* 17(1): 45–63.

Messerschmidt, J. 2012. Engendering gendered knowledge: Assessing the academic appropriation of hegemonic masculinity. *Men and Masculinities* 15(1): 56-76.

Mfecane, S., 2013. Can women refuse condoms? Dilemmas of condom use among men living with HIV in South Africa. *Culture, Health and Sexuality* 15(3): 269–83.

Mfecane, S. 2011. Negotiating therapeutic citizenship and notions of masculinity in a South African village. *African Journal of AIDS Research* 10(2): 129–138.

Michielsen, K., M. Cherisch, S. Luchters, P. De Koker, R. Van Rossem and M. Temmerman. 2010. Effectiveness of HIV prevention for youth in sub-Saharan Africa: Systematic review and meta-analysis of randomized and nonrandomized trials. *AIDS* 24(8): 1193–1202.

Mills, E., N. Ford, and P. Mugyeni. 2009. Expanding HIV care in Africa: Making men matter. *The Lancet* 374(9686): 275-276

Mitchell, A., and A. Smith. 2000. Safer-sex messages for adolescents. Do they work? *Australian Family Physician* 29(1): 31–34.

Mkhwanazi, N., E. Stern, E and R. Mashlale. 2011. Peers and porn: learning about sex in South Africa. *Sexuality in Africa Magazine and Monographs* 7 (2): 25-27.

Moffett, H. 2006. 'These women, they force us to rape them': Rape as narrative of social control in post-apartheid South Africa. *Journal of Southern African Studies* 32(1): 129–145.

Moore, E. 2013. Transmission and change in South African motherhood: Black mothers in three-generational Cape Town families. *Journal of Southern African Studies* 39(1): 151-170.

Moore, A., N. Madise, and K. Awusabo-Asare. 2012. Unwanted sexual experiences among young men in four sub-Saharan African countries: prevalence and context. *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care* 14 (9): 1021-1035.

Moore, S., and D. Roosenthal. 2006. *Sexuality in adolescence: current trends*. New York: Taylor and Francis.

Morojele, N., M. Kachieng, E. Mokoko, M. Nkoko, C. Parry. A. Nkowane, K. Moshia, and S. Saxena. 2006. Alcohol use and sexual behavior among risky drinkers and bar and shebeen patrons in Gauteng province, South Africa. *Social Science and Medicine* 62(1): 217-227.

Morrell, R. 2001. *Changing Men in Southern Africa: Global Masculinities*. Durban, South Africa: University of Natal.

Morrell, R. 2003. *Politics, theory and research: Postcolonial masculinities and schooling in South Africa*. Paper to Congress of the Social Sciences and Humanities, Nova Scotia, Canada, 28 May-5 June 2003.

Morrell, R. 2007. Men, masculinities and gender politics in South Africa: A reply to Macleod. *Psychology in Society* 35(1): 15-25.

Morrell, R., R. Jewkes and G. Lindegger. 2012. Hegemonic masculinity/masculinities in South Africa: Culture, power and gender politics. *Men and Masculinities* 15(1): 11–30.

Muehlenhard, C., and Z. Peterson 2005. Wanting and not wanting sex: The missing discourse of ambivalence. *Feminism and Psychology* 15(1): 15-20.

Mukoma, and K. Klepp. 2012. Effects of the SATZ teacher-led school HIV prevention programmes on adolescent sexual behaviour: cluster randomised controlled trials in three sub-Saharan African sites. *International Health* 4(2): 111-122.

Mukoma, W., A. Flisher, N. Ahmed, S. Jansen, C. Matthews, and L. Klepp. 2009. Process evaluation of a school-based HIV/AIDS intervention in South Africa. *Scandinavian Journal of Public Health* 37(2): 37-47.

Mundell, J. 2009. HIV prevention in Africa: Religion, culture, tradition and science. *NGO Pulse*, April 23, 2009.

Napper, L., and G. Fisher. 2012. Development of the perceived risk of HIV scale. *AIDS and Behavior* 16(4): 1075–1083.

National Treasury. 2011. *Confronting Youth Unemployment: Policy Options for South Africa.* Pretoria: National Treasury.

Nduna, M., and V. Maseko. 2008. Discontinued intimacy, denied paternity. *Sexuality in Africa Magazine* 4 (4): 11–14.

Ngwena, C. 2005. Synchronizing traditional legal responses to non-consensual sexual experiences with contemporary human rights jurisprudence. In: *Sex without Consent: Young People in Developing Countries*, edited by S. Jejjebhoy, I. Shah and S. Thapa. London: Zed Books.

National Income Dynamics Study (NIDS), Wave 1. 2008. *Southern Africa Labour and Development Research Unit, University of Cape Town.*

Nkosana, J., and D. Rosenthal. 2007. The dynamics of intergenerational sexual relationships: the experience of schoolgirls in Botswana. *Sexual Health* 4(3): 181–187.

Noar, S., and P. Morrokoff. 2002. The relationship between masculine ideology, condom attitudes and condom use stage of change: A structural equation modelling approach. *International Journal of Men's Health* 1(1): 43–48.

Norris, A., A. Kitabi and E. Worby. 2009. Alcohol and transactional sex: How risky is the mix? *Social Science and Medicine* 69(8): 1167–1776.

Ntshebe, O., J. Pitso and A. Segobye. 2012. The use of culturally themed HIV messages and their implications for future behaviour change communication campaigns: the case of Botswana. *SAHARA J* 3(2): 466–476.

Ojermark, A. 2007. *Presenting life histories: A literature review and annotated bibliography.* London: Chronic Poverty Research Centre Working Paper No. 101. Online at: <http://ssrn.com/abstract=1629210 or http://dx.doi.org/10.2139/ssrn.1629210> [Accessed June 30 2013].

Orner, P., D. Cooper, L. Myer, V. Zweigenthal, L. Bekker and J. Moodley. 2008. Clients' perspectives on HIV/AIDS care and treatment and reproductive health services in South Africa. *AIDS Care* 20(10): 1217–1223.

O'Sullivan, L. 2005. The social and relationship contexts and cognitions associated with romantic and sexual experiences of early-adolescent girls. *Sexuality Research and Social Policy* 2(3): 13–24.

O'Sullivan, L., A. Harrison, R. Morrell and A. Monroe-Wise. 2006. Gender dynamics in the primary sexual relationships of young rural South Africans. *Culture, Health and Sexuality* 8(2): 99–113.

Ott, M., N. Ghani, F. McKezie, J. Rosenberger and D. Bell. 2012. Adolescent boys' experiences of first sex. *Culture, Health and Sexuality* 14(7): 781–793.

Palekar, R., A. Pettifor, F. Behets and C. MacPhail. 2007. Association between knowing someone who died of AIDS and behavior change among South African youth. *AIDS and Behavior* 12(6): 903–912.

Parker, R. 2000. *Framing the sexual subject: The politics of gender, sexuality and power.* San Francisco, California: University of California Press.

Parker, W. 2004. *AIDS in Africa: Concepts of Behaviour Change Scenarios for the future.* Johannesburg: CADRE (Center of AIDS Development, Research & Evaluation).

Parker, W. 2012a. *HIV prevention among adult women: Opportunities for social and behaviour change communication.* Washington, DC: FHI 360/C-change.

Parker, W. 2012b. *Prevention in Action: A Model for Social Mobilization to Address Violence Against Women.* Cape Town: PCI.

Parker, W. 2003. *Reappraising youth prevention in South Africa: The case of lovelife.* Paper to the 1st South African AIDS Conference, Durban, South Africa, August 3-6 2003.

Parker ,W., and R. Borwanker. 2012. *Opportunities for social and behaviour change communication.* Johannesburg: C-Change.

Parker, W., M. Makhubele, P. Ntlabati and C. Connolly. 2007. *Concurrent sexual partnerships amongst young adults in South Africa: Challenges for HIV prevention communication.* Johannesburg, South Africa: Centre for AIDS Development, Research and Evaluation (CADRE).

Pattman, R. 2005. Boys and girls should not get too close: Sexuality, the identities of African boys and girls and HIV/AIDS education. *Sexualities* 8(4): 501–520.

Pattman, R. 2007. Researching and working with boys in Southern Africa in the context of HIV/AIDS- a radical approach. In: *From Boys to Men: Social Constructions of Masculinity in Contemporary Society*, edited by T. Shefer, K. Ratele, A. Strebel, N. Shabalala and R. Buikema. p. 33-49. Cape Town, South: UCT Press.

Patton, M. Q. 2002. *Qualitative Evaluation and Research Methods* (3rd edition). Thousand Oaks, California, Sage Publications.

Peacock, D. 2013. South Africa's Sonke gender justice network: Educating men for gender equality. *Agenda* 27(1): 128-140.

Peacock, D., and G. Barker. 2012. *Working with men and boys to promote gender equality. Expert group meeting on the prevention of violence against women and girls.* Bangkok, Thailand: UN Women.

Peacock, D., B. Khumalo, B. and E. McNab. 2006. Men and gender activism in South Africa: Observations, critiques and recommendations for the future. *Agenda* 20(69): 71–82.

Peacock, D., J. Redpath, M. Weston, K. Evans, A. Duab and A. Greig. 2008. *Gender, Health and HIV and AIDS in South Africa.* Cape Town, South Africa: Sonke Gender Justice.

Peacock, D., L. Stemple, J. Sawires, D. Sharif and T. Coates. 2009. Men, HIV/AIDS and human rights. *Journal of Acquired Immune Deficiency Syndromes* 51(3): 119–125.

Pettifor, A., M. Hudgens, B. Levandowski, H. Rees and M. Cohen. 2007. Highly efficient HIV transmission to young women in South Africa. *AIDS* 21(7): 861–865.

Pettifor, A., C. MacPhail, A. Anderson and S. Maman. 2013. 'If I buy the Kellogg's then he should [buy] the milk': Young women's perspectives on relationship dynamics, gender power and HIV risk in Johannesburg, South Africa. *Culture, Health and Sexuality* 14(5): 447–90.

Pettifor, A., D. Measham, H. Rees and N. Padian. 2004. Sexual power and HIV risk in South Africa. *Emerging Infectious Diseases* 10(11): 1996–2004.

Pettifor, A., K. O'Brien, C. MacPhail, W. Miller and H. Rees. 2009. Early coital debut and associated HIV risk factors among young men and women in South Africa. *International Perspectives on Sexual and Reproductive Health* 35(2): 74–82.

Pettifor, A., H. Rees, I. Kleinschmidt, A. Steffenson, C. MacPhail, L. Hlongwa-Madikizela, K. Vermaak and N. Padian. 2005. Young people's sexual health in South Africa: HIV prevalence and sexual behaviours from a nationally representative household survey. *AIDS* 19(14): 1525–34.

Posel, D. 2003. "*The scandal of manhood:" Unmaking secrets of sexual violence in post-apartheid South Africa and beyond.* Paper to the Sex and Secrecy Conference: Fourth Conference of the International Association for the Study of Sexuality, Culture and Society, Johannesburg, South Africa, 25-28 June 2013.

Quinn, T., and J. Overbaugh. 2005. HIV/AIDS in women: an expanding epidemic. *Science* 308 (5728): 1582-1583.

Ratele, K. 2013. Subordinate black South African men without fear. *Cahiers d'études africaines* 1-2 (209-210): 247-268.

Ratele, K., and T. Shefer. 2002. Stigma in the social construction of sexually transmitted diseases. In: *Psychopathology and Social Prejudice*, edited by D. Hook and G. Eagle. Cape Town, South Africa: UCT Press.

Ratele, K., T. Shefer and M. Botha. 2011. Navigating past 'the white man's agenda' in South Africa: Organizing men for gender transformation of society. In: *Men and Masculinities around*

the World: Transforming Men's Practices, edited by K. Pringle, J. Hearn, E. Ruspini and B. Pease. New York: Palgrave.

Reddy, S., and M. Dune. 2007. Risking it: Young heterosexual femininities in South African context of HIV/AIDS. *Sexualities* 10(2): 159–172.

Rhodes, T., and L. Cusick. 2012. Accounting for unprotected sex: stories of agency and acceptability. *Social Science and Medicine* 55(2): 211-226.

Richter, L., C. Desmond, V. Hosegood, S. Madhavan, M. Maklwane, T. Makusha, R. Morrell, and S. Swartz. 2012. *Fathers and other men in the lives of children and families.* Paper to the Conference on Strategies to Overcome Poverty and Inequality Towards Carnegie III, Cape Town, South Africa, 3-7 September 2012.

Richter, L., and R. Morrell. 2005. *Baba, Fathers and Fatherhood in South Africa.* Pretoria, South Africa: HSRC Press.

Robins, S. 2008. *From Revolution to Rights in South Africa: Social Movements, NGOs and Popular Politics*. Pietermaritzburg, South Africa: University of KwaZulu-Natal Press.

Sandfort, T., J. Nel, E. Rich, V. Reddy and H. Yi. 2008. HIV testing and self-reported HIV status in South African men who have sex with men: Results from a community-based survey. *Sexually Transmitted Infections* 8(4): 425–429.

Sathiparsad, R. 2007. Masculinities in the era of HIV/AIDS: The perspectives of rural male Zulu youth. In: *From Boys to Men: Social Constructions of Masculinity in Contemporary Society*, edited by T. Shefer, K. Ratele, A. Strebel, N. Shabalala and R. Buikema. Cape Town, South: UCT Press.

Savage, M. 1986. The imposition of pass laws on the African population in South Africa 1916-1984. *African Affairs* 85(339): 181-205.

Sawers, L., and E. Stillwagon. 2010. Concurrent sexual partnerships do not explain the HIV epidemics in Africa: A systematic review of the evidence. *Journal of the International AIDS Society* 13(34); doi: 10.1186/1758-2652-13-34.

Schneider, V., K. Cockcroft and D. Hook. 2008. The fallible phallus: A discourse analysis of male sexuality in a South African men's interest magazine. *South Africa Journal of Psychology* 38(1): 136–51.

Seedat, M., R. Jewkes, A. Van Niekerk, S.Suffla and K. Ratele. 2009. Violence and injuries in South Africa: Prioritizing an agenda for prevention. *The Lancet* 374(9694): 1011–1022.

Segal, L. 1990. *Slow motion. Changing masculinities. Changing men*. London: Virago.

Seidler, V. 2006. *Young Men and Masculinities*. London: Zed Books.

Selikow, T. N. Ahmed. A. Flisher, C. Matthews and W. Mukoma. 2009. I am not 'umqwayito': A qualitative study of peers pressure and sexual risk behaviour among young adolescents in Cape Town, South Africa. *Scandinavian Journal of Public Health* 37(2): 107–112.

Sideris, T. 2004a. Men, identity and power: A case study of the re-invention of 'tradition': implications for involving men in training and education about gender. *Agenda* 18(60): 88-93.

Sideris, T. 2004b. "You have to change and you don't know how!": Contesting what it means to be a man in a rural area of South Africa. *African Studies* 63(1): 29-48.

Shefer, T., K. Ratele, A. Strebel, N. Shabalala and R. Buikema. 2008. *From Boys to Men: Social Constructions of Masculinity in Contemporary Society.* Cape Town, South Africa: UCT Press.

Shefer, T., and D. Foster. 2009. Heterosex among young South Africans: Research reflections. In *The Prize and the Price: Shaping Sexualities in South Africa*, edited by M. Stein and M. Van Zyl. Cape Town, South Africa: HSRC Press.

Shefer, T., L. Clowes, and T. Vergnani. 2012. Narratives of transactional sex on a university campus. *Culture, Health and Sexuality* 14 (4): 435–47.

Shisana, O. 2013. *HIV/AIDS in Africa: At least the glass is half full.* Presentation at 6th South African AIDS Conference, Durban South Africa, June 18-21 2013. Online at: <http://www.hsrc.ac.za/en/media-briefs/hiv-aids-stis-and-tb/plenary-session-3-20-june-2013-hiv-aids-in-south-africa-at-last-the-glass-is-half-full> [Accessed 30 July 2013]

Shisana, O., T. Rehle, L. Simbayi, W. Parker, K. Zuma and A. Bhana *et al.* 2005. *South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey*. Cape Town, South Africa: HSRC Press.

Shisana, O., T. Rehle, L. Simbayi, K. Zuma, S. Jooste, V. Pillay-Van Wyk, N.Mbelle, J. Van Zyl, W. Parker, N. Zungu, S. Pezi, and the SABSSm III Implementation Team. 2009. *South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2008: A Turning Tide among Teenagers?* Cape Town, South Africa: HSRC Press.

Sikweyiya, Y., and R. Jewkes. 2009. Force and temptation: South African men's accounts of coercion into sex by men and women. *Culture, Health and Sexuality* 11(5): 529–541.

Simpson, A. 2005. Sons and fathers/boys to men in the time of AIDS: Learning masculinity in Zambia. *Journal of Southern African Studies* 31(3): 569–586.

Sleath, E., and R. Bull. 2009. Male rape victim and perpetrator blaming. *Journal of Interpersonal Violence* 25(6): 969–988.

Smith, C. 2000. Content analysis and narrative analysis. In: *Handbook of Research Methods in Social and Personality Psychology*, edited by H. Reis and C. Judd. Cambridge: Cambridge University Press.

Sonke Gender Justice Network. 2012. Home page. Online at: <http://www.genderjustice.org.za> [Accessed 7 September 2012].

South African Institute of Race Relations (SAIRR). 2010. 'South Africa Survey Online 2008/2009.' Online at: <http://www.sairr.org.za/research-and-publications/south-africa-survey-2008–2009> [Accessed September 30, 2012].

South African National Department of Health. 2013. *Contraception & fertility planning policy and service delivery guidelines.* Manuscript in preparation. Available at: http://www.doh.gov.za/docs/policy/2013/contraception_fertility_planning.pdf [Accessed August 01 2013]

South African Police Service (SAPS). 2008. 'Crime Statistics 2005/2006.' Available at: <http://www.saps.gov.za/statistics/reports/crimestats/2008/> [Accessed November 30, 2012].

Statistics South Africa. 2011. *South African National Census*. Pretoria: Statistics South Africa.

Statistics South Africa. 2012. *Mid-Year Population Estimates.* Pretoria: Statistics South Africa.

Stein, Z., and M. Van Zyl. 2009. *The Prize and the Price: Shaping Sexualities in South Africa*. Cape Town, South Africa: HSRC Press.

Steinberg, J. 2008. *The Three Letter Plague: A Young Man's Journey through a Great Epidemic.* London, UK: Vintage Books.

Strauss, A., and J. Corbin. 1990. *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Newbury Park, California: Sage Publications.

Struckman-Johnson, C. 1998. Forced sex on dates: It happens to men, too. *Journal of Sex Research* 24(1): 234–241.

Susser, I., and Z. Stein. 2004. Culture, sexuality, and women's agency in the prevention of HIV/AIDS in southern Africa. In: *HIV and AIDS in South Africa*, edited by E. Kalipeni, S. Craddock, J. Oppong and J. Ghosh. Oxford: Blackwell Publishing.

Swartz, S., C. Deutsch, M. Makoae, B. Michel, J. Harding, G. Garzouzie, A. Rozani, T. Runciman, and I. Van der Heijden. 2012. Measuring change in vulnerable adolescents: Findings from a peer education evaluation in South Africa. *SAHARA-J* 9(4): 242-254.

Swartz, S., A. Bhana, L. Richter, and A. Versfeld. 2013. *Promoting young fathers' positive involvement in their children's lives.* Cape Town: HSRC Policy Brief.

Talbot, K., and M. Quayle. 2012. The perils of being a nice guy: Contextual variation in five young women's constructions of acceptable hegemonic and alternative masculinities. *Men and Masculinities* 13(2): 255-278.

Thomas, K. 2004. A better life for some: the loveLife campaign and HIV/AIDS in South Africa. *Agenda* 18(62): 29–35.

Ulin, P., E. Robinson and E. Tolley. 2005. *Qualitative Methods in Public Health: A Field Guide for Applied Research.* San Francisco, California: Jossey-Bass.

UNAIDS. 2010. *Report on the Global AIDS Epidemic.* Geneva: UNAIDS.

Van den Berg, W., D. Peacock and T. Shand. 2012. *Mobilizing men and boys in HIV prevention and treatment: the Sonke Gender Justice Experience in South Africa*. Cape Town: Sonke Gender Justice Network.

Van Klaveren, M., K. Tijdens, M. Hughie-Williams and N. Ramos Martin. 2009. *An Overview of Women's Work and Employment in South Africa: Decisions for Life MDG3 Project.* University of Amsterdam, Working Paper No. 09-79, Amsterdam, The Netherlands.

Varga, C. 2003. How gender roles influence sexual and reproductive health among South Africa adolescents. *Studies in Family Planning* 34(3): 160–172.

Varga, C. 2001. The forgotten 50 percent: A review of sexual and reproductive health literature on boys and young men in sub-Saharan Africa. *African Journal of Reproductive Health* 5(3): 175–195.

Visser, M. 2005. Life skills training as HIV/AIDS preventive strategy in secondary schools: Evaluation of a large-scale implementation process. *SAHARA J-Journal of Social Aspects of HIV/AIDS* 2(1): 203–216.

Visser, M. 2007. HIV/AIDS prevention through peer education and support in secondary schools in South Africa. *Journal of Social Aspects of HIV/AIDS Research Alliance* 4(3): 678-694.

Wade, J. 2008. Masculinity ideology, male reference group identity dependence, and African American men's health-related attitudes and behaviors. *Psychology of Men and Masculinity* 9(1): 5–16.

Waldby, C., S. Kippax and J. Crawford. 1993a. *Cordon sanitaire*: 'clean' and 'unclean' women in the AIDS discourse of young men. In: *AIDS: Facing the Second Decade*, edited by P. Aggelton, P. Davies and G. Hart. London: Falmer Press.

Waldby C., S. Kippax and J. Crawford. 1993b. Research note: Heterosexual men and 'safer sex' practice. *Sociology of Health and Illness* 15(2): 246–256.

Walker, L. 2005. Men behaving differently: South African men since 1994. *Culture, Health and Sexuality* 7(3): 225–238.

Wedgewood, N. 2009. Connell's theory of masculinity: Its origins and influences on the study of gender. *Journal of Gender Studies* 18(4): 329–339.

Wetherhell, M., and N. Edley.1999. Negotiating hegemonic masculinity: Imaginary positions

Whitehead, S. 1999. Hegemonic masculinity revisited. *Gender, Work and Organization* 6(1): 58–62.

World Health Organization (WHO). 2002. *World report on violence and health*. Geneva: WHO.

Wojcicki, J. 2002. 'She drank his money': Survival sex and the problem of violence in taverns in Gauteng, South Arica. *Medical Anthropology Quarterly* 16(3): 267–293.

Wood, K., and R. Jewkes. 1997. Violence, rape and sexual coercion: Everyday love in a South African township. *Gender and Development* 5(2): 41–46.

Wood, R., and R. Jewkes. 2006. Blood blockages and scolding nurses: Barriers to adolescent

Zuma, K., T. Mzolo and E. Makonko. 2011. Age at sexual debut amount South African youth: Results from a national survey. *African Journal of AIDS Research* 10(2): 189–194.

Appendix 1: Interview information sheet

Dear potential participants:

You are invited to take part in an interview to discuss men's health and sexual experiences.

Purpose of the study

The research is aimed at exploring the following:

1. Early sexual experiences of men
2. Men's engagement with sexual relationships
3. Men's management of their sexual and reproductive health.

Study participation

4. The interview will take approximately 1 hour and 30 minutes.
5. The interview will involve discussion of sensitive material (i.e., sexual history).
6. The subject matter is private and confidential.
7. Your participation in this interview is voluntary and you are not obliged to take part in this research.
8. If you agree to participate, you may stop participating in the research at any time or withdraw your participation without penalty.

Confidentiality

9. All digital recording will be transcribed and but your name will not be recorded anywhere (during digital recording of the interview or on the transcript).
10. No one will be able to link you to the responses you give as all individual information will remain confidential.

Sampling

11. The study will be conducted in five provinces: Eastern Cape, Mpumalanga, KwaZulu-Natal, Western Cape, and Gauteng.
12. It will involve a total of 50 male interviews, 25 female interviews, and 10 focus groups with men.
13. Participants will be distributed across three age groups: 18-24, 25-54, 55 and older.

Reimbursement

14. You will be reimbursed as a token of appreciation for your participation in this study.

If you have concerns or questions about the research you may call the researcher, Erin Stern, at XXX-XXX-XXXX or by email at: erin.a.stern@gmail.com.

This research has been approved by the University of Cape Town Human Ethics Research Committee (HREC REF:115/2011).

Appendix 2: Interview topic guide

The project is about men's sexual and reproductive health. The research will be used to improve sexual and reproductive health programmes and campaigns. I am interested in hearing about how men understand sex and relationships and what kinds of things have influenced this understanding and the choices they've made about sex and health.

In this interview, I'm going to ask you to tell me about your life and relationships, such as how you first became aware of sex and about some of the different relationships you've had. There are no right or wrong answers: I just want to listen to you tell your story.

Sometimes talking about sexuality can be sensitive; if there is something I ask that makes you uncomfortable or that you don't want to discuss, you will not be pressured to. I hope that this will be a safe space where you can share things that you may not normally speak about.

Background

1. Can you tell me your current age? Current work/study? Where you grew up? A little bit about yourself?

Early sexual experiences

2. How did you first become aware of sex? *Probes:* Where did you get this information? Family? Peers? School? Porn? Age? Thoughts/feelings towards sex then? When did you first feel attraction for another person?
3. Can you tell me about the first time you experimented sexually, even as a very young person? *Probes:* Talk about the events surrounding and leading up to that? Age?
4. Can you tell me about the first time you had sex? *Probes:* Talk about the events surrounding and leading up to that? What did it mean to you then to have sex for the first time? Did it change your life and social world in any way? Did you take any precautions against pregnancy or diseases? Who initiated this (precautions)? Age? Age of partner? Did you tell anyone about it after? If so, how did they react?
5. <u>(For Xhosa men only)</u> Did you learn anything about sex and/or sexual relationships from initiation? *Probes:* What did you learn? Did it have any impact your sexual relationships, needs

and behaviours after initiation? If so, how? Give me stories to illustrate what you mean.
6. Were there any influences on your early sexual experimentation and experience? *Probes:* Influence of peers, family, social environment, community responses to sexual activity? Masturbation? Older: Have these influences changed over time? If so, how?

Sex and relationships

7. What do you look for in a sexual partner? *Probes:* Culturally? Physically? Emotionally? What qualities would your ideal life partner have?
8. Can you compare the various sexual relationships and casual sexual experiences you have had? *Probes:* How have they differed? Have the types of relationships you seek changed over time?
9. Do you currently have a stable partner? If so, tell me about it. Do you have more than one sexual partner in addition? *Probes:* Under what conditions have your previous or current sexual partners sought more than one partner? Under what conditions have you ever sought more than one partner? Older: have these conditions changed for you over time?
10. What have you learned about men and women's sexual needs? *Probes:* Do men and women differ? How have your own sexual needs changed over time, or as you have grown up? Do you think that you meet your partner's sexual needs? Is it important to you to meet your partner's sexual needs? Tell me about times that you have talked or tried to talk to your partner(s) about sex?
11. How do you feel when your current partner or previous partners were not interested in sex? *Probes:* How do you behave? How long does it last? What effect does it have on you? Do you think a woman has a right to say 'no' to sex? Explain.
12. Have you ever been in love, and if so can you tell me about the first time? *Probes:* Did you feel then that sex was connected with love? Have your feelings about this changed? Do men and women have different thoughts about the connection between love and sex? What makes you say this? Tell me stories that illustrate what you mean.
13. Did a man or a woman ever persuade or force you to have sex when you did not want to? *Probes:* Can you tell me about situation leading up to that event? What was the impact? Did you tell anyone about it? If so, how did they react?

14. Were there any influences on your sexual relationships? *Probes:* Influence of peers, family, social environment, community responses to sexual activity? Masturbation? Older: Have these influences changed over time? If so, how?

HIV and SRH

15. What are your main health worries? *Probes:* What recurrent/frequent health problems do you have? What do you do about them?

16. When did you first hear about HIV? *Probes:* Where did you find out about HIV for the first time? Did it change the way that you conduct your sexual relationships? How? Recount a situation that makes that clear to me. Older: How do current messages on HIV compare to what you first remember hearing about HIV?

17. What is your opinion on condom use? Why? *Probes:* Did learning about HIV affect your condom use? Where did you learn about condoms? Are condoms accessible to you? Where do you get condoms from? Older: Has the accessibility and promotion of condoms changed over time?

18. Did finding out about HIV motivate you to test for HIV? *Probes:* If so, what motivated you to test? How often have you tested since? Where did/do you go to test? Did it change anything for you?

19. Have you ever worried about other sexually transmitted infections? *Probes:* Where did you find out about this? How have you managed the risk of this? Have you ever been affected by a sexually transmitted infection? Tell me any stories you may have about this to let me understand better.

20. How have you and your partner/s managed birth control in your sexual relationships? *Probes:* Has this changed over time? Where did you learn information about this?

21. Where would you like to access more information on these sexual and reproductive health issues? *Probes*: Would you find it useful to access this information through cell phones? Radio? TV campaigns? Internet (including how you access Internet)? Videos? How could this information be better marketed to your community? To men in particular? Can you give me examples of what has worked and what hasn't worked in the promotion of sexual and reproductive health?

Closing

22. Considering what we have discussed, what do you think women need to know about men?

23. Any questions? Any comments on the interview? Are you OK to finish the interview now?

Appendix 3: Interview consent form

Dear participant:

Purpose of the study

This study is for a University of Cape Town PhD exploring the sexual and reproductive health of South African men aged 18 and older. The research is aimed at exploring the following:

- Early sexual experiences of men
- Men's engagement with sexual relationships
- Men's management of their sexual and reproductive health
- Role of media communication on educating men about their SRH.

Study participation

We would like to invite you to take part in this interview. The interview will be asking you about your early sexual experiences, your sexual relationships and your management of sexual and reproductive healthcare throughout your life. The interview will take approximately 1 hour and 30 minutes.

Your participation in this interview is voluntary and you are not obliged to take part in this research. The choice of whether to participate or not is yours alone. However, we will really appreciate it if you shared your thoughts and experiences with us. If you choose not take part, you will not be affected in any way whatsoever. If you agree to participate, you may stop participating in the research at any time or withdraw your participation without penalty and you will NOT be prejudiced in ANY way.

Reimbursement

All participants will be reimbursed R60 for their time and contribution to this research.

Confidentiality

All digital recording will be transcribed, but your name will not be recorded anywhere (during digital recording of the interview or on the transcript). No one will be able to link you to the responses you give as all individual information will remain confidential. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the ethics committee at the University of Cape Town. Otherwise, records that identify you will be available only to the PhD candidate working on the study. The information you provide may be published. All identifying information will be kept in a locked file cabinet and will not be available to others. We will refer to you by a code number in any publication.

Risks/discomforts

This study will involve a discussion of sensitive and private material – sexuality, sexual experiences. All efforts will be made to make the interview as comfortable for you as possible.

Benefits

There are no immediate benefits to you from participating in this study. However, this study will be extremely helpful to us in having an understanding sexual and reproductive health of South African men and identifying key issues to look for in delivering more effective and acceptable SRH care for men.

Who to contact if you have been harmed or have any concerns

This research has been approved by the University of Cape Town Human Research Ethics Committee (HREC REF: 115/2011). If you have any complaints about ethical aspects of the research or feel that you have been harmed in any way by participating in this study, please call the PhD candidate, Erin Stern, at XXX-XXX-XXXX.

Appendix 4: Focus group information sheet

Dear potential participants:

You are invited to take part in a focus group to discuss men's health and sexual experiences for research on behalf of a PhD student from University of Cape Town.

Purpose of the study

The research is aimed at exploring the following:

15. Early sexual experiences of men
16. Men's engagement with sexual relationships
17. Men's management of their sexual and reproductive health.

Study participation

18. The focus group will take approximately two hours.
19. The focus group will involve discussion of sensitive material – i.e., male sexuality.
20. The subject matter is private and confidential.
21. Your participation in this focus group is voluntary and you are not obliged to take part in this research.
22. If you agree to participate, you may stop participating in the research at any time or withdraw your participation without penalty.

Confidentiality

23. All digital recording will be transcribed and but your name will not be recorded anywhere - during digital recording of the interview and on the transcript.
24. No one will be able to link you to the responses you give as all individual information will remain confidential.

Sampling

25. The study will be conducted in five provinces: Eastern Cape, Mpumalanga, Western Cape, KwaZulu-Natal and Gauteng.
26. It will involve a total of 2 focus groups at each site.

Reimbursement

27. You will be reimbursed R40.00 as a token of appreciation for your participation in this study.

Who to contact if you have been harmed or have any concerns

This research has been approved by the HSRC Research Ethics Committee: 3/23/06/10 and the University of Cape Town Human Ethics Research Committee. If you have any complaints about ethical aspects of the research or feel that you have been harmed in any way by participating in this study, please call the PhD candidate, Erin Stern, at XXX-XXX-XXXX.

Appendix 5: Focus group topic guide

Early sexual experiences

i. Can you tell me how you first became aware of sex? *Probes:* Where did you learn about sex? School? Peers? Porn? Age? Thoughts/ feelings towards sex then?
ii. Can you discuss the first time you felt attracted to another person?
iii. For those of you who have had sex, did you tell anyone about it after your first time? *Probes:* Who did you tell and why? How did they react? How was sex talked about?
iv. Were there any influences on your early sexual experimentation and experience? *Probes:* Influence of peers, family, social environment, community responses to sexual activity? Masturbation?
v. (For Xhosa men only): Did you learn anything about sex and sexual relationships in initiation? *Probes:* What did you learn about sex? Did it impact your sexual relationships, needs and behaviours after initiation? If so, how? Give me stories to illustrate what you mean.

Sex and relationships

vi. Can you compare the meanings of various sexual relationships for men? The difference between casual and established relationships? *Probes:* How do they differ? Does what men look for in partners change over time?
vii. What do men look for in an ideal partner? *Probes:* Culturally? Physically? Emotionally? What is considered to be an ideal life partner?
viii. Do men and/or women in your community tend to have more than one sexual partner at the same time? *Probes:* Under what conditions do you think men seek more than one partner? Under what conditions do you think women seek more than one partner?
ix. What have you learned about men and women's sexual needs? *Probes:* Do men and women differ? How important do you think it is for men to meet their partner's sexual needs?
x. Do you think a woman has a right to say no to sex? Explain. *Probes:* How do you feel when your current partner or previous partners were not interested in sex? How do you behave? How long does it last? What effect does it have on you?

xi. Do you think that sex is connected to love? *Probes:* Do men and women have different thoughts about the connection between love and sex? What makes you say this? Tell me stories that illustrate this.

xii. Were there any influences on your sexual relationships? *Probes:* Influence of peers, family, social environment, community responses to sexual activity? Masturbation?

HIV and SRH

xiii. What are your main health worries?

xiv. When did you first hear about HIV? *Probes:* Where did you get this information What were your initial thoughts? Did it change the way that you conduct sexual relationships or motivate you to test? How? Recount a situation that makes that clear to me.

xv. What is your opinion on condom use? Probes: Where did you learn about condoms? How accessible are they in your community? Where do you get them from? What are reasons for or against condoms? Who should initiate condom use?

xvi. When did you first hear about sexually transmitted infections? *Probes:* Where did you find out about this? Did it change the way you conduct your sexual relationships?

xvii. How have you and your partner/s managed birth control in your sexual relationships? *Probes:* Has this changed over time? Where did you learn information about this? Who should be responsible for family planning?

xviii. Where would you find it useful or ideal to access information on such sexual and reproductive health issues? *Probes*: Would it be useful through cell phones? Radio? TV ads? Campaigns? Internet (including how you access internet)? Videos? How should this information be better marketed to your community? To men in particular? Can you give me examples of what has worked and what has not worked in promotion of sexual and reproductive health?

Closing

xix. Considering what we have discussed, what do you think women need to know about men?

xx. What do men in your community have to do to be perceived as a man?

xxi. Any questions? Any comments on the focus group? Are you OK to finish the focus group now?

Appendix 6: Contract between PhD candidate and interview consultant

Agreement entered into by and between: Erin Stern at University of Cape Town and

Consultant (name):_____.

The parties agree as follows:

1. Engagement of the consultant

Erin Stern and the consultant agree that in consideration of the agreed fee the consultant will be retained to undertake work as described in the terms of reference below.

Under this contract, the services required of the consultant will include:

(1) Coordinating logistics for the individual interviews (including participant recruitment, venue, consent forms, participants reimbursement and receipts of payment, audio recording of the interview);
(2) Reviewing the research protocol, proposed methodology and instruments prior to conducting the interview;
(3) Conduct of individual interviews (approximately 1 hour and 30 minutes to 2 hours);
(4) Conduct of focus groups (approximately 2 hours);
(5) Consistency across the interviews and focus groups;
(6) The interviews and focus groups must be audio recorded. The consultant will ensure that the recordings are of appropriate quality (i.e., audible for the purposes of transcription);
(7) Write a short report (2-3 pages) findings and reflections from each interview and focus group;
(8) The recordings must be sent to the Erin Stern;
(9) Signed consent and payment forms must be handed to Erin Stern;
(10) Digital audio files should be deleted from consultant's personal computers upon confirmed receipt by Erin Stern to protect participant's confidentiality.

2. Remuneration

You will be paid R750 for each interview and R1 000 for each focus group conducted. This will cover:

- Time spent preparing for and conducting the interview/focus group;
- Summary notes, findings and reflections from the interview/focus group;
- Downloading the digital files and ensuring they get to Erin Stern immediately post the interview.

The fee quoted above per interview is understood to be *inclusive* of costs such as phone calls, email/Internet costs, and computer usage.

I understand that I am free to withdraw at any time from interviewing and subsequent payment without penalty or judgment.

I understand that I may be burdened with sensitive information from these interviews. I will thus have on-going support and opportunities for debriefing if necessary.

I accept the offer of a Contract made by Erin Stern.

Signed at …….....……. on this the ….....……. day of 2010.

Name: _____

Signature: _____

As witnesses:

1. _____
2. _____

Appendix 7: Interviewer guides

Interviewer guide for interviews

- Know the probes and use them to ensure that people elaborate in these areas, if they don't already speak about the issues mentioned in probes.
- We want detailed and personal stories, not opinions and thoughts.
- When the guide says 'older' only ask these questions of the middle (25–54) and older age groups (55+).
- If questions are not appropriate to the respondent move along. But always be creative and invite them to describe their experiences. So if they have only ever had one partner, the questions about other partners are not relevant. Nonetheless get them to talk a bit about their experiences of only ever having one partner, what that has entailed, what it has meant to them, etc. This is not explicitly stated in the questionnaire, but you are encouraged to follow their story and its meanings, rather than simply get the questions answered in order. There are many possibilities for them to introduce elements of their sexuality story that are not in the questionnaire (for example, same sex relationships). Follow the stories as they come up, but be careful not to become obsessed with one story line; and remember what material you have to cover in your 1.5 hours.
- Try to get ages at which things happened, so that we can develop some sense of the biographical time line.
- Probe for details, but try not to get stuck in detail.
- Have a conversation more than an interview. Get comfortable with the person, be interested in their story, and give them time to remember experiences. Invite respondents to recount experiences, and to give lived examples (preferably their own, but stories of other people they know well may also be of value to the study) whenever they start talking at the level of ideas or abstractions.

Interviewer guide for focus group discussions

- Explain the importance of the digital recording process to the group;
- Ensure appropriate timing and flow of discussion (this may sometimes cause you to interrupt and move on to next question);
- At the beginning, ask participants to feel free to contribute to the discussion;
- Inform participants to be sensitive to the perspectives of others and allow others to speak;
- Inform participants to speak clearly, one at a time;
- Ask participants to treat what others say confidentially and to note that participants are not required to divulge personal information about themselves or their relationships. They are being asked to give their views on relationships.

Appendix 8: Cash receipt form

Cash receipt form

This is to confirm that I have received the following amount as reimbursement of my time and for participating in an interview about men's sexual and reproductive health.

Participant's name	Telephone number	Amount	Date	Signature

Research site: _____

Interviewer: _____

Date: _____