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On: 17 September 2014, At: 12:14

Publisher: Routledge

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Sex Education: Sexuality, Society and Learning

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/csed20>

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Published online: 15 Sep 2014.

To cite this article: Erin Stern, Diane Cooper & Andrew Gibbs (2014): Gender differences in South African men and women's access to and evaluation of informal sources of sexual and reproductive health (SRH) information, *Sex Education: Sexuality, Society and Learning*, DOI: [10.1080/14681811.2014.947363](https://doi.org/10.1080/14681811.2014.947363)

To link to this article: <http://dx.doi.org/10.1080/14681811.2014.947363>

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Gender differences in South African men and women's access to and evaluation of informal sources of sexual and reproductive health (SRH) information

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(Received 27 January 2014; accepted 18 July 2014)

While much research has documented unsatisfactory sexual and reproductive health (SRH) awareness among young people in South Africa, understanding of gender differences in access to and evaluation of SRH information is limited. This paper concerned itself with men and women's informal sources and content of SRH, and gendered divergences around accessibility, evaluation, and impact of such information. Fifty sexual history narrative interviews and twenty-five narrative interviews with women were conducted with participants purposively sampled from a range of ages, cultural and racial backgrounds, and in urban and rural sites across five provinces in South Africa. Data were analysed using thematic analysis. While young women were more likely to learn about SRH information from family members, they also reported greater regulation concerning their sexuality. This could enhance stigma surrounding women's sexuality and hinder open communication. Men predominantly learned about sex through pornography and peers, which was reported to encourage sexual prowess to the neglect of practising safer sex. Lack of adequate SRH instruction for young people as revealed through the narratives had significant and often negative implications for men and women's early safer sex behaviours. In response to these insights, recommendations are offered to strengthen informal sources of SRH awareness.

Keywords: young people; sexual and reproductive health; gender; informal sources; South Africa

Introduction

Acquiring awareness and knowledge of sexual and reproductive health (SRH) is the first step towards recognising and preventing higher-risk sexual behaviour. Yet, the South African National HIV Prevalence, Incidence and Behaviour Survey 2012 found that only 26.8% of individuals aged 15 and older were knowledgeable about the sexual transmission and prevention of HIV (Shisana et al. 2014). Moreover, HIV prevalence among young people (aged 15–24) in South Africa is unacceptably high at 7.1% (Shisana et al. 2014). In South Africa, women aged 15–24 have an HIV prevalence three to four times higher than their male peers and incidence peaks at an earlier age than in men (Shisana et al. 2014). While women are physiologically more vulnerable to acquiring HIV from unprotected sexual intercourse than men (Quinn and Overbaugh 2005), social factors influencing this include young women having sex with older men (Katz and Low-Beer 2008) and the high levels of sexual and physical violence against women in South Africa, which contributes to HIV transmission in both direct and indirect ways (Jewkes et al.

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2010). Young women often have less economic power and are more likely to engage in transactional sex (Jewkes et al. 2012). This may increase their vulnerability to acquiring HIV as men who play a provider role may feel entitled to decide the terms of sex including whether or not to use condoms (Shefer, Clowes, and Vergnani 2012). Moreover, in heterosexual encounters, relationship norms typically expect men to initiate sex, while women are encouraged to be relatively passive (O'Sullivan et al. 2006), which minimises the potential for equal sexual decision-making (Pattman 2005). Related to such hegemonic gendered dynamics is the difficulty for many women to insist on male condom use (Reddy and Dune 2007). Even so, the responsibility for contraceptive method use, besides male condoms, is commonly relegated to women, and such paradoxes often negatively influence safer-sex practices in relationships.

Significant gender disparities among South African young people's HIV-risk perceptions have also been documented. One study in 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). Young women typically receive more support from family members to practise safer sexual behaviours in accordance with their own perceptions of HIV risk (MacIntyre et al. 2004). They may also be subject to harsher controls around retaining their virginity than young men (Pettifor et al. 2004). Yet, 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 knowledgeable about sex may make them more reluctant to admit ignorance, vulnerability or seek information, which can promote their engagement in higher-risk sexual behaviours (Measor 2004). 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).

Even when people have relatively high levels of SRH awareness, people do not always have the motivation or ability to adopt safer sex behaviours (Campbell 2003), or the social support to sustain personal change (Parker 2012). For instance, young people have been found to perceive their risk of acquiring HIV to be low due to a general feeling of invulnerability (Moore and Rosenthal 2006), and even in contexts where there is high HIV prevalence, they know about HIV transmission and themselves engage in risky sexual behaviours (MacPhail and Campbell 2001; Pettifor et al. 2004). Nonetheless, it is still important to understand how and in what context young people become aware of SRH, as this can strongly influence their motivations and risk-perceptions related to adopting safer sexual behaviours. Although much research has evaluated the impact of school-based and formalised sex education programmes on young people's SRH awareness, risk perceptions and early sexual behaviours (Underhill, Operario, and Montgomery 2007; Iyer and Aggleton 2013), much less is known about the influence of informal sources of SRH communication on these factors. By informal sources, we refer to SRH information provided outside of the realm of the formal education settings or programme initiatives, which is generally more regulated and supported.

Specifically, in this paper we exclude formal sources of SRH information such as through school curricula, religious institutions and other formal 'intervention programmes', which are numerous in South Africa. This paper rather concerns itself with the relatively unexplored domain of informal sources of sex and SRH information, which may be provided in a variety of contexts. For example, information received in a school environment could be of an informal nature, for being outside of the education curriculum, such as through extra-curricular activities or from peers at school. Informal

sources of SRH information can be highly accessible and relevant to young people, which warrants the necessity of evaluating their content and impact. For instance, the South African National HIV Prevalence, Incidence and Behaviour Survey 2012 found that 50.6% of young people aged 18–24 indicated television programmes as the most common source of information that ‘encouraged them to consider HIV as a serious condition’ (Shisana et al. 2014, 97). The second highest source of information for doing so was radio programmes, given by 30.8% of respondents. This paper assessed participants’ informal sources and content of SRH, and whether there were any gender differences in terms of access to and evaluations of such information. Gender differences were warranted as critical to understand given the disparity in HIV prevalence rates, risk perceptions, and vulnerability to poor SRH across gender. How such information could influence participants’ adoption of safer sexual health practices and risk perceptions was also assessed.

Sexual history narrative interviews, which foreground subjective experiences and meaning, were conducted to capture a holistic and nuanced perspective of men and women’s access to and evaluation of SRH information. A narrative approach appreciates that adopting safer sexual health is not only about SRH awareness, but is also related to people’s motivations and risk perceptions around sexual health. Listening to stories can provide a rich understanding of cultural and social norms, including the normative gendered repertoires that influence how young people understand and make sense of SRH information that they acquire. 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. Sexual history narratives can thus document the fluidity of risk perceptions and sexual health practices, and provide a valuable tool to assess the impact of SRH information on men and women’s SRH practices and risk perceptions.

Methods

Participants

Sexual history narrative interviews were conducted with 50 men and 25 women from three age groups (ages 18–24, 25–54 and 55+ years) to assess variations within and among respondents’ lifespan. The focus of the primary study was to assess the relationship between hegemonic masculinity and men and women’s SRH; as such, more men than women were sampled in the study from which this paper draws data. Research took place 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 varied sites were purposively selected to enhance the representation of participants. This is particularly important in the South African context, as it is a diverse country with 11 official languages and has continued divisions along racial and cultural lines (Anderson, Beutel, and Maughan-Brown 2007). In each site, participants were recruited from urban and rural areas. Participants represented a range of first-language speakers, as can be seen in Table 1, which also details the age, sex, race and residential demographics of the participants. Efforts were made to recruit participants who self-identified as heterosexual to assess how heterosexual norms are constructed and maintained through exposure to informal sources of SRH information. By comparing heterosexual men and women’s sexual-history narratives, differences in reported gender norms and sexual behaviours could be assessed.

Table 1. 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	25–54	isiXhosa	Black	Grahamstown
4	Male	25–54	isiXhosa	Black	Grahamstown
5	Male	25–54	Afrikaans	Coloured	Grahamstown
6	Male	25–54	Afrikaans	Coloured	Grahamstown
7	Male	25–54	English	Asian	Grahamstown
8	Male	25–54	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	25–54	English	White	Grahamstown
13	Female	25–54	Afrikaans	White	Grahamstown
14	Female	25–54	isiXhosa	Black	Grahamstown
15	Female	25–54	isiXhosa	Black	Grahamstown (rural)
16	Male	25–54	isiXhosa	Black	Cape Town
17	Male	18–24	isiXhosa	Black	Cape Town
18	Male	18–24	Afrikaans	Coloured	Cape Town (rural)
19	Male	25–54	Afrikaans	Coloured	Cape Town
20	Male	55+	Afrikaans	White	Cape Town
21	Male	25–54	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	25–54	isiXhosa	Black	Cape Town
26	Female	25–54	Afrikaans	Coloured	Cape Town
27	Female	55+	Afrikaans	Coloured	Cape Town (rural)
28	Female	25–54	English	White	Cape Town
29	Female	25–54	isiXhosa	Black	Cape Town
30	Female	55+	isiXhosa	Black	Cape Town (rural)
31	Male	18–24	isiZulu	Black	Pietermaritzburg (rural)
32	Male	25–54	isiZulu	Black	Pietermaritzburg
33	Male	25–54	isiZulu	Black	Pietermaritzburg (rural)
34	Male	55+	isiZulu	Black	Pietermaritzburg (rural)
35	Male	18–24	seSotho	Black	Pietermaritzburg
36	Male	25–54	seSotho	Black	Pietermaritzburg
37	Male	25–54	English	Indian	Pietermaritzburg
38	Male	55+	English	Indian	Pietermaritzburg
39	Male	18–24	English	White	Pietermaritzburg
40	Male	25–54	Afrikaans	Coloured	Pietermaritzburg
41	Female	25–54	isiZulu	Black	Pietermaritzburg (rural)
42	Female	25–54	isiZulu	Black	Pietermaritzburg
43	Female	25–54	Afrikaans	Coloured	Pietermaritzburg
44	Female	18–24	English	Indian	Pietermaritzburg
45	Female	25–54	seSotho	Black	Pietermaritzburg
46	Male	18–24	isiZulu	Black	Johannesburg
47	Male	25–54	isiZulu	Black	Johannesburg
48	Male	18–24	sePedi	Black	Johannesburg
49	Male	25–54	sePedi	Black	Johannesburg
50	Male	25–54	seTswana	Black	Johannesburg
51	Male	55+	seTswana	Black	Johannesburg (rural)
52	Male	25–54	seSotho	Black	Johannesburg
53	Male	25–54	English	Indian	Johannesburg

(Continued)

Table 1. (Continued).

Participant #	Sex	Age group (years)	First language	Race	Location
54	Male	18–24	Afrikaans	White	Johannesburg
55	Male	18–24	English	White	Johannesburg
56	Female	55+	English	White	Johannesburg
57	Female	25–54	isiZulu	Black	Johannesburg
58	Female	18–24	seTswana	Black	Johannesburg (rural)
59	Male	18–24	isiXhosa	Black	Coffee Bay (rural)
60	Male	25–54	isiXhosa	Black	Coffee Bay (rural)
61	Male	55+	isiXhosa	Black	Coffee Bay (rural)
62	Female	25–54	isiXhosa	Black	Coffee Bay (rural)
63	Female	55+	isiXhosa	Black	Coffee Bay (rural)
64	Male	18–24	SeSwati	Black	Nelspruit (rural)
65	Male	25–54	SeSwati	Black	Nelspruit
66	Male	25–54	Afrikaans	Coloured	Nelspruit
67	Male	18–24	xiTsonga	Black	Nelspruit (rural)
68	Male	25–54	xiTsonga	Black	Nelspruit (rural)
69	Male	18–24	isiZulu	Black	Nelspruit
70	Male	25–54	seSotho	Black	Nelspruit
71	Female	25–54	sePedi	Black	Nelspruit
72	Female	25–54	SeSwati	Black	Nelspruit
73	Female	25–54	xiTsonga	Black	Nelspruit (rural)
74	Female	18–24	xiTsonga	Black	Nelspruit (rural)
75	Female	25–54	seSotho	Black	Nelspruit

Recruitment

Participants who shared particular characteristics, including age, racial, cultural, urban/rural and gender categories, were selected through purposive sampling. The first author distributed a project information sheet explaining the project and the benefits and risks of participating, to a community contact well acquainted with one rural and one urban community in each study province. Community contacts were developed through the non-governmental organisations, the 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). Each community contact randomly distributed the information sheet to potentially eligible people in terms of the age, racial, gender and sexual orientation selection criteria. In keeping with the approved ethical guidelines for the study, community contacts were given R100 (~ US\$10.00) as a stipend for each participant they recruited. This was in order to reimburse them for the transport and communication costs of recruiting participants. The first author contacted individuals who expressed a willingness to participate to set up a suitable time and venue for conducting an interview. To triangulate the initial purposeful sampling method, snowball sampling was also used to recruit further participants whereby the initial participants recommended further eligible participants for study recruitment to the researchers. An advantage of this sampling technique is that it 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.

Procedure

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 South African Human Sciences Research Council (REF 3/23/06/10). Before

each interview, informed written consent was obtained from the participant, after the risks and benefits of participating in the study had been discussed orally. Data collection occurred between August 2010 and December 2011. The first author conducted most interviews with English-speaking women. Among the remaining participants, experienced qualitative researchers conducted the interviews. Interviews 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. Interviewees were given R100 to cover the cost of their time during study participation. Interviews were conducted privately in locations providing quiet and secure environments. On average, interviews lasted for two hours, in order to allow for a rapport to be built between the interviewees and interviewers and to allow for sufficient time to probe the narratives. 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) were explored in relation to participants' own sexual experiences. Questions in the topic guide were aimed at eliciting stories, with the researcher saying relatively little and acting primarily as an attentive listener. All interviews were tape-recorded and then transcribed verbatim. Where necessary, interviews were translated into English. The interviewers recorded notes on contextual details and non-verbal expressions immediately after each interview, which were also used for the analysis.

Data management and analysis

A thematic analysis was conducted to extract key themes and compare the men and women's access to and evaluation of informal sources of SRH information. Thematic networks reveal prominent themes in a text at different levels and so provide a rich, detailed and holistic account of data (Braun and Clarke 2006). NVivo 10 qualitative data management software was used to manage the data coding. After carefully reading the transcripts, a preliminary coding structure was established to analyse the data systematically by the first author. Coding was regularly discussed between the researchers for the sake of conceptual alignment on existing and emerging codes. The validity of the findings was discussed with the interviewers who had conducted the research. Once all text segments were given basic codes, the codes were organised into basic themes by allocating similar codes together. Additional themes were created during this process, which required continual referral to the text to identify relevant latent meanings. Data were reviewed for major trends, cross-cutting themes were identified and issues for further exploration were prioritised before the final analysis. An overall interpretation of the study findings was formulated, showing how thematic areas related to one another and explaining how the network of concepts responded to the original study questions.

Findings

Four major sources of informal SRH information were identified: from family, media, pornography and peers.

Information acquired from family members

The majority of young women recalled obtaining some SRH education from family members, however, hardly any young men spoke about parents, particularly fathers, as a source of SRH information. One man bemoaned the lack of a father figure in his life,

believing that through the active involvement of a father in advising about sex, he would have waited longer to have had sex and practised safer sex:

I didn't have a father figure. I believe that if a person had an opportunity whereby their parents would be telling you at a certain age that there is something called sex, and 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 and you get pressure from friends, there is no person telling you 'this is the reality'. I didn't get those lessons. (Sipho, Johannesburg, male Black isiZulu-speaking participant, age group 18–24 years)

Several participants explained that it was viewed as culturally taboo 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. Maybe they felt like they were giving us permission or a go-ahead to go do it [have sex]. Maybe we will want to experiment. (Dyondzeka, rural Nelspruit, female Black xiTsonga-speaking participant, age group 25–54 years)

Many participants felt unable to be honest about the extent of their own sexual activity with their parents due to concerns that parents would respond negatively. This was particularly the case among women, who more often related parents' attempts to regulate their sexuality:

But I didn't talk to her about it [sex] because, 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. They would go ballistic on you. If you asked them about it, they would say they don't know. So don't ask them about those questions. (Eleanor, Grahamstown, female Coloured Afrikaans-speaking participant, age group 25–54 years)

Where women participants did report receiving sex education from their parents, they tended to evaluate it poorly. Sex education within the family was often authoritative, didactic and did not involve open discussion about sexuality and relationships. Although many women recalled being told not to engage in any sexual activity to prevent pregnancy, particularly once they had begun menstruating, they were typically inadequately taught how pregnancy occurs:

My mum used to frighten us! 'Don't play near boys, they will make you pregnant.' 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, 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. (Thirani, rural Nelspruit, female Black xiTsonga-speaking participant, age group 25–54 years)

In contrast to these negative perceptions of parental advice on sex, a few young women reported a strong appreciation of learning about sex and SRH from their parents or other female relatives. They felt that this had resulted in them being better equipped to protect themselves from STIs and pregnancy. One young woman (Bongikele, Nelspruit, female Black siSwati-speaking participant, age group 25–54 years) recalled that her mother encouraged her to always use condoms after her older brother died of AIDS. While hardly any men recalled receiving SRH information from their parents, those who did tended to strongly value this:

I was kind of embarrassed, speaking to my mom about that for the first time. But I remember that she, being a nurse, 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, so here's the book, and if you have any other questions, just ask.' It really helped me to be know what to expect and to make sure I was safe. (Floris, Grahamstown, male White Afrikaans-speaking participant, age group 25–54 years)

Some male participants reported learning about sex from their older brothers, which was typically accompanied by pressure to engage in sex. One young man (Siyanda, rural Grahamstown, male Black isiXhosa-speaking participant, age group 18–24 years) reported that his major motivation for first sex was in order to make his (older) brother proud of him.

Information acquired through the media

A variety of media channels, including television, radio, print media, Internet and cell phone communication influenced participants' awareness and perceptions of sex and SRH. Many participants, particularly young men, discussed how their first exposure to sex through television had awakened their desire to have sex:

There used to be a TV programme called *Emmanuelle*¹ and seeing this show and also hearing from friends who said it's nice, it got me interested. (Thando, Cape Town, male Black isiXhosa-speaking participant, age group 18–24 years)

However, some participants were critical about the media's portrayal of sex. One woman, who suggested the media had played an active role in supporting her decision to have sex, denounced the fact that the glamorisation of sex through television had generated unrealistic expectations for her first sexual experience:

When you watch these TV programmes and movies, the way they make it seem, it's like 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. (Faranah, Pietermaritzburg, female Indian English-speaking participant, age group 25–54 years)

Television was also criticised for not portraying health risks associated with unprotected sex and rarely including clear demonstrations of condom use:

Movies in particular may show a love scene but they will never ever mention HIV/AIDS or allude to the fact that we have a persistent threat called HIV/AIDS whenever there is a sexual encounter. (Brennan, Grahamstown, male Asian English-speaking participant, age group 18–24 years)

Another criticism of the media, including television and radio, was that it lacked spaces for discussion and clarification of issues related to sex and information, which could allow for misinterpretation. One young woman reported how face-to-face workshops provided more effective 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 and ask questions men to men are important. Making it real. (Bina, Nelspruit, female Black seSotho-speaking participant, age group 25–54 years)

Nevertheless, the media was also viewed as a positive resource for learning about SRH, with some participants, mostly women, having used books, pamphlets and the Internet to gain SRH information. A few young women reported that their 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 themselves from STIs and unwanted pregnancies:

I wasn't even fully aware of what would happen if I did it [sex]. So I read many books about it. I was very eager to know what happens. I think I was 17. The books taught me so much about this, and that obviously you have to be safe. (Thabisa, Grahamstown, female Black isiXhosa participant, age group 18–24 years)

Some participants, particularly younger ones, cited the Internet as a valuable source of SRH information, particularly popular social media websites such as Twitter and

Facebook. One man reported actively conducting Internet research around sex after learning about it from his friends and wanting more knowledge:

And that's why I went to search it on the Internet. I really wanted to know what it's about. Since I heard from my friends that sex is so nice, I wanted to experience this thing. (Thando, Cape Town, male Black isiXhosa participant, age group 18–24 years)

While many viewed the media to be an important resource for learning about SRH, a number of barriers to its use were identified. Internet and print media, including newspapers and books, could be unaffordable or inaccessible, especially in rural areas where there was said to be a generally higher illiteracy rate:

Because newspapers, sometimes they don't even read in rural villages. 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. (Bina, Nelspruit, female Black seSotho-speaking participant, age group 25–54 years)

There was general consensus that cell phone sexual health messaging was more likely to be accessible to the general population:

Cellphones are the best. I think everyone has got a cellphone. So he or she can get a message even in these rural areas. (Rhulani, rural Nelspruit, male Black xiTsonga-speaking participant, age group 18–24 years)

Having sexual health questions answered via cell phones was highly valued because they could allow for personal clarification in an anonymous manner. Yet, one participant pointed out that it was difficult to know whether cell phone messages had been received and to follow up on messages: 'Because sometimes when you send an SMS, some don't even read it' (Bongekile, Nelspruit, female Black sePedi participant, age group 25–54 years). Overall, more women reported researching SRH information through the media than men. One man surmised that:

Women become more sexually aware earlier than men [do] and take the topic of sex much more seriously. (Eugene, Cape Town, male Coloured Afrikaans-speaking participant, age group 25–54 years)

Pornography as sexual education

A number of men recalled being introduced to and developing an interest in sex through pornographic films or magazines:

You watch more and more pornos and think I can't wait until I get this ... all you want to do is do what they are doing on TV. (Nial, Pietermaritzburg, male, White English participant, age group 18–24 years)

Some men described watching pornography with their peers and suggested that this put pressure on them to engage in sex in order to prove their manhood:

Then, with that porn video we would watch, they would say we must do that to be a man. (Kefentse, Nelspruit, male Black xiTsonga participant, age group 18–24 years)

Exposure to pornography was also reported to leave many men with unrealistic expectations of sex, which could cause disappointment and misunderstandings of sex. For instance, one participant discussed how he thought sex was painful for women, which he reported to have inferred from watching pornography. Only after his first sexual experience did he realise this was not necessarily the case:

At first I thought she was feeling pain because she was screaming and crying. But then 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 enjoying, and it is natural. (Mabotse, Johannesburg, male Black sePedi-speaking participant, age group 18–24 years)

Some men also reported that pornography constructed unrealistic understandings of how they should perform during sex in order to satisfy their female partner. For instance, one man said:

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 and she won't be responding. (Kunene, Nelspruit, male Black siSwati-speaking participant, age group 25–54 years)

Learning about sex through pornography was reported to be an overwhelmingly male phenomenon, and none of the women interviewed reported learning about sex from pornography. However, it is important to note that the absence of women who reported to access pornography may reflect a socially desirable response because of dominant gender norms that discourage women's pornography use.

Information acquired from peers

Several participants, mostly young men, recalled learning about sex from their peers. This was often said to create pressure for them to conform to certain gendered expectations, whereby 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' (Mabotse, Johannesburg, male Black sePedi-speaking participant, age group 18–24 years).

A few men were critical of learning about sex primarily from peers because it was often accompanied by pressure to have sex and represented an inadequate source of SRH 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' (Tapiwa, Johannesburg, male Black isiZulu-speaking participant, age group 18–24 years).

Indeed, 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 before she first had sex, but they told her she could not become pregnant the first time she had sex:

I asked 'but what happens if we have sex?' They say, 'you won't fall pregnant the first time.' It was out of naiveté, and it was wrong. It does happen the first time. (Eleanor, Pietermaritzburg, female Coloured Afrikaans-speaking participant, age group 25–54 years)

However, there were some exceptions to this. One participant (Onalenna, Johannesburg, female Black seTswana-speaking participant, age group 18–24 years) recalled how she was influenced by her peers to practise safer sex, as they encouraged her that as long as she used a condom, there would be 'no problem'.

Discussion

Significant gender differences in terms of access to and evaluation of informal sources of SRH were found. Young women were more likely to get sexual health information from family members and through their own research than men. The female participants also reported more family regulation around their sexuality, which could enhance the stigma of their sexuality and hinder open communication with parents. 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 organised around sexual prowess and domination, and rarely supported safer-sex practices.

Both men and women highly valued parental communication around sex and SRH, yet few participants reported that their parents played an instructive and positive role in their sex education. Some participants discussed the cultural taboo in families on parents discussing 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 hiding their sexual activity from their parents for fear of hostile reactions, revealing the extent of stigma around young people's sexuality. When participants did report receiving SRH from parents, it was often authoritarian, characterised by vague warnings against pregnancy and STIs rather than open discussions including positive aspects of sex and relationships. Such findings are similar to other studies including those by Aggleton and Campbell (2000) and Bhana (2007) who found that parents might be open to discussing the prevention of STIs with their children, but were reluctant to discuss broader sexual health and sexuality. It has been surmised that parents may also find it difficult to discuss the pleasurable sides of sex with children for conflicting with conceptions of childhood innocence (Bhana 2007; McLaughlin et al. 2012). The unsatisfactory level of early sex education from parents is concerning given that the literature suggests a positive correlation between parental communication around sex education and adolescents' sexual health and awareness, decreased sexual risk behaviours and teenage pregnancy (Campbell and MacPhail 2002; Bastien, Kajula, and Muhwezi 2011). Indeed, parents and family members are increasingly positioned as playing an important role in providing SRH information to children (O'Donnell et al. 2007; Kesterson and Coleman 2010). Nonetheless, a few participants, mainly women, reported receiving comprehensive sex education from family members, predominantly when they first menstruated. The fact that more women reported family members' advice about protective sexual behaviour could reflect parental anxieties about teenage pregnancy as well as the greater societal pressure for young women to retain their virginity.

Several participants recalled learning about sex through the media, which was a highly valued form of SRH communication. Cell phone communication was said to be highly accessible, and provided the potential for follow-up while retaining anonymity. Yet, some participants lamented the fact that there was no real anchoring of sexual knowledge transmitted through the media in the person's experience and life world, and that this therefore did not adequately 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 STI risk and prevention. Several women reported that researching sex and sexual health enhanced their understanding of how to practise safer sex. In contrast, men were less likely to actively seek information on sexual health, and be aware of where to access such information. This may be influenced by hegemonic norms of masculinity that portray men as tough and invulnerable, and expect men to be well informed about sexual issues (Peacock et al. 2009). It is likely that generational differences played out in the role of media communication providing SRH information, particularly in the context of increasing globalisation of the media in South Africa. For instance, older participants were less likely to mention the media as a source of SRH information, while for younger people it was more likely to be both a source of SRH information and a way to actively engage and seek such information.

None of the women recalled learning about sex through pornography, whereas many men suggested pornography taught them about sex and sexual techniques, which reflects the highly gendered appropriateness of this media as a form of sex education. Pornography was reported to create 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 practising safer sex, and could influence men's expectations and understandings of sex, including women's sexuality. The consumption of pornography has been linked in some studies to men's greater tolerance for and participation in aggression and sexual violence against women (Flood 2010). Moreover, most mainstream pornography is said to encourage the sexual objectification of women in which dominance over or violence towards women prevails (Artz 2012). Given that 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 men than women recalled learning about sex from their peers. Indeed, there seemed to be little communication about sex for men from sources other than peers, which may explain their critical influence. Various studies have also noted that peers provide the primary source of information about sex and HIV for many South African youth, particularly young men. This is problematic since peer-led knowledge is often misguided and uninformed (MacPhail and Campbell 2001; Gevers et al. 2012; McLaughlin et al. 2012). In this study, peer 'education' rarely involved promoting the importance of practising safer sex and some participants recalled learning inaccurate information from their peers. The finding that young people, particularly young men, are susceptible to peer influences around sexual decision-making and risk-taking is consistent with the findings of other studies (MacPhail 2003; Brook et al. 2006; Selikow et al. 2009). For instance, peer pressure to be sexually active and disapproval of condoms have been found to increase sexual activity among boys and reduce condom use (Campbell and MacPhail 2002).

The South African National HIV Prevalence, Incidence and Behaviour Survey 2012 found significant differences in knowledge levels of HIV according to age, race, locality and province. Thus, it is also necessary to examine differences in SRH access and awareness along other factors including race and location, especially given the significant disparities in HIV prevalence rates according to these factors (Shisana et al. 2014). While the data presented in this paper do not allow for an understanding of how these factors shape people's knowledge of SRH including HIV, they do point to the ways in which other social factors are important in understanding people's knowledge of SRH and warrant further research.

Implications

Since participants who did receive open and accurate sexual education from their parents highly valued this, educational materials to support parents around how to have open and honest discussions with their children about sex should be more readily available. This should include opportunities for parents to address their own concerns about imparting sexual health education to their children, including reflection on their own gender biases. The important role of fathers discussing SRH with their sons has increasingly been recognised (Walker 2004). Fathers should be encouraged through health promotion activities to be, 'more aware and honest and value their unique role in talking about sexual issues with their sons' (Walker 2004, 247). Other channels for family members 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 programmes 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.

Given that the media was cited as a prominent source of SRH information for being anonymous, accessible and easy to relate to, HIV prevention should continue to embrace the use of social media, such as Facebook and Twitter, to target young people. However, participants acknowledged that not everyone has sufficient Internet access to allow for such engagement. Locally appropriate social media channels such as the cell phone chat programme, Mixit, which has a high user rate in rural areas, should be explored for providing SRH information and messaging. 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 pornography (Flood 2010). If men are also educated to view pornography critically, they may be more resistant to violent and sexist themes that tend to accompany mainstream pornography (Flood 2010; Artz 2012).

As many men identified peers as a critical source of SRH information, consideration of the impact of 'formal' peer education approaches is important. Peer educators, for sharing socio-economic characteristics, yet challenging stereotypical norms and attitudes, have been found to be accessible, credible and influential educators (MacPhail and Campbell 2001; Evans and Tripp 2006). A number of studies have demonstrated effective health outcomes of peer education, including increasing condom use, delaying sexual debut and reduction in multiple sexual partners (Campbell and MacPhail 2002; Foss et al. 2007; Mash and Mash 2012). Yet, some studies have also found that peer education has limited impact without addressing the broader environment (Mukoma et al. 2009; Mathews et al. 2012). Given the prominence of peers as men's source of sex education, it would be valuable to explore in greater depth what works best within peer group provision of sex education, and to locate these interventions within efforts to create more enabling social environments for individuals to implement and sustain sexual behaviour changes.

Limitations

Reports of sexual history are, of necessity, retrospective and subject to problems of recall which may have affected the reliability and validity of the narratives, especially with regard to their recall of early exposure to and impressions of SRH information. Men and women may also have narrated their sexual attitudes and SRH practices in response to gendered expectations, especially given the potential stigma and secrecy among young people to reveal early sexual activities to researchers (Hardon and Posel 2012). As noted in the literature on masculinities, men's dialogues about their sexual behaviour may be more performative than a reflection of reality (Connell 1995; Frosh, Phoenix, and Pattman 2002). Recognition of the way in which participants might use their gender identity to affirm appropriate behaviours and attitudes was acknowledged as a potential bias. Nevertheless, the way men and women perform to gender norms is insightful for the study objectives. Given the diversity of South African cultures and contexts, the limited sample of 75 individuals is not sufficient to infer generalisations about South African youth, or a particular social or cultural group. However, the aim of qualitative research is not to generalise a phenomenon but rather to generate rich insights. By providing rich and

nuanced descriptions, the sexual history narratives contribute insights relevant to the study research questions as well as potentially to those in other similar study contexts. The fact that the data were sometimes gathered in participants' first languages and then translated into English may mean that some amount of translator bias limited the accuracy of the transcripts.

Conclusion

Although men reported less-protective discourses around their sexuality than women, men also reported fewer accurate sources of informal SRH information. This marks a critical gap to be addressed, especially given the documentation of young men's greater decision-making power in sexual relationships. Given the powerful impact of informal sources of SRH information on young people's SRH awareness, attitudes and sexual practices, more needs to be known about the content, context, access to and evaluation of such information, and how this is implicated by factors including gender. This is particularly the case since informal sources of SRH information are typically less regulated, supported and evaluated than more formalised sources of SRH information.

Funding

This study was funded and made possible by USAID through Johns Hopkins Health Education South Africa (JHESSA), University of Cape Town Research Associateship and Deutsche Gesellschaft fuer Internationale Zusammenarbeit (GIZ).

Note

1. 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*.

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