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Sexual decision-making and negotiation in the midst of AIDS: youth in KwaZulu-Natal, South Africa*

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'We don't talk about things like condoms, sex, or STDs. It is not that kind of relationship' (female, aged 17)

'[Sex] is a symbol of power in the affair..Once you have sex with a woman, you have a strong say in the running of the relationship' (male, aged 26)

Abstract

This paper addresses issues surrounding sexual negotiation and decision-making among black South African youth in the face of AIDS. It explores choices made by young men and women regarding sexual activity and the extent to which it is influenced by HIV/AIDS. Communication between partners was poor, and young women appeared powerless to enforce their preferences in sexual situations. AIDS was not a significant factor in any aspect of sexual decision-making. Socio-cultural factors and the state of the HIV pandemic in South Africa were offered as explanations for the findings.

This paper addresses issues surrounding sexual decision-making and negotiation among black South African youth in the face of AIDS. The objectives were to explore choices made by young people regarding when, how (i.e. protected or not), and with whom to have sex, and the extent to which HIV/AIDS influences this process. A primary aim was to examine the potential role of youths' self-perceived risk of HIV infection in the sexual negotiation process. Finally, of particular importance was focus on other aspects of sex such as the meaning attached to condoms and to the sex act itself; factors which are inextricably linked with sexual behaviour and decision-making.

Reported here are results from interviews with young black men and women in Durban, a large coastal city in KwaZulu-Natal province. The above comments by male and female participants are typical of the problems and conflicting needs of youth in this study navigating sexual relationships. For the young girl who provided the first comment, the bond with her steady boy-friend was not close enough to broach sex-related matters despite regular intercourse with him. The words of the young man reflect a clear perception of sex as a lever by which to control his partner and their relationship. The findings of this study underscore the need to focus on socio-cultural, ideological and violence-related factors in understanding the dynamics of sexual negotiation and decision-making , and ultimately of sexual behaviour itself.

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HIV/AIDS in South Africa and Kwazulu-Natal

In the mid-1990s, it appears HIV/AIDS will be an ineradicable presence for the foreseeable future. At conferences and in research circles retrospectives on the first decade of AIDS and calls for new perspectives in the second decade of AIDS have begun to emerge.[1] AIDS is frequently no longer referred to as an epidemic but a pandemic, with no cure in sight and only marginally effective treatment regimens available.

The facts are sobering and the numbers defy the imagination. HIV has infected 27.9 million individuals worldwide, 21.9 million of whom are presently living with the disease (UNAIDS 1996). In 1996, an estimated 3.1 million new infections occurred, translating into 8500 infections per day. Most newly infected adults will be those who are in the 15 - 24 year age group, who engage in unprotected heterosexual intercourse, and who live in Africa (UNAIDS 1996).

Africa holds the vast majority of the world's HIV infected population. Approximately 64 per cent (14 million people) of those living with HIV/AIDS reside in Sub-Saharan African countries (UNAIDS 1996). In South Africa, HIV infection rates are alarming. The most recent national survey revealed a countrywide seropositivity rate of 10.4 per cent.[2] In KwaZulu-Natal province, where this study was undertaken, the same survey revealed 18.2 per cent seropositivity. This reflects a 26 per cent increase over the previous year's figures (14.4 %) for the province (Fifth National HIV Survey, October/November 1995).

The HIV-related situation in KwaZulu-Natal is exacerbated by the youthful demographic profile and seroprevalence rates among young people. Half of KwaZulu-Natal's population is aged 19 years or less; nearly one-third is between the ages of ten and 24 years. Thus, 2.6 million individuals belong to that segment of the provincial population which has recently entered or will soon enter sexual activity (SA Population Census 1991).[3] Regarding HIV infection, the seropositivity rate among persons under 20 years of age is 9.8 per cent, and it is 11.8 per cent in the 20-24 year age group. Both these figures are close to double the national average for the same cohort; and are probably an underestimate of the current status of HIV in the province (Whiteside et al. 1995). Thus, AIDS is a critical issue among youth in KwaZulu-Natal, a province which has the dubious distinction of being the epicentre of HIV/AIDS in South Africa.

Research needs

Given the current state of HIV/AIDS and the lack of viable therapeutic alternatives, changing sexual behaviour is one of the few potentially effective options in combating its spread (Ulin

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1 This was a prevalent theme at the most recent Pan African Federation for Mother and Child Health Conference, held in Midrand, South Africa, 3-6 September, 1996. See also Herdt 1992 and Lindenbaum 1992.

2 National HIV statistics in South Africa are compiled through a yearly sentinel survey of antenatal clinic attenders. The figures cited here were drawn from the Sixth National Survey amongst Women Attending Antenatal Clinics in South Africa, October/November 1995. Because many African countries do not undertake national or regular HIV surveys, contextualizing South African data proves difficult. Recent small-scale antenatal clinic attender studies in neighbouring African countries have recorded varying rates of HIV infection: Swaziland 18 per cent, Botswana 29-40 per cent (urban samples), Malawi 6-11 per cent (rural samples) and 13-20 per cent (urban samples), Zimbabwe 32-38 per cent (urban samples). Figures compiled from US Bureau of the Census, October-November 1995.

3 Moreover, adolescents have a tendency toward high-risk sexual practices such as early initiation of intercourse and low rates of contraceptive use. See results of the following studies: United States Congress 1991; Boult and Cunningham 1991; Agyei, Mukisa-Gapere and Epema 1994.

1992; Sibthorpe 1992; Orubuloye, Caldwell and Caldwell 1993; LeFranc et al. 1996). This not only entails encouraging 'safe sex' practices such as condom use or monogamy, but necessitates an emphasis on subtle aspects of sexuality which affect sexual behaviour, such as sexual negotiation and decision-making (Worth 1989; Dixon-Mueller 1993; Balmer et al. 1995). Moreover, intervention efforts must not concentrate exclusively on sexual behaviour itself but adopt a more ecological approach. This means focus on political, economic, and socio-cultural determinants of high-risk sexual practices and attention to why risky behaviour is frequently continued despite population awareness of its negative health consequences.

A growing number of social scientists has begun examining the subtleties of sexual decision-making in their exploration of sexual behaviour and factors which influence it. With this has come the recognition that for many people unsafe sex is a rational choice which is perceived to result in, and safeguard, benefits such as emotional intimacy, trust, legitimacy and even economic stability (Sibthorpe 1992; Pivnick 1993; Sobo 1993, 1994, 1995; LeFranc et al. 1996). In addition, issues such as varied perception of risk have come under examination as affecting individual decisions regarding the circumstances under which sexual intercourse occurs (Lindan et al. 1991; Ulin 1992; Kline, Kline and Oken 1992; Moore and Rosenthal 1992; Keller 1993; Gielen et al. 1994; Romero-Daza 1994; Detzer et al. 1995; Lear 1995, 1996). Particularly with conditions such as HIV/AIDS, characterized by a long incubation period and symptoms often difficult to distinguish from other illnesses, disbelief in the existence of the disease and thus of personal risk for infection is not an uncommon reaction (Farmer 1992; Keller 1993; Green 1994; Romero-Daza 1994; Whiteside et al. 1995; Varga and Makubalo 1996; Varga 1996a, 1997a). Acknowledgement of risk for HIV infection may also necessitate confrontation with matters concerning personal or partners' sexual histories; a process which may at best lead to embarrassment, and at worst to the destabilization of intimate personal relationships. Thus, many prefer to view themselves as 'safe' rather than face the psycho-social consequences of possible HIV infection (Worth 1989; McGrath 1992; Sibthorpe 1992; Keller 1993; Sobo 1993, 1995; Pivnick 1993; Varga and Makubalo 1996; Varga 1996a; Bajos et al. 1997).

Finally, there is increasing acknowledgment of the need to view sexual behaviour as embedded in socio-cultural context, and carrying symbolic meaning. Sexual matters such as unprotected sex (or conversely condom use), number of sex partners, amount of vaginal fluid present during intercourse, and perceived side-effects of female hormonal contraception may all be interpreted within a cultural framework that conditions beliefs and decision-making (Caldwell and Caldwell 1987; Taylor 1990; Ulin 1992; Preston-Whyte and Zondi 1992; Runganga, Pitts and McMaster 1992; Brown, Ayowa and Brown 1993; Pitts, Magunje and McMaster 1994; Setel 1996; Varga and Makubalo 1996; Bond and Dover 1997; Feldman et al. 1997; Varga 1997a,b). For long-term effectiveness, HIV intervention strategies targeting sexual behaviour change must be based on a thorough understanding of the higher-order influences and interpersonal dynamics shaping the practices themselves (Gupta and Weiss 1993; McGrath, Rwabukwali and Schumann 1993).

Sexual decision-making and negotiation research

Most studies have found women relatively powerless in sexual decision-making. One study (Worth 1989) found resistance to condoms among minority women in a drug rehabilitation program to be the result of a combination of personal preferences and socio-cultural factors, and partners' objections to condoms. The negative implications of condom use conflicted with values surrounding relationships, womanhood and family. Fundamental to women's enjoyment of sex was affirmation of trust and fidelity through unprotected sex. Also significant was fulfilment of family and gender roles through pregnancy and childbearing (see Pivnick 1993). Moreover, some women appeared unable to exert an influence over condom

use through fear of rejection and stigmatization by partners. Such factors led women's sexual risk-taking—unprotected sex—to be characterized as a rational means of maintaining social and economic survival (Worth 1989:304).

Other research has revealed similar matters in sexual decision-making. Several recent studies (Sibthorpe 1992; Pivnick 1993; Sobo 1993; see also Sobo 1994, 1995) focused on socio-cultural issues surrounding sexual behaviour among individuals at risk for HIV infection.[4] A predominant theme linking these works was the powerful positive symbolism attached to unprotected sex and negative connotations of condom use. Despite awareness of HIV risk, unprotected sex with intimate personal partners was nearly always chosen over condom use. As in Worth's (1989) study, condom use carried the stigma of infidelity and lack of trust.

For many women, the nature of the social bond with a partner seems to affect sexual decision-making. Casual sexual encounters and sex for economic purposes might be considered superficial, and thus not threatened by issues such as condom use. Conversely, condom use with a steady personal partner would introduce an element of distrust and disequilibrium to an intimate relationship (Sibthorpe 1992; Kline et al. 1992; Varga 1996 a,b, 1997a). Power inequity and emotional and financial dependence of women upon their partners also seem to present significant obstacles to sexual decision-making. In one study, spousal relations were characterized as 'adult-child relationships' (Pivnick 1993:441). Women described their long-term partners as behaving more like fathers than husbands; thereby diminishing their status and decision-making authority in the relationship.

Risk perception may also heavily influence sexual decisions and practices. Sobo's work (1993, 1994, 1995) has revealed that women's self-esteem and social status may be strongly linked to involvement in what they perceive to be committed, monogamous relationships. Under such circumstances, condom use is interpreted as insulting, and suggestive of infidelity, lack of love and disrespect from partners. Thus the author described 'condomless sex' as 'an adaptive and defensive practice [which] helps women maintain desired, idealized images of partners, relationships, and selves' (Sobo 1993:478; see also Bajos et al. 1997).

Finally, Kline et al. (1992) provide a marked contrast to other works. Through interviews with African-American and Hispanic women in a drug rehabilitation clinic, the authors challenged the notion of women's powerlessness and 'culturally stereotyped characterizations of minority women' (p.447) in sexual decision-making and negotiation. Study participants demonstrated a substantial degree of power and independence in sexual decision-making, with considerable control over practices such as condom use, anal sex, and abstinence even when economically dependent upon their partners (p.450). The unusual nature of these findings was attributed to women's low self-perceived risk for HIV infection and loosening of traditional gender roles accompanying socio-economic and social upheaval (Pp. 455-456). Such research provides a reminder of the need to carefully re-evaluate acceptance of models linking women's powerlessness and gender-role stereotypes to low condom use.

Adolescent-focused research

[4] Sibthorpe and Pivnick both worked with intravenous drug users: Sibthorpe with men and women, and Pivnick with women only. Sobo conducted research with impoverished pregnant African-American women attending an inner-city antenatal clinic.

Some research has centred upon sexual decision-making and negotiation among adolescents. Studies by Kaloff (1995), Tolman (1994), and Fullilove et al. (1990)[5] explored sexual negotiation and gender-related power issues among American teenagers. Kaloff found that for African-American girls non-traditional gender roles (platonic or egalitarian relationships with men) were associated with less dependency and greater decision-making power in sexual situations. This contrasted with findings of other adolescent-focused research.

Elsewhere, adolescent girls have been found to express confusion and powerlessness in attempting to articulate personal sexual desires and in reconciling such needs with those of their partners (Fullilove et al. 1990; Tolman 1994). Such conflict appears to be a product of pressures imposed by conventional gender roles, the closed manner in which American society addresses sexual issues, and poor intergenerational and partner communication on sexual matters. Moreover, as in studies among adult women (Worth 1989; Dixon-Mueller 1993; Varga 1996a,b, 1997a) the symbolism of sexual relations and notions of appropriate female sexual conduct prove a powerful deterrent to safe sex practices.

Other perspectives on sexual decision-making come from work focused on adolescent girls' choices with regard to early childbearing (Hogan and Kitagawa 1985; Pete and DeSantis 1990; Jacobs 1994; Gordon 1996). While the focus is often primarily on decision-making concerning fertility, the relevance of such studies to sexual decision-making matters is obvious. The picture painted is one of the initiation of sex as a reasoned decision frequently made against a background of social destabilization, family relationships characterized by lack of affection and poor communication between parents and children, ineffective authority figures, and the need to establish acceptance, intimacy and autonomy among peers (Hogan and Kitagawa 1985; Pete and DeSantis 1990; Jacobs 1994). Thus, for some adolescents deferring to the desires of one's sex partner, avoiding contraceptive use, and even sex itself become a means of escaping social and family upheaval, and finding love and adulthood.

Few studies have addressed adolescent sexuality, self-perceived risk and sexual decision-making in the context of HIV/AIDS. Working with university students, Lear (1995, 1996) found a general absence of sexual communication between partners and misconceptions about the motivations of one's sex partner. This led to confusion in and lack of preparation for sexual situations. Again reminiscent of research among adult women (see Fullilove et al. 1990; Sibthorpe 1992; Varga 1996a,b,c, 1997a), gender and degree of intimacy in a relationship were important factors in assessment of self-risk for HIV infection. Condom use was most likely in casual sexual relationships or those in which trust had not been established; and was stopped if the relationship became long-term. Moreover, students viewed sexual experimentation as positively for males, but associated with female promiscuity. Moore and Rosenthal's (1992) work among secondary school students revealed similar results.

Africa-focused research

A few recent studies have examined HIV/AIDS-related sexual decision-making and negotiation in an African context. In West Africa, Orubuloye et al. (1993) explored sexual empowerment of Nigerian (Yoruba) women. Women's apparent success in refusing unwanted intercourse was attributed to their economic independence and strong lineage ties. In Central Africa, McGrath et al. (1993) worked with Ugandan (Baganda) women. Despite a high level of AIDS awareness, women accepted multiple sex partners from economic need or for sexual satisfaction. While willing to change their own sexual behaviour, Baganda women felt

[5] Fullilove et al. (1990) also conducted interviews with adult women in this study. Responses of older and younger participants were very similar with regard to issues in sexual decision-making and negotiation.

themselves defenceless against HIV infection because of partners' culturally sanctioned high-risk behaviour and the belief that partners would not respond to safe-sex messages.

Schoepf (1992) has addressed HIV/AIDS-related sexual decision-making and behaviour among women in Zaire. This study was unusual in examining sexual-decision-making among both African and European women in Zaire who do not fit conventional notions of 'high-risk' individuals. Perhaps the most important finding from Schoepf's research is confirmation of 'the fact that HIV is spreading not because of exotic cultural practices but because of many people's normal responses to situations of everyday life' (Schoepf 1992:275).

Little research has been undertaken in East and Southern Africa. A study in Kenya explored sexual decision-making and negotiation between partners in stable, long-term relationships (Balmer et al. 1995). As in other Africa-focused studies, acceptance of gender-specific sexual behaviour and discomfort with the negative connotations of both condoms and female contraception figured prominently in sexual decision-making and lack of sexual negotiation over appropriate sexual comportment. Although male participants admitted that women often did make the final decision regarding timing of intercourse, initiation and rejection strategies used by both partners were indirect and rarely involved open communication. Finally, in South Africa Miles (1992) studied sexual negotiation issues among black and white women through discourse analysis.

Adolescent-focused research in Africa

Available information on sexual issues among African adolescents is limited in scope. A common approach to AIDS and sexual activity among African adolescents is knowledge, attitudes, and practices (KAP) surveys (Nichols, Woods and Gates 1987; Ajayi et al. 1991; Boohene, Tsodzai and Hardee-Cleveland 1991; Agyei and Epema 1994). Such work is critical in providing a strong descriptive foundation for understanding adolescent sexual behaviour and sexuality. Nonetheless, it reveals little about socio-cultural and interpersonal factors which determine teenagers' sexual behaviour or about AIDS-related sexual negotiation.

Qualitative work exploring various AIDS-related aspects of African adolescents' sexuality and decision-making is scarce. In South Africa, few studies have addressed these issues. LeClerc-Madlala (1997) examined black South African youths' reactions to the threat of AIDS and its potential effect on sexual behaviour and attitudes toward sexual relationships. Fear of dying alone was offered by subjects as the rationale for purposeful attempts to spread HIV by engaging in unprotected sex with multiple partners. Varga and Makubalo (1996) found AIDS to be a minor issue among teenage girls, with violence an over-riding factor in their sexual decision-making. Some research has begun investigating socio-cultural factors influencing sexual decision-making and negotiation among adolescents in Tanzania (Nnko and Poole 1997) and Zambia (Nzovu and Lwanga 1997).

Similarities and gaps in existing studies

Western and Africa-focused research on sexual decision-making and negotiation share several themes and weaknesses. Their findings suggest that a combination of socio-economic and gender-based powerlessness, poor partner communication, cultural values associated with fertility and sexuality, and need for emotional intimacy leads both girls and women to remain in risky sexual partnerships. However, while research of this kind is vital in laying the foundations for understanding sexual networking, its ramifications are limited by several factors.

Most studies investigating sexual decision-making concentrate on women who are probably not representative of women in general or of the populations of which they are members. The majority of participants in the studies reviewed here were women whose socio-

demographic characteristics predisposed them to risky sexual relationships and HIV infection and transmission. Focus on such select groups calls into question the extent to which research results can be generalized to the broader populace. Commenting about their own work, Kline et al. (1992) suggest their results be interpreted with caution given that women in the study were from a narrow age-group (early thirties) and were participants in a drug rehabilitation program. Similar questions can be raised regarding the studies, both Western and Africa-focused, reviewed here.

Moreover, the nearly exclusive focus on women presents a considerable 'gender gap' in research on sexual decision-making and negotiation. Despite repeated calls to take heterosexual men into account, the male perspective remains a largely unknown element in the sexual equation (Gilmore 1990; Vogelman 1990; Dixon-Mueller 1993; Gupta and Weiss 1993; Cornwall and Lindisfarne 1994; Gage and Njogu 1994; Harvey and Gow 1994; Romero-Daza 1994; Biddlecom, Casterline and Perez 1996; Grady et al.1996; Wood, Maforah and Jewkes 1996) This is puzzling especially if one considers that men constitute one half of the sexually active population, and are necessary members of most sexual relationships. The need for male-focused sexuality research, both specific to HIV/AIDS and in general, is particularly acute for adolescents and African populations, for whom both unsafe sexual behaviour and risk of HIV infection appear to be especially problematic.

A final limitation of current sexual decision-making and negotiation research is the absence of a dyadic focus on sexual relations. Available research frequently considers the views and characteristics of only one partner—or gender—in isolation, not as a dynamic between two individuals. The result is an incomplete portrayal of a situation which is by definition created through the inter- action between partners in a sexual relationship. Thus, most works examine sexual decision-making but neglect sexual negotiation. In demography, anthropology, and related health and social sciences, there is an increasing call for sexual and reproductive health research characterized by greater gender balance and attention to couples' sexual dynamics (Dixon-Mueller 1993; Cornwall and Lindisfarne 1994; Greenhalgh 1994; Biddlecom et al. 1996; Grady et al. 1996; Ringheim 1996; Zeidenstein and Moore 1996).

Terminology

Before proceeding, it is necessary to define several frequently used terms whose connotations are often unclear. These are: sexual behaviour, sexuality, sexual decision-making, and sexual negotiation. In this paper, 'sexual behaviour' denotes physical actions associated with the act of sexual intercourse, such as penetration, contraceptive use, intercrural sex,[6] or ejaculation. Dixon-Mueller (1993:273) distinguishes sexual behaviour as 'actions that are empirically observable (in principle at least): what people do with others or with themselves, how they present themselves sexually'.[7] 'Sexuality' is a broader concept including both personal feelings, desires, and beliefs, and socially accepted attitudes, norms and meaning respecting interaction with members of the same and opposite sex. Referring once again to Dixon-Mueller (1993:273), '..sexuality is a more comprehensive concept [than sexual behaviour] that encompasses physical capacity for arousal and pleasure (libido) as well as personalized and

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[6] External sex between the thighs of the female partner. In traditional Zulu culture, this practice, known as *ukusoma*, was a socially acceptable and encouraged practice in the sex socialization of Zulu youth (Krige 1936; Vilakazi 1962; Van der Vliet 1974).

[7] Dixon-Mueller includes acts and verbal communication leading up to intercourse—what may be described as foreplay—in her definition of sexual behaviour. Here, such actions are included in 'sexual negotiation' in order to distinguish them from behaviour associated with sexual disease acquisition and transmission.

shared social meanings attached both to sexual behaviour and the formation of sexual and gender identities'. This distinction is especially significant when addressing determinants of sexual behaviour and behaviour change. Without focus on sexuality as the basis of sexual behaviour, interventions targeting sexual behaviour change are likely to be superficial, short-lived, and ineffective in the long-term.

'Sexual decision-making' and 'sexual negotiation' are phrases often employed without clarity or even used synonymously. Here, sexual decision-making is defined as decisions, preferences and resolutions made by an individual regarding the conditions, such as timing of intercourse or contraceptive use, under which sexual relations occur. In contrast, 'sexual negotiation' includes the verbal and non-verbal interaction and dynamic between partners in deciding how and when intercourse will take place. Moreover, both processes of sexual decision-making and sexual negotiation are heavily influenced by conceptual and ideological factors affecting what is perceived as appropriate gender-specific behaviour.

The distinction between these two terms is critical in understanding the determinants of sexual behaviour. Individual decisions, while significant in reflecting beliefs and intentions with regard to sexual practices, may not necessarily be enforced once one has entered a sexual partnership. Of equal, or perhaps greater, importance is focus on both partners and the dynamic between them in determining the circumstances under which sexual intercourse occurs. By definition, sex necessitates the participation of at least two people; thus it stands to reason that sexual behaviour is a product of the combination of partners' sexuality, decision-making, and negotiation (Dixon-Mueller 1993; Cornwall and Lindisfarne 1994; Gage and Njogu 1994; Greenhalgh 1994; Biddlecom et al. 1996; Grady et al. 1996; Ringheim 1996; Varga 1996c, 1997a; Zeidenstein and Moore 1996; Bajos et al. 1997).

Methods

Subjects and venues

Female study participants were black African primigravida adolescent antenatal clinic attenders aged up to 19 years. Subjects were interviewed on one occasion while waiting for antenatal examinations. In order to control for the potential effect of migration, only young women who had been living in the community for a minimum of three years were included in the study. Interviews were conducted in Zulu with the aid of a black African female fieldworker. The clinic was an urban primary health care facility in a former black township to the northwest of Durban.

Male study participants were young black African men who had been involved in sexual relationships with adolescent girls (up to 19 years old) which had resulted in pregnancy and subsequent parenthood within the previous three years. All subjects resided in Durban: in the same northwest township as female participants, and in three other neighbourhoods of the city. The same residence restrictions applied as with female subjects. Interviews took place in individuals' homes and were conducted in Zulu with a young black African male fieldworker.

Male subject selection took place through snowballing. The first male subject interviewed was a 26 year-old man who had recently finished university studies. Through him, the researcher established a network of acquaintances which led to interviews. Study aims were explained to each potential male and female participant, and verbal consent received before recruitment.

Data collection

The interview format consisted of two sections: structured questions focused on HIV/AIDS-related knowledge and attitudes[8]; and an open-ended section addressing sexual negotiation and decision-making issues between the subjects and the partners with whom they had experienced fatherhood or become pregnant. Topics in the open-ended segment included discussion of HIV/AIDS-related issues and self-perceived risk for HIV infection; the timing, role, and expectations of sex in a relationship; and condom use.

Results

Socio-demographic characteristics

Interviews were collected for 39 female and 24 male participants. Mean age was 18 years (range 15-19 years) for females, and 24 for males (range 18-26 years)[9]. Females had an average of 7.2 schooling years, and males eight years.[10] All study participants were unmarried.

Among male participants, 29 per cent had been involved with multiple teenage pregnancies. Mean age at first experience of fatherhood was 21 years. Mean age of the female partner with whom male subjects had their first child was 18 years.

HIV/AIDS-related knowledge

Knowledge regarding HIV prevention, acquisition, transmission, and consequences of infection was high among female participants. All subjects had heard of AIDS, and 81.2 per cent stated that the condition is fatal. When asked to list means by which AIDS can be acquired, unprotected sex (49%), blood contact (24%) and multiple partners (13%) were the most frequent responses.

Girls were also asked about specific behaviour related to HIV transmission. Nearly all viewed sex, multiple partners, shared razors and unprotected intercourse (i.e. without a condom) as potentially effective means of disease transmission. Most agreed with the statement that AIDS can be transmitted through a single sexual encounter.

When asked to list various effective modes of AIDS prevention, girls most often noted condoms (78%), abstinence (61.2%), and external or intercrural sex (*ukusoma*) (12.5%). Finally, 32.9 per cent of female subjects felt it was not possible to carry the virus without displaying physical symptoms.

Owing to time limitations it was not possible to gather questionnaire data on HIV/AIDS awareness among male participants. However, all the young men in the study had heard of AIDS, and approximately half felt it to be a real disease which could potentially pose a threat to the communities in which they lived, though not necessarily to themselves. All were aware

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[8] The structured questionnaire was conducted only among female subjects. For males, HIV/AIDS awareness and knowledge were discussed in the course of open-ended interviews.

[9] In South Africa, adolescent childbearing is prevalent. The adolescent pregnancy rate is 300-400 per 1000, and 40-50% of all live births are to adolescents (SA Ministry of Welfare 1995; Goosen and Klugman 1996). A recent reproductive history survey conducted in an urban township near the site of this study found that women under 20 constituted 52.6% of primigravidae (Varga 1997b). No data are available for men's average age at first fatherhood.

[10] In the reproductive history survey (Varga 1997b), 88.2% of currently teenaged girls had some secondary school but had not matriculated; 11.8% had completed secondary school. Two males had university degrees.

of the connection between unprotected sexual intercourse and HIV and other sexually transmitted diseases; and all knew condoms to be an effective means of prevention. None knew or had seen anyone who was HIV-infected or had AIDS.

Sexual decision-making and negotiation themes

Discussion of HIV/AIDS-related issues and self-perceived risk for HIV infection

Among female participants, 61 per cent felt AIDS-related issues were not appropriate to discuss with a partner. Only 39 per cent had talked about any aspect of HIV with their most recent boy-friend. None of the male participants had discussed AIDS with the mothers of their children.

Several issues emerged in this regard. First, female subjects were inclined to focus on lack of intimacy in the relationship as a reason for avoiding discussion of HIV/AIDS with partners. Said one 17 year-old girl: 'I would be afraid to talk to him [boy-friend] about AIDS. He is not the kind of person I can discuss such things with. It is not that kind of relationship'.

Threat of rejection or stigmatization and fear of physical abuse or coercion were also mentioned as communication barriers. With regard to the former, girls' typical comment was that if AIDS were brought up in conversation it might suggest they suspected their partners of being infected or, even worse, that they were trying to hide their own infected status. With regard to violence, one 19-year-old girl offered the following explanation for remaining silent: 'No, we don't discuss AIDS. I'm scared of him because he used to beat me. So I don't want to talk about things that might make him upset'. This young woman also implied that such a violent response would probably be due to her partner's interpreting the subject as suggestive of her infidelity.

Male participants most frequently discussed disbelief in the existence of AIDS and the opinion that it is the female partner's responsibility to protect against HIV infection. One 21-year-old said: 'I have never seen anyone who is sick [has AIDS]..I don't believe there is such a sickness. It is a myth from the old government or maybe from overseas'. Another young man who was unemployed and living with his parents stated quite emphatically: 'if a girl wants to be mine, she must stay clean, take care of herself and avoid it [AIDS]'.

Also implicit in both male and female subjects' comments was the notion of trust in one's partner as a safeguard against contracting HIV/AIDS. This reasoning was used to create a perception of low risk. Consider the comments of two young men, both in their early twenties:

I only have sex with clean, trustworthy girls. I would know if they had AIDS.

We talked about the fact that trust and fidelity will prevent STDs and AIDS.

The concept of trust was sometimes even used as a tactic to ensure fidelity. A 17-year-old respondent in her seventh month of pregnancy noted of the father of her baby: 'he said he won't get AIDS since he only has one partner. If he does get it, he will know it is from me.' Later in the interview, this young woman noted that subsequent to her boy-friend making such a statement, she was terrified to bring up the topic of AIDS for fear of his suspecting her of having had other partners and been infected with HIV. Thus, she preferred to remain silent on the issue and maintain the stability of the relationship.

Neither male nor female participants mentioned HIV/AIDS in the context of decisions to initiate sex with a new partner or to engage in practices such as condom use or monogamy. When the topic was introduced by the interviewer, it solicited responses similar to those enumerated regarding discussion of HIV/AIDS itself. As noted, a number of respondents stated they did not believe in the existence of AIDS; thus for them it was not a relevant factor in sexual decision-making. Among those who acknowledged its existence, the predominant view was low perceived risk of HIV infection combined with other more pressing concerns, such as demonstrating masculinity and social prowess, expressing commitment and trust, or avoiding physical abuse, in relation to sexual decision-making and negotiation.

Timing, role, and expectations of sex in a relationship

Male participants were adamant that sex must take place within the first few weeks (generally the first two weeks) of a relationship in order for it to be viewed as serious and legitimate. Having a true girl-friend necessitated sexual intercourse. According to one man, 'if someone is in love with a woman and breaks up with her before they have sex, that affair is as if it never even existed'. To stress the symbolic importance of sex, a 24-year-old man noted:' it is my procedure to have sex with the girl in the first two weeks of the affair .. to prove if [she] is really committed to me and prepared to do anything to make me happy'.

Men viewed sex as an expression of pleasure and affection; though not necessarily commitment on the part of the male partner. This was articulated very clearly by a 24-year-old father of two children from different women when he described his sexual relationships: 'Sex is something you do in order to enjoy each other… It is about love and pleasure, but you can still get pleasure without having to be deeply in love with your sex partner'.

As illustrated by the quotation at the beginning of this paper, sex was a man's means of establishing power within the relationship. Having multiple sex partners was a particular status symbol, the yardstick by which masculinity, intelligence and success were measured among one's male friends. Male participants described strategies resulting in many partners as a reflection of male intelligence, cunning, and wit. The following words from a 25-year-old participant were typical of many in the study, 'It's not enough to get her to fall in love with you…To show that you control the relationship, you must be able to show your friends that you have slept with her'.

For these young men, the socio-cultural and conceptual value of having multiple sex partners was also reflected in the Zulu terms they used to describe their sexual experience. Of utmost importance was the distinction between a man with many partners, *isoka*, and a man having only one or none, *isishimane*. The former was the ultimate compliment, while the latter was an insulting and derogatory label. One male participant noted that his family greeted news of his third illegitimate child with relief, as it demonstrated beyond a doubt his public *isoka* status.

Several men emphasized the distinction between the positive connotation of *isoka* and promiscuity, which was extremely undesirable. Participants were emphatic about the fact that the two were completely unrelated concepts. Being an *isoka* was considered a natural, laudable and traditional part of African manhood. In contrast, being promiscuous was seen as distasteful and dirty. Promiscuity was usually associated with women thought to have many sex partners; such women being known as *izifebe,* whores. The following statements portray the strong sentiments surrounding *isoka* and *isishimane*, and that achievement of *isoka* was viewed by male study participants as something of a cultural birthright.

> Many girl-friends is an old culture of Africans… My own father had many wives and there was nothing wrong with that… *isoka* is not a promiscuous person. Those two words come from different contexts and they mean different things (male, 24).

> I am a man… I cannot have one affair. I am not *isishimane*. For a man to have three girl-friends is very reasonable behaviour (male, 18).

Like male participants, most young women stressed the absolute necessity of sex as part of a normal relationship. Their statements also corroborated those of their male counterparts in confirming intercourse as a woman's means of demonstrating love and commitment to a relationship. This was such a powerful belief that girls frequently relied on it as justification for not refusing unwanted sex. These notions are clearly embodied in the words of an 18-year-old girl who said simply: 'I don't refuse because I know that he is the only one for me. I don't want to lose him, so I must satisfy him'.

Consequences of refusal of sex

In the course of the study, refusal of sexual advances—and the repercussions of such actions—became a major focus of discussions with female participants. Over half (55 %) reported having refused sexual advances from their most recent boy-friend. Of these women, 71 per cent admitted their attempts to avoid sex had not been successful. Refusal nearly always resulted in physical coercion, abuse or boy-friends' threats of rejection. Many female subjects chose not to refuse sex in order to avoid physical abuse and maintain the stability of the relationship. One 19-year-old described the following pattern with her steady boy-friend: 'I do refuse [sex] although I usually have to do it anyway. It doesn't end there. I know he is going to hit me if I don't… I am even scared to tell him I am tired of sex'.

Attempts to discuss female partners' refusal of sex with men frequently drew indirect responses. Several participants avoided the issue completely, and a few appeared to find the question nonsensical. One means of eliciting responses from young men was to initiate discussion of recently publicized South African rape statistics and local activists' efforts to increase public awareness of sexual violence. In this context, many men felt the statistics were exaggerated, and were uninterested in public awareness movements. They were generally of the opinion that women should and do anticipate sex as part of a relationship, and that most women want sexual satisfaction as much as men.

In a few interviews, the issue of rape and its exact definition became a topic of conversation. A common comment was that it is a man's duty to satisfy a woman sexually in order to keep her from becoming bored and finding another boy-friend. Physical coercion or abuse in participants' own relationships arose in only one interview, after the topic of rape had been debated at length. Given the context of the discussion, the young man was asked if in retrospect he considered his sexual advances potentially aggressive. After some thought, he responded, 'I do not rape anyone. All my girl-friends enjoy my company'.

Condom use

Condom use appeared to play a minor role in male participants' contraceptive practices, and was not a topic of discussion with partners. Those who had experienced sex with condoms used them only until trust had been established in the relationship. Condoms were also avoided because they made sexual intercourse an impersonal and uncontrolled experience. According to one male university student, 'Condoms take away sexual control both physically and psychologically. They take away [a man's] control of the process'.

Among men, when the issue of contraception was introduced they nearly always assumed this meant female methods, ignoring condoms in their commentaries. Partial explanation for this may be that among these young men, condoms were associated primarily with prevention of HIV and other sexually transmitted diseases (STDs), not with contraception. One participant elaborated at length upon current local social marketing strategies emphasizing the connection between condom use and AIDS or STDs, not pregnancy. This sentiment was also evident in the comment, 'If I do not trust a girl, that is the only time I make use of a condom to prevent diseases'.

Over half the female subjects said they had avoided discussion or requesting use of condoms. Reasons for such silence mirror many themes uncovered here regarding other HIV and sexuality-related issues: fear of physical abuse, rejection, or lack of intimacy in the relationship. Those who talked about it (47%) said their partners usually rejected condoms on the grounds that they made sex less pleasurable. One female subject said her boy-friend refused condoms because he wanted the sexual experience to be 'meat to meat'.

As with males, young women generally did not stress condoms as a means of contraception. Instead, condoms were connected with protection against STDs and AIDS, and suggested the moral implications of infidelity and risk of sexual diseases. The association between condom use and promiscuity led one young female participant to describe how angry she was with her boy-friend when she began to suspect him of using condoms: 'He has refused to use them [with me]. But I don't trust him, because I found some in his pocket. Maybe he uses them for other [casual] girl-friends'. Later, she said that despite her discovery she was still seeing him regularly and that she had not confronted him with the issue.

Finally, as with HIV-related discussion, a predominant justification among both young men and women for avoiding condoms was trust and fidelity. For these reasons study participants felt they did not need the discussion, or use, of condoms; and perceived themselves at low risk of STD and HIV infection. None of the male study participants said they had used condoms with any regularity, and only one female participant had experienced sex with a condom. The interplay between partners regarding condom use and the rationale used to conceive of themselves as safe from infection is illustrated in statements from three female teenagers.

> [He] said he doesn't have any… diseases, so why should he use a condom?
> He says if a man doesn't trust a woman, that is the only time to use [condoms].
> He refused to use them. He says he is faithful to me, so why bother?

Discussion

The commentaries of these adolescents illustrate several aspects of their approach to sexual decision-making and negotiation, and the role HIV/AIDS plays in this process. Perhaps unsurprisingly, there was a general tendency to avoid direct communication with partners about the conditions under which intercourse would take place; actions were based on unspoken assumptions about the kind of behaviour considered appropriate in a dating relationship. In addition, the dynamic within the relationship was routinely guided by the preferences of male partners. For young women, this translated into decision-making

powerlessness if their desires clashed with those of their partners. Moreover, it seems that awareness of HIV/AIDS was not a factor in adolescents' sexual decision-making and communication. As in much research among minority women and adolescents in the US and Africa (Worth 1989; Sibthorpe 1992; Moore and Rosenthal 1992; Sobo 1993,1994, 1995; Pivnick 1993; McGrath et al. 1993; Romero-Daza 1994; Lear 1995, 1996), it appears that for these young South Africans sexual negotiation and decision-making were influenced, and in many cases overridden, by a complex set of social and cultural factors which far outweighed the potential threat of HIV infection.

Socio-cultural context and transition

A partial explanation for the sexual dynamics revealed among these Zulu young people lies in a socio-cultural context which has not fostered sexual negotiation skills, and in which segregated gender roles are culturally sanctioned. Both historical and contemporary factors have contributed to this situation. In traditional Zulu culture, sex play was encouraged but regulated,[11] and education regarding sexual matters was undertaken separately for boys and girls by their older peers. Gender roles differed substantially; women were taught to be submissive and obsequious, men to be forthright and assertive (Krige 1936; Van der Vliet 1974; Kies 1987). In the polygynous and patrilineal Zulu world view, women were recognized primarily in their role as childbearers, and once married were 'absorbed into' the ancestral lineage of their husbands. The imagery and ritual surrounding marriage clearly demonstrates the process by which a bride shed her former persona, ultimately becoming fully integrated into her husband's lineage (Krige 1936; Ngubane 1981).[12] In traditional Zulu society, a woman was clearly assumed to be part of her partner's domain.

In the midst of recent social transition and rapid urbanization in South Africa, many traditional Zulu lifeways have undergone dramatic transformations. However, traditional sexual socialization and values have not yet completely eroded. Rather, they have been adapted to a new social environment and become entangled with contemporary social sexual norms. Consequently, adolescents are left in a precarious position by receiving a combination of conflicting messages about sexuality and sexual behaviour. Teenage girls in particular frequently find themselves in untenable double-bind situations. A young Zulu woman may simultaneously be under pressure from friends and boy-friends to have early and unprotected sex, forgo birth control owing to its association with promiscuity, conceive a child and demonstrate her womanhood, *and* avoid pregnancy in order to finish school and find a job (Craig and Richter-Strydom 1983; O'Mahoney 1987; Preston-Whyte and Zondi 1992; see also Olaniyan 1992; Bledsoe and Cohen 1993 for perspectives elsewhere in Africa). Traditional support and information networks have fallen away, being replaced by limited alternatives for acquiring skills to handle new demands. Moreover, contemporary reproductive health programs have been described as having 'adopted a sanitized version of sexuality that treats intercourse as an emotionally neutral act' (Dixon-Mueller 1993:276). Thus it is sadly appropriate that Nash describes contemporary black South African adolescents as 'caught in a web of change' regarding sexual matters (Nash 1990:147).

Culturally sanctioned differences in gender roles and expectations of sexual relations may also contribute to poor sexual negotiation (see McGrath et al. 1993; Romero-Daza 1994; Balmer et al. 1995). Here, such factors were evident in both male and female participants'

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[11] Intercrural sex was an accepted and encouraged form of sex play between young unmarried partners.

[12] Ngubane discusses the vivid and emotional mourning rituals performed by the bride's family during the wedding, symbolizing the loss or death of their daughter to the lineage of her new husband.

emphasis on women's fidelity and expression of love through sex, in sharp contrast to the powerful *isoka* imagery for men: an ideal which appears to be a well-entrenched aspect of Zulu masculinity (Vilakazi 1962).[13] In many cases, such a divide resulted in the emotional manipulation of female partners. Many female respondents voiced considerable apprehension about proving their fidelity (through avoiding condom use), dissociating themselves as much as possible from HIV, and the potential emotional and physical consequences of refusing sex. Thus, young women's gender roles and the symbolic meaning of sex often rendered them powerless to articulate or follow their own desires (see Tolman 1994).

Even contemporary social marketing strategies may inadvertently foster confusion and lack of sexual communication. A generally held opinion among both male and female participants in this study was that the responsibility for protection against unplanned pregnancy rests entirely with the female partner; and that it was an issue not relevant for discussion between partners. As an explanation, one male respondent offered the opinion that local sex education and reproductive health programs have traditionally targeted women in connection with birth control-related matters. Thus, he said, men are unused to concerning themselves with or taking responsibility for contraception. Such a lack of gender integration in reproductive health policy has also been recognized elsewhere (Dixon-Mueller 1993; Berer 1996).

Gender-based violence and coercion

Recently, physical abuse, coercion, and domestic violence as barriers to both girls' and women's sexual decision-making freedom and reproductive health have received increasing attention (Burgess 1985; Vogelman 1990; Harvey and Gow 1994; Koss and Heise 1994; Heise et al. 1994; Stewart et al. 1996). Such awareness has taken place in both developed (Warshaw 1994; Sanday 1996) and developing countries (Sanday 1981; Heise et al. 1994; Oppong 1995; Glantz and Halperin 1996; LeFranc et al. 1996); and has led Stewart et al. (1996:129) to describe sexual abuse as a universal problem. Here, physical abuse and coercion were distinct and sometimes graphic obstacles in sexual decision-making and negotiation for female participants.[14]

Three factors in particular make the often coercive and violent nature of these youths' sexual dynamics urgently deserving of attention and serve to illustrate the apparent neglect of gender-based violence in the southern Africa context. First, in stark contrast to what was observed and recorded in interviews with females, male participants did not view their sexual behaviour as violent or abusive. A second factor was the reconciled and matter-of-fact manner in which female participants described and bore such behaviour from their partners. Finally, especially distressing is the fact that for these adolescents sexual violence and coercion took place in the context of familiar personal, if not always steady or serious, relationships.

Available ethnographic information on the topic is scanty at best, but appears suggestive of sexual coercion and gender-based violence as culturally acceptable norms in both

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[13] The cultural importance of being considered an *isoka* seems to have changed little through several generations. Vilakazi's description of the status accorded to a sexually experienced man, an *isoka,* could be the words of a young male participant in this study: 'To have a girl accept you as a lover is to get the assurance that you are a normal man. That is why [being an *isoka*] is such a value among the Zulu, for it gives social and psychological poise. To fail to win a woman is to be a social failure (*isishimane*) and it is to be cursed with a social stigma which… is worse than an organic disease'(Vilakazi 1962:50).

[14] In the course of the study, a female fieldworker was hospitalized for a week with head injuries inflicted by her long-standing boy-friend. It was apparently not the first time she had been admitted to hospital for this reason.

traditional and modernizing southern African societies.[15] Accounts in both older and recent ethnographies indicate sexual violence and coercion as a common phenomenon. The manner in which these issues are described suggests such behaviour is viewed as a norm. Schapera (1939) chronicles physical abuse of wives by their husbands as a common reaction to refusal of sexual advances. Of sexual coercion in township life Longmore wrote: 'if the girl refuses the boy openly, he may decide to assault her, to punish her for resisting him' (1959:24). In a Queenstown (Eastern Cape Province) township Kotze notes: 'men may beat their women when they do not observe sexual fidelity or when their own infidelity is questioned by their women' (Kotze 1993:76). Ramphele (1993) paints a similar picture among hostel-dwellers in Cape Town.

That such coercion and violence took place within relationships and between familiar partners suggests that gender-based violence is much more common than conventional statistics indicate. South Africa was recently described as likely to have the highest rate of reported rape in the world (Duke 1997). However, the exact dimensions and definition of rape are unclear, both by South African legal standards and social opinion (Hunt and Milton 1990; see also Warshaw 1994; Heise, Moore and Toubia 1995; Sanday 1996). Moreover, it is becoming increasingly clear that most rape and other forms of sexual violence and coercion take place between acquaintances or in the context of a steady dating relationship (Warshaw 1994; Sanday 1996). Thus, the reported 141 rapes per 100,000 South African females—twice the rate in the United States—are certainly an underestimate; the tip of the iceberg which includes young South African women like those in this study. Ulin (1992:67) has suggested that African women's empowerment lies in 'informal associations and networking'. However, the feasibility of such an approach is questionable, particularly among adolescents, many of whom see unprotected sex and relationships as a means toward intimacy, acceptance, and womanhood.

Only recently has the potential social and reproductive health impact of sexual violence come to be explored in the southern African context (Hansson 1991; Angless 1992; Varga and Makubalo 1996; Wood et al. 1996; Duke 1997). Sanday (1981) and Heise et al. (1994) enumerate cultural, economic, legal, and political factors which sustain gender-based violence; many of these fit the situation in which the adolescents in this study found themselves. Both micro and macro-level factors in South Africa appear to have created a context conducive to gender-based violence and the sexual powerlessness of women.

HIV/AIDS in South Africa: current epidemiological and social status

Why did HIV/AIDS not figure more prominently into these adolescents' sexual negotiation and decision-making? One potential explanation lies in the fact that the pandemic has not yet reached the stage of high public visibility in South Africa. Recent projections estimate the rate of HIV infection in South Africa increasing rapidly through the end of this century, only peaking by the year 2007. HIV's long incubation period without overt physical manifestations

[15] The perpetuation of men's use of African culture as justification for sexual coercion is also obvious in professional academic and university circles. Such opinions were openly voiced and vehemently upheld by male participants from various African countries in discussions at two recent conferences and at a University of Natal seminar presentation focused on gender issues (Pan African Association of Anthropologists annual conference, Pretoria, September 1996; Workshop on Multi-partnered Sexuality and Sexual Networking in East and Southern Africa, Durban, February 1997; University Forum Seminar Series, Durban, March 1997).

has been cited as a major reason for this continued increase (Whiteside et al. 1995). In this study, questionnaire responses revealed that over one-third of female respondents felt a person could not be infected without displaying physical signs ('looking sick'). Such sentiments were reinforced by similar comments made during in-depth interviews with both male and female participants. The magnitude of such barriers is apparent in the comment of one 18-year-old female participant in describing her boy-friend's reaction to HIV-related issues:'... My boy-friend said he hates to hear about it [AIDS]. He doesn't believe it is real. When he hears about it on the radio, he just switches it off'.

Another likely factor at play in adolescents' low self-perceived risk for HIV/AIDS and unwillingness to incorporate AIDS-related issues into sexual relationships is the social disapprobation attached to the disease. All too often HIV/AIDS is linked with perceived immoral segments of society such as prostitutes and homosexuals, and with inappropriate sexual behaviour such as infidelity and promiscuity (Clatts and Mutchler 1989; Bolton 1992; De Bruyn 1992; Herdt and Lindenbaum 1992; McGrath 1992; Scheper-Hughes 1994; Varga 1996b). That HIV infection is so often associated with promiscuity may provide some clarification upon why young men in this study did not view themselves as at risk, while openly acknowledging involvement with multiple sex partners to achieve the *isoka* ideal. As noted above, in the Zulu world view being *isoka* and being promiscuous are conceptually unrelated conditions. Given this reasoning, a young man's pursuit of *isoka* status, and of social success and approval, could not possibly place him at risk for a condition associated almost exclusively with 'dirty women'(Varga 1996b). This rationale might also clarify why HIV or other STD infection would be blamed upon the female partner. From the male viewpoint, his sexual behaviour is natural and normal. Thus, of necessity, infection must come from the female partner.

Risk of HIV/AIDS has potentially dire emotional and conceptual consequences for intimate personal relationships (see works by Sobo cited here). In this context, HIV/AIDS, or hint of risk, suggests that at least one partner has violated the trust, commitment and intimacy of a sexual partnership. For the adolescents in this study, HIV/AIDS may have had added insult. In its association with infidelity, HIV/AIDS infection or its suggestion would be tantamount to a violation of love. Given such a context it is not difficult to understand why HIV/AIDS was such an uncomfortable topic or why attempts to discuss it might have elicited extreme reactions from one's partner. For these young people, silence and low self-perceived risk may have been means of insulation from potential social and emotional rejection.

As with the connotations of AIDS, the negative symbolism of condoms was almost entirely responsible for their avoidance among study participants. It is a bizarre twist of the success of social marketing strategies described by one male participant that condoms were associated with sexual diseases and eschewed for that very reason. Like HIV/AIDS, condoms pose a threat to trust and intimacy, and acknowledge infidelity (Worth 1989; Sibthorpe 1992; Pivnick 1993; Sobo 1993, 1995). All these images are in direct opposition to what these young people sought from a relationship, in the case of young women, or expected from their sex partners, in the case of young men. Thus, they were forced to undergo a cost-benefit analysis: broach taboo subjects like safe sex and risk rejection and physical abuse, or remain silent and hazard HIV/AIDS. For the young men and women in this study, the 'psycho-social benefits of unsafe sex' seemed to outweigh the risks of HIV infection (Sobo 1993).

One aim of this paper was to serve as a first step in furthering exploration of sexual decision-making and negotiation, and to stimulate thought and discussion in approaching these matters from a more gender-balanced and dyadic perspective. There is a pressing need for development of innovative and ethical theory and methodology in this regard; a challenge made greater in the second decade of AIDS. Another objective was to illustrate the importance of attention to socio-cultural factors, and to demonstrate their explanatory value,

in elucidating the determinants of reproductive behaviour. Such issues must be among the first to be examined in attempts to understand sexuality, foster sexual behaviour change, and ultimately curb the spread of HIV/AIDS.

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